STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675462	A. Building B. Wing	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Nursing and Rehabilitation Center	3200 Parkway Big Spring, TX 79720

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 04033 Based on interview and record review the facility failed to ensure the resident had the right to be free from abuse for one (Resident #1) of six residents reviewed for abuse. The facility failed to ensure a safe environment free from abuse for Resident #1, who was combative, when CNA A and NA B continued to provide her care before, during, and after her shower. This failure could affect all residents by placing them at risk of abuse, physical harm, pain, mental anguish, emotional distress, and serious harm. Findings include: Record review of Resident #1's Admission Record dated 10/09/24, indicated she was a [AGE] year-old female admitted to the facility 10/18/23 and readmitted [DATE]. Resident #1's diagnosis included psychotic disorder with delusion due to know physiological condition (characterized by hallucination or delusions that are cause by another medical condition), unspecified psychosis not due to a substance or known physiological condition (mental state characterized by a loss of touch with reality and may involve hallucinations, delusion, disordered thinking and behavioral changes), and Alzheimer's disease (disease that destroys memory and other important mental functions). Record review of Resident #1's Annual Minimum Data Set (MDS) dated [DATE] indicated she had a BIMS score of 2, that revealed she had severe cognitive impairment. MDS's Section E-Behaviors indicated she displayed every 4 to 6 days physical behavioral symptoms directed towards others (hitting, kicking, pushing, scratching, grabbing, abusing others sexually; every 1 to 3 days verbal behavioral symptoms directed towards other (threatening others, screaming at others, cursing at others), and every 4 to 6 days other behavioral symptoms directed toward others (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds). This MDS indicated the above behaviors put Resident #1 at significant risk for physical illness or injury; significantly interfere with the resident's care, and significantly interfere with the resident's participation in activities or social interactions. This MDS indicated Resident #1 rejected evaluation of care (activities of daily living) necessary to achieve the resident's goals for health and well-being. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Care Plan that was undated (because facility was migrating care plans into new system) indicated Care Task-CNA with onset date of 10/18/23 indicated they should document behaviors exhibited during the shift and give the resident a shower and shampoo her hair. This plan included Resident #1 was a high risk for side effects/physical injury due to need for psychotropic medications. This would be addressed by monitoring and documenting behaviors, and giving positive reinforcement, and not use a judgmental tone of voice. This plan indicated problem onset was added on 02/05/24 due to resident observed yelling and cursing at staff and peers at and times she is easily redirected, other times she will not calm down as easily. Resident #1 has attempted to bite staff when staff remove her dentures and has been observed throwing condiments at peers during mealtimes. These behaviors would be addressed by notifying MD and RP if resident behaviors increase. Anticipate residents needs to help decrease behaviors and refer resident to psychiatric services if needed. Record review of Resident #1's Behavior Preassessment Form and Discharge Receiving Acknowledgement indicated FM F signed this report on 07/18/24 agreeing to transfer Resident #1 to this facility for evaluation. Record review of Resident #1's Progress Notes dated 07/18/24 indicated Resident #1 was picked up by Behavioral Center for transport to their facility. Record review of Resident #1's Behavior Hospital's Take Home Medication List dated 08/07/24 indicated Resident #1 was returning to the facility 08/09/24. Record review of Resident #1's Progress Note dated 07/15/24 at 2:15 pm and written by LVN C, indicated resident (Resident #1) requires assistance with ADLs due to confusion and unsteady gait. She was recently at a behavioral hospital due to aggression and combativeness with staff and other residents. Since returning she continues to exhibit aggression and agitation. Record review of Resident #1's Progress Note dated (late entry) 07/15/24 at 3:00 pm and written by LVN D, indicated resident (Resident #1) was in her wheelchair, was alert and her confusion was normal. The male CNA (CNA A) was wheeling resident (Resident #1), who was swinging at staff and refusing to go to the shower. Nurse Aide (NA B) assisted resident into the shower. After resident was showered, she continued to be agitated, and was screaming in the hallway. Staff reported resident slapped NA B twice. When resident was wheeled down to the nurses' station resident was noted to have a small skin tear to her right forearm which was treated with dressing dry/intact. Record review of Resident #1's Progress Note (late entry) dated 07/15/24 at 4:00 pm and written by LVN D, indicated resident's (Resident #1) complained of paint to her index finger, middle finger, and ring finger on her left hand. Old bruising was noted to both hands/forearms, and left index lower knuckles were swollen. Mobile X-ray unit was called to x-ray resident's left hand. Record review of Resident #1's Progress Note dated 07/15/24 at 8:47 pm and written by LVN D, indicated mobile x-ray arrived at the facility to x-ray resident's left hand, and swelling was noted to left pointer finger. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Progress Note dated 07/15/24 at 11:11 pm and written by LVN D, indicated x-ray results acute osseous abnormalities, osteopenia can obscure subtle bone lesions, a subtle bony abnormality or fracture may not be readily apparent on x-ray, thus clinical correlation and further imaging including follow up to CT (computed tomography that helps detect diseases and injuries), MRI (magnetic resonance imaging used to form pictures of the anatomy and the physiological process inside the body), or x-ray are as advise as needed. Record review of Resident #1's Patient Report (X-ray) dated 07/15/24 included findings of left hand: bones had no fracture of subluxation, joints had no sclerotic or destructive changes, and soft tissues had articular surfaces that were unremarkable. Review of Resident #1's Incident report dated 07/15/24 and written by LVN D indicated resident was in her wheelchair and was alert with confusion as normal. Resident #1 was swinging and kicking at staff and was refusing her shower. NA B assisted Resident #1 with her shower. After her shower, Resident #1 continue to be agitated and was screaming in the hallway. Staff (NA B) reported that she was slapped twice by Resident #1 during her shower. Resident #1 was taken to the nurses' station and LVN D noted she had a small skin tear to her right forearm and treated it with a dressing. LVN D noted that Resident #1 complained of pain to her index, middle finger, and ring finger on her left hand, there was bruising to both hands/forearms, and left index's lower knuckle was swollen. Afterwards, mobile x-ray was called to x-ray left hand (3 view). Resident #1's level of pain was a 4. Record review of NA B's witness statement dated 07/15/24 indicated When CNA A was pushing Resident #1's wheelchair she was reaching and grabbing his body. Then when CNA A was getting her through the shower door she started to shout. So, I went in to help and she was still shouting. When we were taking all her clothing off, she was swinging her arms a lot to try to hit her and CNA A. She attempted to reach enough to graze my face and slap my face, while were showering her and trying to dress her. While we bathed her, I had to hold her arms against her body so CNA A and I could properly do our task. Record review of LVN D's Witness Statement dated 07/15/24 indicated at 3 pm Resident #1 was sitting in her wheelchair at the nurses' station, and was alert and her confusion was normal. CNA A wheeled her (Resident #1) in her wheelchair to go give her a shower, she started swinging at him and made attempts to hold the handrails. After her shower Resident #1 was yelling loudly in the hallway and saying call the police. Resident #1 was swinging and attempting to hit staff, and she did slap female's face (NA B). While bathing her female staff (NA B) had to hold her hands while the male staff (CNA A) wash her off. Resident #1 attempt to bite staff (CNA A and NA B) while removing her dirty clothes. Record review of CNA A's General In-services with hire dated of 08/28/13 included the courses he had completed on 08/30/24: Abuse Prevention in Person with Dementia, Abuse, Neglect & Exploitation Prevention, Challenging Behaviors: Care and Intervention Dementia, and Resident Rights. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/09/24 at 10:42 am with Family Member F (FM F) indicated she had informed facility's staff that if Resident #1 displayed behaviors, staff should call her, and she would go to the facility to help Resident #1. FM F said on 07/15/24 she received a call from LVN D, who informed her Resident #1 was being combative. Minutes later, FM F said she entered the facility and could hear and see Resident #1 kicking, swinging her arms, crying, and yelling that they were trying to get her into her room; however, there was nobody near her. FM F said Resident #1 has a history of hallucinating, and on 07/15/24 said she had been attacked in the shower, and her nails were broken, her fingers were swollen, and she could not bend her fingers. FM F said she did not suspect abuse but said the staff should not have forced Resident #1 to take a shower. FM F said in the room she discovered a skin tear on Resident #1's calf that had bled into her shoe, and this looked like it was caused by her wheelchair. FM F said Resident #1's bra was ripped, she had blood on her shirt, and a skin tear to her elbow, which looked like it was caused by the grab bar. FM F said staff should have called her if Resident #1 was combative, but they did not. I received a call after staff had completed her shower. FM F said on 07/15/24 she did not suspect abuse, but when Resident #1 continued to complain about CNA A, who was working on the same hall where Resident #1's room was located, she reported her concerns and added the 07/15/24 shower incident. Afterwards, facility's staff investigated this incident. FM F said she did not want anybody terminated she just wanted the staff to be better trained, and after she complained she did not see CNA A working in the hallway where Resident #1's room was located. FM F said she had in the past informed staff to call her if Resident #1 was combative but had not told them to call her to assist with the showers. Since this incident 07/15/24, she asked staff to call her and she would help with Resident #1's showers, and they have called her for her assistance. Interview on 10/10/24 at 10:56 am was attempted with Resident #1 over the phone, who did not talk over the phone. During an interview on 10/09/24 at 1:20 pm with LVN F indicated Resident #1 becomes combative when she must shower. If she becomes combative staff should stop