STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344 Based on interview and record review, the facility failed to ensure to address, resolve and have a prompt resolution of all grievances in accordance with facility policy for 1 of 8 (Resident #1), 1 Family Member (Family Member J) and staff (CNA E). The facility failed to document, resolve, and follow up on grievances related to Resident #2's behavior on behalf of Resident #1. The facility failed to document, resolve, and follow up on grievances related to Resident #2's behavior on behalf of Family Member J. The facility failed to document, resolve, and follow up on grievances related to Resident #2's behavior on behalf of CNA E. This failure had the potential to cause residents, staff and family feelings of helplessness, diminished quality of life and at risk for grievances not being addressed or resolved promptly. Findings included: Record review of Resident #1's face sheet, dated 05/08/24, revealed a [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include Cerebral infarction (stroke), major depressive disorder, anxiety (increased feelings of fear, dread and uneasiness), cognitive communication deficit (difficulty understanding and communicating). Record review of Resident #1's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 04, which indicated the resident's cognition was severely impaired. Section B Hearing, Speech and Vision revealed that Resident #1 had slurred speech, could make himself understood and usually understood others. Record review of Resident #1's Care Plan, dated 02/29/24, revealed that he was a max assist, depends on staff for meeting his needs, requires tube feeding, has depression (impaired ability to remember), was on antianxiety medications, and that he was pulled from the bed on 04/25/24. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's progress notes revealed the following: 04/25/24 at 05:08 PM LVN A documented: Resident #1 was found on the floor was pulled out of bed by another resident (unidentified) assist Resident #1 back to bed did assessment no injures noted 03/30/24 at 12:49 AM LVN B documented: Other resident (unidentified) tried to pull Resident #1 out of his bed. other resident (unidentified) scratched Resident #1 across his chest x2, under left arm and lower abdomen, also abrasion noted to the right breast area extending to right mid back. immediately separated resident. Other resident (unidentified) was taken to his own room. Record review of Resident #2's face sheet, dated 05/08/24, revealed a [AGE] year-old-male was readmitted to the facility on [DATE] with diagnoses to include dementia (impaired ability to remember), depressive disorder (constant feelings of sadness), mood disorder (emotional deficit), and blindness to the right eye. Record review of Resident #2's Quarterly Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 05, which indicated the resident's cognition was severely impaired. Section B Hearing, Speech and Vision revealed that Resident #2 has clear speech, makes himself understood and understands others. His vision is impaired, and he does not wear corrective lenses. Section E Behavior revealed that he had not had any incidents of physical or verbal behavior. Record review of Resident #2's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 05, which indicated the resident's cognition was severely impaired. Section B Hearing, Speech and Vision revealed that Resident #2 has clear speech, makes himself understood and understands others. His vision is impaired, and he does not wear corrective lenses. Section E Behavior revealed that he has had physical behaviors such as hitting, kicking, pushing, scratching, grabbing, abusing others. Resident # 2 has exhibited verbal behaviors such as threatening others, screaming and cursing at others. The behaviors in this section were coded to have gotten worse. Record review of Resident #2 care plan, dated 04/30/24 revealed the following: Focus (Date initiated:04/26/24 Date revised:04/26/24) 4-25-24-I pulled another resident out of bed. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Goal I will have no further episodes of aggression through review date. Interventions Placed 1:1 Sent to a behavior support center. Focus (Date initiated:01/22/24 Date revised: 01/22/24) I am an elopement risk/wanderer. Wander risk Goal I will not leave facility unattended through the review date. Interventions Distract me from wandering by offering pleasant diversions. I prefer having snacks. followed by[name of psych care]. notify their MD/NP of any escalation in wandering behaviors, ineffectiveness, or side effects of psychiatric medications. Monitor my location throughout shifts. Document wandering behavior and attempted diversional interventions in behavior log. Focus (Date initiated: 01/22/24 Date revised:01/22/24) I have episodes of verbal and physical aggression r/t dementia. Goal I will not harm self or others through the review date. Interventions Give me as many choices as possible about care and activities. Monitor for physically/verbally aggressive behavior q shift. Document observed behavior and attempted interventions in behavior log. Monitor/document/report PRN any s/sx of me posing danger to self and others. When I become agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Focus (Date initiated:01/22/24 Date revised:01/22/24) (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I have impaired visual function r/t cataracts and glaucoma. I am blind in my right eye. Goal I will show no decline in visual function through the review date. Interventions Arrange consultation with eye care practitioner as required. Monitor/document/report PRN any s/sx of acute eye problems: Change in ability to perform ADLs, Decline in mobility, Sudden visual loss, Pupils dilated, gray or milky, c/o halos around lights, double vision, tunnel vision, blurred or hazy vision. Place frequently used items on my left side so I may see them Record review of Resident #2's progress notes revealed the following: 04/25/24 at 04:55 PM LVN A documented: Resident #2 was found in another residents (unidentified) bed Resident #2 pulled another resident (unidentified) out of bed and stated he (unidentified resident) was in Resident #2 room and bed removed resident (unidentified) out of bed and room Resident #2 did get agitated did get Resident #2 in to own room. 04/24/24 at 08:25 PM the DON documented: 7:37 PM received notification from charge nurse that Resident #2 had pulled another male resident (unidentified) out of his bed to the floor and layed down in his bed. Notified the FNP of incident and received orders that may repeat Lorazepam dose X 1 if ineffective. Notified the PCP of incident and received orders may consult Behavioral Health. 04/23/24 at 11:34 AM the DON documented: Spoke with the FNP about Resident #2 physical aggression last night and swinging walking stick hitting staff. New order received to increase Depakote to 500mg BID and start Xanax 0.25mg every 8 hours as needed x 14 days. 04/23/24 at 1:06 AM LVN A documented: Resident #2 became toward staff called the FNP ordered Lorazepam 2mg he was abusive towards staff did have to redirect Resident #2 04/15/24 at 4:16 AM LVN B documented: Resident #2 continues to wander into other residents' rooms, at shift change he was sitting on bed in room [ROOM NUMBER]b. redirected Resident #2 to his room. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	04/04/24 at 05:11 PM LVN B documented: Another resident (unidentified) informed this nurse that this Resident #2 was in his bed. Attempted assist Resident #2 to his room. Resident #2 refused. CNA attempted to redirect Resident #2 to his room. Resident #2 became combative with staff kicking his feet at staff and attempting to swing walking cane. Staff able to remove walking cane from rt hands and redirect to room. Admin notified. 03/30/24 at 12:26 AM LVN B documented: Resident #2 thought he was in room, and someone was in his bed. Resident #2 tried to pull other resident (unidentified) out of his bed. Resident #2 scratched other resident (unidentified) across his chest x2, under left arm and lower abdomen, also abrasion noted to the right breast area extending to right mid back. immediately separated resident. Resident #2 was taken to his own room. 03/30/24 at 05:27 PM LVN D documented: Resident #2 has slept all day and refused to get up for shower or meals. Resident #2 came to staff during the dinner pass demanding a shower. Explained to Resident #2 that we are in the middle of dinner and cannot stop and give showers at this moment. Resident #2 very aggressively started shouting I don't care what time it is I'm going to get a shower now Resident #2 is legally blind and needs assistance in shower but Resident #2 attempting to go into to back shower room. Tried to explain again to Resident #2 that he will have to wait until after dinner for his shower and resident said, I don't care and began pushing this nurse. Resident #2 began opening other residents' rooms trying to find the shower room. Made sure resident did not enter wrong room. Resident #2 eventually turned around and went back to his room. Record review of the provider investigation report, dated 05/01/24, revealed that Resident #2 had a history combativeness, wandering, verbal aggression, physical aggression and was not on any special supervision. Record review of the provider investigation report, 04/29/24, revealed that Resident #2 had a history combativeness, wandering, verbal aggression, physical aggression and was not on any special supervision but that as a result of the incident with Resident #1 was placed on 1:1. Record review of Resident #2's close monitoring log revealed that Resident #2 was monitored every 30 minutes on 05/08/24-05/10/24. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/08/24 at 1:50 PM, Family Member J stated on 04/25/24, she was notified that Resident #2 had thrown Resident #1 on the floor. Family Member J said she was notified that Resident #1 was assessed, received x-rays, and had no injuries. Family Member J said she spoke with Resident #1 and was told he was not hurting too badly. Family Member J said before the incident on 04/25/24 that she had participated in Resident #1's care plan meeting and specifically had asked what would be done about Resident #2 going into Resident #1 room. Family Member J said it had been suggested that possibly hanging something on Resident #2's door could help Resident #2 find his room. Family Member J said she did not believe that Resident #2 was intentionally targeting Resident #1 but that he was confused. Family Member J said during the care plan meeting, the MDS coordinator, the ADM, the DON, the DM, and the Activities Director were present. She said she brought up the interaction between Resident #1 and Resident #2 because she had been present when Resident #2 would wander into Resident #1 room. Family Member J said she was lucky that Resident #2 had never been violent with her. Family Member J said she had always successfully redirected him out of Resident #1's room. She said the incident on 04/25/24 was not the first time Resident #2 had entered Resident #1's room. Family Member J said the incident on 04/25/24 was the only time she had been notified. Family Member J said she had been told by the staff (LVN A and other CNAs that she could not remember) that there was an incident (did not know the date) where Resident #2 had come into Resident #1's room and tried to pull him off the bed but was unsuccessful. She said she believes the Social Worker may have mentioned to her about Resident #2 attempting to pull Resident #1 off the bed. Family Member J said that there was an instance (unsure of the date) where she had entered Resident #1's room, and Resident #2's walking cane was behind the dresser in Resident #1's room, indicating he had been there. Family Member J said it was her first time bringing it up to the ADM and DON at the care plan meeting, but she had talked to staff and the nurses' numerous times before the care plan meeting. Family Member J said staff had expressed that they were reporting issues, but nothing was being done. Family Member J said that no incidents with Resident #1 and Resident #2 would occur during the day because she or Family Member K would be there during the day. Family Member J said she was there during the day on Monday, Wednesday, Thursday, and Friday. She said Family Member K was at the facility on Wednesday. Family Member J said that before the incident on 04/25/24, nothing had been done to help Resident #2 know where his room was. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/08/24 at 2:58 PM, CNA E stated she could not remember exact dates and times. CNA E stated the first incident between Resident #1 and #2 might have occurred four months ago. CNA E stated that she and CNA F were doing rounds and heard Resident #1 scream aloud. CNA E stated Resident #2 was in Resident #1's room. CNA E stated she observed Resident #1 halfway off the bed. CNA E stated that Resident #2 had his family member in the room. CNA E stated Resident #1 was halfway off of the bed, and she observed the lower half of Resident #1's body off the bed. CNA E said Resident #1 was holding onto the bed rail with his right arm. CNA E stated the incident where Resident #1 was hanging off the bed was the first incident she had ever seen. She said she reported the incident to the charge nurse but could not remember who it was as they have many charge nurses. CNA E stated there was another incident (unsure of the date and time) where Resident #1 screamed. CNA E stated that Resident #2 scratched Resident #1 during this incident. CNA E stated it happened possibly two months ago. CNA E stated Resident #1 had scratches on his chest and right side. CNA E stated this was reported to LVN B. CNA E stated that she had to scream for assistance during this incident. She stated CNA F came to assist her. CNA E stated that this incident scared her and that things were worsening with Resident #2's behaviors. CNA E stated that Resident #2 was telling her that Resident #1's room was his room and yelling at her. CNA E said she kept telling him it was not his room. CNA E said that after they told LVN B, she (LVN B) would notify the appropriate parties. She said Resident #1 appeared scared and had water in his eyes. She said Resident #1 said it was scary. CNA E said Resident #1 used minimal words such as scary, hurt, and oh man to describe what had happened. CNA E said there was another incident where Resident #2 had become agitated and aggressive with staff; this was when she messaged the DON. CNA E said in her text message she notified the DON of her concerns of Resident #2 behavior. CNA E said she did not like what was happening, and it made her sad about what had happened to Resident #1. A record review of the text messages sent to the HHSC investigator on 05/08/24 at 3:28 PM from CNA E revealed on 04/23/24 at 3:28 PM that CNA E expressed concern about Resident #2's behavior, not being trained to take care of residents with Resident #2's behaviors, other residents being afraid and the potential for the incident to be worse. The DON responded that Resident #2's medication was adjusted. CNA E expressed concern about what to do when Resident #2 does not take his medication . CNA E expressed in the text message that Resident #2 had several incidents before the aggressive incident with staff. CNA E referenced the incident with Resident #2 protecting his feeding tube and that CNA E had reported the incident to her charge nurse . The DON responded to the concerns by stating that Resident #2's medication was adjusted and that she was unaware what had happened when Resident #2 became aggressive with staff. During an interview on 05/09/24 at 10:52 AM, the Activity Director stated that she participated in Resident #1's care plan. The Activity Director stated that Family Member J expressed that Resident #2 had wandered into Resident #1's room once or twice. The Activity Director stated they had gloves on the door so Resident #2 knew where his room was. The Activity Director said she does not know what happened to the gloves because they were no longer there. The Activity Director said she was unaware of any other interventions to prevent Resident #2 from entering Resident #1's room. The Activity Director stated she did not feel that Family Member J was upset but did express concern. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/09/24 at 11:00 AM, the DM stated that she participated in Resident #1's care plan. The DM said Family Member J expressed concern about Resident #2 entering Resident #1's room. The DM suggested placing bells or something on Resident #2's door so that he would know which room was his. The DM said Family Member J was concerned that the next time could be worse for Resident #1. The DM stated that before the incident on 04/25/24, Resident #2 had gone into Resident #1's room, but she did not know the date or time. The DM said she was unaware if Resident #2 had been physical with Resident #1. The DM said Family Member J was not upset but concerned. During an interview on 05/09/24 at 11:27 AM, Resident #1 stated that Resident #2 had been in his room [ROOM NUMBER]-5 times. Resident #1 stated no one had come to him and interviewed him about the incident outside of the HHSC investigator. Resident #1 said that he was afraid when he had to hang onto the bed. Resident #1 said he had told multiple CNAs and nurses that he did not want Resident #2 in his room. Resident #1 said he could not remember the names of the staff he told. Resident #1 said he felt like his problem was never solved. Resident #1 said that three times when Resident #2 came into his room, it got physical; he was pulled off the bed, scratched, and pulled halfway off the bed. Resident #1 said he could not remember the date and time when the incidents happened, but that staff knew about it because they had to help him. He said he was afraid when the events happened between him and Resident #2. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including a rationale for the response. Upon receipt of a grievance and/or complaint, the Grievance Officer will review and investigate the allegations and submit a written report of such findings to the Administrator within five (5) working days of receiving the grievance and/or complaint. The Grievance Officer will coordinate actions with the appropriate state and federal agencies, depending on the nature of the allegations. All alleged violations of neglect, abuse and/or misappropriation of property will be reported and investigated under guidelines for reporting abuse, neglect and misappropriation of property, as per state law. The Grievance Officer, Administrator and Staff will take immediate action to prevent further potential violations of resident rights while the alleged violation is being investigated. The Administrator will review the findings with Grievance Officer to determine what corrective actions, if any, need to be taken. The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identified problems. 1. The Administrator, or his or her designee, will make such reports orally within _____ working days of the filing of the grievance or complaint with the facility. 2. A written summary of the investigation will also be provided to the resident, and a copy will be filed in the business office. The results of all grievances files, investigated and reported will be maintained on file for a minimum of three years from the issuance of the grievance decision. Record review of the facility's policy, Resident Rights, dated December 2016 revealed the following: Policy Statement Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation I. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Ralls Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 Avenue P Ralls, TX 79357	

