| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 675668 | A. Building<br>B. Wing | 04/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Wood Memorial Nursing and Rehabilitation Center | 320 Greenville Highway<br>Mineola, TX 75773 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928<br><br>Based on interview and record review the facility failed to ensure the residents had the right to be informed, in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or options he or she preferred for 1 of 13 residents (Resident #13) reviewed for resident rights.<br><br>The facility failed to get written consent from Resident #13 on the HHSC form 3713 for having Seroquel (antipsychotic medication) prescribed.<br><br>This failure could place residents at risk for receiving unnecessary antipsychotic medications without informed consent.<br><br>Findings included:<br><br>Record review of Resident #13's face sheet dated 04/08/25, indicated a [AGE] year-old female who admitted to initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #13 had diagnoses of personality disorder (mental health condition that involves long-lasting, disruptive patterns of thinking, behavior, mood and relating to others), bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), major depression (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and anxiety.<br><br>Record review of Resident #13's quarterly MDS assessment dated [DATE], indicated she was able to be understood and understood others. Resident #13 had a BIMS score of 14, which indicated her cognition was intact. The MDS assessment indicated Resident #13 had taken an antipsychotic medication during the last 7 days of the look back period.<br><br>Record review of Resident #13's comprehensive care plan revised 04/08/25, indicated Resident #13 was at risk for adverse consequences related to receiving antipsychotic medication (Seroquel) for treatment of bipolar disorder. The care plan interventions indicated to administer medications as prescribed by her physician, monitor resident's behaviors and response to medication.<br><br>Record review of Resident #13's physician order report dated 03/09/25-04/09/25, indicated Resident #13 had the following orders:<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Seroquel (quetiapine) 300mg one tablet at bedtime for bipolar disorder with a start date of 06/11/24.<br><br>Seroquel (quetiapine) 150mg one tablet by mouth once a day for bipolar disorder with a start date of 11/15/24.<br><br>Record review of Resident #13's medication administration record dated 04/01/25-04/10/25 indicated she had received Seroquel 150mg one tablet daily in the morning and Seroquel 300mg one tablet daily at bedtime.<br><br>Record review of Resident #13's Consent for Antipsychotic or Neuroleptic Medication Treatment (Form 3713) dated 12/02/24, indicated Resident #13 was taking Seroquel for Bipolar Disorder. Resident #13 did not sign the consent acknowledging the consent to the prescribed antipsychotic medication.<br><br>During an interview on 04/08/25 at 10:06 AM, Resident #13 said she was aware she was receiving Seroquel. Resident #13 said she consented to taking Seroquel but unable to recall if she signed a consent.<br><br>During an interview on 04/09/25 at 2:33 PM, the ADON said Resident #13 should have signed the consent when the medication was ordered. The ADON said Resident #13 was her own responsible party and was aware she was taking Seroquel. The ADON said the consent should be signed by Resident #13 acknowledging the risks and benefits of the medication. The ADON said the DON and herself were responsible for ensuring the proper consents were completed. The ADON said failure to obtain a signed consent indicated Resident #13 did not know the risks of taking Seroquel and if something were to happen, she did not give consent to take it.<br><br>During an interview on 04/09/25 at 2:49 PM, the Administrator said he expected all antipsychotic medication consents to be completed accurately. He said Resident #13 should have had a signed consent for her Seroquel indicating she was aware of the side effects. He said the DON or designee were responsible for ensuring the consent was completed accurately.<br><br>Record review of the facility's policy Psychoactive Medications dated July 2024, indicated . Residents are not given psychotropic medications unless the drug is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication . 9. Consent must be obtained from the resident or resident representative prior to administering a psychotropic medication (excluding an emergency). a. A consent form for antipsychotic/neuroleptic medication utilizing Texas form 3713 must be completed and signed by the resident or resident representative. Consent must be obtained in writing . |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>46892<br><br>Based on observation, interview, and record review, the facility failed to provide a safe, clean, and comfortable homelike environment for 1 of 2 shower rooms (B hall) reviewed for homelike environment.<br><br>The facility failed to ensure the shower room on B hall did not have black grime buildup on the walls and missing tiles on the floor.<br><br>This failure could place the residents at risk for a decreased quality of life, an uncomfortable, unhomelike environment due to unsanitary conditions.