with the care, inform the charge nurse, and return later to attempt the care. During an interview on 10/09/24 at 1:30 pm with CNA G indicated if a Resident #1 becomes combative during her care, she will offer her the baby doll, which she keeps with her most of the day, and that calms her down at times. If a resident who is showering and becomes combative, she will stop the care, pull the call light to prevent leaving the resident in the shower unattended, and wait for the nurse. During an interview on 10/09/24 at 1:30 pm with CNA H indicated if Resident #1 becomes combative she will offer her doll to her to calm her down, and that sometimes works. CNA H said if during a shower a resident becomes combative or refuse their shower, staff should stop the care, pull the call light so you don't leave resident in the shower unattended, and wait for the nurse. During an interview on 10/09/24 at 1:40 pm with CNA H indicated if a resident becomes combative during their shower, staff should stop the care, pull the call light to prevent leaving the resident in the shower unattended, and wait for the nurse. Interviews and messages were attempted with NA B on 10/09/24 at 3:04 pm, 10/09/24 at 3:08 pm, and 10/10/24 at 11:22 pm; however, NA B, who no longer was employed by the facility, did not return these messages. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/09/24 at 3:50 pm, Certified Nurse Aide (CNA A) indicated on 07/15/24 Resident #1 was combative at the nurses' station, but he could not recall how she was being combative. CNA A said at the nurses' station he tilted Resident #1's wheelchair back as she sat in the wheelchair, to prevent her from grabbing the rails or planting her feet on the floor. CNA A said he pushed Resident #1, who was angry, in her wheelchair to the shower room. In the shower area, Resident #1 attempted to bite him and nurse aide (NA B); however, he could not recall if she bit him or left bite marks on his body. CNA A said he and NA B tried taking off Resident #1's clothes as she scratched at him and NA B but could not recall where she scratched him. CNA A said NA B held down Resident #1's hand and could not recall if she was resisting. CNA A said he washed Resident #1's hair and body, dried her, and dressed her as Resident #1 resisted care, was combative, and yelled at him and NA B. After Resident #1 was showered, CNA A said he dressed her, then pushed her in her wheelchair into the hallway, where Resdent #1 was left screaming, but CNA A could not recall what she was saying. Shortly afterwards, CNA A said LVN D directed him not to care for Resident #1, instead the nurses would take care of her. A couple of days later, CNA A said LVN E informed him that Resident #1 in the future would be showered by a female staff only. CNA A said Resident #1 was already in the shower and that is why he continued showering. CNA A said he suspects Resident #1 sustained the injuries from grabbing the rails in the shower and from hitting and scratching him and NA B. CNA A said he knew that if a resident becomes combative you should stop and report to the charge nurse; however, Resident #1 had behaviors all the time and she needed to take her shower. CNA A said he did not have an answer as to why he did not stop and call the charge nurse when Resident #1 resisted being taken to the shower, during the shower, and after the shower. CNA A said he could not recall why he did not use the call light in the shower area to call for the nurse. CNA A said NA B assisted him with showering Resident #1, and she can confirm he did not mistreat her during Resident #1's shower. During an interview on 10/09/24 at 4:29 pm with LVN D indicated said she was at the nurses' station and could not recall witnessing Resident #1 being upset before her shower on 07/15/24. Then CNA A approached Resident #1, who was at the nurses' station, and told her he was going to give her a shower. Resident #1 responded by planting her feet onto the floor and saying she did not want to shower. CNA A tilted Resident #1's wheelchair back as she sat in her wheelchair and pushed her to the shower area. Resident #1 was swinging her arms backwards at CNA A and tried to grab the hall's rails. NA B followed them into the shower area to assist with Resident #1's shower. LVN D said she did not see anything wrong with CNA A taking Resident #1, who was upset, to the shower area because this is how she reacts when she is getting a shower. Minutes later, Resident #1 was in the hallway yelling police. LVN D said the staff reported to her that during Resident #1's shower, she was swinging and attempting to hit them, and did slap NA B on her face. That was when NA B said she had to hold her hands while CNA A washed her body. LVN D said NA B informed her that Resident #1 attempted to bite them when they were removing her clothes. LVN D said she did not recall hearing the shower's call light beeping during Resident #1's shower. LVN D said FM F informed her Resident #1's fingers were hurting, and she replied she would call for an order to get x-ray mobile unit to x-ray her fingers. LVN D said she assessed Resident #1's hand and noted one of the knuckles was swollen; however, there were no fingernails missing. Afterwards, LVN D directed CNA A not to care for Resident #1 until he was directed to do so. LVN D said she was not informed by anyone that Resident #1's bra was ripped nor that she was abused by anyone. LVN D said CNA A and NA B should have stopped Resident #1's shower, used the call light to request her assistance, and she would have called FM F to assist with the shower. LVN D said on 07/15/24 she called FM F after the shower because she was screaming in the hallway, and she arrived shortly afterwards. LVN D said Resident #1's family member (FM F) had requested she be called if they were having trouble with Resident 1's care. In the past she had called FM F, who would arrive at the facility within minutes to assist with Resident #1's care. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/10/24 at 10:05 am with a Non-staff N (NS N) indicated on 09/09/24 FM F complained that a male and female staff (CNA A and NA B) forced Resident #1 to take a shower on 07/15/24, even after she became combative. FM F informed her that she was informed that Resident #1 was displaying behaviors, which is when she went to the facility. Upon entering the facility, she discovered Resident #1 in the hallway with the CNA A and NA B, and that is when CNA and NA B threw their arms up in the air and walked off. FMA said she saw that Resident #1 was upset, and her fingernails were ripped off, her fingers were bruised, and she had blood going into her shoes. FM F said Resident #1 reported to her that CNA A forced her to shower, and her doll was thrown under the sink. NS N said FM F said CNA A was going to assist Resident #1 to the bathroom, but she refused. NS N said FM F said she wanted CNA A terminated. Resident #1 was sent to the behavioral unit on 07/18/24, 3 days after the shower on 07/15/24. NS N said FM F denied Resident #1 having any behaviors and informed her the facility had reported the 07/15/24 shower incident on 09/05/24, after she had alleged abused. NS N said on 09/09/24 she received a call from Admin M requesting to discharge Resident #1 because they could not meet her needs. In addition, Admin M informed her that she tried to moved Resident #1 to the facility's secure unit due to her behaviors (exit seeking and combativeness towards staff and other). NS N said she went to the facility and witnessed Resident #1, who has dementia, display these behaviors; however, FM F refused to move her to the facility's secure unit. During an interview on 10/10/24 at 10:58 am with MD J's LVN I indicated when Resident #1 was refusing her shower and became combative, staff should have stopped the shower process, and attempted the shower later in the day. During an interview on 10/10/24 at 4:15 am with Admin M indicated when FM F said she had concerns because Resident #1 asked why CNA A was not in jail, and she did not want him working at facility. Admin M said she reported this allegation to Health and Human Services and initiated an investigation against CNA A and NA B. Admin M said she identified in her investigation that CNA A and NA B on 07/15/24 should have stopped Resident #1's shower when she became combative. These staff should have called the charge nurse and let her take over and offer the shower later. Admin M she suspended CNA A, NA B did not return to work, she in-serviced the staff, and reassigned CNA A to the secure unit. Admin M said NA B stopped working at the facility after this incident. Admin M said she was not informed that Resident #1 was abused by anyone on 07/15/24. Afterwards, Admin M implemented and in-service indicating staff should stop care when a resident becomes combative, report to the charge nurse after ensuring resident is safe, including using a call light to alert the nurse, and attempt the care later. During an interview on 10/10/24 at 11:14 am with MD K indicated when Resident #1 was refusing her shower and became combative, staff should have stopped the shower process, and tired again later. During an interview on 10/14/24 at 10:15 am with Staff L indicated before 07/15/24 Resident #1 has been combative during her showers and when staff applied her AVAP machine (newer modality of non-invasive ventilation that integrates the characteristics of both volume and pressure-controlled non-invasive ventilation). Staff L said this Resident #1's Care Plan for triggered items, which was current as of 10/09/24, included notifying the physician and family member when Resident #1 had behaviors, but not notifying the family member to assist when Resident #1's combativeness. Staff L said she had not updated Resident #1's care plan to include her behaviors of being combative during showers, offering her a baby doll that staff said calms her down, and calling her family member to assist with her care when she becomes combative, per family members request. Staff L said if a resident is combative, they should stop care, notify a charge nurse, and attempt care later. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility's Policy and Procedure for Preventing Abuse (undated) included facility would not condone any form of resident abuse and will continually monitor facility's policies, procedures, training programs, systems, etc., to assist in preventing resident abuse. Preventing resident abuse is a primary concern for this facility. It is our goal to achieve and maintain an abuse free environment. This abuse prevention/intervention program includes, but is not necessarily limited to the following: Rotating staff working with difficult abusive residents; Monitoring staff on all shifts to identify appropriate behaviors towards residents; Assessing, care planning, and monitoring of residents with needs and behaviors that may lead to conflict or neglect; Assessing resident with signs and symptoms of behavior problems and developing and implementing care plan that can assist in resolving, behavioral issues; and encouraging all personnel, residents, family members, visitors, etc., to report any signs and suspected incident of abuse to facility management immediately.