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. be treated with respect, kindness, and dignity; c. be free from abuse, neglect, misappropriation of property, and exploitation; u. voice grievances to the facility, or other agency that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal; v. have the facility respond to his or her grievances;

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344 Based on, interview and record review, the facility failed to implement their written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 1 of 8 residents (Residents #1) reviewed for abuse and neglect. The facility Staff (Administrator) failed to report the incident that occurred on 03/30/2024 and 04/04/2024 between Resident #1 and Resident #2 to the governing state agency. CNA H &I failed to report allegations of abuse to the abuse coordinator within 2 hours of incident. These failures could place the residents in the facility at risk of lacking timely reporting of incidents, risk of abuse, neglect, exploitation, or misappropriation of their property by staff members and contribute to further resident abuse. Findings included: Record review of Resident #1's face sheet, dated 05/08/24, revealed a [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include Cerebral infarction (stroke), major depressive disorder, anxiety (increased feelings of fear, dread, and uneasiness), cognitive communication deficit (difficulty understanding and communicating). Record review of Resident #1's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 04, which indicated the resident's cognition was severely impaired. Section B Hearing, Speech and Vision revealed that Resident #1 had slurred speech, could make himself understood and usually understood others. Record review of Resident #1 Care Plan, dated 02/29/24, revealed that he is a max assist, depends on staff for meeting his needs, requires tube feeding, has depression (impaired ability to remember), is on antianxiety medications, and that he was pulled from the bed on 04/25/24. Record review of Resident #1's progress notes revealed the following: 04/25/24 at 05:08 PM LVN A documented: Resident #1 was found on the floor was pulled out of bed by another resident (unidentified) assist Resident #1 back to bed did assessment no injures noted 03/30/24 at 12:49 AM LVN B documented: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Other resident (unidentified) tried to pull Resident #1 out of his bed. other resident (unidentified) scratched Resident #1 across his chest x2, under left arm and lower abdomen, also abrasion noted to the right breast area extending to right mid back. immediately separated resident. Other resident (unidentified) was taken to his own room. Record review of Resident #2's face sheet, dated 05/08/24, revealed a [AGE] year-old-male was readmitted to the facility on [DATE] with diagnosis to include dementia (impaired ability to remember), depressive disorder (constant feelings of sadness), mood disorder (emotional deficit), and blindness to the right eye. Record review of Resident #2's Quarterly Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 05, which indicated the resident's cognition was severely impaired. Section B Hearing, Speech and Vision revealed that Resident #2 has clear speech, makes himself understood and understands others. His vision is impaired, and he does not wear corrective lenses. Section E Behavior revealed that he had not had any incidents of physical or verbal behavior. Record review of Resident #2's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 05, which indicated the resident's cognition was severely impaired. Section B Hearing, Speech and Vision revealed that Resident #2 has clear speech, makes himself understood and understands others. His vision is impaired, and he does not wear corrective lenses. Section E Behavior revealed that he has had physical behaviors such as hitting, kicking, pushing, scratching, grabbing, abusing others. Resident # 2 has exhibited verbal behaviors such as threatening others, screaming and cursing at others. The behaviors in this section were coded to have gotten worse. Record review of Resident #2 care plan, dated 04/30/24 revealed the following: Focus (Date initiated:04/26/24 Date revised:04/26/24) 4-25-24-I pulled another resident out of bed. Goal I will have no further episodes of aggression through review date. Interventions Placed 1:1 Sent to a behavior support center. Focus (Date initiated:01/22/24 Date revised: 01/22/24) (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I am an elopement risk/wanderer. Wander risk Goal I will not leave facility unattended through the review date. Interventions Distract me from wandering by offering pleasant diversions. I prefer having snacks. followed by psychiatric services. notify their MD/NP of any escalation in wandering behaviors, ineffectiveness, or side effects of psychiatric medications. Monitor my location throughout shifts. Document wandering behavior and attempted diversional interventions in behavior log. Focus (Date initiated: 01/22/24 Date revised:01/22/24) I have episodes of verbal and physical aggression r/t dementia. Goal I will not harm self or others through the review date. Interventions Give me as many choices as possible about care and activities. Monitor for physically/verbally aggressive behavior q shift. Document observed behavior and attempted interventions in behavior log. Monitor/document/report PRN any s/sx of me posing danger to self and others. When I become agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Focus (Date initiated:01/22/24 Date revised:01/22/24) I have impaired visual function r/t cataracts and glaucoma. I am blind in my right eye. Goal I will show no decline in visual function through the review date. Interventions Arrange consultation with eye care practitioner as required. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Monitor/document/report PRN any s/sx of acute eye problems: Change in ability to perform ADLs, Decline in mobility, Sudden visual loss, Pupils dilated, gray or milky, c/o halos around lights, double vision, tunnel vision, blurred or hazy vision. Place frequently used items on my left side so I may see them Record review of Resident #2's progress notes revealed the following: 04/25/24 at 04:55 PM LVN A documented: Resident #2 was found in another residents (unidentified) bed Resident #2 pulled another resident (unidentified) out of bed and stated he (unidentified resident) was in Resident #2 room and bed removed resident (unidentified) out of bed and room Resident #2 did get agitated did get Resident #2 in to own room. 04/24/24 at 08:25 PM the DON documented: 7:37 PM received notification from charge nurse that Resident #2 had pulled another male resident (unidentified) out of his bed to the floor and laid down in his bed. Notified the FNP of incident and received orders that may repeat Lorazepam dose X 1 if ineffective. Notified the PCP of incident and received orders may consult Behavioral Health. 04/23/24 at 11:34 AM the DON documented: Spoke with the FNP about Resident #2 physical aggression last night and swinging walking stick hitting staff. New order received to increase Depakote to 500mg BID and start Xanax 0.25mg every 8 hours as needed x 14 days. 04/23/24 at 1:06 AM LVN A documented: Resident #2 became toward staff called the FNP ordered Lorazepam 2mg he was abusive towards staff did have to redirect Resident #2 04/15/24 at 4:16 AM LVN B documented: Resident #2 continues to wander into other residents' rooms, at shift change he was sitting on bed in room [ROOM NUMBER]b. redirected Resident #2 to his room. 04/04/24 at 05:11 PM LVN B documented: Another resident (unidentified) informed this nurse that this Resident #2 was in his bed. Attempted assist Resident #2 to his room. Resident #2 refused. CNA attempted to redirect Resident #2 to his room. Resident #2 became combative with staff kicking his feet at staff and attempting to swing walking cane. Staff able to remove walking cane from rt hands and redirect to room. Admin notified. 03/30/24 at 12:26 AM LVN B documented: (continued on next page)