<br><br>Findings included:<br><br>During an observation and interview on 04/09/2025 at 4:04 PM, an observation of the shower room on B hall revealed the shower was missing tiles on the floor, the walls of the shower room had thick black gunk on them. LVN A said it looked like the shower room had not been cleaned. LVN A said housekeeping should be cleaning the shower, but she had not seen them clean it recently. LVN A said it was important for the shower to be clean for hygiene purposes and cleanliness, and the tile missing could result in mildew.<br><br>During an observation on 04/10/2025 at 8:38 AM, the shower on B hall had black gunk on the walls, a pink stain on the floor, and tiles on the shower floor were missing.<br><br>During an interview on 04/10/2025 at 8:42 AM, CNA F said housekeeping was responsible for cleaning the showers. CNA F said he had seen one of the housekeepers cleaning the shower on B hall yesterday (04/09/2025). CNA F said the tile on the shower floor had been missing for about 40-45 days. CNA F said he did not know if the missing tile had been logged on the maintenance log for it to be repaired. CNA F said it was important for the shower to be clean for infection control and to prevent cross contamination. CNA F said it was important for the missing tile to be repaired because it could cut somebody, cause the shower chair to get stuck, and cause an accident.<br><br>During an interview on 04/10/2025 at 8:48 AM, the Maintenance Director said he was aware that the shower on B hall had missing tiles on the floor, and it had been going on for a few months. The Maintenance Director said the repair was the next one in line to be done. The Maintenance Director said it was important for the shower room not to have missing tiles because nobody wanted a nasty shower, and it could cause a slight injury to the residents.<br><br>During an interview on 04/10/2025 at 10:39 AM, Housekeeper L said she was not responsible for cleaning the shower on B hall. Housekeeper L said one of the other housekeepers was responsible, but she did not know who. Housekeeper L said the CNAs were responsible for cleaning the shower when they did their showers, and then the housekeeper cleaned it.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 04/10/2025 at 10:42 AM, the Housekeeping/Laundry Supervisor said the showers should be cleaned every day by the housekeepers. The Housekeeping/Laundry Supervisor said she was aware of the shower room on B hall having the black gunk on the walls. The Housekeeping/Laundry Supervisor said they had to scrub the walls to get them clean, but then every couple of days it would come back. The Housekeeping/Laundry Supervisor said Housekeeper M was responsible for cleaning the shower on B hall. The Housekeeping/Laundry Supervisor said it was important for the showers to be clean because it can end up with germ buildup and infection could go through the roof and everybody will start getting sick.<br><br>During an interview on 04/10/2025 at 10:51 AM, Housekeeper M said the showers should be cleaned every week. Housekeeper M said when she scrubbed the shower walls most of the black build up came off. Housekeeper M said the last time she cleaned the shower on B hall was Monday (04/07/2025). Housekeeper M said she had notified her supervisor about having difficulty removing the black build up on the walls of the shower. Housekeeper M said she had noticed the missing tiles on the floor of the shower but had not reported it to anybody because sometimes she got busy and forgot about it. Housekeeper M said it was important for the shower to be clean for the residents because it could make them sick if it was dirty. Housekeeper M said the missing tiles on the floor of the shower could cause the residents to fall.<br><br>During an interview on 04/10/2025 at 11:22 AM, the Administrator said he was made aware of the condition of the shower on B hall that morning (the morning of 04/10/2025). The Administrator said housekeeping was responsible for cleaning the showers. The Administrator said the showers should be cleaned daily by housekeeping and then a deep clean was completed weekly by the Housekeeping/Laundry Supervisor. The Administrator said the shower room should be clean for cleanliness and because they did not want to deal with dirt, and it could affect the resident's psychological well-being. The Administrator said the shower missing tiles on the floor should be repaired because it was just a bumpy ride for the shower chair in or out, and it needed to look good.<br><br>Record review of the Maintenance Log Work Order requests for the months of May 2024 through the Month of March 2025 did not indicate a work order for the shower on B hall. There were no work orders for the month of April 2025.<br><br>Record review of the facility's policy titled, Resident Rights, revised February 2021, indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity . |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892<br><br>Based on interview and record review, the facility failed to ensure prompt efforts were made to resolve grievances for 2 of 18 residents (Resident #3 and Resident #13) reviewed for grievances.<br><br>1. The facility did not ensure a grievance was filed for Resident #3's underwear that was part of the facility fire.<br><br>2. The facility did not ensure a grievance was filed for Resident #13's missing pants.<br><br>These failures could place residents at risk for grievances not being addressed or resolved promptly.