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	01/06/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43849 Based on observation, interviews and record review, the facility failed to develop and implement abuse policies and procedures to prohibit, prevent and investigate allegations of abuse for 1 of 6 residents (Resident #1) reviewed for abuse. The Facility failed to establish abuse policies and procedures that mandate reporting of all allegations of abuse to the State Agency when Resident #1 made an outcry of abuse. The Facility failed to establish abuse policies and procedures that ensure reporting of all findings of allegations of abuse to the State Agency within five days of knowledge of the alleged abuse. These failures could place residents as risk for abuse and neglect. Findings included: Resident #1 A record Review of Resident #1's face sheet, dated 12/12/24, revealed an [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of dementia with (memory loss) and the presence of a pacemaker. A record review of Resident #1's comprehensive MDS assessment dated [DATE] revealed diagnoses of Adjustment Disorder, Hallucinations, Dementia with Behavioral Disturbance, and Anxiety. Section B, Hearing/Speech and Vision revealed Resident #1 had moderate difficulty as it relates to hearing [B0200]. Resident #1 had a hearing aid [B0300]. Resident #1 usually could make herself understood [B0700] and had the ability to understand others [B0800]. Section C, Cognitive Patterns, a BIMS score of 1, indicating the resident was severely cognitively impaired. Section E revealed Resident #1 did not exhibit physical behavior (hitting, kicking, pushing, scratching, grabbing, and abusing) during the review [E0200]. A record review of Resident #1's care plan, dated 12/12/24, revealed a focused area, initiated on 11/29/24, Resident #1 had a communication problem r/t hearing deficit (had a left hearing aid). A focused area, initiated on 11/29/24, revealed Resident #1 had a pacemaker/defibrillator. Record review of Resident #1's care plan, dated 12/12/24, did not reveal any behaviors. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's progress notes dated from 09/11/24- 12/12/24 did not reveal any progress notes related to the incident on 11/27/24 between Resident #1 and LVN C. A record review of the facility incident report, dated 01/03/25, did not reveal any incidents involving Resident #1 on 11/27/24. There were no provider investigation reports available for review that involved Resident #1 prior to 12/12/24. Record Review of the provider investigation report, dated 12/12/24, revealed the finding of abuse was unconfirmed. The Report stated review of the video footage revealed Resident #1 was not pushed into the table by LVN C, and that LVN C spoke in a loud voice so Resident #1 could hear her. During an interview on 12/12/24 at 9:50 AM, the ADM stated she was the abuse coordinator for the facility. She said if her staff witnessed or suspected abuse, they should remove the resident, and then they should immediately report the allegation of abuse to the charge nurse. She said the staff then can go to her or the DON. She said if someone accidentally bumped a resident, it would not be an incident that the facility would have to report. She said if there was intent, an incident would be required to be reported. She said, Things happen accidentally all the time. She said if there were an injury, she would proceed as usual, but if there were no injury, then there would be no need for additional monitoring. The ADM said she was unaware of incidents involving a staff member accidentally running into a resident. During an interview on 12/12/24 at 11:50 AM, the ADM stated on 11/27/24, CNA A texted her, and she called CNA A back. She said she was told by CNA A that LVN C yelled at Resident #1. The ADM said she watched the cameras and observed LVN C roll a wheelchair between two residents (one being Resident #1). In the video, she saw Resident #1 standing up fast. She said that maybe the wheelchair that LVN C was pushing may have hit Resident #1's chair, but she could not tell. The ADM denied seeing evidence of abuse. During an interview on 12/12/24 at 12:40 PM, LVN D stated on 11/27/24 Resident #1 was crying and holding her chest. She said Resident #1 had her speak into her left ear because she could not hear very well. LVN D said Resident #1 told her, The woman taking care of me hurt me and stated LVN C hit her. LVN D said Resident #1 did not share specifics of the incident, nor did Resident #1 name LVN C specifically, but did describe