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F 0607

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Resident #2 thought he was in room, and someone was in his bed. Resident #2 tried to pull other resident (unidentified) out of his bed. Resident #2 scratched other resident (unidentified) across his chest x2, under left arm and lower abdomen, also abrasion noted to the right breast area extending to right mid back. immediately separated resident. Resident #2 was taken to his own room.

03/30/24 at 05:27 PM LVN D documented:

Resident #2 has slept all day and refused to get up for shower or meals. Resident #2 came to staff during the dinner pass demanding a shower. Explained to Resident #2 that we are in the middle of dinner and cannot stop and give showers at this moment. Resident #2 very aggressively started shouting I don't care what time it is I'm going to get a shower now Resident #2 is legally blind and needs assistance in shower but Resident #2 attempting to go

into to back shower room. Tried to explain again to Resident #2 that he will have to wait until after dinner for his shower and resident said, I don't care and began pushing this nurse. Resident #2 began opening other residents' rooms trying to find the shower room. Made sure resident did not enter wrong room. Resident #2 eventually turned around and went back to his room.

Record review of the provider investigation report, dated 05/01/24, revealed that Resident #2 had a history combativeness, wandering, verbal aggression, physical aggression and was not on any special supervision.

Record review of the provider investigation report, 04/29/24, revealed that Resident #2 had a history combativeness, wandering, verbal aggression, physical aggression and was not on any special supervision but that as a result of the incident with Resident #1 was placed on 1:1.

Record review of Resident #2's close monitoring log revealed that Resident #2 was monitored every 30 minutes on 05/08/24-05/10/24.

During an interview on 05/08/24 at 11:42 AM, the DON stated Resident #2 had advanced dementia. The DON said she, as the DON, had been trained on what to do regarding reporting ANE. She said their system for monitoring ANE was to educate staff through in-services. The DON said all staff had been trained on reporting ANE. The DON said staff were trained upon hire, annually, and when an incident arose. The DON said staff had been trained to report abuse immediately to the abuse coordinator, and she expected her staff to do so. The DON said she was unaware why CNA H and I did not report the allegations of verbal abuse immediately. She said all staff were responsible for reporting ANE immediately to the abuse coordinator. The DON said the ADM was the abuse coordinator.

During an interview on 05/08/24 at 11:42 AM, the ADM stated she was unsure of the date and exact time, but CNA G came to her and told her that he needed to tell her something. The ADM said CNA G told her that he was told by CNA H & I that LVN A was ugly to Resident #2. The ADM said that she immediately suspended LVN A upon being notified of the situation. She stated she immediately suspended CNA H & I. The ADM stated she reported the incident to the state. She said they conducted safe surveys. She said Resident #2 could not recall the incident. The ADM stated they reported the incident to the sheriff's department.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During her investigation, the ADM said CNA H admitted that she witnessed LVN A yelling at Resident #2. CNA I also admitted that LVN A yelled at Resident #2. The ADM stated she immediately educated CNA H & I that she was supposed to report it immediately. The ADM said she was unaware why the staff did not report the incident because she was physically in the facility the night of the incident (04/25/24). She said The CNAs did not give her a reason why they did not report it immediately. She said she was never notified until the next morning. The ADM stated that CNA H was an agency staff member but that they had an understanding that all ANEs should be reported immediately. The ADM stated when she spoke with LVN A that LVN A denied the allegations of verbal abuse but that LVN A did tell Resident #2 to get out of bed, which was not his. She said LVN A did admit that she was loud. After consulting with her corporate office, the ADM decided to terminate LVN A based on interviews and her past involvement in other incidents. The ADM stated that she did not terminate the CNAs because they had never had issues with their performance and had reeducated them on ANE. The ADM stated they also considered that CNA H & I did report the incident to another coworker even though they should have reported it to the abuse coordinator as trained. She said the potential negative outcome of not reporting allegations of abuse immediately to the abuse coordinator could place residents and staff in harm's way. The ADM stated they were at the facility to protect the residents. The ADM stated her system to monitor that the abuse policy was being followed implemented, and staff was reporting allegations of abuse was that they trained staff through inservices. The ADM stated policies and signs were posted with the ADM's name and number on the wall. She said she had been trained on the abuse policy, and all staff had been trained. She said she expected to be notified of ANE immediately when and if it happened. She said all staff were responsible for reporting and following the abuse policy. She said she did not know why CNA H and I did not report the allegations immediately. The ADM stated it was reported to her that on 04/25/24, around 7:30 PM. The ADM said that Resident #2 went into Resident #1's room. The ADM stated Resident #1 and Resident #2's rooms are next to each other. She stated staff heard yelling but was unsure where the yelling was coming from. She stated when staff entered the room, they observed Resident #1 on the floor, and Resident #2 was in Resident #1's bed. The ADM stated staff redirected Resident #2 to his room, assessed Resident #1 and did not identify any injuries on either resident. The ADM stated she was notified and physically came to the facility to attempt to get additional support from a local behavior support center for Resident #2's behavior. She said Resident #2 was transported to a behavior support center the same night. The ADM stated that Resident #2 had never done this to Resident #1 before. She stated Resident #1 had a history of aggressive behavior with staff. The ADM said as a result of this incident, on 04/25/24, they conducted training with staff over resident rights, ANE, and that they had consulted with the local behavior support center to conduct training on dealing with aggressive behaviors, but no official date had been set. During an interview on 05/08/24 at 12:37 PM, CNA G stated he did not remember the exact date but he had come in at the beginning of his shift. CNA G stated he was getting a report from the night-time CNAs, and it was passed on that Resident #2 had pulled Resident #1 out of bed. CNA G said he was told by CNA H &I that when Resident #2 refused to leave Resident #1's bed, LVN A yelled loudly for Resident #2 to get the fuck out of the bed. CNA G said he was told it was so loud that everyone in the facility could hear it. CNA G said that CNA H & I appeared concerned with how LVN A approached the situation. CNA G stated he immediately reported it to LVN D, and the ADM. CNA G stated as a result of his report of LVN A's verbal abuse immediately that the ADM started getting witness statements but was unaware of what was done with LVN A. CNA G stated he had not seen LVN A back at the facility since the incident. He stated he reported the incident immediately because he had been trained to report all allegations of ANE immediately to the abuse coordinator. (continued on next page)

