STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675502	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasanton North Nursing and Rehabilitation	404 Goodwin St Pleasanton, TX 78064

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on observation, interview and record review the facility failed to immediately inform the resident's physician, and notify, consistent with his or her authority the resident representative when there was a change in condition status for 1 of 8 residents (Resident #1) reviewed for restraint and abuse, in that:. The facility failed to ensure Resident #1's physician and RP were notified when it was discovered on 3/01/2024 Resident #1 had been restrained by facility staff including RN A. This failure could place all residents at risk of a delay in medical treatment and could result in not receiving appropriate care and interventions. The findings included: Record review of Resident #1's face sheet dated 4/15/2024 revealed an admitted [DATE] with readmitted [DATE] with diagnoses which included: dementia moderate with behavioral disturbance, unsteadiness on feet and generalized muscle weakness. Record review of Resident #1's significant change MDS assessment dated [DATE] revealed a BIMS score could not be assessed because the resident was rarely or never understood. The assessment indicated Resident #1 required moderate assistance to go from sitting to standing, moderate assistance to walk and was totally dependent on staff for ADL care. The assessment indicated Resident #1 had two or more falls since admission to the facility and no restraints were being used. Record review of Resident #1's Care Plan for falls dated 9/28/2023 revealed a revision 2/21/2024 for an intervention which included that Resident #1 would be seated in the front dining room within eyesight when not in his bed. Also, on 2/21/2024 an intervention was added that reflected [Resident #1] will have seat belt attached to wheelchair and must be locked when in wheelchair and seatbelt must be released every 2 hours, it was revised on 2/26/2024 and removed from the active care plan. Record review of Resident #1's Care Plan for elopement dated 8/11/2021 revealed the resident liked to wander and was disoriented to place, had impaired safety awareness and a cognitive impairment and had verbalized wanting to leave the facility with a history of wandering which included: distract Resident #1 by offering pleasant diversions, structured activities, food, conversation, television, book. Resident #1 prefers to socialize with peers in common area. (continued on next page)

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Resident #1's medical record for consents revealed there were no consents for physical restraints. Record review of Resident #1's physician's orders history revealed there were no orders for restraints. Record review of Form 3613-A dated 3/08/2024 and signed by the Administrator revealed an allegation of abuse was confirmed. The report indicated on 3/01/2024 a CNA alleged RN A used a gait belt to keep a resident in the wheelchair and used profanity when she spoke to a resident. The report indicated Resident #1 was the victim . During an observation/interview on 4/16/2024 at 3:26 p.m., Resident #1 was observed seated in his wheelchair in the main front living/dining area nearest the nurse's station. Resident #1 moved almost constantly and kept scooting up toward the edge of his wheelchair where he was redirected calmly by staff. Resident #1 was alert and smiled when spoken to but did not respond when questions were asked. Resident #1 did not have any obvious injuries. During an interview on 4/16/2024 at 10:04 a.m., the DON stated Resident #1 had a fall history. The DON stated there was no pattern of time for the falls because they happened on every shift. She stated the falls were not happening with one particular staff person. She stated she had terminated RN A on night shift for restraining Resident #1 in his wheelchair with a gait belt on 3/01/2024. The DON stated she did not know how often or how many days Resident #1 was restrained. The DON stated RN A admitted to doing it but would not give a time frame, or an exact date . During an interview on 4/17/2024 at 8:09 p.m., the DON stated the charge nurses were responsible for reporting change of condition to the family and physicians. She stated there was no documentation of notification. She stated they also documented notifications in the incident/accident reports. She stated there was no incident/accident report regarding the restraint/abuse of Resident #1. She stated she did not remember if she notified the physician or not but could not find any documentation. The DON stated she did not notify the family because it was his idea to have the resident restrained. The DON stated she was not sure about the policy for reporting. She stated she knew that they have to report to physicians. During an interview on 9:02 a.m., the SW stated she first learned of the restraint and abuse to Resident #1 by the Administrator when she asked her to do an assessment of the resident (date unknown). She stated after completing the assessment she communicated to the Administrator. She stated she did not make any notifications and did not communicate the restraint or abuse to Resident #1's psychological services . She stated her only communication was with the Administrator. During an interview on 4/18/2024 at 9:16 a.m., the Medical Director (MD) stated he had not been made aware of abuse/restraints in the facility. He stated he thought restraints were wrong. The MD stated he typically communicated with the facility and heard about situations like that from a call from the DON, the Administrator or the NP. He stated he would tell them he did not agree with the restraint, but that had not happened, and no one had communicated with him. During an interview on 4/18/2024 at 9:27 a.m., the DON stated she did not notify psychological service providers for Resident #1 regarding the abuse and restraint. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/18/2024 at 9:35 a.m. the clinical psych counselor stated she had not been informed restraints had been used on Resident #1 and she absolutely would have wanted to know. She stated she was not able to advocate for the patient if she did not know. She stated Resident #1 was not able to advocate for himself because he was declining. She stated it was very important and her responsibility to make sure the residents were safe and their needs were addressed. During an interview on 4/18/2024 at 10:56 a.m., the Administrator stated she did not notify the Medical Director because it was another physician's patient. She stated she was not sure who made notifications. During an interview on 4/18/2024 at 11:58 a.m., the psych NP stated she comes to the facility on e time a month to see residents. She stated the facility never consulted with her or notified her regarding restraint or abuse. She stated restraint was not an appropriate intervention and was not indicated for any situation. She stated she would have wanted to know so she could re-evaluate Resident #1 and make some changes if appropriate. During an interview on 4/18/2024 at 1:01 p.m., Resident #1's family member stated he had suggested to the facility they use something to keep Resident #1 from falling. He stated he was talking about a wheelchair seat belt or bed rails for his bed. He stated he had not been notified the resident had been restrained with a gait belt by a staff member. During an interview on 4/19/2024 at 12:08 p.m., the NP for Resident #1's physician stated Resident #1's dementia had continued to progress and he had declined quickly. She stated he was restless and had no safety awareness. She stated restraint was not an appropriate intervention and would just agitate the resident. She stated she had not been notified that he was restrained and would have wanted to know. She stated she had spoken to her supervising physician who also stated he had not had any notification about the subject from the facility. Attempted interview on 4/19/2024 at 12:10 p.m. with Resident #1's physician. No return call was received. A return text was received that stated he was out of town and what the NP had told (this surveyor) was accurate. During an interview on 4/21/2024 at 11:35 a.m., the NP for the Medical Director stated she had not been notified Resident #1 was restrained but absolutely wanted to know. So stated she would want to know so they could have done something to mitigate the need for restrains. She stated the MD had not indicated to her that there had never been a discussion with the facility about restraints. She stated she had no knowledge of any accusations or allegations of abuse to the residents. Record review of a facility policy, titled Change in a Resident's Condition or Status dated February 2021 revealed: Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status.

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 38511 Based on observation, interview, and record review the facility failed to ensure residents had the right to be free from abuse, neglect, and misappropriation of property for 2 of 8 residents (Residents #1 and Resident #5) reviewed for abuse, in that: 1. The facility failed to ensure Resident #1 was free from physical abuse when RN A and NA H restrained the resident using a gait belt wrapped around the resident's abdomen from 10/08/2023 to 3/01/2024 and secured to his wheelchair behind the resident to prevent the resident from standing, used furniture to prevent movement by Resident #1 in his wheelchair and emotional abuse from RN A. 2. The facility failed to ensure Resident's #1 and #5 were free from verbal abuse when RN A used derogatory language and profanity directed at the residents. These failures resulted in the identification of an Immediate Jeopardy (IJ) on 4/18/2024 at 5:27 p.m. The IJ template was provided to the facility on [DATE] at 5:31 p.m. While the IJ was removed on 4/21/2024 the facility remained out of compliance at a level of potential harm with a scope identified as pattern until interventions were put in place to ensure staff members were in compliance with identifying and reporting abuse. These failures could place residents at risk of physical, mental and emotional decline, psychosocial harm and physical injury and could result in a decline in isolation and withdrawal and result in a decline in health. The findings included: 1. Record review of Form 3613 -A, Provider Investigative Report dated 3/08/2024 and signed by the Administrator revealed an allegation of abuse was confirmed. The report indicated on 3/01/2024 a CNA (unidentified) alleged RN A used a gait belt to keep a resident in the wheelchair and used profanity when she spoke to a resident. The report indicated Resident #1 was the victim. The report also indicated RN A told Resident #5 to shut the f%&$ up but Resident #5 was unable to recall foul language. Record review of a photocopy of text conversation (undated) between the DON and RN A revealed the DON sent a text to RN A that indicated she had been trying to reach RN A by phone to let her know she was suspended pending investigation because it was reported she used a gait belt to restrain Resident #1 and profanity when speaking to Resident #5. The DON indicated in the text she had to report it to state. RN A responded by asking if she should go to work on Monday and Tuesday. RN A stated, I did use a gait belt, but I don't recall using profanity with any resident .sorry about the belt but I was just trying to keep him from falling. The DON responded by telling RN A not to go to work Monday or Tuesday. This document was signed by the DON. Record review of a handwritten document dated 3/01/2024 and signed by the DON revealed agency CNA B called her (the DON) and told her RN A on the night shift was using a gait belt to restrain Resident #1 in his wheelchair at night. The document indicated CNA B could not give specific dates or times. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a handwritten document dated 3/04/2024 and signed by the DON revealed CNA D stated she had witnessed RN A use a gait belt to restrain Resident #1 in his wheelchair. The document indicated CNA D could not remember exact dates and times and stated CNA D did not report it because she was scared of retaliation from RN A. Record review of a handwritten document dated 3/04/2024 and signed by the DON revealed CNA N stated she had witnessed RN A use a gait belt to restrain Resident #1 at night. She stated she did not report it because she was afraid of retaliation and could not remember exact dates and times. Record review of Resident #1's face sheet dated 4/15/2024 revealed an admitted [DATE] with readmitted [DATE] with diagnoses which included: dementia moderate with behavioral disturbance, unsteadiness on feet and generalized muscle weakness. Record review of Resident #1's significant change MDS assessment dated [DATE] revealed a BIMS score of could not be assessed because the resident was rarely or never understood. The assessment indicated Resident #1 required moderate assistance to go from sitting to standing, moderate assistance to walk and was totally dependent on staff for ADL care. The assessment indicated Resident #1 had two or more falls since admission to the facility and no restraints were being used. Record review of Resident #1's Care Plan for falls dated 9/28/2023 revealed a revision 2/21/2024 for an intervention which included that Resident #1 would be seated in the front dining room within eyesight when not in his bed. Also, on 2/21/2024 an intervention was added that read Resident #1 will have seat belt attached to wheelchair and must be locked when in wheelchair and seatbelt must be released every 2 hours, it was revised on 2/26/2024 and removed from the active care plan. Record review of Resident #1's Care Plan for elopement dated 8/11/2021 revealed the resident liked to wander and was disoriented to place, had impaired safety awareness and a cognitive impairment and had verbalized wanting to leave the facility with a history of wandering which included: distract Resident #1 by offering pleasant diversions, structured activities, food, conversation, television, book. Resident #1 prefers to socialize with peers in common area. Record review of the Resident #1's consents revealed there were no consents for physical restraints. Record review of Resident #1's physician orders history from admission to current revealed no orders for restraints. During an observation/interview on 4/15/2024 at 10:16 p.m. revealed there were no residents in the main common area or near the nurse's station. The facility lights were low, and the atmosphere was calm/quiet. CNA B was observed near the nurse's station in the hallway. CNA B stated Resident #1 had returned from the hospital today and had been confused and combative with staff which she described as normal behavior for the resident. CNA B stated Resident #1 kept wandering to different hallways saying he was going to beat someone up. She stated she approached him in a calm way, redirected him and just talked to him which was how she was trained to respond. She stated although he was confused, she eventually got him to bed. During an observation on 4/15/2024 at 10:19 p.m., Resident #1 was observed on a low bed, with fall mat in place. The resident was sleeping and had the covers pulled up over his head. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation on 4/15/2024 at 10:45 p.m., Resident #1 remained asleep in his bed. During an observation/interview on 4/16/2024 at 3:26 p.m., Resident #1 was observed seated in his wheelchair in the main front living/dining area nearest the nurse's station. Resident #1 moved almost constantly and kept scooting up toward the edge of his wheelchair where he was redirected calmly by staff . Resident #1 was alert and smiled when spoken to but did not respond when questions were asked. Resident #1 did not have any obvious injuries. During an observation on evening shift at 4/16/2024 at 8:22 p.m., Resident #1 was observed asleep in his bed with the covers over his head, low bed with fall mat in place. During an interview on 4/16/2024 at 10:04 a.m., the DON stated she was the facility ADON until 1/01/2024 when she became the DON. She stated Resident #1 had a fall history and had run out of new interventions to try. She stated after every fall she updated Resident #1's care plan. She stated the most effective intervention was to keep Resident #1 within eyesight. She stated on 4/04/2024 she put a goal for him to be up in his wheelchair out of his room when awake to prevent Resident #1 from ambulating unassisted. The DON stated there was no pattern of time for the falls because they happened on every shift. She stated the falls were not happening with one particular staff person. She stated she had terminated RN A on night shift for restraining Resident #1 in his wheelchair with a gait belt. The DON stated Resident #1 was more active on night shift. The DON stated she did have enough staff to care for him. She stated he was so unsteady on his feet that by the time the staff saw him stand up it was too late. The DON stated she did not know how often or how many days Resident #1 was restrained. The DON stated when she asked staff about it she could not get a good answer. The DON stated the staff said they did not report the restraint earlier because they were scared of retaliation. The DON stated the facility did discuss restraining Resident #1 because a family member brought it up. The family member wanted Resident #1 restrained. The DON stated she briefly added restraint to Resident #1's care plan, but he never had an order for restraint. She stated they presented it to their legal team, and it did not pass through. She stated legal said, absolutely not. The DON stated she never got as far as assessing Resident #1 to see if he could undo a seatbelt in the wheelchair because it never got that far. She stated RN A was not using a seatbelt she was using a gait belt as a restraint, and he could not undo it. The DON stated the facility did not have cameras in the facility. The DON stated RN A admitted to doing it but would not give a time frame, or an exact date. The DON stated RN A admitted to restraining Resident #1 2-3 times, but she was very vague. 2. Record review of Resident #5's face sheet dated 4/18/2024 revealed an admitted [DATE] with diagnoses which included: Alzheimer's disease, psychotic disorder with delusions due to known physiological condition and recurrent major depressive disorder. Record review of Resident #5's quarterly MDS assessment dated [DATE] revealed a BIMS score of 6 which indicated a severe cognitive impairment. Record review of Resident #5's annual MDS assessment dated [DATE] revealed a BIMS score was not assessed. Record review of Resident #5's Care Plan dated last revised on 3/27/2023 revealed Resident #5 sometimes had behaviors which included shouting with interventions which included: attempt interventions before behavior escalates, make sure resident not in pain or uncomfortable. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #5's psychosocial assessment dated [DATE] revealed Resident #5's memory recall included staff faces and names and that he was in a facility. The assessment indicated the resident understand his surroundings and had severely impaired decision-making skills and socially inappropriate behaviors with a note anxiety, yells, prefers to be alone in room The assessment revealed Resident denies that anyone has told him anything to upset him. During on observation on 4/15/2024 at 10:25 p.m., Resident #5 was observed sleeping in bed, low bed, fall mat in place. During an interview on 4/17/2024 at 3:17 p.m., the DON stated none of the residents in the facility were reliable for an interview due to dementia. She stated all residents in the facility had a diagnosis of dementia with memory issues. She stated some of the residents also had hallucinations/delusions and would not be able to give a reliable interview regarding restraint/abuse. The DON stated RN A worked night shift from 6 pm to 6 am. She stated she had two witnesses who worked from 6 pm to 10 pm who confirmed the allegations of abuse against RN A, CNA C and CNA D . The DON stated she initially suspended RN A when the allegation surfaces (date unknown) but right away she thought she was going to have to let RN A go. The DON stated since RN A admitted the allegation , they let her go. The DON stated there would have been a bigger investigation had she denied the allegations. The DON stated RN A told her she was the only person who restrained a resident, but she was really vague. The DON stated she asked RN A about the times and dates, but RN A did not know how long it had occurred. The DON stated she interviewed Resident #5 about the verbal abuse , and he said everyone was nice to him, but he could not remember, and he had no complaints from other residents. She stated she interviewed CNA E who worked for an agency, but she denied seeing abuse and the other regular staff member (unknown name) said she didn't see it either. The DON stated on 3/01/2024 when she received the allegations of abuse, she had approximately 31 staff. She stated she in-serviced 19 of those staff on abuse and neglect. The DON stated when she called the meeting for the in-service CNA F (night shift) had worked the whole week and she did her a favor by picking up extra shifts, so she excused CNA F from the in-service and the other person (CNA E) from night shift was an agency person. The DON stated agency staff had their own in-services through their agency. She stated if the agency staff are in the building when the meeting was called, they would attend. The DON stated she did not in-service night shift staff because she does not see the night shift people because they occur during the daytime . The DON stated as part of the abuse investigation she completed a skin assessment of Resident #1 and found no new skin conditions . During an observation/interview on 4/17/2024 at 3:30 p.m., Resident #5 was seated on his bed with his clothes thrown on the floor beside him. There were no visible injuries noted. Resident #5 stated he was fine. He stated he had lived at the facility for [AGE] years (which showed confusion) and was stated he did not know who any of the people were in the numerous personal photos posted near his bed on the wall. Resident #5 had a childlike demeanor. He was unable to answer detailed interview questions and did not have memory recall of answer questions about past events. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/17/2024 at 3:46 p.m., CNA B stated she worked for a staffing agency and first began working at the facility in August 2023. CNA B stated on 3/01/2024 (unknown time) she notified the DON via text that she needed to talk to her. CNA B stated CNA E notified the DON by talking to her and text that RN A was doing stuff to the residents on the same night. CNA B stated she did not talk to the DON about what was occurring until the next morning which was 3/01/2024 when the DON came to the facility. CNA B stated Resident #1 wandered and would go into rooms. She stated RN A did not want him to wander so he started to get aggressive. She stated he was pulling on the handrails and kicking. CNA B stated RN A told the CNA's to go get a gait belt and tie Resident #1 down. CNA B stated we (CNA B and CNA E) told her they were not going to do it. CNA B stated CNA E took RN A a gait belt and gave it to her (RN A) but CNA E did not use it. CNA B stated RN A stated fine, it was going to be on her anyways (meaning she was the one who would get in trouble), like RN A did not care and tied him down anyway. CNA B stated the DON asked her the dates and it was two shifts prior so it would have been on 2/28/2024 around med pass time which was approximately 8:00 p.m. CNA B stated she also told the DON it really bothered her that RN A wanted to restrain Resident #1. She stated she also let the DON know it was not the first time. CNA B stated she did not tell the DON because she forgot about it until now, but RN A would also get the big couch in the main living area and block the entrance to prevent Resident #1 from coming out of the room. CNA B stated she knew that was also a restraint. She stated Resident #1 knew he could not get out of the room, so he just sat there in his wheelchair. She stated RN A stated she wanted to keep him there because he was wandering and trying to get into rooms, and she did not want him to move while she was sitting down and the CNA's were down the halls working. CNA B stated one day, (date unknown) Resident #1 was having a good day and was in a good mood. He looked at RN A and stated, I love you and RN A looked right at him and stated, I hate you. CNA B stated it really broke her heart. She stated she told RN A wow and just walked off. CNA B stated Resident #1 did not say anything, but he knew. She stated she could see it in his eyes that he knew. CNA B stated one night (date unknown) Resident #5 could smell her dinner when she was warming it up and he yelled he wanted a cheeseburger. CNA B stated RN A yelled Shut the fuck up. CNA B stated Resident #5 was in his room and got quiet. CNA B stated after she reported it to the DON a lot of other staff started talking. These were not one day events. No one had wanted to report it. She stated CNA E and CNA K both had talked about the abuse, and both had information. CNA B stated she wrote a witness statement. She stated a lot of staff wrote witness statements to the DON. CNA B stated she had not spoken to the Administrator and did not even know who the Administrator was. She stated she was trained to report abuse which was what she did. CNA B stated after this event there was a training. She stated they were told to read and sign something, but she could not remember what it was about. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/17/2024 at 4:11 p.m., CNA D stated she was regular full-time staff at the facility. She stated she did not work with RN A often. CNA D stated RN A was loud, and she was rude, but she never saw abuse. CNA D stated the handwritten statement written by the DON was not accurate. CNA D stated when the DON called her and asked her about the gait belt on Resident #1, she told the DON, no. CNA D stated she thought the DON misunderstood her. CNA D stated RN A did ask her to put a gait belt on as a restraint on Resident #1, but she did not understand what the meant. CNA D stated she responded to RN A by telling her she was going to lay him down in bed. She stated she did lay him down and he stayed in bed. CNA D stated RN A told her to get the gait belt because Resident #1 was trying to walk. She stated this occurred before 9:30 p.m. because she did her last rounds at 9:30 p.m. and left by 10:00 p.m. She stated this occurs sometimes before Christmas. She stated she thought it was somewhere between October and November 2023. She stated it was hard to remember the dates. CNA D stated she did not think using a gait belt to restrain Resident #1 was abuse. She stated she did not understand. She stated it was not until the DON told her what was going on (unknown date) and there were other reports of abuse and the use of restraint by RN A that she told the DON what she knew about RN A. CNA D stated she never saw any other resident with a gait belt on or a restraint. She stated RN A was just rude and loud. She would tell the residents things like it's enough already. CNA D stated it was not the way she personally would talk to the residents, but it was not abusive. She stated she never heard RN A cuss at a resident. CNA D stated after the events they had a meeting where they talked about restraint, abuse, and neglect but she could not remember what was taught. She stated they had to watch some videos and take a quiz. She stated she was trained to report abuse immediately to the Administrator. (continued on next page)

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	675502	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasanton North Nursing and Rehabilitation	404 Goodwin St Pleasanton, TX 78064

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/17/2024 at 4:31 p.m., CNA E stated she worked with an agency and had worked at the facility regularly for 3-4 months, mostly on the weekends with RN A. CNA E stated RN A told her Resident #1 was problematic and aggressive. CNA E stated RN A told her the facility used a gait belt restrain on him because he was a fall risk and did not sit still. CNA E stated she asked RN A if there was a doctor's order for the restraint and she said no. CNA E stated once she learned there was no doctors order she no longer assisted. CNA E stated RN A stated it was okay to use it because she was going to take the fall for it (she was the one who would get in trouble). CNA E stated she took pictures and sent them to her agency and also told the DON about it. CNA E stated she did not want to work at the facility anymore because of it. CNA E stated it was just Resident #1 that she was witness to. She stated she did not have knowledge of any other residents. CNA E stated there were other aides who assisted in strapping Resident #1 down, including NA H . She stated she could not remember the names of the other aides. She stated Resident #1 would not cooperate with RN A. He would try to go from sitting to standing. She stated it was the way RN A spoke to Resident #1, he would regularly hit RN A and be aggressive with her. CNA E stated RN A would tie Resident #1 down by putting him either in his wheelchair or a regular chair and she would loop the gait belt around his abdomen and then loop the buckle in the back where he would not reach it or untie it. CNA E stated RN A would put the gait belt on pretty tight. CNA E stated LVN L, a morning nurse asked about the redness on Resident #1's abdomen and she told the nurse RN A straps Resident #1 down. She stated LVN L asked me additional information and then asked if she had informed the DON. CNA E stated LVN L said there were no orders for restraint. CNA E stated she told the DON the third time she saw it. She stated this started in January 2023. She stated she told the DON, RN A makes her do things she was not supposed to do. She stated she told the DON on the week of 2/23/2024-2/27/2024 but was not sure the exact day. She stated she also talked on the phone with the DON on 2/11/2024-2/12/2024 about it. She stated the DON was surprised and listened to her side of the story. She stated after she initially told the DON on 2/11/2024-2/12/2024, RN A called the DON and complained about her. CNA E stated she specifically told the DON she (RN A) strapped Resident #1 down with a gait belt word for word. CNA E stated the DON stated she would talk to RN A. CNA E stated RN A was not sent home and continued to work at the facility. She stated multiple other staff also reported it to the DON (unknown staff, unknown dates). CNA E stated RN A was verbally abusive to residents as well. She stated she was nasty and unkind to Resident #5. CNA E stated RN A would say shut up and fuck off to the residents. She stated or RN A would tell them they smell, or they were not loved. CNA E stated she told the DON she would never work with RN A again. CNA E stated She stated she was trained to report abuse to her agency. She stated her agency was a data base and she entered it into the data base but could not remember when this occurred, she stated she thought she reported it to her agency in January 2023. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/17/2024 at 5:11 p.m., CNA N stated on a Monday in February 2024 she stayed over from day shift to work until 10 p.m. with RN A and agency CNA E. She stated on that Monday, CNA E told her RN A was making the aides put Resident #1 in a chair with a gait belt. She stated they strapped him to the chair like a restraint and then was mean to the residents telling them to shut up and called them stupid. CNA N stated CNA E told her RN A and CNA E got into and she called the DON. CNA N stated on Tuesday, the next day she again stayed until 10 p.m. with RN A. She stated Resident #1 was in the front main living/dining room area trying to stand up. CNA N stated RN A was passing meds and could see Resident #1 from where she was standing. CNA N stated RN A yelled at her to grab Resident #1 and then get a gait belt and put it around him. CNA N stated she told RN A no. CNA N stated RN A yanked the gait belt out of her hand and stated she was doing it herself. CNA N stated she again told RN A no, and told her she would sit with Resident #1 so he would not need a restraint. CNA N stated RN A tried to put the gait belt around Resident #1, but she (CNA N) put her hand out and stopped RN A from wrapping it around him. CNA N demonstrated how RN A took the gait belt and reached around the front of the resident with the gait belt with intentions to strap it around his abdomen and secure it in the back. CNA N stated she believes if she had not been there to stop her RN A would have strapped Resident #1 down with the gait belt. CNA A stated RN A walked off. CNA N stated she asked CNA E and CNA G what had happened with RN A. She stated they told her RN A had asked them to put a gait belt restraint on Resident #1 and they did because RN A told them to. CNA N stated on Friday, RN A was still working at the facility, and said she guessed it was not a big deal and she was not in trouble because someone had told on her and she was still working. CNA N stated she let the DON and the Administrator know what RN A said about not getting in trouble. She stated that was on a Friday (date unknown). CNA N stated it then became a big deal and she has not seen RN A since. CNA N stated to her knowledge no other residents were not involved. CNA N stated RN A was not verbally the nicest, but more like she was inconvenienced by the residents rather than abusive towards them. CNA N stated she never heard name called. She stated RN A did use profanity but not directed towards the residents. CNA N stated the first time she told anyone about it was that Friday 3/01/2024. She stated CNA E was very upset about the way RN A was treating the residents. CNA N stated she told the DON and the Administrator together what she had witnessed. She stated she also told the DON and Administrator that RN A was walking around making fun of it, like it was a big joke that she had been doing it and was not getting in any trouble. She stated RN A was slamming drawers on the med carts around the residents. She stated she told all of this to management. CNA N stated Resident #1 did not seem up set because of his dementia but some of the staff was upset about it, including CNA E. She stated the residents do not understand because of their dementia. CNA N stated she had been trained to report abuse to the Administrator immediately. She stated she waited to report it because CNA E stated she had already reported it and at that point she had not seen it herself. She stated when RN A tried it, she was able to stop her. CNA N stated by Friday, 3/01/2024 she decided they needed to hear her side of the story. She stated she did not see any injuries to Resident #1. She stated management responded by saying there would be a state investigation. CNA N stated she was not asked to write a witness statement from facility management. She stated she would be willing to write out her version on a piece of paper in front of this surveyor for proof. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/17/2024 at 6:10 p.m., the ADON was presented as a witness by the DON. The ADON stated CNA D told her she did see RN A strap Resident #1 to a chair with a gait belt but because RN A was a registered nurse, she did not report it because Who are they going to believe a RN or a CNA? The ADON stated CNA D stated she actually witnessed it and told the ADON approximately one month ago. The ADON stated she was a charge nurse when this occurred and did not become the ADON until 3/01/2024. The ADON stated the first time she knew anything about the situation was when all the chatter started about it when the facility reported it to state (3/01/2024). She stated she hard NA H and CNA C talk about it, but this was after it was already reported. The ADON stated she never heard any residents complain and did not see any change in any resident behaviors. The ADON stated restraint was abuse. The ADON stated she heard RN A state things like go over there or leave that alone in a loud voice but never heard her cuss or call a resident a name. She stated she never heard RN A raise her voice at a resident, she just used a loud voice. The ADON stated she has come to assist night shift before when they needed help but did not know where that was. She stated it was to do extra work. She stated she was new to the job and was still training. The ADON stated there had never been a discussion between management staff about monitoring night shift. The ADON stated she was not responsible for training any of the staff. During an observation and interview on 4/17/2024 at 6:35 p.m., the Maintenance Director measured the opening of the main living area to be 93 inches and the couch in the main living area was 74 inches. When placed in the middle of the doorway there was a 4.5 inch opening on each side of the couch which was too small for wither a wheelchair or a person to be able to walk through. The Maintenance Director stated there used to be two couches in the main living area, but one was thrown away on an unknown date. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/17/2024 at 6:45 p.m. CNA F stated she was regular full-time staff at the facility and worked many extra shifts. CNA F stated she saw Resident #1 restrained by RN A with her own eyes. CNA F stated RN A stated it was for his own protection. CNA F stated RN A stated she knew it was wrong and she knew she was going to take the blame for it. CNA F stated she saw RN A get a gait belt out of the closet because she kept having to get Resident #1 to sit down. CNA F stated RN A stated she could not keep watching him, so she strapped him down for his own safety. CNA F stated RN A used the gait belt across Resident #1's stomach and buckled in behind the resident in the back. CNA F stated Resident #1 responded by just sitting there. She stated he fiddled with it but did not scream or holler and did not try to get out. CNA F stated Resident #1 normally tried to stand up and his was off balance. CNA F denied participating in strapping Resident #1 to the chair or seeing any other staff member doing it. She stated she did witness RN A applying the straps. CNA F stated CNA E got in a heated exchange of words with RN A about strapping Resident #1 down. CNA F stated she could not remember when this occurred. She stated she could not remember what months this occurs. She stated she saw it maybe 2-3 times. She stated she thought the first time she saw it was before Christmas, but she could not be sure. CNA F stated she never reported it because RN A stated she was going to take the blame for it. CNA F stated she knows restraint was a form of abuse. She stated she did not report the abuse because she relied on RN A's word that she was going to take the blame. CNA F stated she knows she should have reported it. CNA F denied knowledge of any other resident abuse. She denied knowledge of verbal/emotional abuse. CNA F stated RN A had a very hard deep voice, a very strong voice. She stated when RN A spoke at the nurses station, she could be heard all the way down at the end of the hall but it was not in a disrespectful way. CNA F stated RN A was a really good nurse. CNA F stated she did see RN move the couch and put in blocking the entrance/exit of the main living room to keep Resident #1 from getting out of the room. CNA F stated they normally work with one nurse and two aides at night. She stated they would all take turns watching the residents. She stated some of the residents do not sleep at night and there had been some chaotic nights. She stated on the chaotic nights they still made sure the residents needs were met. CNA F stated she did not complete the abuse training in-service after the incident and still had not completed it as of this interview. She stated she worked to help the DON out by working an extra shift and the DON gave her permission to be excluded from the abuse class. CNA F stated she had taken abuse training in the past and she had been trained to report restraint, abuse including physical, verbal and sexual abuse immediately to the Administrator. During an interview on 4/17/2024 at 7:10 p.m. LVN J stated there were two-night shift nurses. She was one of them and RN A was the other one. She stated they did not work on the same nights. LVN J stated she had no knowledge of the restraint of Resident #1 or any other resident. She stated she learned about it when RN A was fired. She stated she knows RN A worked a lot of hours and did not have full time aides and was given agency staff to work with. LVN J stated it was not RN A's fault. She stated RN A did they best she could. LVN J stated the facility was a restraint free facility. She stated they could not use restraints because it was a dignity issue, and the residents could hurt themselves if restrained. She stated she was trained to report abuse, including restraint to the Administrator immedi [TRUNCATED]

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on observation, interview and record review the facility failed to ensure that residents are free from physical or chemical restraints imposed for purpose of discipline or convenience and that are required to treat the resident's medical symptoms for 1 of 8 (Resident #1) residents reviewed for restraint, in that; The facility failed to ensure that Resident #1 was free from restraint when RN A and NA H tied Resident #1 to a wheelchair with a gait belt wrapped around his abdomen and secured behind the resident out of reach and by using furniture to block his movement while in the wheelchair on multiple occasions from 10/082023-03/01/2024. This failure resulted in the identification of an Immediate Jeopardy (IJ) on 4/18/2023 at 5:27 p.m. The IJ template was provided to the facility on [DATE] at 5:31 p.m. While the IJ was removed on 4/21/2024 the facility remained out of compliance at a level of potential harm with a scope identified as pattern until interventions were put in place to ensure staff members were in compliance with identifying and reporting abuse. This failure could affect residents by placing them at risk of abuse, physical harm, pain, mental anguish, emotional distress, and serious harm. The findings included: 1. Record review of Form 3613-A, Provider Investigative Report dated 3/08/2024 and signed by the Administrator revealed an allegation of abuse was confirmed. The report indicated on 3/01/2024 a CNA alleged RN A used a gait belt to keep a resident in the wheelchair. The report indicated Resident #1 was the victim. Record review of a photocopy of text conversation between the DON and RN A (undated) revealed the DON sent a text to RN A that indicated she had been trying to reach RN A by phone to let her know she was suspended pending investigation because it was reported she used a gait belt to restrain Resident #1 . The DON indicated she had to report it to state. RN A responded by asking if she should go to work on Monday and Tuesday. RN A stated, I did use a gait belt .sorry about the belt but I was just trying to keep him from falling. The DON responded by telling RN A not to go to work Monday or Tuesday. This document was signed by the DON. Record review of a handwritten document dated 3/01/2024 and signed by the DON revealed agency CNA B called her (the DON) and told her RN A on the night shift was using a gait belt to restrain Resident #1 in his wheelchair at night. The document indicated CNA B could not give specific dates or times. Record review of a handwritten document dated 3/04/2024 and signed by the DON revealed CNA D stated she had witnessed RN A use a gait belt to restrain Resident #1 in his wheelchair. The document indicated CNA D could not remember exact dates and times and stated CNA did not report it because she was scared of retaliation from RN A. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a handwritten document dated 3/04/2024 and signed by the DON revealed CNA N stated she had witnessed RN A use a gait belt to restrain Resident #1 at night. She stated she did not report it because she was afraid of retaliation and could not remember exact dates and times. Record review of Resident #1's face sheet dated 4/15/2024 revealed an admitted [DATE] with readmitted [DATE] with diagnoses which included: dementia moderate with behavioral disturbance, unsteadiness on feet and generalized muscle weakness. Record review of Resident #1's significant change MDS assessment dated [DATE] revealed a BIMS score of could not be assessed because the resident was rarely or never understood. The assessment indicated Resident #1 required moderate assistance to go from sitting to standing, moderate assistance to walk and was totally dependent on staff for ADL care. The assessment indicated Resident #1 had two or more falls since admission to the facility and no restraints were being used. Record review of Resident #1's Care Plan for falls dated 9/28/2023 revealed a revision 2/21/2024 for an intervention which included that Resident #1 would be seated in the front dining room within eyesight when not in his bed. Also, on 2/21/2024 an intervention was added that read Resident #1 will have seat belt attached to wheelchair and must be locked when in wheelchair and seatbelt must be released every 2 hours, it was revised on 2/26/2024 and removed from the active care plan. Record review of Resident #1's Care Plan for elopement dated 8/11/2021 revealed the resident liked to wander and was disoriented to place, had impaired safety awareness and a cognitive impairment and had verbalized wanting to leave the facility with a history of wandering which included: distract Resident #1 by offering pleasant diversions, structured activities, food, conversation, television, book. Resident #1 prefers to socialize with peers in common area. Record review of the Resident #1's consents revealed there were no consents for physical restraints. Record review of Resident #1's physician orders history from admission to current revealed no orders for restraints. During an observation/interview on 4/15/2024 at 10:16 p.m. revealed there were no residents in the main common area or near the nurse's station. The facility lights were low, and the atmosphere was calm/quiet. CNA B was observed near the nurse's station in the hallway. CNA B stated Resident #1 had returned from the hospital today and had been confused and combative with staff which she described as normal behavior for the resident. CNA B stated Resident #1 kept wandering to different hallways saying he was going to beat someone up. She stated she approached him in a calm way, redirected him and just talked to him which was how she was trained to respond. She stated although he was confused, she eventually got him to bed. During an observation on 4/15/2024 at 10:19 p.m., Resident #1 was observed on a low bed, with fall mat in place. The resident was sleeping and had the covers pulled up over his head. During an observation on 4/15/2024 at 10:45 p.m., Resident #1 remained asleep in his bed. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation/interview on 4/16/2024 at 3:26 p.m., Resident #1 was observed seated in his wheelchair in the main front living/dining area nearest the nurse's station. Resident #1 moved almost constantly and kept scooting up toward the edge of his wheelchair where he was redirected calmly by staff. Resident #1 was alert and smiled when spoken to but did not respond when questions were asked. Resident #1 did not have any obvious injuries. During an observation on evening shift at 4/16/2024 at 8:22 p.m., Resident #1 was observed asleep in his bed with the covers over his head, low bed with fall mat in place. During an interview on 4/16/2024 at 10:04 a.m., the DON stated she was the facility ADON until 1/01/2024 when she became the DON. She stated Resident #1 had a fall history and had run out of new interventions to try. She stated after every fall she updated Resident #1's care plan. She stated the most effective intervention was to keep Resident #1 within eyesight. She stated on 4/04/2024 she put a goal for him to be up in his wheelchair out of his room when awake to prevent Resident #1 from ambulating unassisted. The DON stated there was no pattern of time for the falls because they happened on every shift. She stated the falls were not happening with one particular staff person. She stated she had terminated RN A on night shift for restraining Resident #1 in his wheelchair with a gait belt. The DON stated Resident #1 was more active on night shift. The DON stated she did have enough staff to care for him. She stated he was so unsteady on his feet that by the time the staff saw him stand up it was too late. The DON stated she did not know how often or how many days Resident #1 was restrained. The DON stated when she asked staff about it, she could not get a good answer. The DON stated the staff said they did not report the restraint earlier because they were scared of retaliation. The DON stated the facility did discuss restraining Resident #1 because a family member brought it up. The family member wanted Resident #1 restrained. The DON stated she briefly added restraint to Resident #1's care plan, but he never had an order for restraint. She stated they presented it to their legal team, and it did not pass through. She stated legal said, absolutely not. The DON stated she never got as far as assessing Resident #1 to see if he could undo a seatbelt in the wheelchair because it never got that far. She stated RN A was not using a seatbelt she was using a gait belt as a restraint, and he could not undo it. The DON stated the facility did not have cameras in the facility. The DON stated RN A admitted to doing it but would not give a time frame, or an exact date. The DON stated RN A admitted to restraining Resident #1 2-3 times, but she was very vague. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/17/2024 at 3:17 p.m., the DON stated none of the residents in the facility were reliable for an interview due to dementia. She stated all residents in the facility had a diagnosis of dementia with memory issues. She stated some of the residents also had hallucinations/delusions and would not be able to give a reliable interview regarding restraint/abuse. The DON stated RN A worked night shift from 6 pm to 6 am. She stated she had two witnesses who worked from 6 pm to 10 pm who confirmed the allegations of abuse against RN A, CNA C and CNA D. The DON stated she initially suspended RN A when the allegation surfaces (date unknown) but right away she thought she was going to have to let RN A go. The DON stated since RN A admitted the allegation, they let her go. The DON stated there would have been a bigger investigation had she denied the allegations. The DON stated RN A told her she was the only person who restrained a resident, but she was really vague. The DON stated she asked RN A about the times and dates, but RN A did not know how long it had occurred. She stated she interviewed CNA E who worked for an agency, but she denied seeing abuse and the other regular staff member (unknown name) said she didn't see it either. The DON stated on 3/01/2024 when she received the allegations of abuse, she had approximately 31 staff. She stated she in-serviced 19 of those staff on abuse and neglect. The DON stated when she called the meeting for the in-service CNA F (night shift) had worked the whole week and she did her a favor by picking up extra shifts, so she excused CNA F from the in-service and the other person (CNA E) from night shift was an agency person. The DON stated agency staff had their own in-services through their agency. She stated if the agency staff are in the building when the meeting was called, they would attend. The DON stated she did not in-service night shift staff because she does not see the night shift people because they occur during the daytime. The DON stated as part of the abuse investigation she completed a skin assessment of Resident #1 and found no new skin conditions. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/17/2024 at 3:46 p.m., CNA B stated she worked for a staffing agency and first began working at the facility in August 2023. CNA B stated on 3/01/2024 (unknown time) she notified the DON via text that she needed to talk to her. CNA B stated CNA E notified the DON by talking to her and text that RN A was doing stuff to the residents on the same night. CNA B stated she did not talk to the DON about what was occurring until the next morning which was 3/01/2024 when the DON came to the facility. CNA B stated Resident #1 wandered and would go into rooms. She stated RN A did not want him to wander so he started to get aggressive. She stated he was pulling on the handrails and kicking. CNA B stated RN A told the CNAs to go get a gait belt and tie Resident #1 down. CNA B stated we (CNA B and CNA E) told her they were not going to do it. She stated CNA E took RN A a gait belt and gave it to her but CNA E did not use it. CNA B stated RN A stated fine, it was going to be on her anyways (meaning she was the one who would get in trouble), like she did not care and tied him down anyway. CNA B stated the DON asked her the dates and it was two shifts prior so it would have been on 2/28/2024 around med pass time which was approximately 8:00 p.m. CNA B stated she also told the DON; it really bothered her that RN A wanted to restrain Resident #1. She stated she also let the DON know it was not the first time. CNA B stated she did not tell the DON because she forgot about it until now, but RN A would also get the big couch in the main living area and block the entrance to prevent Resident #1 from coming out of the room. CNA B stated she knew that was also a restraint. She stated Resident #1 knew he could not get out of the room, so he just sat there in his wheelchair. She stated RN A stated she wanted to keep him there because he was wandering and trying to get into rooms, and she did not want him to move while she was sitting down and the CNAs were down the halls working. She stated, these were not one day events. No one had wanted to report it. She stated CNA E and CNA K both had talked about the abuse, and both had information. CNA B stated she wrote a witness statement. She stated a lot of staff wrote witness statements to the DON. CNA B stated she had not spoken to the Administrator and did not even know who the Administrator was. She stated she was trained to report abuse which is what she did. CNA B stated after this event there was a training. She stated they were told to read and sign something, but she could not remember what it was about. During an interview on 4/17/2024 at 4:11 p.m., CNA D stated she was regular full-time staff at the facility. She stated she did not work with RN A often. CNA D stated RN A was loud, and she was rude, but she never saw abuse. CNA D stated the handwritten statement written by the DON was not accurate. CNA D stated when the DON called her and asked her about the gait belt on Resident #1, she told the DON, no. CNA D stated she thought the DON misunderstood her. CNA D stated RN A did ask her to put a gait belt on as a restraint on Resident #1 but she did not understand what the meant. CNA D stated she responded to RN A by telling her she was going to lay him down in bed. She stated she did lay him down and he stayed in bed. CNA D stated RN A told her to get the gait belt because Resident #1 was trying to walk. She stated this occurred before 9:30 p.m. because she did her last rounds at 9:30 p.m. and left by 10:00 p.m. She stated this occurs sometimes before Christmas. She stated she thought it was somewhere between October and November 2023. She stated it was hard to remember the dates. CNA D stated she did not think using a gait belt to restrain Resident #1 was abuse. She stated she did not understand. She stated it was not until the DON told her what was going on (unknown date) and there were other reports of abuse and the use of restraint by RN A that she told the DON what she knew about RN A. CNA D stated she never saw any other resident with a gait belt on or a restraint. CNA D stated after the events they had a meeting where they talked about restraint, abuse, and neglect but she could not remember what was taught. She stated they had to watch some videos and take a quiz. She stated she was trained to report abuse immediately to the Administrator. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/17/2024 at 4:31 p.m., CNA E stated she worked with an agency and had worked at the facility regularly for 3-4 months, mostly on the weekends with RN A. CNA E stated RN A told her Resident #1 was problematic and aggressive. CNA E stated RN A told her the facility used a gait belt restrain on him because he was a fall risk and did not sit still. CNA E stated she asked RN A if there was a doctor's order for the restraint and she said no. CNA E stated once she learned there was no doctors order she no longer assisted. CNA E stated RN A stated it was okay to use it because she was going to take the fall for it (she was the one who would get in trouble). CNA E stated she took pictures and sent them to her agency and also told the DON about it. CNA E stated she did not want to work at the facility anymore because of it. CNA E stated it was just Resident #1 that she was witness to. She stated she did not have knowledge of any other residents. CNA E stated there were other aides who assisted in strapping Resident #1 down, including NA H. She stated she could not remember the names of the other aides. She stated Resident #1 would not cooperate with RN A. He would try to go from sitting to standing. She stated it was the way RN A spoke to Resident #1, he would regularly hit RN A and be aggressive with her. CNA E stated RN A would tie Resident #1 down by putting him either in his wheelchair or a regular chair and she would loop the gait belt around his abdomen and then loop the buckle in the back where he would not reach it or untie it. CNA E stated RN A would put the gait belt on pretty tight. CNA E stated LVN L, a morning nurse asked about the redness on Resident #1's abdomen, and she told the nurse RN A straps Resident #1 down. She stated LVN L asked me additional information and then asked if she had informed the DON. CNA E stated LVN L said there were no orders for restraint. CNA E stated she told the DON the third time she saw it. She stated this started in January 2023. She stated she told the DON; RN A made her do things she was not supposed to do. She stated she told the DON on the week of 2/23/2024-2/27/2024 but was not sure the exact day. She stated she also talked on the phone with the DON on 2/11/2024-2/12/2024 about it. She stated the DON was surprised and listened to her side of the story. She stated after she initially told the DON on 2/11/2024-2/12/2024, RN A called the DON and complained about her. CNA E stated she specifically told the DON She (RN A) strapped Resident #1 down with a gait belt word for word. CNA E stated the DON stated she would talk to RN A. CNA E stated RN A was not sent home and continued to work at the facility. She stated multiple other staff also reported it to the DON (unknown staff, unknown dates). CNA E stated She stated she was trained to report abuse to her agency. She stated her agency was a data base and she entered it into the data base but could not remember when this occurred, she stated she thought she reported it to her agency in January 2023. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/17/2024 at 5:11 p.m., CNA N stated on a Monday in February 2024 she stayed over from day shift to work until 10 p.m. with RN A and agency CNA E. She stated on that Monday, CNA E told her RN A was making the aides put Resident #1 in a chair with a gait belt. She stated they strapped him to the chair like a restraint. CNA N stated CNA E told her RN A and CNA E got into and she called the DON. CNA N stated on Tuesday, the next day she again stayed until 10 p.m. with RN A. She stated Resident #1 was in the front main living/dining room area trying to stand up. CNA N stated RN A was passing meds and could see Resident #1 from where she was standing. CNA N stated RN A yelled at her to grab Resident #1 and then get a gait belt and put it around him. CNA N stated she told RN A no. CNA N stated RN A yanked the gait belt out of her hand and stated she was doing it herself. CNA N stated she again told RN A no and told her she would sit with Resident #1 so he would not need a restraint. CNA N stated RN A tried to put the gait belt around Resident #1, but she (CNA N) put her hand out and stopped RN A from wrapping it around him. CNA N demonstrated how RN A took the gait belt and reached around the front of the resident with the gait belt with intentions to strap it around his abdomen and secure it in the back. CNA N stated she believes if she had not been there to stop her RN A would have strapped Resident #1 down with the gait belt. CNA A stated RN A walked off. CNA N stated she asked CNA E and CNA G what had happened with RN A. She stated they told her RN A had asked them to put a gait belt restraint on Resident #1 and they did because RN A told them to. CNA N stated on Friday, RN A was still working at the facility, and said she guessed it was not a big deal and she was not in trouble because someone had told on her and she was still working. CNA N stated she let the DON and the Administrator know what RN A said about not getting in trouble. She stated that was on a Friday (3/01/2024). CNA N stated it then became a big deal and she has not seen RN A since. CNA N stated to her knowledge no other residents were not involved. She stated CNA E was very upset about the way RN A was treating the residents. CNA N stated she told the DON and the Administrator together what she had witnessed. She stated she also told the DON and Administrator that RN A was walking around making fun of it, like it was a big joke that she had been doing it and was not getting in any trouble. She stated she told all of this to management. CNA N stated Resident #1 did not seem upset because of his dementia but some of the staff was upset about it, including CNA E. She stated the residents do not understand because of their dementia. CNA N stated she had been trained to report abuse to the Administrator immediately. She stated she waited to report it because CNA E stated she had already reported it and at that point she had not seen it herself. She stated when RN A tried it, she was able to stop her. CNA N stated by Friday, 3/01/2024 she decided they needed to hear her side of the story. She stated she did not see any injuries to Resident #1. She stated management responded by saying there would be a state investigation. CNA N stated she was not asked to write a witness statement from facility management. She stated she would be willing to write out her version on a piece of paper in front of this surveyor for proof. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/17/2024 at 6:10 p.m., the ADON was presented as a witness by the DON. The ADON stated CNA D told her she did see RN A strap Resident #1 to a chair with a gait belt but because RN A was a registered nurse, she did not report it because Who are they going to believe a RN or a CNA? The ADON stated CNA D stated she actually witnessed it and told the ADON approximately one month ago. The ADON stated she was a charge nurse when this occurred and did not become the ADON until 3/01/2024. The ADON stated the first time she knew anything about the situation was when all the chatter started about it when the facility reported it to state (3/01/2024). She stated she heard NA H and CNA C talk about it, but this was after it was already reported. The ADON stated she never heard any residents complain and did not see any change in any resident behaviors. The ADON stated restraint was abuse. The ADON stated she has come to assist night shift before when they needed help but did not know where that was. She stated it was to do extra work. She stated she was new to the job and was still training. The ADON stated there had never been a discussion between management staff about monitoring night shift. The ADON stated she was not responsible for training any of the staff. During an observation/interview on 4/17/2024 at 6:35 p.m., the Maintenance Director measured the opening of the main living area to be 93 inches and the couch in the main living area was 74 inches. When placed in the middle of the doorway there was a 4.5 inch opening on each side of the couch which was too small for wither a wheelchair or a person to be able to walk through. The Maintenance Director stated there used to be two couches in the main living area, but one was thrown away on an unknown date. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/17/2024 at 6:45 p.m. CNA F stated she was regular full-time staff at the facility and worked many extra shifts. CNA F stated she saw Resident #1 restrained by RN A with her own eyes. CNA F stated RN A stated it was for his own protection. CNA F stated RN A stated she knew it was wrong and she knew she was going to take the blame for it. CNA F stated she saw RN A get a gait belt out of the closet because she kept having to get Resident #1 to sit down. CNA F stated RN A stated she could not keep watching him, so she strapped him down for his own safety. CNA F stated RN A used the gait belt across Resident #1's stomach and buckled in behind the resident in the back. CNA F stated Resident #1 responded by just sitting there. She stated he fiddled with it but did not cream or holler and did not try to get out. CNA F stated Resident #1 normally tried to stand up and his was off balance. CNA F denied participating in strapping Resident #1 to the chair or seeing any other staff member doing it. She stated she did witness RN A applying the straps. CNA F stated CNA E got in a heated exchange of words with RN A about strapping Resident #1 down. CNA F stated she could not remember when this occurred. She stated she could not remember what months this occurs. She stated she saw it maybe 2-3 times. She stated she thought the first time she saw it was before Christmas, but she could not be sure. CNA F stated she never reported it because RN A stated she was going to take the blame for it. CNA F stated she knows restraint was a form of abuse. She stated she did not report the abuse because she relied on RN A's word that she was going to take the blame. CNA F stated she knows she should have reported it. CNA F denied knowledge of any other resident abuse. CNA F stated RN A was a really good nurse. CNA F stated she did see RN move the couch and put in blocking the entrance/exit of the main living room to keep Resident #1 from getting out of the room. CNA F stated they normally work with one nurse and two aides at night. She stated they would all take turns watching the residents. She stated some of the residents do not sleep at night and there had been some chaotic nights. She stated on the chaotic nights they still made sure the residents needs were met. CAN F stated she did not complete the abuse training in-service after the incident and still had not completed it as of this interview. She stated worked to help the DON out by working an extra shift and the DON gave her permission to be excluded from the abuse class. CNA F stated she had taken abuse training in the past and she had been trained to report restraint, abuse including physical, verbal and sexual abuse immediately to the Administrator. During an interview on 4/17/2024 at 7:10 p.m. LVN J stated there were two-night shift nurses. She was one of them and RN A was the other one. She stated they did not work on the same nights. LVN J stated she had no knowledge of the restraint of Resident #1 or any other resident. She stated she learned about it when RN A was fired. She stated she knows RN A worked a lot of hours and did not have full time aides and was given agency staff to work with. LVN J stated it was not RN A's fault. She stated RN A did they best she could. LVN J stated the facility was a restraint free facility. She stated they could not use restraints because it was a dignity issue, and the residents could hurt themselves if restrained. She stated she was trained to report abuse, including restraint to the Administrator immediately. During an interview on 4/17/2024 at 7:19 p.m., CNA K stated she worked for an agency. She stated she had worked with RN A. CNA K stated RN A was a little rude and did not move much. She stated RN A passed meds and then would just sit at the desk. CNA K stated RN A never asked her to put a restraint or use a gait belt on a resident. She stated she never saw one put on a resident but did hear RN A state she was going to have to put a gait belt on Resident #1 to keep him in his wheelchair so he would not fall. CNA K stated she tried to just keep to herself and not pay attention. She stated she really did not have any knowledge and for the most part RN A was alright with her. She stated she could not really remember working at the facility when asked if she had reported it. She replied I don't remember to all further questions about details and training and declined further interview. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/17/2024 at 7:24 p.m., CNA G stated she was full time staff at the facility. She stated the very first time she worked nights at the facility, a Saturday night (2/10/2024-2/11/2024), RN A asked NA H to put a gait belt around Resident #1. CNA G stated NA H physically put the gait belt around the resident clasping it in the back. CNA G stated she asked NA H what she was doing it and NA H stated she was restraining Resident #1. CNA G stated had asked RN A if there were doctor's order and she said no, it was just the way she did it so he would not have any falls. CNA G stated she told NA H she had to take it off Resident #1 because there were no doctor's orders and NA H said no. CNA G stated she knew it was against the law to restrain residents in the state of Texas. She stated CNA E and RN A got in an argument over it. CNA G stated it just did not sit right with her and felt like the DON would have told her if they were supposed to restrain Resident #1. CNA G stated CNA E said it had happened before and that she had reported it to her agency. CNA G stated RN A got really upset with her when she told her to take it off. CNA G stated she asked CNA E to help her take it off Resident #1. She stated RN A told her and CNA E if we touched Resident #1, we would get in trouble. CNA G stated CNA E and RN A got in a screaming match and a lot of abuse things were said by both parties. She stated both CNA E and RN A were calling the DON trying to resolve it. CNA G stated she told the DON about the gait belt. She stated she was not able to hear the DON's response. She stated while CNA E was talking to the DON on the phone RN A continued yelling at CNA E. CNA G stated she did hear CNA E tell the DON that RN A placed a gait belt around Resident #1 and that she told NA H to do it to. CNA G stated she heard CNA E tell the DON that she (CNA G) had taken it off. CNA G stated she does not know what was said after that point because CNA E had to go outside to continue the conversation because RN A was yelling. CNA G stated after this happened everything calmed down and she took Resident #1 to bed. CNA G stated when she came back to work on Sunday (date unknown) RN A tried to do it again. She stated RN A told NA H to do it and this time NA H refused. CNA G stated RN A said if ya'll are not going to do it then she was going to do it. CNA G stated she told RN A no and told her she was just going to lay Resident #1 down in bed. CNA G stated RN A stated if he stays in bed then that is perfect. CNA G stated she never witnessed RN A physically put the gait belt on Resident #1 but she did witness her tell NA H to do it. She stated those were the only two days she worked with RN A. She stated she told the DON she was not going to work with RN A anymore because of it and moved to working day shift. CNA G stated this occurred on Super Bowl weekend 2/11/2024. She stated she worked both 2/10/2024 and 2/11/2024. CNA G stated after CNA E reported the restraint to the DON, RN A stayed at the facility and worked the whole shift. She stated no one went home. She stated the DON never came to the facility that night. CNA G stated she was new to the facility at the time and did not have anyone's phone numbers to report it but she knew CNA E reported it. She stated CNA E showed her where she had reported it (to her agency) multiple times, 3 times in total on the portal. She stated after this occurred the facility eventually put phone numbers up to report abuse. CNA G stated RN A continued to work in at the facility until sometimes in March (date unknown). CNA G denied knowledge of abuse or restraint of any other resident. She stated it was just Resident #1. She stated Resident #1 looked really confused by the restraint and he was trying to fight it. She stated he did not know why he could not get up. She stated it was tied around him like a seat belt. She stated he was trying to get up and stand up which was causing the wheelchair to move forward with him. She stated it was almost making the wheelchair fall over while he was trying to stand up. CNA G stated it looked really weird [TRUNCATED]

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety 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** 38511 Based on record review and interview the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect and exploitation for 1 of 8 residents (Resident #1) reviewed for restraint and abuse, in that; The facility failed to develop and implement and abuse policy that clearly defines restraint as abuse and ensure staff had the knowledge of how and where to report allegations of restraint and abuse. This failure resulted in the identification of an Immediate Jeopardy (IJ) on 4/18/2023 at 5:27 p.m. The IJ template was provided to the facility on [DATE] at 5:31 p.m. While the IJ was removed on 4/21/2024 the facility remained out of compliance at a level of potential harm with a scope identified as isolated until interventions were put in place to ensure staff members were in compliance with identifying and reporting abuse. This failure could place all residents at risk for potential abuse due to restraint due to unreported restraint and abuse and result in continued abuse, physical harm, psychosocial harm and a decline in health and potential for injury. The findings included: Record review of a facility policy titled Abuse and Neglect-Clinical Protocol dated 2022 revealed: 1. Abuse is defined at 483.5 as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enable through the use of technology. 2. The nurse will report findings to the physician. As needed, the physician will assess the resident/patient to verify or clarify such findings, especially if the cause or source of the problem is unclear. The policy did not identify or define restraint as a form of abuse. Record review of a facility policy titled Recognizing Signs and Symptoms of Abuse/Neglect undated revealed To aid in abuse prevention, all personnel are to report any signs and symptoms of abuse/neglect to their supervisor or to the Director of Nursing Services Immediately. This policy contradicts other evidence including an interview with the Administrator who identified herself as the abuse coordinator. Record review of Form 3613-A Provider Investigative Report dated 3/08/2024 and signed by the Administrator revealed an allegation of abuse was confirmed. The report indicated on 3/01/2024 a CNA alleged RN A used a gait belt to keep a resident in the wheelchair and used profanity when she spoke to a resident. The report indicated Resident #1 was the victim. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's face sheet dated 4/15/2024 revealed an admitted [DATE] with readmitted [DATE] with diagnoses which included: dementia moderate with behavioral disturbance, unsteadiness on feet and generalized muscle weakness. Record review of Resident #1's significant change MDS assessment dated [DATE] revealed a BIMS score of could not be assessed because the resident was rarely or never understood. The assessment indicated Resident #1 required moderate assistance to go from sitting to standing, moderate assistance to walk and was totally dependent on staff for ADL care. The assessment indicated Resident #1 had two or more falls since admission to the facility and no restraints were being used. Record review of Resident #1's Care Plan for falls dated 9/28/2023 revealed a revision 2/21/2024 for an intervention which included that Resident #1 would be seated in the front dining room within eyesight when not in his bed. Also, on 2/21/2024 an intervention was added that read Resident #1 will have seat belt attached to wheelchair and must be locked when in wheelchair and seatbelt must be released every 2 hours, it was revised on 2/26/2024 and removed from the active care plan. Record review of Resident #1's Care Plan for elopement dated 8/11/2021 revealed the resident liked to wander and was disoriented to place, had impaired safety awareness and a cognitive impairment, and had verbalized wanting to leave the facility with a history of wandering which included: distract Resident #1 by offering pleasant diversions, structured activities, food, conversation, television, book. Resident #1 prefers to socialize with peers in common area. Record review of the Resident #1's consents revealed there were no consents for physical restraints. Record review of Resident #1's physician orders history from admission to current revealed no orders for restraints. During an interview on 4/16/2024 at 10:04 a.m., the DON stated she had terminated RN A on night shift for restraining Resident #1 in his wheelchair with a gait belt. The DON stated Resident #1 was more active on night shift. She stated he was so unsteady on his feet that by the time the staff saw him stand up it was too late. The DON stated she did not know how often or how many days Resident #1 was restrained. The DON stated when she asked staff about it, she could not get a good answer. The DON stated the staff said they did not report the restraint earlier because they were scared of retaliation. The DON stated the facility did discuss restraining Resident #1 because a family member brought it up. The family member wanted Resident #1 restrained. The DON stated she briefly added restraint to Resident #1's care plan, but he never had an order for restraint. She stated they presented it to their legal team and it did not pass through. She stated legal said, absolutely not. The DON stated she never got as far as assessing Resident #1 to see if he could undo a seatbelt in the wheelchair because it never got that far. She stated RN A was not using a seatbelt she was using a gait belt as a restraint, and he could not undo it. The DON stated the facility did not have cameras in the facility. The DON stated RN A admitted to doing it but would not give a time frame, or an exact date. The DON stated RN A admitted to restraining Resident #1 two to three times, but she was very vague. (continued on next page)

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	675502	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasanton North Nursing and Rehabilitation	404 Goodwin St Pleasanton, TX 78064