how she looked and what she had on. LVN D said she assessed Resident #1 and took her vitals. She said Resident #1's vitals were normal and not concerning, but she did observe two lumps near Resident #1's pacemaker and felt it was swollen. LVN D said Resident #1 was in a lot of pain. She said the area around the pacemaker was tender to touch. She said CNA A observed the small lumps near Resident #1's pacemaker. LVN D said she was unfamiliar with Resident #1 and did not know her baseline. LVN D said she reached out to Physician E and obtained an order for pain medication (Tylenol 325 mg) because Resident had no existing orders for pain. LVN D said she reached out to the ADM via text message. LVN D said she told the ADM that Resident #1 was crying and that the area around the pacemaker was swollen and tender to touch. LVN D said she told the ADM that Resident #1 was nauseated. LVN D said she reported her assessment findings to the ADM. CNA A told her she had reported the incident between Resident #1 and LVN C to the ADM. She said CNA A told LVN D that CNA A told the ADM that she and CNA B saw LVN C hit Resident #1 against the table multiple times. A record review of LVN D's written statement, dated 12/14/24, revealed the following: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/27/24 at 6:31 PM, the ADM texted LVN D, stating, There was an incident with Resident #1 and LVN C, and she (Resident #1) was upset with LVN C but says her (Resident #1) chest is hurting. Could you (LVN D) go and assess her (Resident #1)? 6:32 PM: LVN D replied to the ADM text message, Yes. 6:35 PM: LVN D texted the ADM that Resident #1 claimed that LVN C hit her (Resident #1). 6:37 PM: LVN D texted the ADM that Resident #1 was showing her left upper chest and crying. 6:38 PM: LVN D texted the ADM that Resident #1 was hurting, and the area (around the pacemaker) was swollen and tender. 6:41 PM: LVN D texted the ADM that Resident #1 had two bumps near her pacemaker. 6:42 PM: LVN D texted the ADM that Resident #1 was nauseated from how emotional she (Resident #1) was. LVN D said she would get Resident #1 two Tylenol and that Resident #1 might need x-rays. 6:43 PM: LVN D texted the ADM that the pain medication was needed because Resident #1 was tender to touch and the bumps she was feeling with the swelling. 6:45 PM: LVN D texted the ADM, asking what she (the ADM) wanted her (LVN D) to do. LVN D wrote the ADM never responded to any of her text messages. 6:54 PM: LVN D texted the ADM that she received an order from Physician E for Tylenol because Resident #1 did not have any orders for pain medication. 6:44 PM: LVN D attempted to contact the ADM. LVN D indicated the ADM did not answer. 6:50 PM: LVN D texted Physician E asking if it was okay for Resident #1 to have Tylenol (650 mg) because Resident #1 was complaining of pain. 6:54 PM: LVN D indicated that Physician E responded to give Resident #1 tramadol 50 mg, and LVN D responded okay. 7:44 PM: LVN D texted the ADM, indicating Resident #1 complained of pain under her pacemaker and that LVN D felt two lumps. 7:51 PM ADM called LVN D, and the ADM acknowledged her text messages and LVN D said she reported to the ADM that CNA A had said another staff told her to report the incident that had occurred between Resident #1 and LVN C. LVN D indicated during the phone conversation she reported to the ADM that CNA A reported to her that LVN C always mistreats the residents on the memory care unit. She said she reported the findings of her assessment to the ADM and the ADM asked if the two lumps had been there and LVN D stated she did not know. LVN D indicated that she was asked by the ADM if the bumps could have been caused by Resident being bumped on the table and LVN D indicated she responded that it depended on how she was sitting. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN D's written statement additionally stated, On 12/1/24 or 12/2/24, the DON asked her what happened on 11/27/24. LVN D reported to the DON that the ADM told her to assess Resident #1. LVN D indicated she told the DON that Resident #1 alleged that LVN C hit her, and that CNA A witnessed the incident. LVN D indicated that she was unfamiliar with Resident #1 and did not have the facts of the incident to document. LVN D indicated that the ADM instructed her that the ADM would investigate and that she would not write anything down until she investigated by watching the video. A record review of Resident #1's detailed order report dated, 11/27/24, revealed that LVN D had entered a medication ordered by Physician E for Tylenol 325 mg