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Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/08/24 at 01:34 PM, Resident #2 said he did not recall staff yelling at him, felt safe, had difficulty seeing things, and had no physical incidents with staff or other residents. Resident #2 said he knew where his room was but could not recall a specific room number. He said he did not have any additional concerns. During an interview on 05/08/24 at 1:50 PM, Family Member J stated on 04/25/24, she was notified that Resident #2 had thrown Resident #1 on the floor. Family Member J said she was notified that Resident #1 was assessed, received x-rays, and had no injuries. Family Member J said she spoke with Resident #1 and was told he was not hurting too badly. During an interview on 05/08/24 at 2:02 PM, Resident #1 stated via telephone that Resident #2 had pulled him off the bed, and he did not want it to happen again. During an interview on 05/08/24 at 2:03 PM, Family Member K stated via telephone that she was physically with Resident #1 but that he had a hard time talking because of his stroke. Family Member K said there was an incident where LVN A walked into the room (unsure of the date), and Resident #1 was sideways, hanging onto the bed with one arm. She said she believed there was another incident where Resident #1 tried to protect his feeding tube site. She said she was concerned that this was happening when Resident #1 was sleeping, and that Resident #1 could not defend himself. Family Member K said the staff knew about the incidents and needed to do something. Family Member K said that she had not physically told anyone but was told by Family Member J that she had. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/08/24 at 2:18 PM, CNA F stated she was unsure of the exact dates, but about a month before the interview, She and CNA E had caught Resident #2 in Resident #1 room. CNA F said Resident #2 was confused and had difficulty seeing. CNA F said she did not believe Resident #2 was being mean or awful to Resident #1, but he thought he was in his (Resident #2) room. CNA F stated Resident #1 was yelling. CNA F said when they got to Resident #1's room (she and CNA E), they observed the door closed and the lights off. CNA F said when they turned on the lights, they observed Resident #2 trying to pull Resident #1 off the bed. CNA F stated water was on the floor, and Resident #1 Head was on the bed rail. She observed the side table turned over, and Resident #1 was protecting his feeding tube site and crying. CNA F attempted to redirect Resident #2, but he refused to leave. CNA F stated this incident was reported to LVN B. CNA F stated LVN B said she reported the incident to the appropriate parties. CNA F stated a week after that incident (unsure of the exact date), Resident #2 was back in Resident #1's room. CNA F stated that Resident #1 had pushed his call light, and Resident #2 was standing in Resident #1's room when they got to him. CNA F stated that when they attempted to redirect him out of Resident #1's room, Resident #2 stated he wanted his jacket, and they grabbed his hand. Finally, Resident #2 went with them. CNA F stated that there had been a lot of changes in the facility as far as room changes and believed that the separation by gender may have contributed to Resident #2 being confused about where he was going and, in addition, his difficulty being blind. CNA F stated Resident #2 had been moved three or four times. CNA F stated the difficulty they had been having with Resident #2 had been reported to LVN A and LVN B (unsure of the exact time and date). She stated she was under the impression that, as the CNA, she was to report to her charge nurse and that they would proceed further if needed. She said her charge nurses had told her that the incidents with Resident #2 had been reported to higher people. CNA F stated they had wondered when something would be done. CNA F stated she was frustrated with all the incidents that had occurred with Resident #2. She stated that although Resident #2 was not evil and was sweet, his behaviors had worsened, and he had become more confused. CNA F stated that outside of the incidents with Resident #1, Resident #2 had become aggressive with her, and CNA G. CNA F stated that if something had been done, some of the incidents with Resident #2 could have been prevented. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/08/24 at 2:58 PM, CNA E stated she could not remember exact dates and times. CNA E stated the first incident between Resident #1 and #2 might have occurred four months ago. CNA E stated that she and CNA F were doing rounds and heard Resident #1 scream aloud. CNA E stated Resident #2 was in Resident #1 room. CNA E stated she observed Resident #1 halfway off the bed. CNA E stated that Resident #1 had his family member in the room. CNA E stated Resident #1 was halfway off of the bed, and she observed the lower half of Resident #1's body off the bed. CNA E said Resident #1 was holding onto the bed rail with his right arm. CNA E stated the incident where Resident #1 was hanging off the bed was the first incident she had ever seen. She said she reported the incident to the charge nurse but could not remember who it was as they have many charge nurses. CNA E stated there was another incident (unsure of the date and time) where Resident #1 screamed. CNA E stated that Resident #2 scratched Resident #1 during this incident. CNA E stated it happened possibly two months ago. CNA E stated Resident #2 had scratches on his chest and right side. CNA E stated this was reported to LVN B. CNA E stated that she had to scream for assistance during this incident. She stated CNA F came to assist her. CNA E stated that this incident scared her and that things were worsening with Resident #2's behaviors. CNA E stated that Resident #2 was telling her that Resident #1's room was his room and yelling at her. CNA E said she kept telling him it was not his room. CNA E said that after they told LVN B, she (LVN B) would notify the appropriate parties. She said Resident #1 appeared scared and had water in his eyes. She said Resident #1 said it was scary. CNA E said Resident #1 used minimal words such as scary, hurt, and oh man to describe what had happened. CNA E said there was another incident where Resident #2 had become agitated and aggressive with staff; this was when she messaged the DON. CNA E said she did not like what was happening, and it made her sad about what had happened to Resident #1. During an interview on 05/08/24 at 3:29 PM, LVN A stated that she no longer worked at the facility. LVN A stated on 04/25/24 that she did not witness Resident #2 pulling Resident #1 out of the bed. LVN A stated that she had heard Resident #1 scream and thought it was another resident. LVN A said that when she walked down the hallway, one of the CNAs came running towards her. LVN A stated she could not remember the CNAs name. LVN A when she went into Resident #1's room and observed Resident #2 in Resident #1's bed and Resident #1 was on the floor. LVN A said this was not the first interaction between Resident #1 and Resident #2. LVN A stated this was the second time this had happened. LVN A said that during the incident on 04/25/24, Resident #2 yelled at the staff. LVN A stated she raised her voice for Resident #2 to get out of Resident #1's bed. LVN A said that they were finally able to get Resident #2 out of Resident #1 room. LVN A said she notified the DON of the incident. LVN A stated the DON said that she told the ADM and that the ADM was on the way to the facility to send Resident #2 out for behavior support. LVN A said she had experienced Resident #2 becoming agitated with staff on 04/18/24. She stated that the FNP, PCP, DON, and ADM knew about the incident. She said she had been told by other staff that Resident #2 had attempted to pull Resident #1 out of bed before. She said she was unaware of any interventions that had been put in place. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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F 0607

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During an interview on 05/08/24 at 10:25 PM, CNA I stated on 04/25/24, it was around 7 PM or 9 PM when the residents that smoke go out. CNA I said she observed Resident #1 on the floor. CNA I said she went to get LVN A, and that was when she (LVN A) told Resident #2 to get the fuck out. CNA I said she redirected Resident #2 to his room. CNA I stated she and CNA H placed Resident #1 back in bed. CNA I said their shift was over at 6:00 AM the next morning, and LVN A worked the remainder of her shift. CNA I stated that she did not report the verbal incident because the LVN A knew about it as she was there and had said the words to Resident #2. CNA I stated she reported the incident to the oncoming shift the next morning. CNA I said the ADM and DON reeducated her. CNA I said that she had never heard LVN A curse at the residents but had observed her be loud. CNA I said she and her coworker (CNA H) did discuss that the interaction between Resident #2 and LVN A was aggressive and abrasive. CNA I said she was more focused and glad that Resident #1 was not hurt. CNA I said after that incident and Resident #2 received a shot of Ativan he came back out and was trying to throw a shoe at Resident #1. CNA I said that most of the time when she worked with Resident #2, he would always try to go into Resident #1's room. CNA I said this occurred at least three times a week. Before the incident on 04/25/24, CNA I said that Resident #2 never made physical contact with Resident #1 on her shift. CNA I said there was nothing ever done that she could recall to alleviate the situation, but the staff had placed gloves on the outer door at one point. She stated she could not provide a picture of the gloves on the door to the HHSC worker. CNA I said that she had been trained to report allegations of ANE immediately.

During an interview on 05/08/24 at 10:51 PM, LVN D stated that the incident on 04/25/24 was the second time that Resident #2 had attempted to pull Resident #1 out of bed. She stated she was not present but had received the information in the report as she typically worked the day shift. LVN D said that they had to redirect Resident #2 consistently. LVN D stated that she did not feel that Resident #2 was explicitly targeting Resident #1 but that he was confused as to where his room was.

An attempt to contact LVN B was made on 05/08/24 at 10:57 PM. LVN B said she would contact her DON and ADM and return the call. Additional attempts to speak with LVN B were made on 05/09/24 at 10:29 AM. LVN B did not answer.

During an interview on 05/09/24 at 10:52 AM, the Activity Director stated that she participated in Resident #1's care plan. The Activity Director stated that Family Member J expressed that Resident #2 had wandered into Resident #1's room once or twice.