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/17/2024 at 3:17 p.m., the DON stated RN A worked night shift from 6 pm to 6 am. She stated she had two witnesses who worked from 6 pm to 10 pm who confirmed the allegations of abuse against RN A were CNA C and CNA D. The DON stated she initially suspended RN A when the allegation surfaces (date unknown) but right away she thought she was going to have to let RN A go. The DON stated since RN A admitted the allegation, they let her go. The DON stated RN A told her she was the only person who restrained a resident, but she was really vague. The DON stated she asked RN A about the times and dates, but RN A did not know how long it had occurred. During an interview on 4/17/2024 at 3:46 p.m., CNA B stated on 3/01/2024 (unknown time) she notified the DON via text that she needed to talk to her. CNA B stated CNA E notified the DON by talking to her and text that RN A was doing stuff to the residents on the same night. CNA B stated she did not talk to the DON about what was occurring until the next morning which was 3/01/2024 when the DON came to the facility. CNA B stated Resident #1 wandered and would go into rooms. She stated RN A did not want him to wander so he started to get aggressive. She stated he was pulling on the handrails and kicking. CNA B stated RN A told the CNAs to go get a gait belt and tie Resident #1 down. CNA B stated we (CNA B and CNA E) told her they were not going to do it. She stated CNA E took RN A a gait belt and gave it to her, but CNA E did not use it. CNA B stated RN A stated fine, it was going to be on her anyways (meaning she was the one who would get in trouble), like she did not care and tied him down anyway. CNA B stated the DON asked her the dates and it was two shifts prior so it would have been on 2/28/2024 around med pass time which was approximately 8:00 p.m. CNA B stated she also told the DON; it really bothered her that RN A wanted to restrain Resident #1. She stated she also let the DON know it was not the first time. CNA B stated she did not tell the DON because she forgot about it until now, but RN A would also get the big couch in the main living area and block the entrance to prevent Resident #1 from coming out of the room. CNA B stated she knew that was also a restraint. She stated Resident #1 knew he could not get out of the room, so he just sat there in his wheelchair. She stated RN A stated she wanted to keep him there because he was wandering and trying to get into rooms, and she did not want him to move while she was sitting down, and the CNAs were down the halls working. CNA B stated she had not spoken to the Administrator and did not even know who the Administrator was. She stated she was trained to report abuse which is what she did (to the DON). During an interview on 4/17/2024 at 4:11 p.m., CNA D stated she did not think using a gait belt to restrain Resident #1 was abuse. She stated she did not understand. She stated RN A did ask her to put a gait belt on as a restraint on Resident #1 but she did not understand what the meant. CNA D stated she responded to RN A by telling her she was going to lay him down in bed. She stated she did lay him down and he stayed in bed. CNA D stated RN A told her to get the gait belt because Resident #1 was trying to walk. She stated this occurred before 9:30 p.m. because she did her last rounds at 9:30 p.m. and left by 10:00 p.m. She stated this occurs sometimes before Christmas. She stated she thought it was somewhere between October and November 2023. She stated it was hard to remember the dates She stated it was not until the DON told her what was going on (unknown date) and there were other reports of abuse and the use of restraint by RN A that she told the DON what she knew about RN A. CNA D stated she never saw any other resident with a gait belt on or a restraint. CNA D stated after the events they had a meeting where they talked about restraint, abuse, and neglect but she could not remember what was taught. She stated they had to watch some videos and take a quiz. She stated she was trained to report abuse immediately to the Administrator. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/17/2024 at 4:31 p.m., agency CNA E stated she was trained to report abuse to her agency. CNA E stated RN A told her Resident #1 was problematic and aggressive. CNA E stated RN A told her the facility used a gait belt restrain on him because he was a fall risk and did not sit still. CNA E stated she asked RN A if there was a doctor's order for the restraint and she said no. CNA E stated once she learned there was no doctors order she no longer assisted. CNA E stated RN A stated it was okay to use it because she was going to take the fall for it (she was the one who would get in trouble). CNA E stated she took pictures and sent them to her agency and also told the DON about it. CNA E stated she did not want to work at the facility anymore because of it. CNA E stated it was just Resident #1 that she was witness to. She stated she did not have knowledge of any other residents. CNA E stated there were other aides who assisted in strapping Resident #1 down, including NA H. She stated she could not remember the names of the other aides. She stated Resident #1 would not cooperate with RN A. He would try to go from sitting to standing. She stated it was the way RN A spoke to Resident #1, he would regularly hit RN A and be aggressive with her. CNA E stated RN A would tie Resident #1 down by putting him either in his wheelchair or a regular chair and she would loop the gait belt around his abdomen and then loop the buckle in the back where he would not reach it or untie it. CNA E stated RN A would put the gait belt on pretty tight. CNA E stated LVN L, a morning nurse asked about the redness on Resident #1's abdomen, and she told the nurse RN A straps Resident #1 down. She stated LVN L asked me additional information and then asked if she had informed the DON. CNA E stated LVN L said there were no orders for restraint. CNA E stated she told the DON the third time she saw it. She stated this started in January 2023. She stated she told the DON; RN A makes her do things she was not supposed to do. She stated she told the DON on the week of 2/23/2024-2/27/2024 but was not sure the exact day. She stated she also talked on the phone with the DON on 2/11/2024-2/12/2024 about it. She stated the DON was surprised and listened to her side of the story. She stated after she initially told the DON on 2/11/2024-2/12/2024, RN A called the DON and complained about her. CNA E stated she specifically told the DON she (RN A) strapped Resident #1 down with a gait belt word for word. CNA E stated the DON stated she would talk to RN A. CNA E stated RN A was not sent home and continued to work at the facility. She stated multiple other staff also reported it to the DON (unknown staff, unknown dates). She stated she thought she reported it to her agency in January 2023. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/17/2024 at 5:11 p.m., CNA N stated she reported the restraint of Resident #1 on Friday 3/01/2024 to the DON and Administrator together after having knowledge of it for several days. She stated on a Monday in February 2024 she stayed over from day shift to work until 10 p.m. with RN A and agency CNA E. She stated on that Monday, CNA E told her RN A was making the aides put Resident #1 in a chair with a gait belt. She stated they strapped him to the chair like a restraint and then was mean to the residents telling them to shut up and called them stupid. CNA N stated CNA E told her RN A and CNA E got into and she called the DON. CNA N stated on Tuesday, the next day she again stayed until 10 p.m. with RN A. She stated Resident #1 was in the front main living/dining room area trying to stand up. CNA N stated RN A was passing meds and could see Resident #1 from where she was standing. CNA N stated RN A yelled at her to grab Resident #1 and then get a gait belt and put it around him. CNA N stated she told RN A no. CNA N stated RN A yanked the gait belt out of her hand and stated she was doing it herself. CNA N stated she again told RN A no and told her she would sit with Resident #1 so he would not need a restraint. CNA N stated RN A tried to put the gait belt around Resident #1, but she (CNA N) put her hand out and stopped RN A from wrapping it around him. CNA N demonstrated how RN A took the gait belt and reached around the front of the resident with the gait belt with intentions to strap it around his abdomen and secure it in the back. CNA N stated she believes if she had not been there to stop her RN A would have strapped Resident #1 down with the gait belt. CNA A stated RN A walked off. CNA N stated she asked CNA E and CNA G what had happened with RN A. She stated they told her RN A had asked them to put a gait belt restraint on Resident #1 and they did because RN A told them to. CNA N stated on Friday, RN A was still working at the facility, and said she guessed it was not a big deal and she was not in trouble because someone had told on her and she was still working. CNA N stated she let the DON and the Administrator know what RN A said about not getting in trouble. She stated that was on a Friday (3/01/2024). CNA N stated it then became a big deal and she has not seen RN A since. CNA N stated to her knowledge no other residents were not involved. CNA N stated RN A was not verbally the nicest, but more like she was inconvenienced by the residents rather than abusive towards them. CNA N stated she never heard name called. She stated RN A did use profanity but not directed towards the residents. CNA N stated the first time she told anyone about it was that Friday 3/01/2024. She stated CNA E was very upset about the way RN A was treating the residents. CNA N stated she told the DON and the Administrator together what she had witnessed. She stated she also told the DON and Administrator that RN A was walking around making fun of it, like it was a big joke that she had been doing it and was not getting in any trouble. She stated RN A was slamming drawers on the med carts around the residents. She stated she told all of this to management. CNA N stated Resident #1 did not seem upset because of his dementia but some of the staff was upset about it, including CNA E. She stated the residents do not understand because of their dementia. CNA N stated she had been trained to report abuse to the Administrator immediately. She stated she waited to report it because CNA E stated she had already reported it and at that point she had not seen it herself. She stated when RN A tried it, she was able to stop her. CNA N stated by Friday, 3/01/2024 she decided they needed to hear her side of the story. She stated management responded by saying there would be a state investigation. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/17/2024 at 6:45 p.m. CNA F stated she had taken abuse training in the past and she had been trained to report restraint, abuse including physical, verbal, and sexual abuse immediately to the Administrator. CNA F stated she saw Resident #1 restrained by RN A with her own eyes. CNA F stated RN A stated it was for his own protection. CNA F stated RN A stated she knew it was wrong and she knew she was going to take the blame for it. CNA F stated she saw RN A get a gait belt out of the closet because she kept having to get Resident #1 to sit down. CNA F stated RN A stated she could not keep watching him, so she strapped him down for his own safety. CNA F stated RN A used the gait belt across Resident #1's stomach and buckled in behind the resident in the back. CNA F stated Resident #1 responded by just sitting there. She stated he fiddled with it but did not cream or holler and did not try to get out. CNA F stated Resident #1 normally tried to stand up and his was off balance. CNA F denied participating in strapping Resident #1 to the chair or seeing any other staff member doing it. She stated she did witness RN A applying the straps. CNA F stated CNA E got in a heated exchange of words with RN A about strapping Resident #1 down. CNA F stated she could not remember when this occurred. She stated she could not remember what months this occurs. She stated she saw it maybe 2-3 times. She stated she thought the first time she saw it was before Christmas, but she could not be sure. CNA F stated she never reported it because RN A stated she was going to take the blame for it. CNA F stated she knows restraint was a form of abuse. She stated she did not report the abuse because she relied on RN A's word that she was going to take the blame. CNA F stated she knows she should have reported it. CNA F stated she did see RN move the couch and put in blocking the entrance/exit of the main living room to keep Resident #1 from getting out of the room. CNA F stated she knows she should have reported it. During an interview on 4/17/2024 at 7:10 p.m. LVN J stated she was trained to report abuse, including restraint to the Administrator immediately. She stated was one of them and RN A was the other one. She stated they did not work on the same nights. LVN J stated she had no knowledge of the restraint of Resident #1 or any other resident. She stated she learned about it when RN A was fired. She stated she knows RN A worked a lot of hours and did not have full time aides and was given agency staff to work with. LVN J stated it was not RN A's fault. She stated RN A did they best she could. LVN J stated the facility was a restraint free facility. She stated they could not use restraints because it was a dignity issue, and the residents could hurt themselves if restrained. During an interview on 4/17/2024 at 7:19 p.m., CNA K stated RN A never asked her to put a restraint or use a gait belt on a resident. She stated she never saw one put on a resident but did hear RN A state she was going to have to put a gait belt on Resident #1 to keep him in his wheelchair so he would not fall. CNA K stated she tried to just keep to herself and not pay attention. She stated she could not really remember working at the facility when asked if she had reported it. She replied I don't remember to all further questions about details and training and declined further interview. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/17/2024 at 7:24 p.m., CNA G stated restraint was considered abuse and was supposed to be reported to the Administrator immediately. She stated the very first time she worked nights at the facility, a Saturday night (2/10/2024-2/11/2024), RN A asked NA H to put a gait belt around Resident #1. CNA G stated NA H physically put the gait belt around the resident clasping it in the back. CNA G stated she asked NA H what she was doing it and NA H stated she was restraining Resident #1. CNA G stated had asked RN A if there were doctor's order and she said no, it was just the way she did it so he would not have any falls. CNA G stated she told NA H she had to take it off Resident #1 because there were no doctor's orders and NA H said no. CNA G stated she knew it was against the law to restrain residents in the state of Texas. She stated CNA E and RN A got in an argument over it. CNA G stated it just did not sit right with her and felt like the DON would have told her if they were supposed to restrain Resident #1. CNA G stated CNA E said it had happened before and that she had reported it to her agency. CNA G stated RN A got really upset with her when she told her to take it off. CNA G stated she asked CNA E to help her take it off Resident #1. She stated RN A told her and CNA E if we touched Resident #1, we would get in trouble. CNA G stated CNA E and RN A got in a screaming match and a lot of abuse things were said by both parties. She stated both CNA E and RN A were calling the DON trying to resolve it. CNA G stated she told the DON about the gait belt. She stated she was not able to hear the DON's response. She stated while CNA E was talking to the DON on the phone RN A continued yelling at CNA E. CNA G stated she did hear CNA E tell the DON that RN A placed a gait belt around Resident #1 and that she told NA H to do it to. CNA G stated she heard CNA E tell the DON that she (CNA G) had taken it off. CNA G stated she does not know what was said after that point because CNA E had to go outside to continue the conversation because RN A was yelling. CNA G stated after this happened everything calmed down and she took Resident #1 to bed. CNA G stated when she came back to work on Sunday (date unknown) RN A tried to do it again. She stated RN A told NA H to do it and this time NA H refused. CNA G stated RN A said if ya'll are not going to do it then she was going to do it. CNA G stated she told RN A no and told her she was just going to lay Resident #1 down in bed. CNA G stated RN A stated if he stays in bed then that is perfect. CNA G stated she never witnessed RN A physically put the gait belt on Resident #1 but she did witness her tell NA H to do it. She stated those were the only two days she worked with RN A. She stated she told the DON she was not going to work with RN A anymore because of it and moved to working day shift. CNA G stated this occurred on Super Bowl weekend 2/11/2024. She stated she worked both 2/10/2024 and 2/11/2024. CNA G stated after CNA E reported the restraint to the DON, RN A stayed at the facility and worked the whole shift. She stated no one went home. She stated the DON never came to the facility that night. CNA G stated she was new to the facility at the time and did not have anyone's phone numbers to report it but she knew CNA E reported it. She stated CNA E showed her where she had reported it (to her agency) multiple times, 3 times in total on the portal. She stated after this occurred the facility eventually put phone numbers up to report abuse. CNA G stated RN A continued to work in at the facility until sometimes in March (date unknown). CNA G denied knowledge of abuse or restraint of any other resident. She stated it was just Resident #1. She stated Resident #1 looked really confused by the restraint and he was trying to fight it. She stated he did not know why he could not get up. She stated it was tied around him like a seat belt. She stated he was trying to get up and stand up which was causing the wheelchair to move forward with him. She stated it was almost making the wheelchair fall over while he was trying to stand up. CNA G stated it looked really weird. She stated RN A then placed Resident #1 in the corner of the main living room area with a table in front of him blocking his wheelchair with furniture so he could not move. She stated he still had the gait belt around his abdomen at the time. She stated the gait belt was on tight and she was not able to get her fingers under the belt. CNA G stated she could not tell if Resident #1 was in any pain. She stated he just looked frustrated and confused. She stated Resident #1 could not really express his feelings because of the dementia. She stated he was unable to talk. CNA G stated on one of the days she was unsure how long Resident #1 had been in the restraint. She stated he was already in it when she saw it around 8:00 p.m. She stated she heard RN A tell NA H to put it on his but she did not see it occur. She stated she just heard RN A yell at NA H. She stated the words she heard were get the gait belt and NA H went and did it. CNA G stated she had always been taught they could not prevent a resident from moving by placement of furniture because that in of itself was considered restraint. She stated she was also told that the facility does not use restraints except by doctor order and we