x2 PRN every 4 hours for general discomfort. A record review of Resident #1's order administration note dated, 11/27/24, revealed LVN D entered a note for Tylenol 325 mg x2 PRN every 4 hours for general discomfort. The note indicated Resident #1 complained of pain in her chest on the left side. A record review of Resident #1's MAR/TAR dated November 1-30th, revealed on 11/27/24 at 6:50PM, Resident #1 had a pain level of 5 and was administered acetaminophen tablet 325 mg (2 tablets by mouth). No further indication of pain was noted in the MAR/TAR, and no additional pain medication was given. During an observation and interview on 12/12/24 at 3:55 PM, observation of Resident #1's pacemaker site revealed no lumps, bruising, or redness. Resident #1 did flinch when MA P touched the pacemaker site and stated the site was tender. Resident #1 said she had it (pacemaker) for a long time. Resident #1 did not disclose any information regarding LVN C or the incident from 11/27/24. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/12/24 at 4:00 PM, the ADM stated CNA A said Resident #1 was crying and that LVN C had hollered at her. She said CNA A reported to her that LVN C was trying to push another resident through two residents (one resident being Resident #1). The ADM said Resident #1 was hard of hearing. She said she did interview LVN C, and she denied hollering at Resident #1. LVN C stated she elevated her voice as she came behind her. The ADM said Resident #1 did complain of chest pain. The ADM said she was told by CNA A that she took Resident #1 to her room and noticed Resident #1 had a pacemaker. The ADM said CNA A told her that when she went to touch Resident #1, Resident #1 was guarded. The ADM said Resident #1 had a history of exaggerating things. The ADM said she was told by CNA A that Resident #1 was upset. The ADM said that since Resident #1 was upset with LVN C, it was best that LVN C does not assess her. The ADM sent LVN D to assess Resident #1. The ADM said LVN D reported that Resident #1 complained of pain during the assessment. The ADM said she observed the cameras, and LVN C was moving the wheelchair through two residents (one resident being Resident #1). The ADM said she never observed Resident #1 hit her chest. The ADM said she did not observe Resident #1 crying in the video. The ADM said she did have information to support that she investigated the incident, and LVN C did not intentionally bump Resident #1. She said she did not interview LVN D. The ADM said no one reported to her that LVN C was agitated. The ADM said she started looking into the incident on 11/27/24 and finished on 11/28/24 after she watched the cameras. She said there was no allegation of abuse, so she did not report the incident to HHSC. She said it was normal for Resident #1 to cry. She said if nothing was wrong, then it does not have to be documented. She said that she did not believe there was an allegation of abuse, but the reason she did not have LVN C work with Resident #1 was because Resident #1 was upset with LVN C. The ADM said Family Member G was not notified because there was no allegation of abuse. She said no protection or preventative measures were put in place because there was no allegation of abuse, but maybe the tables needed to be spaced out correctly. The ADM would not allow the State surveyors to view the camera footage until authorized by her attorney. Record review of video of the alleged abuse, dated 11/27/24, was provided by facility via email on 1/5/25 at 9:30PM revealed no indication of abuse. The video revealed LVN C pushed a Resident in a wheelchair between two residents. LVN C pushed an unknown Resident closer to table and then attempted to pass through and bumped Resident #1 chair in the process. LVN C moved Resident #1's chair closer to the table. Resident #1 was not moved forcefully. Resident #1 immediately moved chair away from table and looked behind her. LVN C talked to Resident #1 and motioned for her to move her chair forward. Resident #1 stood up, looked at LVN C and moved the chair toward the table. LVN C left the dining room with an unknown resident in wheelchair, and Resident #1 sat back down in chair. NA walked up to Resident #1 and rubbed her left shoulder and walked away. CNA A walked to Resident #1, and Resident #1 pulled at Resident #1's shirt and rubbed her upper left chest. CNA A bent over and looked at Resident #1 chest, and then walked back to food tray cart. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/12/24 at 4:38 PM, the DON stated she was off when the incident between Resident #1 and LVN C occurred. She said she was notified on Monday (12/2/24) when she returned from work via email from the ADM. The DON said the email from the ADM said she had investigated the incident between Resident #1 and LVN C. She said the email said that Resident #1 reported her chest hurt and that Resident #1 hit her chest on the table, but the ADM found that Resident #1 did not hit her chest on the table. The DON said that she spoke with Resident #1, and Resident #1 reported that everything was fine. Resident #1 never mentioned the incident involving LVN C. The DON said that on 12/02/24, she observed Resident #1 at the dining table and observed an ample space between Resident #1 and the table. The DON said the dining room chairs cannot fit under the tables. She said the arms of the chairs were level with the table, hindering Resident#1 from being able to be bumped against the table. The DON said where Resident #1's pacemaker was located, she could not have hit it against the table. The DON said she observed the video surveillance. She said that Resident #1 was very quick with her movements. She said she observed Resident #1 seated at the dining room table. She said she saw LVN C pushing the geriatric chair. She said Resident #1 was hard of hearing. The DON said she observed an unidentified resident motioning to Resident #1 to move. The DON said Resident #1 attempted to move, but it was only a tiny fraction. The DON said she observed LVN C take her right hand and motion in front of Resident # 1 to move. She said that Resident #1 then got out of her chair. She said she did not observe Resident #1 crying during the video surveillance. The DON said she spoke with LVN C about her tone, and LVN C said Resident #1 scared her when she jumped up so fast from the dining room table. The DON said that the incident between Resident #1 and LVN C was not reported to HHSC because no allegation of abuse was made. The DON said she spoke with LVN D after 11/27/24 but that LVN D did not report any additional information about the incident, only that she felt awkward having to conduct the assessment on Resident #1. The DON said Resident #1 had a history of accusatory behavior. During an interview on 12/13/24 at 7:20 PM, the ADM stated the potential negative outcome for not following the abuse policy and reporting abuse to HHSC could become withdrawn, isolated, or depressed. The ADM said she did not report the incident to HHSC because it was not reported to her that there was ever an allegation of abuse. The ADM expected all allegations of abuse to be reported to the charge nurse and then to herself and the DON. The ADM said she expected the family to be notified if there was an allegation of abuse. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/24 at 1:23 PM, LVN C stated on 11/27/24, during dinner, she was pushing a resident in the dining room. As she passed Resident #1, she bent down and asked her to scoot her chair up. LVN C said she tapped Resident #1, and Resident #1 jumped up, causing her chair to slam against the wheelchair she was pushing. She said Resident #1 was visibly upset but not crying. She said Resident #1 was speaking Spanish and appeared to be cussing. She said she was unaware that Resident #1 was in pain. She said she was unaware that Resident #1 was upset with her because Resident #1 spoke Spanish, and she did not. LVN C said she told Resident #1 that she was sorry and provided care for another resident. She said she never had any contact with the ADM or LVN D after the incident on 11/27/24. She worked the remainder of her shift and provided no care to Resident #1. She said she had contact with Resident #1 after the incident because she returned to the memory care unit, and Resident #1 said hi to her. She said Resident #1 did not appear to be upset. She said she was never instructed not to have any contact with Resident #1 or questioned about the incident involving Resident #1. She said she was unaware that there was an allegation of abuse made. She said there was no documentation to reflect the incident on 11/27/24 because it was not an incident to report. She said Resident #1 acts this way (becoming upset) regularly. She said they had not been trained to document or report the incident but to give Resident #1 space to calm down. She said she did not assess the resident, nor was she aware that any assessment had been done. She said she was unaware if CNA A had taken Resident #1 to her room. She said the only staff in the dining room during the incident was CNA A. During an interview on 01/03/25 at 03:41 PM