During an interview on 05/09/24 at 11:27 AM, Resident #1 stated that Resident #1 had been in his room [ROOM NUMBER]-5 times. Resident #1 said out of those 4-5 times, Resident #2 had become physical with him. Resident #1 stated no one had come to him and interviewed him about the incident outside of the HHSC investigator. Resident #2 said that he was afraid when he had to hang onto the bed. Resident #1 said he had told multiple CNAs and nurses that he did not want Resident #2 in his room. Resident #2 said he could not remember the names of the staff he told. Resident #2 said he felt like his problem was never solved. Resident #1 said that three times when Resident #2 came into his room, it got physical; he was pulled off the bed, scratched, and pulled halfway off the bed. Resident #1 said he could not remember the date and time when the incidents happened but that staff knew about it because they had to help him.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/09/24 at 1:07 PM, the ADM clarified that during the initial interview, she stated the incident between Resident #2 and Resident #1 had never happened was because three weeks prior, staff had reported that Resident #2 had gone into the room and scratched Resident #1 and LVN B had redirected Resident #2 out. The ADM stated she was unsure where the scratch was. The ADM stated this type of information was typically reported to the DON. The ADM stated she did not report the incident to the state agency because the nurse had intervened and redirected Resident #2 out of the room. The ADM said she was unaware that Resident #2 had encountered Resident #1 multiple times. The ADM said she was unaware that Resident #2 had attempted to pull Resident #1 out of the bed before the incident on 04/25/24. The ADM said they were monitoring Resident #2's behavior through psychiatric services and medication adjustments. The ADM stated that the staff had expressed concerns about them getting hurt, but she was unaware of the ongoing issues with Resident #1. She said she was only aware of one incident where Resident #2 had become aggressive with staff. She said she was unaware of any other incidents. The ADM said she knew that most of Resident #2's incidents or behaviors occurred at night. The ADM said she did not implement any other interventions outside of the medication adjustments and monitoring from psychiatric services and notifying the family, PCP, and FNP. The ADM said she had never interviewed Resident #1 to see if this had happened. The ADM had never delegated to interview Resident #1. The ADM said the night of the incident (04/25/24), she was more concerned with his well-being and what happened. The ADM said part of the investigation process was interviewing key witnesses and residents and finding out what happened. The ADM said the potential negative outcome of not reporting allegations of abuse to the state governing agency was that resident harm or the resident's safety could be compromised. The ADM said she was unaware of the additional incidents outside of the incident on 04/25/24 between Resident #1 and Resident #2. The ADM said her system for monitoring ANE was that signs were posted that instructed staff to contact her regarding ANE concerns. The ADM said they educate staff to report allegations of abuse immediately, and the ANE policy was attached to those inservices. The ADM said she expected the staff to report immediately if they witnessed or suspected abuse. The ADM said she and the staff had also been trained to report allegations of ANE immediately. The ADM said everyone was responsible for following the abuse policy and reporting ANE immediately. During an interview on 05/09/24 at 2:17 PM, the DON stated that the only other incident she knew of between Resident #1 and Resident #2 was where Resident #2 scratched Resident #1. The DON said she was unsure of the date and time when this incident occurred. The DON said that Resident #2 was redirected out of the room. The DON said she was unaware of any other incidents. The DON said that she could not think of any other interventions put in place outside of psychiatric medication adjustments and close monitoring. The DON stated she never interviewed Resident #1. The DON said once an incident was reported to the ADM, she would relinquish the investigation process to the ADM because she had so much on her plate. The DON said the potential negative outcome of not reporting allegations of abuse was that abuse could continue to happen. The DON said she was aware of two incidents between Resident #1 and Resident #2 and was unaware that this was an ongoing situation. The DON said their system for monitoring ANE reporting and following the ANE policy was to educate staff through inservices. The DON said she had never observed Resident #2 enter Resident #1's room. The DON said she expected staff to report all incidents of abuse to the abuse coordinator. Record review of salesforce (tulip) revealed from January 2024 until May 2024 date no other reports have been made to state in regard to Resident #1 and Resident #2 other then the incident that has us in the facility. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy, Abuse, Neglect, Exploitation General Policy, Filing, undated revealed the following: PROCEDURE : Investigation All facility employees, family members and volunteers and educated that alleged or suspected violations involving mistreatment, neglect or abuse including injuries of unknown origin and involuntary seclusion and misappropriation of elder property are reported IMMEDIATELY to the Administrator.<b [TRUNCATED]

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344 Based on interview and record review the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 1 of 8 residents (Resident #2) reviewed for care plan revisions. The facility failed to ensure Resident #2's care plan (focus, goals and interventions) was updated to reflect his increasingly ongoing incident of physical and verbal aggressive behaviors. This failure could place residents at risk of not receiving appropriate interventions to meet their current needs. The findings included: Record review of Resident #2's face sheet, dated 05/08/24, revealed an [AGE] year-old-male was readmitted to the facility on [DATE] with diagnosis to include dementia (impaired ability to remember), depressive disorder (constant feelings of sadness), mood disorder (emotional deficit), and blindness to the right eye. Record review of Resident #2's Quarterly Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 05, which indicated the resident's cognition was severely impaired. Section B Hearing, Speech and Vision revealed that Resident #2 has clear speech, makes himself understood and understands others. His vision is impaired, and he does not wear corrective lenses. Section E Behavior revealed that he had not had any incidents of physical or verbal behavior. Record review of Resident #2's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 05, which indicated the resident's cognition was severely impaired. Section B Hearing, Speech and Vision revealed that Resident #2 has clear speech, makes himself understood and understands others. His vision is impaired, and he does not wear corrective lenses. Section E Behavior revealed that he has had physical behaviors such as hitting, kicking, pushing, scratching, grabbing, abusing others. Resident # 2 has exhibited verbal behaviors such as threatening others, screaming and cursing at others. The behaviors in this section were coded to have gotten worse. Record review of Resident #2 care plan, dated 04/30/24 revealed the following: Focus (Date initiated:04/26/24 Date revised:04/26/24) (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4-25-24-I pulled another resident out of bed. Goal I will have no further episodes of aggression through review date. Interventions Placed 1:1 Sent to a behavior support center. Focus (Date initiated:01/22/24 Date revised: 01/22/24) I am an elopement risk/wanderer. Wander risk Goal I will not leave facility unattended through the review date. Interventions Distract me from wandering by offering pleasant diversions. I prefer having snacks. followed by psychiatric services. notify their MD/NP of any escalation in wandering behaviors, ineffectiveness, or side effects of psychiatric medications. Monitor my location throughout shifts. Document wandering behavior and attempted diversional interventions in behavior log. Focus (Date initiated: 01/22/24 Date revised:01/22/24) I have episodes of verbal and physical aggression r/t dementia. Goal I will not harm self or others through the review date. Interventions Give me as many choices as possible about care and activities. Monitor for physically/verbally aggressive behavior q shift. Document observed behavior and attempted interventions in behavior log. Monitor/document/report PRN any s/sx of me posing danger to self and others. When I become agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focus (Date initiated:01/22/24 Date revised:01/22/24) I have impaired visual function r/t cataracts and glaucoma. I am blind in my right eye. Goal I will show no decline in visual function through the review date. Interventions Arrange consultation with eye care practitioner as required. Monitor/document/report PRN any s/sx of acute eye problems: Change in ability to perform ADLs, Decline in mobility, Sudden visual loss, Pupils dilated, gray or milky, c/o halos around lights, double vision, tunnel vision, blurred or hazy vision. Place frequently used items on my left side so I may see them Record review of Resident #2's progress notes revealed the following: 04/25/24 at 04:55 PM LVN A documented: Resident #2 was found in another residents (unidentified) bed Resident #2 pulled another resident (unidentified) out of bed and stated he (unidentified resident) was in Resident #2 room and bed removed resident (unidentified) out of bed and room Resident #2 did get agitated did get Resident #2 in to own room. 04/24/24 at 08:25 PM the DON documented: 7:37 PM received notification from charge nurse that Resident #2 had pulled another male resident (unidentified) out of his bed to the floor and layed down in his bed. Notified the FNP of incident and received orders that may repeat Lorazepam dose X 1 if ineffective. Notified the PCP of incident and received orders may consult Behavioral Health. 04/23/24 at 11:34 AM the DON documented: Spoke with the FNP about Resident #2 physical aggression last night and swinging walking stick hitting staff. New order received to increase Depakote to 500mg BID and start Xanax 0.25mg every 8 hours as needed x 14 days. 04/23/24 at 1:06 AM LVN A documented: Resident #2 became toward staff called the FNP ordered Lorazepam 2mg he was abusive towards staff did have to redirect Resident #2 04/15/24 at 4:16 AM LVN B documented: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 continues to wander into other residents' rooms, at shift change he was sitting on bed in room [ROOM NUMBER]b. redirected Resident #2 to his room. 04/04/24 at 05:11 PM LVN B documented: Another resident (unidentified) informed this nurse that this Resident #2 was in his bed. Attempted assist Resident #2 to his room. Resident #2 refused. CNA attempted to redirect Resident #2 to his room. Resident #2 became combative with staff kicking his feet at staff and attempting to swing walking cane. Staff able to remove walking cane from rt hands and redirect to room. Admin notified. 03/30/24 at 12:26 AM LVN B documented: Resident #2 thought he was in room, and someone was in his bed. Resident #2 tried to pull other resident (unidentified) out of his bed. Resident #2 scratched other resident (unidentified) across his chest x2, under left arm and lower abdomen, also abrasion noted to the right breast area extending to right mid back. immediately separated resident. Resident #2 was taken to his own room. 03/30/24 at 05:27 PM LVN D documented: Resident #2 has slept all day and refused to get up for shower or meals. Resident #2 came to staff during the dinner pass demanding a shower. Explained to Resident #2 that we are in the middle of dinner and cannot stop and give showers at this moment. Resident #2 very aggressively started shouting I don't care what time it is I'm going to get a shower now Resident #2 is legally blind and needs assistance in shower but Resident #2 attempting to go into to back shower room. Tried to explain again to Resident #2 that he will have to wait until after dinner for his shower and resident said, I don't care and began pushing this nurse. Resident #2 began opening other residents' rooms trying to find the shower room. Made sure resident did not enter wrong room. Resident #2 eventually turned around and went back to his room. Record review of the provider investigation report, dated 05/01/24, revealed that Resident #2 had a history combativeness, wandering, verbal aggression, physical aggression and was not on any special supervision. Record review of the provider investigation report, 04/29/24, revealed that Resident #2 had a history combativeness, wandering, verbal aggression, physical aggression and was not on any special supervision but that as a result of the incident with Resident #1 was placed on 1:1. Record review of Resident #2's close monitoring log revealed that Resident #2 was monitored every30 minutes on 05/08/24-05/10/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/09/24 at 11:10 AM, the MDS Coordinator stated that she was aware that Resident #2 had pulled Resident #1 out of the bed only once. The MDS Coordinator said that she was unaware that Resident #2 had increased physical or verbal aggression behaviors. The MDS Coordinator said revising the care plan if the behaviors differ was customary. The MDS Coordinator said that Resident #2 did not understand well and that all staff could do was redirect him with a snack or an activity. The MDS Coordinator stated that she revises the care plan each time there was an MDS update. The MDS Coordinator said the MDS was updated annually, quarterly, and sometimes on an off cycle. The MDS Coordinator said she would also update if there was a significant change. The MDS Coordinator said she looked over the care plans each time there was a care plan meeting. The MDS Coordinator said she would have revised the care plan if it had been reported to her each time Resident #2 pulled any resident out of bed. The MDS Coordinator said the interventions were what the staff do to care for the resident, and staff should be watching him closely. During an interview on 05/09/24 at 1:07 PM, the ADM said the potential negative outcome of not revising the care plan with the resident's current behavior was harm could come to the resident. The ADM said she believed that the care plan should continually be revised depending on the situation. The ADM said she was unaware that no revisions had been made to Resident #2's verbal and physical care plan since January 2024. The ADM said that Resident #2 has had an incident of verbal and physical aggression since January 2024. The ADM said the MDS coordinator had a checklist that she followed and would ask specific questions so that she was able to update the care plan accordingly. The ADM said she had a general understanding of care plans and revision but had not been trained to complete care plans. The ADM said she expected care plans to be revised if something happened or the resident changed. The ADM said ultimately, she, the DON, and the MDS coordinator were responsible for care plans. The ADM said if the care plan was not revised, staff used old information to care for residents. The ADM said all the staff use the care plans. During an interview on 05/09/24 at 2:17 PM, the DON stated the potential negative outcome of not revising care plans was that the care plan may not be appropriate for the resident. The DON said she was unaware that Resident #2's care plan had not been updated regarding Resident #2 physical and verbal aggression. The DON said their system to monitor care plans was if she knew that an update was needed, she would communicate with the MDS Coordinator via telephone or email. The DON said if the MDS coordinator does not know the information, she would be unable to revise. The DON said she had been trained regarding care plan revisions. The DON said she expected residents' care plans to be revised if they knew the specific needs. The DON said Resident #2 has had incidents of physical and verbal aggression since January 2024. The DON said the MDS Coordinator was responsible. The DON said she sometimes looks at the care plans if she was looking for things but does not necessarily monitor them. Record review of the facility's policy, Care Plans, Comprehensive Person-Centered, dated December 2016 revealed the following: Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Each resident's comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: 3. Request revisions to the plan of care; The comprehensive, person-centered care plan will: 1. Include measurable objectives and timeframes; 2. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; 3. Incorporate identified problem areas; 4. Incorporate risk factors associated with identified problems; 5. Reflect treatment goals, timetables and objectives in measurable outcomes; 6. Identify the professional services that are responsible for each element of care; 7. Reflect currently recognized standards of practice for problem areas and conditions. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 8. When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers. 9. Care planning individual symptoms in isolation may have little, if any, benefit for the resident. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. The Interdisciplinary Team must review and update the care plan: 10. When there has been a significant change in the resident's condition; b. When the desired outcome is not met; c. When the resident has been readmitted to the facility from a hospital stay; and