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/17/2024 at 7:51 p.m., agency CNA M stated she was trained to notify the DON for any problems at the facility. She stated she only worked one night at the facility with RN A. She stated she had problems with RN A and did have to call the DON for interventions. She stated she refused to return to work at the facility after that one night due to issues with RN A. CNA M stated she had no knowledge of restraint or abuse. During an interview on 4/17/2024 at 7:53 p.m., agency CNA P stated she was trained to report abuse to her agency and to the Administrator. She stated she was trained they were not supposed to restrain people and she would report as abuse. She stated she had no knowledge of abuse or neglect at the facility. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/17/2024 at 8:09 p.m., the DON stated she first learned issues involving abuse/restraint regarding on evening/night shift when CNA B called her on 3/01/2024. She stated after she talked to CNA B, she also spoke with CNA E. The DON stated she did not obtain a statement of what happened from CNA E because her and RN A had argued on the shift, and she knew they were not getting along. The DON stated she wanted to only consider facts. The DON stated the argument between RN A and CNA E occurred sometime in February. She estimated it to be 2/27/2024 or 2/28/2024. She stated it was shortly before CNA B told her about the gait belt. The DON stated she did not bring CNA E back to work for approximately two weeks because she thought she was the problem. The DON stated what was reported to her in February was that RN A was rude and disrespectful. There was nothing about a gait belt. The DON stated after she talked to CNA E on the phone in February, RN A called her and told her CNA E was lazy and did not want to work with her. The DON stated she asked what she meant by that, and RN A wanted CNA E to do vital signs, but CNA E was giving showers. The DON stated she told RN A that the nurse typically obtains vital signs, but RN A did not like that answer. The DON stated she did not come to the facility during that shift to assess the situation. She stated they both agreed to get along and she (DON) felt the situation was okay. The DON stated she also talked to other staff but could not remember who she talked to. She stated the other staff told her RN A was rude. DON stated both RN A and CNA E were shouting but both agreed they could finish the shift. She stated no one told her about a gait belt restraint and she did not know how it impacted the residents. The DON stated she did not believe she received any notification about restraint or abuse or the use of a gait belt on 2/11/2024. She stated night shift nurse should report abuse to her. She stated she was certain no one told her about a gait belt as a restraint. She stated the staff only told her about it when she specifically asked questions about it. The DON stated RN A told her the gait belt restraint was to keep Resident #1 from falling. The DON stated no one had told her anyone was using furniture to block Resident #1. She stated that would be violating the rights of the resident and they could be injured. She stated their resident population, due to dementia just do not understand. She stated the resident's do not even understand something you do not want them to do. The DON stated the charge nurse was responsible for ensuring the safety of residents, for ensuring they were free from abuse and restraint on night shift. The DON stated she was responsible for monitoring the charge nurses. She stated she monitored the charge nurses by having a ton of in-services. She stated she had periodically dropped in at night to deliver supplies, to start an IV or just to peek in a window. She stated both the charge nurses and her were responsible for monitoring agency staff. The DON stated the agency was responsible for ensuring their staff had their own training. The DON stated the facility ensured residents were safe and free from harm by constant in-services and weekly skin assessments and observations. The DON stated does and does not consider restraint abuse, depending on the circumstances. The DON stated for Resident #1 his own family member wanted him to have a seat belt on his wheelchair. She stated she does not think in this case it would be considered abuse because he would not even realize he had one on. The DON stated she knows they are not supposed to use a gait belt as a restraint, but it was a hard one to consider and she didn't know if she would consider it abuse. The DON stated a restraint for Resident #1 did not pass legal because they are a restraint free facility. The DON stated her only question was if RN A was at that point of needing to use a gait belt as a restraint, why did she not call and tell anyone. The DON stated she does consider furniture placement as abuse because it prevents movement. She stated Resident #1 had to have some way to burn his energy and if he cannot stand, he wants to move. She stated he used his feet to self-propel in the wheelchair around the facility. The DON stated their policy indicated the facility was restraint free. She stated they could not block their vision or impede residents from getting out of bed. She stated the abuse policy did indicate restraint was abuse to her knowledge. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/18/2024 at 9:16 a.m., the Medical Director (MD) stated he had not been made aware of abuse/restraints in the facility. He stated he thought restraints were wrong. The MD stated he typically communicated with the facility and heard about situations like this from a call from the DON, the Administrator, or the NP. He stated he would tell them he did not agree with the restraint, but that had not happened, no one had communicated with him. He stated he communicated with the DON when he came to the facility and during QAPI meetings to discuss incidents to try to make things better. The MD stated the last QAPI was a few weeks ago and restrains was not part of the discussion. During an interview on 4/18/2024 at 10:56 a.m., the Administrator stated she was the abuse coordinator. She stated she expected the staff to notify her regardless of time immediately for any suspected abuse. She stated her phone numb [TRUNCATED]

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on observation, interviews and record reviews, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain good personal hygiene for 1 of 4 residents (Resident #3) reviewed for ADL care, in that; The facility failed to ensure Resident #3 was provided incontinent care when he pressed the call light and requested assistance from NA H. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life. The findings included: Record review of Resident #3's face sheet dated 4/15/2024 revealed an admitted [DATE] with diagnoses which included: progressive supranuclear ophthalmoplegia [Steele-[NAME]-[NAME] disease} (a rare disease that gradually destroys nerve cells in the parts of the brain that control eye movements, breathing, and muscle coordination) depression, and aphasia (the loss of ability to use and comprehend language). Record review of Resident #3's quarterly MDS assessment dated [DATE] revealed a BIMS score of 14 which indicated the resident was cognitively intact. Resident #3's functional abilities included: moderate assistance with transfers and was always incontinent of bowel and frequently incontinent of urine. Record review of Resident #3's Care Plan dated 6/15/2023 revealed the resident had a physical functioning deficit with interventions which included: call bell within reach. Record review of Resident #3's Care Plan dated 8/09/2023 revealed the resident had an alteration in elimination related to bowel and bladder incontinence with interventions which included: call bell within {reach} and reminders to use call bell as needed. Record review of Form 3613-A Provider Investigative Report dated 11/06/2023 revealed on 10/30/2024 a family member NA H neglected Resident #3 because he was not changed one time. The facility documented a skin assessment was completed and no injuries were noted. NA H was suspended pending investigation and notifications were made. A 1:1 in-service was provided to NA H. Record review of a video (undated) provided by a family member revealed a staff member (identified as NA H) turn off Resident #3's call light and stated, I am leaving but I will let them know. Resident #3 could be heard responding ok. There was no other information in the video of what occurred before or after this interaction. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation/interview on 4/11/2024 at 4:29 p.m., Resident #3 stated he used his call light when he needed assistance from staff and demonstrated how he used the call light which was pinned to his recliner in which he was sitting. When Resident #3 pressed his call light a staff member immediately responded to check on the resident. Resident #3 stated he required the assistance of two staff members for care and then changed his answer to one staff member. He stated staff responded when he pressed his call light, and he had no concerns. Resident #3 was difficult to understand and his response to questions were inconsistent. He declined further interview and stated no to further questions. During an interview on 4/17/2024 at 11:40 a.m. Resident #3's family members stated the family had cameras in the resident's room and could see when Resident #3 pushed the call light and when no one responded. The family members stated NA H had a history of telling the next shift Resident #3 needed to be changed instead of changing him. The family members stated Resident #3 was upset one day and told them by talking to the camera that he did not get changed by NA H when requested. They stated they reviewed the video camera footage and saw NA H turn off Resident #3's call light when he requested to be changed (date unknown). The family members stated they were very upset and sent the video footage to the Abuse Coordinator (name unknown). The family members stated the facility staff talked to them and took their complaint very seriously. The family stated they told the facility they did not want NA H to care for Resident #3 any longer and the facility had honored that request . During an interview on 4/17/2024 at 12:25 p.m., the DON stated in October 2023 when the incident occurred, she was the ADON. The DON stated as she recalled NA H answered Resident #3's call light and Resident #3 stated he needed to be changed. The DON stated NA H told the resident she would be right back but did not come right back. The DON stated a family member called the former DON and reported the incident. The DON stated she could not remember if she participated in the investigation at the time. The DON stated the investigation revealed the finding was true. She stated NA H was suspended during the investigation and received disciplinary action. The DON stated NA H's excuse for not providing care was she got sidetracked or got busy. The DON stated they had not received any complaints either before or after this incident about NA H. During an interview on 4/17/2024 at 12:31p.m., the former DON stated Resident #3's family was very good about communicating questions and concerns and had a camera in the resident's room. She stated the family communicated with her via text concerns for a missing incontinent episode. She stated she could not remember exactly what was said or the complaint. She stated she could not recall the date. The former DON stated she sent NA H home so she could investigate. She stated she could not remember the outcome of the investigation just that the family did not want NA H to take care of the resident any longer. The former DON stated the issue was resolved. She stated a skin assessment was completed with no changes in the skin. She stated she re-educated staff on abuse/neglect. The former DON stated staff should honor their word. They should go back and change the resident even if they had to stay an extra 30 minutes after their shift or they should communicate to another staff member to complete the task. She stated the staff was not perfect, but they were expected to honor their word. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/2024 at 12:55 p.m., NA H stated on 10/30/2023 at approximately 6:10 p.m., she saw Resident #3's call light on. She stated her shift ended at 6:00 p.m. and she was coming back from retrieving her lunch bag to leave but was still clocked in for work. She stated she was exhausted and ready to leave for the day. NA H stated she entered Resident #3's room and the resident stated he needed to be changed. NA H stated she told Resident #3 she was leaving for the day, and she would tell the ladies up front (other staff). NA H stated when she left the room another resident's call light came on across the hallway. She stated she assisted the other resident. NA H stated she honestly forgot to mention Resident #3 needed to be changed when she went up front. She stated the next day a family member saw the encounter on a camera and told the DON. She stated the DON told her she messed up and had her leave for the day. NA H stated she felt bad because it was an honest mistake and then later learned the family did not want her taking care of Resident #3 anymore. NA H stated she did not complete any training that she could remember after the incident . During an interview on 4/17/2024 at 1:09 p.m., the DON stated she had misspoken, and they were not able to find any written disciplinary action for NA H. the DON stated her expectations of staff would be that when a resident requested incontinent care, even at the end of a shift, the staff should have gathered the supplies and should have changed the resident. The DON stated I will be right back was acceptable if they did not have the supplies on them at the time and you are going to gather supplies. She stated it was not acceptable to tell someone to pass it along. The DON stated the facility had not conducted any staff training on resident rights or call light response in response to the incident. Record review of computer-based training provided to NA H on 11/03/2024 post incident revealed the following training completed: Neglect, Abuse, Mental Health: Caring for the Older Adult in LTC. A copy of the facility abuse/neglect policy was documented as given to NA H on 11/03/2023. Record review of an in-service training to facility staff on 10/31/2024 titled Abuse/Neglect was provided by the former DON. The in-service training was signed by 13 of approximately 35 staff members which included NA H. Record review of a facility policy titled Activities of Daily Living (ADL's), Supporting dated March 2018 revealed: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 2. Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: c. elimination (toileting).