<br><br>Findings included:<br><br>1. Record review of a face sheet dated 04/09/2025 indicated Resident #3 was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on ,d+[DATE]//2024 with diagnoses which included dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life without behaviors), and anxiety and chronic obstructive pulmonary disease (chronic inflammatory lung condition that affects the respiratory system).<br><br>Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #3 understood others and was understood. The MDS assessment indicated Resident #3 had a BIMS score of 15, which indicated his cognition was intact. The MDS assessment indicated Resident #3 was independent for eating, required setup or clean-up assistance with toileting, dressing, and personal hygiene and partial to moderate assistance with showering/bathing self.<br><br>During an interview on 04/08/2025 at 11:28 AM, Resident #3 said there had been a fire in the laundry department and all his underwear had been destroyed. Resident #3 said he had 3 sets left but was unable to report how many underwear he lost. Resident #3 said he had asked several of the CNAs, nurses, and the laundry about his underwear being destroyed and nobody knows nothing.<br><br>2. Record review of Resident #13's face sheet dated 04/08/25, indicated a [AGE] year-old female who admitted to initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #13 had diagnoses of personality disorder (mental health condition that involves long-lasting, disruptive patterns of thinking, behavior, mood and relating to others), bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), major depression (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and anxiety.<br><br>Record review of Resident #13's Quarterly MDS assessment dated [DATE], indicated she was understood and understood others. The MDS assessment indicated Resident #13 had a BIMS score of 14, which indicated her cognition was intact.<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 04/08/2025 at 10:06 AM, Resident #13 said she had lost her $40 pants and had been missing them for a while. Resident #13 said she reported it to the Administrator, and he did not do anything. Resident #13 said her pants had not been found or replaced.<br><br>During an interview on 04/09/2025 at 3:12 PM, Laundry Aide H said she was aware Resident #3 lost some underwear in the fire. Laundry Aide H said when clothing was missing, she wrote down the item and went to look for it in the residents' rooms. Laundry Aide H said if the item was not located, she would notify the Administrator. Laundry Aide H said she had notified her manager about the clothes that were lost in the fire. She said there was not a lot of clothes lost because she had delivered majority of the clothes prior to the fire, but she knew Resident #3's underwear were not delivered. Laundry Aide H said most of the items lost in the fire were socks and underwear. Laundry Aide H said it was important for the residents clothing to be returned to them because it belonged to them, and it could be something personal to them that they really wanted. She said the facility was their home and it is where they stayed every day and they needed to feel safe and be happy where they were living.<br><br>During an interview on 04/09/2025 at 3:29 PM, Laundry Aide K said Resident #3 had told her he had lost some boxers in the fire. Laundry Aide K said the boxers had not been replaced, and she did not know if the clothes that were lost in the fire were going to be replaced. Laundry Aide K said if clothing was reported as missing by the residents to her, she would look for the clothes and if she could not find it, she would let the resident know she had not found the clothes. Laundry Aide K said she was not told if something was not found she needed to report it. Laundry Aide K said it was important for the residents clothing to be returned to them because that was the only thing they had, and they could not go to the store and get more.<br><br>During an interview on 04/09/2025 at 3:33 PM, the Housekeeping/Laundry Supervisor said there were not that many clothes that were lost in the fire. The Housekeeping/Laundry Supervisor said when the fire occurred the only thing in the laundry were the dirties. The Housekeeping/Laundry Supervisor said she was aware some of the clothes were burned, but not all of it. The Housekeeping/Laundry Supervisor said Resident #3 lost some underwear. The Housekeeping/Laundry Supervisor said nobody had her to write a grievance, but she believed one was done. The Housekeeping/Laundry Supervisor said Resident #13 had been missing some sky blue pants for months, and they had searched everywhere for the pants, and she had no idea where they went. The Housekeeping/Laundry Supervisor said she had not been told to write a grievance when clothes were reported missing to her. The Housekeeping/Laundry Supervisor said if she received a grievance that clothes were missing, she would go look for it and if she was unable to find it in the laundry she would check the residents' rooms. The Housekeeping/Laundry Supervisor said she notified the Administrator, the nurses and the CNAs when clothing was missing. The Housekeeping/Laundry Supervisor said it was important for the residents clothing to be returned to them because it could affect them financially and emotionally.