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344 Based on interviews, and record reviews the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and that each resident received adequate supervision and assistance devices to prevent accidents for 1 of 8 (Residents #1) residents reviewed for adequate supervision and prevention of accidents. The facility staff (Administrator and DON) failed to adequately address Resident #2's ongoing behavior of entering Resident #1's room. The facility (Administrator and DON) failed to address resident #2's ongoing physical and verbal behavior with appropriate interventions. These failures to put supervision measures in place could result in harm to Resident #2 and the remaining residents in the facility. The findings included: Record review of Resident #1's face sheet, dated 05/08/24, revealed a [AGE] year-old-male was admitted to the facility on [DATE] with diagnosis to include Cerebral infarction (stroke), major depressive disorder, anxiety (increased feelings of fear, dread and uneasiness), cognitive communication deficit (difficulty understanding and communicating). Record review of Resident #1's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 04, which indicated the resident's cognition was severely impaired. Section B Hearing, Speech and Vision revealed that Resident #1 had slurred speech, could make himself understood and usually understood others. Record review of Resident #1 Care Plan, dated 02/29/24, revealed that he is a max assist, depends on staff for meeting his needs, requires tube feeding, has depression (impaired ability to remember), is on antianxiety medications, and that he was pulled from the bed on 04/25/24. Record review of Resident #1's progress notes revealed the following: 04/25/24 at 05:08 PM LVN A documented: Resident #1 was found on the floor was pulled out of bed by another resident (unidentified) assist Resident #1 back to bed did assessment no injures noted 03/30/24 at 12:49 AM LVN B documented: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Ralls Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 1111 Avenue P, Ralls, TX 79357	