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 38511 Based on observation, interview and record review the facility failed to ensure 1 of 1 Nurses' Aides (NA H) were not working in the facility longer than four months without having completed a competency evaluation program. The facility failed to ensure NA H was certified within four months of hire as full-time staff. This deficient practice place residents at risk for receiving care from an individual whose skill level was unproven. The findings included: Record review of the facility staff roster (undated) provided upon entrance revealed NA H was listed as a Nursing Assistant with a hire date of 10/11/2022. Record review of employee personnel files revealed NA H had a completed and notarized LTCR Form 3767 dated 6/01/2023 which indicated the DON (former ADON) was the instructor and had provided training from 11/01/2022 through 12/31/2022 to NA H. The personnel file indicated NA H was still listed as non-certified. During an observation/interview on 4/15/2024 at 10:15 p.m., NA H was observed working in the facility during evening/night shift providing resident care. NA H stated the facility had 3 hallways. She stated she was working a split assignment in which she had one hallway and half of another hallway, and another CNA had half the split hallway and the 3rd hallway as the assignment. During an interview on 4/17/2024 at 12:55 p.m. NA H stated she had worked at the facility for two years full time as a nurse aide and was not certified. She stated she had enrolled in the class to take her certification but failed the written test. She stated she did not remember the date. She stated she did not have the intention to retake the exam at this time because she did not have the money and could not afford the class. She stated she did not know when the deadline for completing the class was and referred questioning to the DON stating the DON had the information. During an interview on 4/17/2024 at 1:09 p.m., the DON stated NA H had failed the certification test for clinical skills in bed making. The DON stated NA H had to reschedule to re-take the exam. The DON stated she did not know when NA H completed the training. She stated there was a deadline for re-taking the exam which had passed. The DON stated the facility paid for the first exam but if the staff failed, they were responsible to pay for the retake. During an interview on 4/18/2024 at 12:51 p.m., the DON stated NA H was the only nurse aide working in the facility. She stated NA H took the certification class in 2022 and failed the clinical skills portion of the test. The DON stated she did not have the documentation for the failure. She stated she was not aware of any time restrictions for non-certified nurse aides working in the facility and was not aware of any regulatory requirements that require a nurse aide to become certified . (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy titled Nurse Aide Qualifications and Training Requirements dated August 2022 revealed: Nurse aides must undergo a state-approved training program. 5. The facility will not employ any individual as a nurse aide for more than four (4) months full-time, temporary, per diem or otherwise, unless: 1. That individual has completed a training program and competency evaluation program, or a competency evaluation program approved by the state. 7. Nursing assistants failing to successfully complete the required training program within the first four (4) months of their date of employment may be terminated from employment or may be reassigned to non-nursing related services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored properly in the cart for 1 (Licensed Nurse Medication Cart) of 2 medication carts, in that: The facility failed to ensure controlled medications for Resident's #1, #5, #8, and #19 were kept in their original packaging, appropriately labeled and secured with two locks when LVN J pre-dispersed DEA controlled substances which included: 1. One dosage of clonazepam for Resident #1 2. One dosage of Lyrica and one dosage Ativan for Resident #5 3. One dosage of Lyrica for Resident #8 4. Two dosages of liquid morphine for Resident #19. This failure could place residents at risk of not receiving prescribed medications as ordered and drug diversions. The findings included: 1. Record review of Resident #1's face sheet dated 4/15/2024 revealed an admitted [DATE] with readmitted [DATE] with diagnoses which included: dementia moderate with behavioral disturbance, unsteadiness on feet and generalized muscle weakness. Record review of Resident #1's significant change MDS assessment dated [DATE] revealed a BIMS score of could not be assessed because the resident was rarely or never understood. Record review of Resident #1's physician orders revealed an order for clonazepam (benzodiazepine prescription drug and DEA schedule IV-controlled substance list, a medication that has a calming effect on the brain and nerves and used to treat seizures, anxiety and to promote sleep) 1 mg, give 1 tablet two times a day which was scheduled for 8:00 pm on evening/night shift, related to dementia with a start date of 1/14/2024. 2. Record review of Resident #5's face sheet dated 4/18/2024 revealed an admitted [DATE] with diagnoses which included: Alzheimer's disease, psychotic disorder with delusions and generalized anxiety disorder. Record review of Resident #5's quarterly MDS assessment dated [DATE] revealed a BIMS of 6 which indicated a severe cognitive impairment. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's physician orders for April 2024 revealed an order for Ativan 0.5 mg (benzodiazepine which is a scheduled IV controlled substance by DEA and used to treat anxiety) give 1 tablet by mouth every 8 hours related to anxiety disorder with a schedule time of administration on evening/night shift of 12:00 am (midnight) with a start date of 7/14/2022 and Pregabalin (Lyrica) 75 mg, give 1 tablet by mouth two times a day for nerve pain, with a schedule time of administration on evening/night shift of 8:00 p.m. (a schedule V controlled substance defined by DEA used to treat pain), with a start date of 4/07/2021. 3. Record review of Resident #8's face sheet dated 4/15/2024 revealed an admitted [DATE] with readmitted [DATE] with diagnoses which included: dementia of unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance or anxiety, recurrent depressive disorders, and heart failure. Record review of Resident #8's annual MDS assessment dated [DATE] revealed a BIMS score that could not be determined due to low cognitive function. Record review of Resident #8's physician orders for April 2024 revealed an order for Lyrica 75 mg capsule (a schedule V controlled substance defined by DEA used to treat pain), give one capsule by mouth at bedtime for pain. 4. Record review of Resident #19's face sheet dated 4/22/2024 revealed an admitted [DATE] with diagnoses which included: Parkinsonism, Alzheimer's disease and pseudobulbar disorder (a nervous system disorder that causes inappropriate involuntary laughing and crying). Record review of Resident #19's quarterly MDS dated [DATE] revealed the BIMS score was not obtained. Record review of Resident #19's physician orders for April 2024 revealed an order for morphine sulfate concentrate oral solution (a schedule II narcotic by DEA used to treat pain) 20 mg/ml, give 0.5 ml sublingually (under the tongue) every 6 hours for chronic pain for 4 weeks with a start dated of 4/14/2024. During an observation/interview on 4/17/2024 at 8:35 p.m., LNV J was observed writing the name of multiple residents on clear medication cups and lining them up on the top of her medication cart. LVN J then dispensed different medications into the cups and began placing them in the top left drawer of her medication cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation/interview on 4/17/2024 at 8:42 p.m., of LVN J's medication cart with LVN J revealed 3 medication cups labeled with the names of Resident #19 which contained a small amount of blue liquid. LVN J stated the liquid was liquid morphine intended for Resident #19. There was also a medication cup with the name of Resident #5 that contained one white and red capsule and one small white pill in the drawer. LVN J identified the capsule as Lyrica and the pill as Ativan. There was a 3rd medication cup in the top left drawer with the name of Resident #1 which contained one greenish pill labeled with 833 which LVN J identified as clonazepam. (Upon review it was discovered the label a green round pill 833 was identified as 1 mg clonazepam). An observation of the top of the medication cart where LVN J was in the process of dispensing pills into the cups revealed an additional cup with a small amount of blue liquid which LVN J identified as liquid morphine for Resident #19. LVN J stated Resident #19 received two separate dosages of morphine during her shift. She stated she pre-dispensed both doses. The observation also revealed a medication cup with Resident #8's name and had a small blue and white capsule imprinted with the 75 PGBN which LVN J identified as Lyrica (upon review 75 PGBN was identified as 75 mg pregabalin, same as Lyrica). LVN J stated she pre-dispensed the medication before she intended to administer the medication so she could watch the residents while the CNA staff made their rounds. She stated she pulled the medications now but did not intend to administer the medications until later in the shift. LVN J stated that was the method that she had always used while working in the facility. She stated, you need to understand this is the best way to keep the residents safe. She stated she guaranteed she never mixed up the medications or gave the wrong medication to the wrong resident. LVN J stated she was trained to dispense medication as she went. She stated it was important to dispense narcotics/medications to ensure the right medication to the right patient, and stated she did that even though they were pre-dispensed . During an interview on 4/17/2024 at 8:49 p.m., the DON stated she was not aware that any staff were pre-dispensing narcotics into medication cups and it was not the facility's policy to dispense any medication before it was administered. The DON stated the medications could spill out of the medication cups and get mixed up. During an interview on 4/24/2024 at 11:06 a.m., the DON stated she had not been notified of any concerns from residents or staff in regards to administration of any controlled substance. The DON stated all narcotics/controlled substances should be secured behind two locks. She stated when they were in their original containers, they were locked in a separate locked compartment of the medication cart and the medication cart itself was locked. The DON stated when they were in a regular draw (such as top left drawer) the medications were not secured behind two locks. The DON stated as stated the risk was also the medications could tip over and spill and then the nurse would have a drawer full of pills. Record review of the Practitioner's Manual: An Informational Outline of the Controlled Substances Act revised 2023 at https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-071)(EO-DEA226)_Practitioner's_Manual_(final).pdf as reviewed on 4/26/2023 revealed: Section II: Schedules of Controlled Substances: Drugs and other substances that are considered controlled substances under the CSA are divided into five schedules. A controlled substance is placed in its respective schedule based on whether it has a currently accepted medical use in treatment in the United States and its relative abuse potential and likelihood of causing dependence when abused. Scheduled II substances have a high potential for abuse. Scheduled IV substances may lead to limited physical dependance or psychological dependance. Scheduled V substances may lead to limited physical dependence or psychological dependence. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a facility policy, titled Administering Medication dated 2021 revealed: 2. The Director of Nursing Services will supervise and direct all nursing personnel who administer medications and/or have related functions. 3. Medications must be administered in accordance with the orders, including any required time frame. This policy did not indicate how medications (or controlled substances) were to be dispensed and administered. Record review of a facility policy, titled Controlled Substances dated 2018 revealed: The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal and documentation of schedule II and other controlled substances. 5. Controlled substances must be stored in the medication room in a locked container, separate from containers for any non-controlled medications. This container must remain locked at all times, except when it is accessed to obtain medications for residents. This policy did not indicate how controlled substances should be kept secured on the medication cart or how they should be dispensed.