with NA, she stated she was in the dining room during the incident. She stated Resident #1 told her she (Resident #1) hit her chest on the table. She stated Resident #1 was in pain and crying but she never looked at Resident #1 chest. She stated she never reported the incident to the ADM. During an interview on 01/06/25 at 02:15 PM with CNA A, she stated she witnessed the incident between LVN C and Resident #1. She stated Resident #1's wheelchair was bumped by LVN C and LVN C raised her voice and asked Resident #1 to scoot up. She stated Resident #1 was hard of hearing and wore a hearing aide in the left ear and barely hears out of the right ear. She stated Resident #1 complained of chest pain. She stated she looked at Resident #1 upper chest where her pacemaker was and did not see any knots, bruising or redness. She stated she reported the incident to the ADM because the resident was upset with the LVN C (the charge nurse). She stated LVN C was naturally a loud person, and she did not feel LVN C was yelling at her. She stated she monitored the resident though out the rest of her shift (2p-10P) and Resident #1 had no mental or emotional distress. Record review of a progress note dated 12/17/24 revealed the following from the SW - Spoke with [Resident #1's family member] this date. Asked [family member] to come in and speak with SW and resident at a time that is convenient for him. Spoke to him about how she will sometimes state that she is being mistreated. SW told [family member] that I spoke with [Resident #1] today and she said that she was good, was not afraid and did not have any problems with anyone. [family member] stated that [Resident #1] has vacillated back and forth from stating that she is ok, to not being ok and that people are mistreating her for the last five years. SW reassured [family member] that we would make sure that [Resident #1] was taken care of. [family member] stated that he will make an appointment to come see us and he appreciated the information. [Sic] (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43849 Based on observation, interviews and record review, the facility failed to ensure all allegations of abuse were reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury to other officials, including the State Survey Agency for 1 of 6 residents (Resident #1) reviewed for abuse. The Administrator failed to report allegations of abuse to HHSC when Resident #1's alleged abuse against LVN C. This failure could place residents as risk for abuse and neglect. Findings included: Resident #1 A record Review of Resident #1's face sheet, dated 12/12/24, revealed an [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of dementia with (memory loss) and the presence of a pacemaker. A record review of Resident #1's comprehensive MDS assessment dated [DATE] revealed diagnoses of Adjustment Disorder, Hallucinations, Dementia with Behavioral Disturbance, and Anxiety. Section B, Hearing/Speech and Vision revealed Resident #1 had moderate difficulty as it relates to hearing [B0200]. Resident #1 had a hearing aid [B0300]. Resident #1 usually could make herself understood [B0700] and had the ability to understand others [B0800]. Section C, Cognitive Patterns, a BIMS score of 1, indicating the resident was severely cognitively impaired. Section E revealed Resident #1 did not exhibit physical behavior (hitting, kicking, pushing, scratching, grabbing, and abusing) during the review [E0200]. A record review of Resident #1's care plan, dated 12/12/24, revealed a focused area, initiated on 11/29/24, Resident #1 had a communication problem r/t hearing deficit (had a left hearing aid). A focused area, initiated on 11/29/24, revealed Resident #1 had a pacemaker/defibrillator. Resident #1's care plan, dated 12/12/24, did not reveal any behaviors. Record review of Resident #1's progress notes dated from 09/11/24- 12/12/24 did not reveal any progress notes related to the incident on 11/27/24 between Resident #1 and LVN C. A record review of the facility incident report, dated 01/03/25, did not reveal any incidents involving Resident #1 on 11/27/24. There were no provider investigation reports available for review that involved Resident #1 prior to 12/12/24. (continued on next page)