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Other resident (unidentified) tried to pull Resident #1 out of his bed. other resident (unidentified) scratched Resident #1 across his chest x2, under left arm and lower abdomen, also abrasion noted to the right breast area extending to right mid back. immediately separated resident. Other resident (unidentified) was taken to his own room. Record review of Resident #2's face sheet, dated 05/08/24, revealed a [AGE] year-old-male was readmitted to the facility on [DATE] with diagnosis to include dementia (impaired ability to remember), depressive disorder (constant feelings of sadness), mood disorder (emotional deficit), and blindness to the right eye. Record review of Resident #2's Quarterly Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 05, which indicated the resident's cognition was severely impaired. Section B Hearing, Speech and Vision revealed that Resident #2 has clear speech, makes himself understood and understands others. His vision is impaired, and he does not wear corrective lenses. Section E Behavior revealed that he had not had any incidents of physical or verbal behavior. Record review of Resident #2's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 05, which indicated the resident's cognition was severely impaired. Section B Hearing, Speech and Vision revealed that Resident #2 has clear speech, makes himself understood and understands others. His vision is impaired, and he does not wear corrective lenses. Section E Behavior revealed that he has had physical behaviors such as hitting, kicking, pushing, scratching, grabbing, abusing others. Resident # 2 has exhibited verbal behaviors such as threatening others, screaming and cursing at others. The behaviors in this section were coded to have gotten worse. Record review of Resident #2 care plan, dated 04/30/24 revealed the following: Focus (Date initiated:04/26/24 Date revised:04/26/24) 4-25-24-I pulled another resident out of bed. Goal I will have no further episodes of aggression through review date. Interventions Placed 1:1 Sent to a behavior support center. Focus (Date initiated:01/22/24 Date revised: 01/22/24) (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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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 0689 Level of Harm - Actual harm Residents Affected - Few	I am an elopement risk/wanderer. Wander risk Goal I will not leave facility unattended through the review date. Interventions Distract me from wandering by offering pleasant diversions. I prefer having snacks. followed by psychiatric services. Notify their MD/NP of any escalation in wandering behaviors, ineffectiveness, or side effects of psychiatric medications. Monitor my location throughout shifts. Document wandering behavior and attempted diversional interventions in behavior log. Focus (Date initiated: 01/22/24 Date revised:01/22/24) I have episodes of verbal and physical aggression r/t dementia. Goal I will not harm self or others through the review date. Interventions Give me as many choices as possible about care and activities. Monitor for physically/verbally aggressive behavior q shift. Document observed behavior and attempted interventions in behavior log. Monitor/document/report PRN any s/sx of me posing danger to self and others. When I become agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Focus (Date initiated:01/22/24 Date revised:01/22/24) I have impaired visual function r/t cataracts and glaucoma. I am blind in my right eye. Goal I will show no decline in visual function through the review date. Interventions Arrange consultation with eye care practitioner as required. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Monitor/document/report PRN any s/sx of acute eye problems: Change in ability to perform ADLs, Decline in mobility, Sudden visual loss, Pupils dilated, gray or milky, c/o halos around lights, double vision, tunnel vision, blurred or hazy vision. Place frequently used items on my left side so I may see them Record review of Resident #2's progress notes revealed the following: 04/25/24 at 04:55 PM LVN A documented: Resident #2 was found in another residents (unidentified) bed Resident #2 pulled another resident (unidentified) out of bed and stated he (unidentified resident) was in Resident #2 room and bed removed resident (unidentified) out of bed and room Resident #2 did get agitated did get Resident #2 in to own room. 04/24/24 at 08:25 PM the DON documented: 7:37 PM received notification from charge nurse that Resident #2 had pulled another male resident (unidentified) out of his bed to the floor and laid down in his bed. Notified the FNP of incident and received orders that may repeat Lorazepam dose X 1 if ineffective. Notified the PCP of incident and received orders may consult Behavioral Health. 04/23/24 at 11:34 AM the DON documented: Spoke with the FNP about Resident #2 physical aggression last night and swinging walking stick hitting staff. New order received to increase Depakote to 500mg BID and start Xanax 0.25mg every 8 hours as needed x 14 days. 04/23/24 at 1:06 AM LVN A documented: Resident #2 became toward staff called the FNP ordered Lorazepam 2mg he was abusive towards staff did have to redirect Resident #2 04/15/24 at 4:16 AM LVN B documented: Resident #2 continues to wander into other residents' rooms, at shift change he was sitting on bed in room [ROOM NUMBER]b. redirected Resident #2 to his room. 04/04/24 at 05:11 PM LVN B documented: Another resident (unidentified) informed this nurse that this Resident #2 was in his bed. Attempted assist Resident #2 to his room. Resident #2 refused. CNA attempted to redirect Resident #2 to his room. Resident #2 became combative with staff kicking his feet at staff and attempting to swing walking cane. Staff able to remove walking cane from rt hands and redirect to room. Admin notified. 03/30/24 at 12:26 AM LVN B documented: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #2 thought he was in room, and someone was in his bed. Resident #2 tried to pull other resident (unidentified) out of his bed. Resident #2 scratched other resident (unidentified) across his chest x2, under left arm and lower abdomen, also abrasion noted to the right breast area extending to right mid back. immediately separated resident. Resident #2 was taken to his own room. 03/30/24 at 05:27 PM LVN D documented: Resident #2 has slept all day and refused to get up for shower or meals. Resident #2 came to staff during the dinner pass demanding a shower. Explained to Resident #2 that we are in the middle of dinner and cannot stop and give showers at this moment. Resident #2 very aggressively started shouting I don't care what time it is I'm going to get a shower now Resident #2 is legally blind and needs assistance in shower but Resident #2 attempting to go into to back shower room. Tried to explain again to Resident #2 that he will have to wait until after dinner for his shower and resident said, I don't care and began pushing this nurse. Resident #2 began opening other residents' rooms trying to find the shower room. Made sure resident did not enter wrong room. Resident #2 eventually turned around and went back to his room. Record review of the provider investigation report, dated 05/01/24, revealed that Resident #2 had a history combativeness, wandering, verbal aggression, physical aggression and was not on any special supervision. Record review of the provider investigation report, 04/29/24, revealed that Resident #2 had a history combativeness, wandering, verbal aggression, physical aggression and was not on any special supervision but that as a result of the incident with Resident #1 was placed on 1:1. Record review of Resident #2's close monitoring log revealed that Resident #2 was monitored every30 minutes on 05/08/24-05/10/24. During an interview on 05/08/24 at 11:42 AM, the ADM stated Resident #2 went into Resident #1's room. The ADM stated Resident #1 and Resident #2's rooms were next to each other. She stated staff heard yelling from Resident #1. She stated when staff entered the room, they observed Resident #1 on the floor, and Resident #2 was in Resident #1's bed. The ADM stated staff redirected Resident #2 to his room, assessed Resident #1 and did not identify any injuries on either resident. The ADM stated she was notified and physically came to the facility to attempt to get additional support from a local behavior support center for Resident #2's behavior. She said Resident #2 was transported to the behavior support center the same night. The ADM stated that Resident #2 had never done this to Resident #1. She stated Resident #1 had a history of aggressive behavior with staff. The ADM said as a result of this incident, on 04/25/24, they conducted training with staff over resident rights, ANE, and that they had consulted with the local behavior support center to conduct training on dealing with aggressive behaviors, but no official date had been set. During an interview on 05/08/24 at 01:34 PM, Resident #2 said he did not recall staff yelling at him, felt safe, had difficulty seeing things, and had no physical incidents with staff or other residents. Resident #2 said he knew where his room was but could not recall a specific room number. He said he did not have any additional concerns. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/08/24 at 1:50 PM, Family Member J stated on 04/25/24, she was notified that Resident #2 had thrown Resident #1 on the floor. Family Member J said she was notified that Resident #1 was assessed, received x-rays, and had no injuries. Family Member J said she spoke with Resident #1 and was told he was not hurting too badly. Family Member J said before the incident on 04/25/24 that she had participated in Resident #1 care plan meeting and specifically had asked what would be done about Resident #2 going into Resident #1 room. Family Member J said it had been suggested that possibly hanging something on Resident #2's door could help Resident #2 find his room. Family Member J said she did not believe that Resident #2 was intentionally targeting Resident #1 but that he was confused. Family Member J said during the care plan meeting, the MDS coordinator, the ADM, the DON, the DM, and the Activities Director were present. She said she brought up the interaction between Resident #1 and Resident #2 because she had been present when Resident #2 would wander into Resident #1 room. Family Member J said she was lucky that Resident #2 had never been violent with her. Family Member J said she had always successfully redirected him out of Resident #1's room. She said the incident on 04/25/24 was not the first time Resident #2 had entered Resident #1's room. Family Member J said the incident on 04/25/24 was the only time she had been notified. Family Member J said she had been told by the staff (LVN A and other CNAs that she could not remember) that there was an incident (did not know the date) where Resident #2 had come into Resident #1's room and tried to pull him off the bed, but was unsuccessful. She said she believe the Social Worker may have mentioned to her about Resident #2 attempting to pull Resident #1 off the bed. Family Member J said that there was an instance (unsure of the date) where she had entered Resident #1's room, and Resident #2 walking cane was behind the dresser in Resident #1's room, indicating he had been there. Family Member J said it was her first time bringing it up to the ADM and DON at the care plan meeting, but she had talked to staff and the nurses numerous times before the care plan meeting. Family Member J said staff had expressed that they were reporting issues, but nothing was being done. Family Member J said that no incidents with Resident #1 and Resident #2 would occur during the day because she or Family Member K would be there during the day. Family Member J said she was there during the day on Monday, Wednesday, Thursday, and Friday. She said Family Member K was at the facility on Wednesday. Family Member J said that before the incident on 04/25/24, nothing had been done to help Resident #2 know where his room was. During an interview on 05/08/24 at 2:02 PM, Resident #1 stated via telephone that Resident #2 had pulled him off the bed, and he did not want it to happen again. During an interview on 05/08/24 at 2:03 PM, Family Member K stated via telephone that she was physically with Resident #1 but that he had a hard time talking because of his stroke. Family Member K said there was an incident where LVN A walked into the room (unsure of the date), and Resident #1 was sideways, hanging onto the bed with one arm. She said she believed there was another incident where Resident #1 tried to protect his feeding tube site. She said she was concerned that this was happening when Resident #1 was sleeping, and that Resident #1 could not defend himself. Family Member K said the staff knew about the incidents and needed to do something. Family Member K said that she had not physically told anyone but was told by Family Member J that she had. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Ralls Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 Avenue P Ralls, TX 79357	

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/08/24 at 2:18 PM, CNA F stated she was unsure of the exact dates, but about a month before the interview, She and CNA E had caught Resident #2 in Resident #1 room. CNA F said Resident #2 was confused and had difficulty seeing. CNA F said she did not believe Resident #2 was being mean or awful to Resident #1, but he thought he was in his (Resident #2) room. CNA F stated Resident #1 was yelling. CNA F said when they got to Resident #1's room (she and CNA E), they observed the door closed and the lights off. CNA F said when they turned on the lights, they observed Resident #2 trying to pull Resident #1 off the bed. CNA F stated water was on the floor, and Resident #1's head was on the bed rail. She observed the side table turned over, and Resident #1 was protecting his feeding tube site and crying. CNA F attempted to redirect Resident #2, but he refused to leave. CNA F stated this incident was reported to LVN B. CNA F stated LVN B said she reported the incident to the appropriate parties. CNA F stated a week after that incident (unsure of the exact date), Resident #2 was back in Resident #1's room. CNA F stated that Resident #1 had pushed his call light, and Resident #2 was standing in Resident #1's room when they got to him. CNA F stated that when they attempted to redirect him out of Resident #1's room, Resident #2 stated he wanted his jacket, and they grabbed his hand. Finally, Resident #2 went with them. CNA F stated that there had been a lot of changes in the facility as far as room changes and believed that the separation by gender may have contributed to Resident #2 being confused about where he was going and, in addition, his difficulty being blind. CNA F stated Resident #2 had been moved three or four times. CNA F stated the difficulty they had been having with Resident #2 had been reported to LVN A and LVN B (unsure of the exact time and date). She stated she was under the impression that, as the CNA, she was to report to her charge nurse and that they would proceed further if needed. She said her charge nurses had told her that the incidents with Resident #2 had been reported to higher people. CNA F stated they had wondered when something would be done. CNA F stated she was frustrated with all the incidents that had occurred with Resident #2. She stated that although Resident #2 was not evil and was sweet, his behaviors had worsened, and he had become more confused. CNA F stated that outside of the incidents with Resident #1, Resident #2 had become aggressive with her, and CNA G. CNA F stated that if something had been done, some of the incidents with Resident #2 could have been prevented. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/08/24 at 2:58 PM, CNA E stated she could not remember exact dates and times. CNA E stated the first incident between Resident #1 and #2 might have occurred four months ago. CNA E stated that she and CNA F were doing rounds and heard Resident #1 scream aloud. CNA E stated Resident #2 was in Resident #1 room. CNA E stated she observed Resident #1 halfway off the bed. CNA E stated that Resident #2 had his wife in the room. CNA E stated Resident #1 was halfway off of the bed, and she observed the lower half of Resident #1's body off the bed. CNA E said Resident #1 was holding onto the bed rail with his right arm. CNA E stated the incident where Resident #1 was hanging off the bed was the first incident she had ever seen. She said she reported the incident to the charge nurse but could not remember who it was as they have many charge nurses. CNA E stated there was another incident (unsure of the date and time) where Resident #1 screamed. CNA E stated that Resident #2 scratched Resident #1 during this incident. CNA E stated it happened possibly two months ago. CNA E stated Resident #2 had scratches on his chest and right side. CNA E stated this was reported to LVN B. CNA E stated that she had to scream for assistance during this incident. She stated CNA F came to assist her. CNA E stated that this incident scared her and that things were worsening with Resident #2's behaviors. CNA E stated that Resident #2 was telling her that Resident #1's room was his room and yelling at her. CNA E said she kept telling him it was not his room. CNA E said that after they told LVN B, she (LVN B) would notify the appropriate parties. She said Resident #1 appeared scared and had water in his eyes. She said Resident #1 said it was scary. CNA E said Resident #1 used minimal words such as scary, hurt, and oh man to describe what had happened. CNA E said there was another incident where Resident #2 had become agitated and aggressive with staff; this was when she messaged the DON. CNA E said she did not like what was happening, and it made her sad about what had happened to Resident #1. A record review of text messages sent to the HHSC investigator on 05/08/24 at 3:28 PM from CNA E revealed on 04/23/24 at 3:28 PM that CNA E expressed concern about Resident #2's behavior, not being trained to take care of residents with Resident #2's behaviors, other residents being afraid and the potential for the incident to be worse. The DON responded that Resident #2's medication was adjusted. CNA E expressed concern about what to do when Resident #2 does not take his medication. CNA E expressed in the text message that Resident #2 had several incidents before the aggressive incident with staff. CNA E referenced the incident with Resident #2 protecting his feeding tube and that CNA E had reported the incident to her charge nurse. The DON responded to the concerns by stating that Resident #2's medication was adjusted and that she was unaware what had happened when Resident #2 became aggressive with staff. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/08/24 at 3:29 PM, LVN A stated that she no longer worked at the facility. LVN A stated on 04/25/24 that she did not witness Resident #2 pulling Resident #1 out of the bed. LVN A stated that she had heard Resident #1 scream and thought it was another resident. LVN A said that when she walked down the hallway, one of the CNAs came running towards her. LVN A stated she could not remember the CNAs name. LVN A said she went into Resident #1 room and observed Resident #2 in Resident #1's bed and Resident #1 was on the floor. LVN A said this was not the first interaction between Resident #1 and Resident #2. LVN A stated this was the second time this had happened. LVN A said that during the incident on 04/25/24, Resident #2 yelled at the staff. LVN A stated she raised her voice for Resident #2 to get out of Resident #1's bed. LVN A said that they were finally able to get Resident #2 out of Resident #1 room. LVN A said she notified the DON of the incident. LVN A stated the DON said that she told the ADM and that the ADM was on the way to the facility to send Resident #2 out for behavior support. LVN A said she had experienced Resident #2 becoming agitated with staff on 04/18/24. She stated that the FNP, PCP, DON, and ADM knew about the incident. She said she had been told by other staff that Resident #2 had attempted to pull Resident #1 out of bed before. She said she was unaware of any interventions that had been put in place. During an interview on 05/08/24 at 10:25 PM, CNA I stated on 04/25/24, it was around 7 PM or 9 PM when the residents that smoke go out. CNA I said she observed Resident #1 on the floor. CNA I said she went to get LVN A, and that was when she (LVN A) told Resident #2 to get the fuck out. CNA I said she redirected Resident #2 to his room. CNA I stated she and CNA H placed Resident #1 back in bed. CNA I said after that incident and Resident #2 received a shot of Ativan he came back out and was trying to throw a shoe at Resident #1. CNA I said that most of the time when she worked with Resident #2, he would always try to go into Resident #1's room. CNA I said this occurred at least three times a week. Before the incident on 04/25/24, CNA I said that Resident #2 never made physical contact with Resident #1 on her shift. CNA I said there was nothing ever done that she could recall to alleviate the situation, but the staff had placed gloves on the outer door at one point. She stated she could not provide a picture of the gloves on the door to the HHSC worker. CNA I said that she had been trained to report allegations of ANE immediately. During an interview on 05/08/24 at 10:51 PM, LVN D stated that the incident on 04/25/24 was the second time that Resident #2 had attempted to pull Resident #1 out of bed. She stated she was not present but had received the information in the report as she typically worked the day shift. LVN D said that they had to redirect Resident #2 consistently. LVN D stated that she did not feel that Resident #2 was explicitly targeting Resident #1 but that he was confused as to where his room was. An attempt to contact LVN B was made at 10:57 PM. LVN B said she would contact her DON and ADM and return the call. Additional attempts to speak with LVN B were made on 05/09/24 at 10:29 AM. LVN B did not answer. During an interview on 05/09/24 at 10:21 AM, the FNP stated that she had consistently been seeing Resident #2 for psychiatric services. The FNP said she was making frequent medication adjustments. The FNP said she was only aware of one incident where Resident #2 had pulled a resident out of the bed, but no other incidents had been reported. The FNP said it had been reported that he had become aggressive with staff. (continued on next page)