<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 04/10/2025 at 11:14 AM, the Administrator said there were no clothes in the laundry when the fire happened. The Administrator said nobody had reported to him Resident #3 was missing underwear. The Administrator said if clothes were reported missing the Housekeeping/Laundry Supervisor would be notified and a search would be conducted to see if the clothes was in another resident's room. If the item was not found immediately a grievance would be completed. Any of the staff could complete a grievance for missing clothes. The Administrator said the staff should be aware they can complete a grievance. The Administrator said the Social Worker was responsible for the grievances. The Administrator said Resident #13 had not reported to him that she was missing any pants. The Administrator said it was important for a grievance to be filed for missing clothing because the residents could get upset and it would affect their psychological well-being.<br><br>During an interview on 04/15/2025 at 11:37 AM, the Social Worker said she was responsible for the grievances. The Social Worker said if she was made aware of a grievance, she wrote it up. The Social Worker said after a grievance was written, she put it on her log, and notified the department head the grievance belonged to. The Social Worker said for missing clothes the grievance went to the Housekeeping/Laundry Supervisor. The Social Worker said she kept a copy of the grievances to follow up on them. The Social Worker said the problem was when things were not conveyed to her and any of the staff could write a grievance, but it did not happen. The Social Worker said she was not told about Resident #3's underwear or Resident #13's pants. The Social Worker said any grievance was important to be addressed for the resident's peace of mind for them to know that they were taken seriously. The Social Worker said it was important for the residents' clothes to be returned to them because it was theirs and it could make the residents upset.<br><br>Record review of the grievances from September 2024-April 2025 did not indicate any grievances for Resident #3 or Resident #13.<br><br>Record review of the facility's policy titled, Grievances, Recording and Investigating, revised 01/12/2023, indicated, All grievances filed with the facility will be investigated and corrective actions will be taken to resolve the grievance(s). 1. The facility will make information on how to file a grievance available to residents, family, and staff .The Administrator or designee will record and maintain all grievances in the Grievance Log. 5. The Resident Grievance Form will be filed with the Administrator or designee and the resolution will be identified within three (3) working days of the concern. 6. The resident, or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended, within 3 working days of the filing of the grievance . |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47612<br><br>Based on observation, interview, and record review, the facility failed to ensure the right of the residents to be free from abuse for 11 of 24 residents (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9, Resident #10, Resident #11) reviewed for abuse.<br><br>The facility did not ensure Resident #2 was free from abuse when Resident #11 hit him in his right eye on [DATE].<br><br>The facility did not ensure Resident #11 was free from abuse when Resident #1 slapped him in the face [DATE].<br><br>The facility did not ensure Resident #2 was free from abuse when Resident #11 hit him on his right cheek on [DATE].<br><br>The facility failed to ensure Resident #7 was free from abuse when CNA R slapped Resident #7 on the back of her right hand on [DATE].<br><br>The facility failed to ensure Resident #9 and Resident #8 were free from abuse when Resident #8 open handed hit Resident #9 on her right upper shoulder and then Resident #9 turned back and swung her arm back and hit Resident #8 on [DATE].<br><br>The facility failed to ensure Resident #10 was free from abuse when his family member slapped him on his left cheek on [DATE].<br><br>The facility failed to ensure Resident #5 and Resident #6 were free from abuse when Resident #5 and Resident #6 got into a verbal altercation, and then Resident #5 hit Resident #6 3 times on his head on [DATE].<br><br>The facility failed to ensure Resident #3 and Resident #4 were free from abuse when Resident #4 spit and cussed at Resident #3, which resulted in Resident #3 hitting Resident #4 on the back of his head on [DATE].<br><br>These failures could place residents at risk of physical harm, mental anguish, or emotional distress.<br><br>The findings included:<br><br>1.Record review of a face sheet dated [DATE], indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (the most common cause of dementia, a neurodegenerative disorder that gradually damages memory and thinking skills), Unspecified psychosis not due to a substance or known physiological condition (a diagnosis used when psychotic symptoms are present, but they don't fit neatly into any specific psychotic disorder category), unspecified dementia (dementia where the specific cause or type was not identified).<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of the quarterly MDS assessment, dated [DATE] indicated Resident #1 had severe cognitive impairment. By staff assessment, Resident #1's BIMS was inconclusive. The MDS assessment indicated Resident #1 had no behaviors of hitting, kicking, pushing, scratching, grabbing, or abusing others.