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	675462	A. Building B. Wing	01/06/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of the provider investigation report, dated 12/12/24, revealed the finding of abuse was unconfirmed. The Report stated review of the video footage revealed Resident #1 was not pushed into the table by LVN C, and that LVN C spoke in a loud voice so Resident #1 could hear her. During an interview on 12/12/24 at 9:50 AM, the ADM stated she was the abuse coordinator for the facility. She said if her staff witnessed or suspected abuse, they should remove the resident, and then they should immediately report the allegation of abuse to the charge nurse. She said the staff then can go to her or the DON. She said if someone accidentally bumped a resident, it would not be an incident that the facility would have to report. She said if there was intent, an incident would be required to be reported. She said, Things happen accidentally all the time. She said if there were an injury, she would proceed as usual, but if there were no injury, then there would be no need for additional monitoring. The ADM said she was unaware of incidents involving a staff member accidentally running into a resident. During an interview on 12/12/24 at 11:50 AM, the ADM stated on 11/27/24, CNA A texted her, and she called CNA A back. She said she was told by CNA A that LVN C yelled at Resident #1. The ADM said she watched the cameras and observed LVN C roll a wheelchair between two residents (one being Resident #1). In the video, she saw Resident #1 standing up fast. She said that maybe the wheelchair that LVN C was pushing may have hit Resident #1's chair, but she could not tell. The ADM denied seeing evidence of abuse. During an interview on 12/12/24 at 12:40 PM, LVN D stated on 11/27/24, LVN D said Resident #1 was crying and holding her chest. She said Resident #1 had her speak into her left ear because she could not hear very well. LVN D said Resident #1 told her, The woman taking care of me hurt me and stated LVN C hit her. LVN D said Resident #1 did not share specifics of the incident, nor did Resident #1 name LVN C specifically, but did describe how she looked and what she had on. LVN D said she assessed Resident #1 and took her vitals. She said Resident #1's vitals were normal and not concerning, but she did observe two lumps near Resident #1's pacemaker and felt it was swollen. LVN D said Resident #1 was in a lot of pain. She said the area around the pacemaker was tender to touch. She said CNA A observed the small lumps near Resident #1's pacemaker. LVN D said she was unfamiliar with Resident #1 and did not know her baseline. LVN D said she reached out to Physician E and obtained an order for pain medication (Tylenol 325 mg) because Resident had no existing orders for pain. LVN D said she reached out to the ADM via text message. LVN D said she told the ADM that Resident #1 was crying and that the area around the pacemaker was swollen and tender to touch. LVN D said she told the ADM that Resident #1 was nauseated. LVN D said she reported her assessment findings to the ADM. CNA A told her she had reported the incident between Resident #1 and LVN C to the ADM. She said CNA A told LVN D that CNA A told the ADM that she and CNA B saw LVN C hit Resident #1 against the table multiple times. A record review of LVN D's written statement, dated 12/14/24, revealed the following: On 11/27/24 at 6:31 PM, the ADM texted LVN D, stating, There was an incident with Resident #1 and LVN C, and she (Resident #1) was upset with LVN C but says her (Resident #1) chest is hurting. Could you (LVN D) go and assess her (Resident #1)? 6:32 PM: LVN D replied to the ADM text message, Yes. 6:35 PM: LVN D texted the ADM that Resident #1 claimed that LVN C hit her (Resident #1). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of video of the alleged abuse, dated 11/27/24, was provided by facility via email on 1/5/25 at 9:30PM revealed no indication of abuse. The video revealed LVN C pushing a Resident in a wheelchair between two residents. LVN C pushed an unknown Resident closer to table and then attempts to pass through bumping the Resident #1 chair in the process. LVN C moved Resident #1"s chair closer to table. Resident #1 was not moved forcefully. Resident #1 immediately moves chair away from table and looks behind her. LVN C talked to Resident #1 and motioned for her to move her chair forward. Resident #1 stands up, looks at LVN C and moves chair towards table. LVN C proceeds to leave dining room with an unknown resident in wheelchair, and Resident #1 sits back down in chair. NA walked up to Resident #1 and rubbed her left shoulder and walks away. CNA A walks to Resident #1, and Resident #1 pulls at Resident #1's shirt and rubs her upper left chest. CNA A bends over and looks at Resident #1 chest, and then walks back to food tray cart. During an interview on 12/12/24 