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

During an interview on 05/09/24 at 10:52 AM, the Activity Director stated that she participated in Resident #1's care plan. The Activity Director stated that Family Member J expressed that Resident #2 had wandered into Resident #1's room once or twice. The Activity Director stated they had gloves on the door so Resident #2 knew where his room was. The Activity Director said she does not know what happened to the gloves because they are no longer there. The Activity Director said she was unaware of any other interventions to prevent Resident #2 from entering Resident #1's room. The Activity Director stated she did not feel that Family Member J was upset but did express concern.

During an interview on 05/09/24 at 11:00 AM, the DM stated that she participated in Resident #1's care plan. The DM said Family Member J expressed concern about Resident #2 entering Resident #1's room. The DM suggested placing bells or something on Resident #2's door so that he would know which room was his. The DM said Family Member J was concerned that the next time could be worse for Resident #1. The DM stated that before the incident on 04/25/24, Resident #2 had gone into Resident #1's room, but she did not know the date or time. The DM said she was unaware if Resident #2 had been physical with Resident #1. The DM said Family Member J was not upset but concerned.

During an interview on 05/09/24 at 11:10 AM, the MDS Coordinator stated that she was aware that Resident #2 had pulled Resident #1 out of the bed only once. The MDS Coordinator said that she was unaware that Resident #1 had increased physical or verbal aggression behaviors. The MDS Coordinator said revising the care plan if the behaviors differ was customary. The MDS Coordinator said that Resident #2 did not understand well and that all staff could do was redirect him with a snack or an activity. The MDS Coordinator stated that she revises the care plan each time there was an MDS update. The MDS Coordinator said the MDS was updated annually, quarterly, and sometimes on an off cycle. The MDS Coordinator said she would also update us if there was a significant change. The MDS Coordinator said she looked over the care plans each time there was a care plan meeting. The MDS Coordinator said she would have revised the care plan if it had been reported to her each time Resident #2 pulled any resident out of bed. The MDS Coordinator said the interventions were what the staff do to care for the resident, and staff should be watching him closely.

During an interview on 05/09/24 at 11:27 AM, Resident #1 stated that Resident #2 had been in his room [ROOM NUMBER]-5 times. Resident #1 stated no one had come to him and interviewed him about the incident outside of the HHSC investigator. Resident #1 said that he was afraid when he had to hang onto the bed. Resident #1 said he had told multiple CNAs and nurses that he did not want Resident #2 in his room. Resident #1 said he could not remember the names of the staff he told. Resident #1 said he felt like his problem was never solved. Resident #1 said that three times when Resident #2 came into his room, it got physical; he was pulled off the bed, scratched, and pulled halfway off the bed. Resident #1 said he could not remember the date and time when the incidents happened but that staff knew about it because they had to help him.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/09/24 at 1:07 PM, the ADM clarified that during the initial interview, she stated the incident between Resident #2 and Resident #1 had never happened was because three weeks prior, staff had reported that Resident #2 had gone into the room and scratched Resident #1 and LVN B had redirected Resident #2 out. The ADM stated she was unsure where the scratch was. The ADM stated this type of information was typically reported to the DON. The ADM stated she did not report the incident to the state agency because the nurse had intervened and redirected Resident #2 out of the room. The ADM said she was unaware that Resident #2 had encountered Resident #1 multiple times. The ADM said she was unaware that Resident #2 had attempted to pull Resident #1 out of the bed before the incident on 04/25/24. The ADM said she was unsure of Resident #1's care plan meeting . The ADM said she, the DON, Family Member J, The MDS Coordinator, the ADM, and the Social Worker may have been there. During the care plan meeting, the ADM said Family Member J did not express concerns about Resident #2 coming into Resident #1's room. The ADM said they did discuss potentially placing something on Resident #2's door but never made it official. The ADM said the discussion about Resident #2 did not occur during Resident #1's care plan meeting. The ADM said they were monitoring Resident #2's behavior through psychiatric services and medication adjustments. The ADM stated that the staff had expressed concerns about them getting hurt, but she was unaware of the ongoing issues with Resident #1. She said she was only aware of one incident where Resident #2 had become aggressive with staff. She said she was unaware of any other incidents. The ADM said she knew that most of Resident #2's incidents or behaviors occurred at night. The ADM said she did not implement any other interventions outside of the medication adjustments and monitoring from psychiatric services and notifying the family, PCP, and FNP. The ADM said she was sure the care plan had interventions to address Resident #2's behaviors. The ADM said all interventions and revisions should be dated. The ADM said grievances were for family and residents. The ADM said if staff had a concern, they should be redirected to HR to identify a solution. The ADM said she did not have a system to track staff concerns. The ADM said she was responsible for grievances. The ADM said all staff had been trained to handle grievances as part of ANE and resident rights training. The ADM said she had never interviewed Resident #1 to see if this had happened. The ADM had never delegated to interview Resident #1. The ADM said the night of the incident (04/25/24), she was more concerned with his well-being and what happened. The ADM said part of the investigation process was interviewing key witnesses and residents and finding out what happened. The ADM said the potential negative harm if they do not attempt to prevent incidents and accidents was that harm could come to the residents and staff. The ADM said the care plan had interventions that helped prevent incidents and accidents. The ADM said they usually would have met weekly if they identified a potential problem. The ADM said that her team had not met every week regarding Resident #2. The ADM said the purpose of preventing incidents and accidents was the residents' overall safety. The ADM said that she could have prevented further incidents if she had known about the multiple incidents between Resident #1 and Resident #2. The ADM said she was unaware of the various times. The ADM said the facility staff monitored incident/accident prevention through daily standup meetings, talking to staff, and in-service. The ADM said she had not done anything specific for the night-time staff but that they had received the same ANE and resident rights training. The ADM said she had no formal training regarding preventing incidents/accidents, but they trained the staff through in-services. The ADM said she had not observed Resident #2 go into Resident #1's room but expected her staff to monitor and redirect as much as possible. The ADM said everyone was responsible for preventing incidents and accidents and