<br><br>Record review of Resident #1's care plan dated [DATE], indicated behavioral symptoms: resident woke up startled and began slapping a male resident that was seated beside her on the couch. Goal: resident will not be aggressive toward other residents in the memory care unit. Approach: in-service staff to assist resident to bed when she was sleepy.<br><br>Record review of the order summary dated [DATE], indicated Resident #1 may reside in the secure care unit due to poor safety awareness and elopement risk with a start date of [DATE].<br><br>Record review of the Provider Investigation Report incident date [DATE] indicated, Resident #1 and Resident #11 were sitting in the common area next to one another, Resident #1 was napping, Resident #1 awakened startled and open-handed slapped Resident #11 several times on the right side of the face. Residents were separated, Resident #1 placed on every 15-minute checks, no other incidents, no other allegation, skin assessment completed, no injuries, emotional assessment complete, no emotional distress, psychological notified, physician notified, Due to residents' cognitive ability and the fact the residents did not have the capacity to act willfully, knowingly, and recklessly we are unconfirming the abuse allegation.<br><br>2. Record review of a face sheet dated [DATE], indicated Resident #2 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (the most common cause of dementia, a neurodegenerative disorder that gradually damages memory and thinking skills), Cerebral infarction due to thrombosis of unspecified precerebral artery(occurs when a blood clot blocks one of the arteries supplying blood to the brain, leading to brain tissue damage), other encephalopathy ( a broad term encompassing any disorder or damage affecting the brain's function or structure).<br><br>Record review of the quarterly MDS assessment, dated [DATE], indicated Resident #2 had severe cognitive impairment. By staff assessment, Resident #2's BIMS was inconclusive. The MDS assessment indicated Resident #2 had no behaviors of hitting, kicking, pushing, scratching, grabbing, or abusing others.<br><br>Record review of Resident #2's care plan dated [DATE], indicated behavioral symptoms: Resident has socially inappropriate/disruptive behavioral symptoms as evidenced by: being combative, agitation, hitting others, and falling on the floor. Goals: Resident will not exhibit socially inappropriate/disruptive behavior such as trying to harm others, cursing, and being combative. Approach: Assess whether the behavior endangers the resident and/or others. Intervene if necessary.<br><br>Record review of the order summary dated [DATE], indicated Resident #2 may reside in the secure unit due to exit seeking and behaviors with a start date of [DATE].<br><br>(continued on next page) |

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| | 675668 | A. Building<br>B. Wing | 04/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Wood Memorial Nursing and Rehabilitation Center | 320 Greenville Highway<br>Mineola, TX 75773 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3. Record review of a face sheet dated [DATE], indicated Resident #11 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Schizophrenia, unspecified (a diagnostic category used when a person exhibits symptoms consistent with schizophrenia but does not meet the full criteria for any specific subtype of schizophrenia.), anxiety disorder (excessive worry, fear, and other physical and behavioral symptoms that interfere with daily life), altered mental status (a change in a person's mental function, ranging from slight confusion to coma).<br><br>Record review of the quarterly MDS assessment, dated [DATE] indicated Resident #11 had severe cognitive impairment. By staff assessment, Resident #11's BIMS was inconclusive. The MDS assessment indicated Resident #11 had no behaviors of hitting, kicking, pushing, scratching, grabbing, or abusing others.<br><br>Record review of Resident #11's care plan dated [DATE], indicated behavioral symptoms: resident had an altercation with another male resident. Goal: resident will not exhibit be aggressive toward other residents and will be safe from harm. Approach: redirected resident, assesses for injury, notified resident representative and nurse practitioner, administered one time dose of Ativan to calm resident's agitation as redirection ineffective, placed on 15-minute observation, notified social worker and psychological notified.<br><br>Record review of the order summary dated [DATE], indicated Resident #11 may reside in the secure unit due to high elopement risks and poor safety awareness with a start date of [DATE].<br><br>Record review of the Provider Investigation Report incident date [DATE] indicated, Resident #11 thought Resident #2 was going to run over his foot in his wheelchair and Resident #11 struck Resident #2 under the right eye. Charge nurse did a skin assessment and noted a small purple bruise under the right eye, no pain per resident. Residents were separated. Resident #11 was place on every 15-minute checks, Resident #2 placed on neuro checks, physician notified, one time order for Resident # 11, requested medication review from pharmacist, safe surveys done, no other negative findings, emotional assessment completed, no negative finding, skin assessment, bruise noted under Resident #2 right eye. Due to residents' cognitive ability and the fact the residents did not have the capacity to act willfully, knowingly, and recklessly we are unconfirming the abuse allegation.