at 4:38 PM, the DON stated she was off when the incident between Resident #1 and LVN C occurred. She said she was notified on Monday (12/2/24) when she returned from work via email from the ADM. The DON said the email from the ADM said she had investigated the incident between Resident #1 and LVN C. She said the email said that Resident #1 reported her chest hurt and that Resident #1 hit her chest on the table, but the ADM found that Resident #1 did not hit her chest on the table. The DON said that she spoke with Resident #1, and Resident #1 reported that everything was fine. Resident #1 never mentioned the incident involving LVN C. The DON said that on 12/02/24, she observed Resident #1 at the dining table and observed an ample space between Resident #1 and the table. The DON said the dining room chairs cannot fit under the tables. She said the arms of the chairs were level with the table, hindering Resident#1 from being able to be bumped against the table. The DON said where Resident #1's pacemaker was located, she could not have hit it against the table. The DON said she observed the video surveillance. She said that Resident #1 was very quick with her movements. She said she observed Resident #1 seated at the dining room table. She said she saw LVN C pushing the geriatric chair. She said Resident #1 was hard of hearing. The DON said she observed an unidentified resident motioning to Resident #1 to move. The DON said Resident #1 attempted to move, but it was only a tiny fraction. The DON said she observed LVN C take her right hand and motion in front of Resident # 1 to move. She said that Resident #1 then got out of her chair. She said she did not observe Resident #1 crying during the video surveillance. The DON said she spoke with LVN C about her tone, and LVN C said Resident #1 scared her when she jumped up so fast from the dining room table. The DON said that the incident between Resident #1 and LVN C was not reported to HHSC because no allegation of abuse was made. The DON said she spoke with LVN D after 11/27/24 but that LVN D did not report any additional information about the incident, only that she felt awkward having to conduct the assessment on Resident #1. The DON said Resident #1 had a history of accusatory behavior. During an interview on 12/13/24 at 7:20 PM, the ADM stated the potential negative outcome for not following the abuse policy and reporting abuse to HHSC could become withdrawn, isolated, or depressed. The ADM said she did not report the incident to HHSC because it was not reported to her that there was ever an allegation of abuse. The ADM expected all allegations of abuse to be reported to the charge nurse and then to herself and the DON. The ADM said she expected the family to be notified if there was an allegation of abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/24 at 1:23 PM, LVN C stated on 11/27/24, during dinner, she was pushing a resident in the dining room. As she passed Resident #1, she bent down and asked her to scoot her chair up. LVN C said she tapped Resident #1, and Resident #1 jumped up, causing her chair to slam against the wheelchair she was pushing. She said Resident #1 was visibly upset but not crying. She said Resident #1 was speaking Spanish and appeared to be cussing. She said she was unaware that Resident #1 was in pain. She said she was unaware that Resident #1 was upset with her because Resident #1 spoke Spanish, and she did not. LVN C said she told Resident #1 that she was sorry and provided care for another resident. She said she never had any contact with the ADM or LVN D after the incident on 11/27/24. She worked the remainder of her shift and provided no care to Resident #1. She said she had contact with Resident #1 after the incident because she returned to the memory care unit, and Resident #1 said hi to her. She said Resident #1 did not appear to be upset. She said she was never instructed not to have any contact with Resident #1 or questioned about the incident involving Resident #1. She said she was unaware that there was an allegation of abuse made. She said there was no documentation to reflect the incident on 11/27/24 because it was not an incident to report. She said Resident #1 acts this way (becoming upset) regularly. She said they had not been trained to document or report the incident but to give Resident #1 space to calm down. She said she did not assess the resident, nor was she aware that any assessment had been done. She said she was unaware if CNA A had taken Resident #1 to her room. She said the only staff in the dining room during