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 04033 Based on observation, interview, and record review, the facility failed to ensure a resident who displayed or was diagnosed with dementia received the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being for one (Resident #1) of six residents reviewed for dementia care. The facility failed to comprehensively assess the physical, mental, and psychosocial needs of Resident #1, who had dementia, and identify the risks and/or to determine underlying causes after she became combative before, during and after her shower. This facility's failure could place residents with dementia at risk for their medical, physical, and psychological needs not being met and resulting in a decline in health. Findings included: Record review of Resident #1's Admission Record dated 10/09/24, indicated she was a [AGE] year-old female admitted to the facility 10/18/23 and readmitted [DATE]. Resident #1's diagnosis included psychotic disorder with delusion due to know physiological condition (characterized by hallucination or delusions that are cause by another medical condition), unspecified psychosis not due to a substance or known physiological condition (mental state characterized by a loss of touch with reality and may involve hallucinations, delusion, disordered thinking and behavioral changes), and Alzheimer's disease (disease that destroys memory and other important mental functions). Record review of Resident #1's Annual Minimum Data Set (MDS) dated [DATE] indicated she had a BIMS score of 2, that revealed she had severe cognitive impairment. MDS's Section E-Behaviors indicated she displayed every 4 to 6 days physical behavioral symptoms directed towards others (hitting, kicking, pushing, scratching, grabbing, abusing others sexually; every 1 to 3 days verbal behavioral symptoms directed towards other (threatening others, screaming at others, cursing at others), and every 4 to 6 days other behavioral symptoms directed toward others (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds). This MDS indicated the above behaviors put Resident #1 at significant risk for physical illness or injury; significantly interfere with the resident's care, and significantly interfere with the resident's participation in activities or social interactions. This MDS indicated Resident #1 rejected evaluation of care (activities of daily living) necessary to achieve the resident's goals for health and well-being. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Care Plan that was undated (because facility was migrating care plans into new system) indicated Care Task-CNA with onset date of 10/18/23 indicated they should document behaviors exhibited during the shift and give the resident a shower and shampoo her hair. This plan included Resident #1 was a high risk for side effects/physical injury due to need for psychotropic medications. This would be addressed by monitoring and documenting behaviors, and giving positive reinforcement, and not use a judgmental tone of voice. This plan indicated problem onset was added on 02/05/24 due to resident observed yelling and cursing at staff and peers at and times she is easily redirected, other times she will not calm down as easily. Resident #1 has attempted to bite staff when staff remove her dentures and has been observed throwing condiments at peers during mealtimes. These behaviors would be addressed by notifying MD and RP if resident behaviors increase. Anticipate residents needs to help decrease behaviors and refer resident to psychiatric services if needed. Record review of Resident #1's Behavior Preassessment Form and Discharge Receiving Acknowledgement indicated FM F signed this report on 07/18/24 agreeing to transfer Resident #1 to this facility for evaluation. Record review of Resident #1's Progress Notes dated 07/18/24 indicated Resident #1 was picked up by Behavioral Center for transport to their facility. Record review of Resident #1's Behavior Hospital's Take Home Medication List dated 08/07/24 indicated Resident #1 was returning to the facility 08/09/24. Record review of Resident #1's Progress Note dated 07/15/24 at 2:15 pm and written by LVN C, indicated resident (Resident #1) requires assistance with ADLs due to confusion and unsteady gait. She was recently at a behavioral hospital due to aggression and combativeness with staff and other residents. Since returning she continues to exhibit aggression and agitation. Record review of Resident #1's Progress Note dated (late entry) 07/15/24 at 3:00 pm and written by LVN D, indicated resident (Resident #1) was in her wheelchair, was alert and her confusion was normal. The male CNA (CNA A) was wheeling resident (Resident #1), who was swinging at staff and refusing to go to the shower. Nurse Aide (NA B) assisted resident into the shower. After resident was showered, she continued to be agitated, and was screaming in the hallway. Staff reported resident slapped NA B twice. When resident was wheeled down to the nurses' station resident was noted to have a small skin tear to her right forearm which was treated with dressing dry/intact. Record review of Resident #1's Progress Note (late entry) dated 07/15/24 at 4:00 pm and written by LVN D, indicated resident's (Resident #1) complained of paint to her index finger, middle finger, and ring finger on her left hand. Old bruising was noted to both hands/forearms, and left index lower knuckles were swollen. Mobile X-ray unit was called to x-ray resident's left hand. Record review of Resident #1's Progress Note dated 07/15/24 at 8:47 pm and written by LVN D, indicated mobile x-ray arrived at the facility to x-ray resident's left hand, and swelling was noted to left pointer finger. (continued on next page)

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	675462	A. Building B. Wing	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Nursing and Rehabilitation Center	3200 Parkway Big Spring, TX 79720