<br><br>Record review of the Provider Investigation Report incident date [DATE] indicated, Resident #2 and Resident #11 were in the dining room preparing to eat when Resident #11 went over and struck Resident #2 in the right cheek. Residents were separated. Resident #11 was placed on every 15-minute checks, families notified physician notified, no new orders, PRN Ativan .5mg prn given, psychological notified, safe survey conducted, no negative findings. Resident #2 skin assessment completed; redness noted to right cheek. Emotional assessment completed, no signs and symptoms of emotional distress from altercation. Due to residents' cognitive ability and the fact the residents did not have the capacity to act willfully, knowingly, and recklessly we are unconfirming the abuse allegation.<br><br>During an observation on [DATE] at 10:30 a.m., Resident #2 and Resident #11 were sitting in the living room with other residents watching TV. Surveyor attempted to interview both residents, however, they were non-interview able.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on [DATE] at 2:12 p.m., CNA O stated she did not witness the incident were Resident #1 slapped Resident #11 or the incident were Resident #11 hit Resident #2. CNA O stated it was her responsibility to redirect the residents when they showed signs of aggression. CNA O stated it was important to keep the residents safe from each other because the facility was their home. CNA O stated the failure with resident-to-resident altercation was the residents could be badly injured.<br><br>During an interview on [DATE] at 2:40 p.m., LVN A stated there were two altercations between Resident #2 and Resident #11. LVN A Resident #2 was making noises in the dining room and Resident #11 hit him on the left side of the face. LVN A stated Resident #11 thought Resident # 2 was going to run over his toes with the wheelchair and hit him in the right eye. LVN A stated she assessed both residents, they were separated and monitored every 15 minutes. LVN A stated it was important to know the resident to be able to notices when they may become aggressive. LVN A stated the failure was the staff did not realize Resident #11 was agitated before he hit Resident #2.<br><br>During an interview on [DATE] at 9:46 a.m., LVN N stated Resident #1 had been sleeping on the couch in the living room when Resident #11 startled her, and she slapped him. LVN N stated Resident # 1 was usually not aggressive toward the other residents. LVN N stated now when Resident #1 tries to lay down in the living room the staff was instructed to redirect Resident #1 to the bed. LVN N stated the safety of the residents was everyone's responsibility. LVN N stated it was important for the residents to feel safe because this was their home.<br><br>46928<br><br>4. Record review of Resident #7 face sheet dated [DATE], indicated a [AGE] year-old female who initially admitted to the facility [DATE] and discharged on [DATE]. Resident #7 had diagnoses of cerebral infarction (stroke), hypertension (high blood pressure), Alzheimer's (progressive disease that destroys memory and other important mental functions), paranoid schizophrenia (mental disorder characterized by hallucinations, delusions, disorganized thinking, and behavior), depression (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and anxiety.<br><br>Record review of Resident #7's significant change in status MDS assessment dated [DATE], indicated Resident #7 was sometimes understood and sometimes understood others. The MDS assessment indicated her BIMS score was 9, which indicated her cognition was moderately impaired. Resident #7 did not have behaviors or refused care. Resident #7 was dependent on staff with toileting, showers, personal hygiene, and eating. Resident #7 was always incontinent of bowel and bladder.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of the facility PIR dated [DATE] with an incident category of abuse indicated Resident #7 was the alleged victim and CNA R was the alleged perpetrator. The report named CNA S as the witness. The report indicated . [CNA S] and [CNA R] were transferring [Resident #7] when she became combative and scratched [CNA R], [CNA S] was able to assist and help remove [Resident #7's] grip, [Resident #7] then grabbed a hold of [CNA S], [CNA R] was able to help [CNA S] get free from [Resident #7]. Then [Resident #7] reached out to grab [CNA R] again, that's when [CNA R slapped [Resident #7] on the back of the hand stating, 'we're not gonna (going to) have any of that'. Head to toe assessment, no redness and/or bruising, no delayed bruising resident without s/s of distress. [CNA R] suspended pending outcome of the investigation, family notified, physician notified, safe surveys conducted no other negative findings. The PIR indicated investigation findings were unconfirmed. The PIR reflected Resident #7's progress note which included the head-to-toe assessment, Resident #7's updated care plan, safe surveys completed on [DATE], and in-service on the abuse and neglect policy completed on [DATE].