the incident was CNA A. During an interview on 01/03/25 at 03:41 PM with NA, she stated she was in the dining room during the incident. She stated Resident #1 told her she (Resident #1) hit her chest on the table. She stated Resident #1 was in pain and crying but she never looked at Resident #1 chest. She stated she never reported the incident to the ADM. During an interview on 01/06/25 at 02:15 PM with CNA A, she stated she witnessed the incident between LVN C and Resident #1. She stated Resident #1 wheelchair was bumped by LVN C and LVN C raised her voice and asked Resident #1 to scoot up. She stated Resident #1 is hard of hearing and wears a hearing aide in the left ear and barely hears out of the right ear. She stated Resident #1 complained of chest pain. She stated she looked at Resident #1 upper chest where her pacemaker is and did not see any knots, bruising or redness. She stated she reported the incident to the ADM because the resident was upset with the LVN C (the charge nurse). She stated LVN C was naturally a loud person, and she did not feel LVN C was yelling at her. She stated she monitored the resident though out the rest of her shift (2p-10P) and Resident #1 had no mental or emotional distress. Record review progress note dated 12/17/24 revealed the following from the SW - Spoke with [Resident #1's family member] this date. Asked [Residents' family member] to come in and speak with SW and resident at a time that is convenient for him. Spoke to him about how she will sometimes state that she is being mistreated. SW told [Resident #'1s family member] that I spoke with [Resident #1's family member] today and she said that she was good, was not afraid and did not have any problems with anyone. [Resident #1's family member] stated that [Resident #1] has vacillated back and forth from stating that she is ok, to not being ok and that people are mistreating her for the last five years. SW reassured [Resident #1's family member] that we would make sure that [Resident #1] was taken care of. [Resident #1's family member] stated that he will make an appointment to come see us and he appreciated the information. [Sic] (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/06/25 at 3:11 PM, the ADM stated at this point she is not sure what she should be reporting or not or what is considered abuse and that she had spent countless nights reading the Provider Letter from HHSC. She stated the incident with Resident #1 was not abuse and that is why she did not report to HHSC. Record review Long-Term Care Regulatory Provider Letter dated 7/10/19 revealed the following: 1.0 Subject and Purpose - This letter provides guidance for reporting incidents to HHSC and . 3.0 Background/History - State and federal law requires an owner or employee of a NF who has cause to believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse, neglect, or exploitation. NFs must report all suspected or alleged incidents involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property. A NF must report these incidents to the HHSC CII section [Emphasis added] A record review of the facility policy, Staff Responsible for Coordinating/Implementing Abuse Prevention Program Policies and Procedures, undated, revealed the following: Policy Statement The administrator assumes the responsibility for the overall coordination and implementation of our facility's prevention program policies and procedures. Policy Interpretation and Implementation The administrator has the overall responsibility for the coordination and implementation of our facility's abuse prevention program policies and procedures. A record review of the facility policy, Reporting Abuse to State Agencies and Other Entities/Individuals, undated, revealed the following: Policy Statement All substantiated incidents of abuse will be promptly reported to appropriate state agencies and other entities or individuals as may be required by law. Should a substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse (including resident to resident abuse) occur, the facility administrator, or his/her designee, will promptly notify the following persons or agencies of such incident: [Emphasis added]. h. The State licensing/certification agency responsible for surveying/licensing the facility. i. The Resident's Representative (Sponsor) of Record. Notices to the above agencies will be made after knowledge of the occurrence of such incident in compliance with local and State requirements. Notices will include, at a minimum: (continued on next page)

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