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Progress Note dated 07/15/24 at 11:11 pm and written by LVN D, indicated x-ray results acute osseous abnormalities, osteopenia can obscure subtle bone lesions, a subtle bony abnormality or fracture may not be readily apparent on x-ray, thus clinical correlation and further imaging including follow up to CT (computed tomography that helps detect diseases and injuries), MRI (magnetic resonance imaging used to form pictures of the anatomy and the physiological process inside the body), or x-ray are as advise as needed. Record review of Resident #1's Patient Report (X-ray) dated 07/15/24 included findings of left hand: bones had no fracture of subluxation, joints had no sclerotic or destructive changes, and soft tissues had articular surfaces that were unremarkable. Review of Resident #1's Incident report dated 07/15/24 and written by LVN D indicated resident was in her wheelchair and was alert with confusion as normal. Resident #1 was swinging and kicking at staff and was refusing her shower. NA B assisted Resident #1 with her shower. After her shower, Resident #1 continue to be agitated and was screaming in the hallway. Staff (NA B) reported that she was slapped twice by Resident #1 during her shower. Resident #1 was taken to the nurses' station and LVN D noted she had a small skin tear to her right forearm and treated it with a dressing. LVN D noted that Resident #1 complained of pain to her index, middle finger, and ring finger on her left hand, there was bruising to both hands/forearms, and left index's lower knuckle was swollen. Afterwards, mobile x-ray was called to x-ray left hand (3 view). Resident #1's level of pain was a 4. Record review of NA B's witness statement dated 07/15/24 indicated When CNA A was pushing Resident #1's wheelchair she was reaching and grabbing his body. Then when CNA A was getting her through the shower door she started to shout. So, I went in to help and she was still shouting. When we were taking all her clothing off, she was swinging her arms a lot to try to hit her and CNA A. She attempted to reach enough to graze my face and slap my face, while were showering her and trying to dress her. While we bathed her, I had to hold her arms against her body so CNA A and I could properly do our task. Record review of LVN D's Witness Statement dated 07/15/24 indicated at 3 pm Resident #1 was sitting in her wheelchair at the nurses' station, and was alert and her confusion was normal. CNA A wheeled her (Resident #1) in her wheelchair to go give her a shower, she started swinging at him and made attempts to hold the handrails. After her shower Resident #1 was yelling loudly in the hallway and saying call the police. Resident #1 was swinging and attempting to hit staff, and she did slap female's face (NA B). While bathing her female staff (NA B) had to hold her hands while the male staff (CNA A) wash her off. Resident #1 attempt to bite staff (CNA A and NA B) while removing her dirty clothes. Record review of CNA A's General In-services with hire dated of 08/28/13 included the courses he had completed on 08/30/24: Abuse Prevention in Person with Dementia, Abuse, Neglect & Exploitation Prevention, Challenging Behaviors: Care and Intervention Dementia, and Resident Rights. (continued on next page)

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	675462	A. Building B. Wing	10/14/2024

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/09/24 at 10:42 am with Family Member F (FM F) indicated she had informed facility's staff that if Resident #1 displayed behaviors, staff should call her, and she would go to the facility to help Resident #1. FM F said on 07/15/24 she received a call from LVN D, who informed her Resident #1 was being combative. Minutes later, FM F said she entered the facility and could hear and see Resident #1 kicking, swinging her arms, crying, and yelling that they were trying to get her into her room; however, there was nobody near her. FM F said Resident #1 has a history of hallucinating, and on 07/15/24 said she had been attacked in the shower, and her nails were broken, her fingers were swollen, and she could not bend her fingers. FM F said she did not suspect abuse but said the staff should not have forced Resident #1 to take a shower. FM F said in the room she discovered a skin tear on Resident #1's calf that had bled into her shoe, and this looked like it was caused by her wheelchair. FM F said Resident #1's bra was ripped, she had blood on her shirt, and a skin tear to her elbow, which looked like it was caused by the grab bar. FM F said staff should have called her if Resident #1 was combative, but they did not. I received a call after staff had completed her shower. FM F said on 07/15/24 she did not suspect abuse, but when Resident #1 continued to complain about CNA A, who was working on the same hall where Resident #1's room was located, she reported her concerns and added the 07/15/24 shower incident. Afterwards, facility's staff investigated this incident. FM F said she did not want anybody terminated she just wanted the staff to be better trained, and after she complained she did not see CNA A working in the hallway where Resident #1's room was located. FM F said she had in the past informed staff to call her if Resident #1 was combative but had not told them to call her to assist with the showers. Since this incident 07/15/24, she asked staff to call her and she would help with Resident #1's showers, and they have called her for her assistance. Interview on 10/10/24 at 10:56 am was attempted with Resident #1 over the phone, who did not talk over the