<br><br>Record review of Resident #7's comprehensive care plan dated [DATE] indicated Resident #7 became combative while being transferred by 2 CNAs and grabbed one CNAs arm and left scratches on her skin. The care plan interventions indicated skin assessment, social services referral for emotional assessment, and psychiatric services to evaluate medications.<br><br>Record review of Resident #7 progress notes dated [DATE] at 7:30 PM and signed by LVN T, indicated head to toe assessment with findings of zero redness/and or bruising noted. Residents without signs and symptoms of distress noted.<br><br>Record review of the in-service sign in sheet dated [DATE], indicated 10 staff members were in-serviced on the abuse and neglect policy.<br><br>Record review of 10 resident safe surveys completed on [DATE] revealed no concerns of abuse.<br><br>Record review of CNA R's employee timecard dated [DATE]-[DATE], revealed on [DATE] CNA R clocked out at 8:01 PM.<br><br>Record review of CNA R's notice of termination indicated CNA R was terminated on [DATE].<br><br>Attempted phone interview on [DATE] at 08:43 AM with CNA R but there was no answer.<br><br>Attempted phone interview on [DATE] at 08:57 AM with LVN T but there was no answer.<br><br>During an interview on [DATE] at 09:00 AM, the HR director said CNA R never returned to work after she was suspended and was terminated.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on [DATE] at 1:43 PM, CNA S said on the day of the incident she had asked CNA R to assist her in transferring Resident #7 to bed. She said Resident #7 was being feisty like she would sometimes be, and CNA R opened slapped the back of Resident #7's right hand really hard. She said CNA R told Resident #7 No ma'am we do not do that. She said Resident #7 got mad and stopped. CNA S said CNA R left the room as soon as she finished assisting her. CNA S said abuse was physically hurting a resident. CNA S said she would notify the abuse coordinator, the administrator, immediately after an abuse allegation. She said she also would notify the charge nurse, DON and ADON. CNA S said she never had any issues with CNA R prior to this incident and no residents had complained to her about CNA R.<br><br>During an interview on [DATE] at 2:49 PM, the Administrator said Resident #7 had been combative with another aide and CNA R was trying to help free Resident #7 from the other aide when she slapped Resident #7 on her hand and said, we aren't going to have any of that. The Administrator said the slap to Resident #7's hand was considered abuse. He said he was the abuse coordinator and expected his staff to notify him immediately regarding any abuse allegations. He said they suspended CNA R and terminated her, conducted abuse/neglect in-service, nurse assessed Resident #7 and conducted safe surveys.<br><br>5. Record review of Resident #9's face sheet dated [DATE], indicated a [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses of cerebral ischemia (insufficient blood flow to the brain), dementia (memory loss), major depression (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and anxiety.<br><br>Record review of Resident #9's annual MDS assessment dated [DATE], indicated she was usually understood and usually understood others. The MDS assessment indicated Resident #9 had a BIMS score of 12, which indicated her cognition was moderately impaired. Resident #9 required supervision or touching assistance with showers and transfers. Resident #9 did not have behaviors.<br><br>Record review of Resident #9's progress note dated [DATE] at 4:30 PM and signed by LVN A indicated . [Resident #9] was elbowed in right shoulder by another resident while they were outside on patio for smoke break. [Resident #9] stated other resident suddenly became angry and accused her of smoking her cigarettes. The other resident elbowed [Resident #9]. [Resident #9] was assessed for injuries with no injuries noted.<br><br>Record review of Resident #9's weekly skin assessment progress note dated [DATE] at 3:06 PM and signed by LVN A revealed no skin issues.<br><br>Record review of Resident #9's progress note dated [DATE] at 4:57 PM and signed by the SW indicated . Resident had an incident with another resident. The other resident hit her for some reason, she's not sure why. SW visited with resident to monitor the situation. She shares that she is ok, but that 'that was crazy', and then kinda (kind of) giggled. Resident appears to be okay. She exhibits no s/s of delayed trauma from the incident. She exhibits no emotional distress from this incident. SW will continue to monitor resident.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #9's comprehensive care plan dated [DATE], indicated Resident #9 was involved in a disagreement with another female resident during smoke break where the other resident elbowed her in the shoulder. The care plan interventions included nursing assessed for injuries, Social Worker conducted emotional assessment, and staff would keep resident separated during smoke breaks out on the back patio.<br><br>During an interview on [DATE] at 3:40 PM, Resident #9 said she did not remember any altercations between any residents.<br><br>6. Record review of Resident #8's face sheet dated [DATE], indicated a [AGE] year-old female who initially admitted to the facility on [DATE] and discharged on [DATE]. Resident #8 had diagnoses of metabolic encephalopathy (a disorder that affects brain function), schizoaffective disorder (mental health condition marked by a mix of hallucinations and delusions), and major depression (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).