phone. During an interview on 10/09/24 at 1:20 pm with LVN F indicated Resident #1 becomes combative when she must shower. If she becomes combative staff should stop with the care, inform the charge nurse, and return later to attempt the care. During an interview on 10/09/24 at 1:30 pm with CNA G indicated if a Resident #1 becomes combative during her care, she will offer her the baby doll, which she keeps with her most of the day, and that calms her down at times. If a resident who is showering and becomes combative, she will stop the care, pull the call light to prevent leaving the resident in the shower unattended, and wait for the nurse. During an interview on 10/09/24 at 1:30 pm with CNA H indicated if Resident #1 becomes combative she will offer her doll to her to calm her down, and that sometimes works. CNA H said if during a shower a resident becomes combative or refuse their shower, staff should stop the care, pull the call light so you don't leave resident in the shower unattended, and wait for the nurse. During an interview on 10/09/24 at 1:40 pm with CNA H indicated if a resident becomes combative during their shower, staff should stop the care, pull the call light to prevent leaving the resident in the shower unattended, and wait for the nurse. Interviews and messages were attempted with NA B on 10/09/24 at 3:04 pm, 10/09/24 at 3:08 pm, and 10/10/24 at 11:22 pm; however, NA B, who no longer was employed by the facility, did not return these messages. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/09/24 at 3:50 pm, Certified Nurse Aide (CNA A) indicated on 07/15/24 Resident #1 was combative at the nurses' station, but he could not recall how she was being combative. CNA A said at the nurses' station he tilted Resident #1's wheelchair back as she sat in the wheelchair, to prevent her from grabbing the rails or planting her feet on the floor. CNA A said he pushed Resident #1, who was angry, in her wheelchair to the shower room. In the shower area, Resident #1 attempted to bite him and nurse aide (NA B); however, he could not recall if she bit him or left bite marks on his body. CNA A said he and NA B tried taking off Resident #1's clothes as she scratched at him and NA B but could not recall where she scratched him. CNA A said NA B held down Resident #1's hand and could not recall if she was resisting. CNA A said he washed Resident #1's hair and body, dried her, and dressed her as Resident #1 resisted care, was combative, and yelled at him and NA B. After Resident #1 was showered, CNA A said he dressed her, then pushed her in her wheelchair into the hallway, where Resdent #1 was left screaming, but CNA A could not recall what she was saying. Shortly afterwards, CNA A said LVN D directed him not to care for Resident #1, instead the nurses would take care of her. A couple of days later, CNA A said LVN E informed him that Resident #1 in the future would be showered by a female staff only. CNA A said Resident #1 was already in the shower and that is why he continued showering. CNA A said he suspects Resident #1 sustained the injuries from grabbing the rails in the shower and from hitting and scratching him and NA B. CNA A said he knew that if a resident becomes combative you should stop and report to the charge nurse; however, Resident #1 had behaviors all the time and she needed to take her shower. CNA A said he did not have an answer as to why he did not stop and call the charge nurse when Resident #1 resisted being taken to the shower, during the shower, and after the shower. CNA A said he could not recall why he did not use the call light in the shower area to call for the nurse. CNA A said NA B assisted him with showering Resident #1, and she can confirm he did not mistreat her during Resident #1's shower. During an interview on 10/09/24 at 4:29 pm with LVN D indicated said she was at the nurses' station and could not recall witnessing Resident #1 being upset before her shower on 07/15/24. Then CNA A approached Resident #1, who was at the nurses' station, and told her he was going to give her a shower. Resident #1 responded by planting her feet onto the floor and saying she did not want to shower. CNA A tilted Resident #1's wheelchair back as she sat in her wheelchair and pushed her to the shower area. Resident #1 was swinging her arms backwards at CNA A and tried to grab the hall's rails. NA B followed them into the shower area to assist with Resident #1's shower. LVN D said she did not see anything wrong with CNA A taking Resident #1, who was upset, to the shower area because this is how she reacts when she is getting a shower. Minutes later, Resident #1 was in the hallway yelling police. LVN D said the staff reported to her that during Resident #1's shower, she was swinging and attempting to hit them, and did slap NA B on her face. That was when NA B said she had to hold her hands while CNA A washed her body. LVN D said NA B informed her that Resident #1 attempted to bite them when they were removing her clothes. LVN D said she did not recall hearing the shower's call light beeping during Resident #1's shower. LVN D said FM F informed her Resident #1's fingers were hurting, and she replied she would call for an order to get x-ray mobile unit to x-ray her fingers. LVN D said she assessed Resident #1's hand and noted one of the knuckles was swollen; however, there were no fingernails missing. Afterwards, LVN D directed CNA A not to care for Resident #1 until he was directed to do so. LVN D said she was not informed by anyone that Resident #1's bra was ripped nor that she was abused by anyone. LVN D said CNA A and NA B should have stopped Resident #1's shower, used the call light to request her assistance, and she would have called FM F to assist with the shower. LVN D said on 07/15/24 she called FM F after the shower because she was screaming in the hallway, and she arrived shortly afterwards. LVN D said Resident #1's family member (FM F) had requested she be called if they were having trouble with Resident 1's care. In the past she had called FM F, who would arrive at the facility within minutes to assist with Resident #1's care. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/10/24 at 10:05 am with a Non-staff N (NS N) indicated on 09/09/24 FM F complained that a male and female staff (CNA A and NA B) forced Resident #1 to take a shower on 07/15/24, even after she became combative. FM F informed her that she was informed that Resident #1 was displaying behaviors, which is when she went to the facility. Upon entering the facility, she discovered Resident #1 in the hallway with the CNA A and NA B, and that is when CNA and NA B threw their arms up in the air and walked off. FMA said she saw that Resident #1 was upset, and her fingernails were ripped off, her fingers were bruised, and she had blood going into her shoes. FM F said Resident #1 reported to her that CNA A forced her to shower, and her doll was thrown under the sink. NS N said FM F said CNA A was going to assist Resident #1 to the bathroom, but she refused. NS N said FM F said she wanted CNA A terminated. Resident #1 was sent to the behavioral unit on 07/18/24, 3 days after the shower on 07/15/24. NS N said FM F denied Resident #1 having any behaviors and informed her the facility had reported the 07/15/24 shower incident on 09/05/24, after she had alleged abused. NS N said on 09/09/24 she received a call from Admin M requesting to discharge Resident #1 because they could not meet her needs. In addition, Admin M informed her that she tried to moved Resident #1 to the facility's secure unit due to her behaviors (exit seeking and combativeness towards staff and other). NS N said she went to the facility and witnessed Resident #1, who has dementia, display these behaviors; however, FM F refused to move her to the facility's secure unit. During an interview on 10/10/24 at 10:58 am with MD J's LVN I indicated when Resident #1 was refusing her shower and became combative, staff should have stopped the shower process, and attempted the shower later in the day. During an interview on 10/10/24 at 4:15 am with Admin M indicated when FM F said she had concerns because Resident #1 asked why CNA A was not in jail, and she did not want him working at facility. Admin M said she reported this allegation to Health and Human Services and initiated an investigation against CNA A and NA B. Admin M said she identified in her investigation that CNA A and NA B on 07/15/24 should have stopped Resident #1's shower when she became combative. These staff should have called the charge nurse and let her take over and offer the shower later. Admin M she suspended CNA A, NA B did not return to work, she in-serviced the staff, and reassigned CNA A to the secure unit. Admin M said NA B stopped working at the facility after this incident. Admin M said she was not informed that Resident #1 was abused by anyone on 07/15/24. Afterwards, Admin M implemented and in-service indicating staff should stop care when a resident becomes combative, report to the charge nurse after ensuring resident is safe, including using a call light to alert the nurse, and attempt the care later. During an interview on 10/10/24 at 11:14 am with MD K indicated when Resident #1 was refusing her shower and became combative, staff should have stopped the shower process, and tired again later. During an interview on 10/14/24 at 10:15 am with Staff L indicated before 07/15/24 Resident #1 has been combative during her showers and when staff applied her AVAP machine (newer modality of non-invasive ventilation that integrates the characteristics of both volume and pressure-controlled non-invasive ventilation). Staff L said this Resident #1's Care Plan for triggered items, which was current as of 10/09/24, included notifying the physician and family member when Resident #1 had behaviors, but not notifying the family member to assist when Resident #1's combativeness. Staff L said she had not updated Resident #1's care plan to include her behaviors of being combative during showers, offering her a baby doll that staff said calms her down, and calling her family member to assist with her care when she becomes combative, per family members request. Staff L said if a resident is combative, they should stop care, notify a charge nurse, and attempt care later. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility's Policy and Procedure for Care Plans that was undated included guidelines to assure any problems identified are addressed in the care plan. And procedures to ensure all goals are measurable and interventions are in place to help achieve the goals, update the plan on a quarterly basis and as needed, use the CCA's as a reference to determine problem or focus area, and any changes in the resident's status will be put on the care plan. Review of facility's Policy and Procedure for Behaviors - Care of the Resident (undated) included purpose to decrease the resident's inappropriate behavior and/or maintain safety during the behavior. The Procedures/Guidelines included If appropriate, stop giving care when the resident is exhibiting inappropriate behavior if resident wound not be put in any risk or danger. Review of the facility's Policy and Procedure for Tub or Shower Bath with Shampooing the Hair that was undated included to explain procedure to resident and encourage resident to participate as much as they can and assist resident to undress as needed.