<br><br>Record review of Resident #8's quarterly MDS assessment dated [DATE], indicated she was usually understood and usually understood others. The MDS assessment indicated Resident #8 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicate Resident #8 exhibited physical and verbal behaviors directed toward others which occurred 1 to 3 days of the 7-day look back period.<br><br>Record review of Resident #8's comprehensive care plan edited on [DATE] indicated Resident #8 was angry at another resident on the patio and used her elbow to hit the other resident in the shoulder. The care plan interventions indicated to redirect resident away from other resident, start Q 15-minute checks, notified nurse practitioners, new order for Ativan 0.5 mg BID for anxiety/aggression, monitor for effectiveness, SW and psychiatric NP to evaluate for possible need to send resident out for inpatient psych stay.<br><br>Record review of Resident #8's physician order report dated [DATE]-[DATE], indicated she had an order for Ativan 0.5mg one tablet twice a day for anxiety with a start date of [DATE].<br><br>Record review of Resident #8's progress note dated [DATE] at 5:29 PM and signed by LVN A, indicated . staff reported [Resident #8] hit another resident while outside smoking. This nurse spoke with resident stating [Resident #8] elbowed her in right shoulder. Stated [Resident #8] got verbally aggressive and said resident asked her to calm down with [Resident #8] getting angry with her and then elbowed her. Resident stated she isn't hurt. Will continue to observe behaviors.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of the facility's PIR dated [DATE] with an incident category of abuse indicated Resident #8 and Resident #9 were the residents involved. The report indicated Resident #8 and Resident #9 were in the residents supervised smoking area when a verbal altercation broke out with [Resident #8] accusing [Resident #9] of smoking her cigarettes. [Resident #9] told [Resident #8] to 'chill out' she has her own cigarettes. That's when [Resident #8] open handed hit [Resident #9] in the shoulder. [Resident #9] [NAME] her elbow back and contacted [Resident #8] in the shoulder. Residents separated, [LVN A]did skin assessments on both residents, no injuries noted. [SW] did emotional assessments on both residents, no negative findings. [Resident #8] placed on q15 minute checks, [Psychiatric NP] notified and increased [Resident #8's] Ativan to 0.5mg BID, physician notified, families notified, safe surveys conducted, no negative findings. The PIR reflected CNA X's witness statement, nurse's notes, Resident #8 and Resident #9's updated care plans, Resident #8's 15-minute location check dated [DATE] and [DATE], safe surveys completed on [DATE], and the abuse and neglect in-service completed on [DATE].<br><br>Record review of CNA X's handwritten witness statement dated [DATE] at 3:30 PM, indicated . I was sitting outside with the smokers and saw [Resident #8] hit [Resident #9] on her arms and took her blanket off her and [Resident #9] told her not to hit her anymore and [Resident #8] stated I will hit you. [Resident #9] stated I don't play that and don't hit me again.<br><br>Record review of Resident #8's progress note dated [DATE] at 4:48 PM and signed by the SW, indicated . Resident had an incident where she hit another resident. She was upset with her over something. SW visited with her and she is still having some issues with cycling, however, the incident has not left any s/s of emotional distress. She voices no concerns. SW will continue to monitor and follow up as needed .<br><br>Record review of the in-service sign in sheet dated [DATE], indicated 23 staff members were in-serviced on the abuse and neglect policy .<br><br>Record review of 10 resident safe surveys completed on [DATE] revealed no concerns of abuse.<br><br>Record review of Resident #8's Q15 minute location checks indicated it was initiated on [DATE] at 3:30 PM and completed on [DATE] at 3:30 PM.<br><br>During an interview on [DATE] at 10:46 AM, Resident #9 said the day of the incident Resident #8 had been eyeing her and then elbowed me. Resident #9 said she then elbowed Resident #8 back. Resident #9 said the staff separated them and did not have any further altercations.<br><br>During an interview on [DATE] at 5:43 PM. LVN A said the day of the incident she was the nurse for both residents. LVN A said she did not witness the incident. LVN A was able to answer questions regarding abuse and neglect in-service, separating the perpetrator, notifying the abuse coordinator immediately for any abuse allegations and types of abuse.<br><br>During an interview on [DATE] at 10:10 AM, the Administrator notified surveyors CNA X was deceased .<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on [DATE] at 2:49 PM, the Administrator said Resident #8 and Resident #9 were arguing over cigarettes. He said Resident #8 hit Resident #9 and then Resident #9 hit Resident #8 back. He said the residents were immediately separated and Resident #8 was placed on q 15-minute checks. He said they in-serviced staff on the abuse and neglect policy, the nurse assessed both residents with no injuries noted, and safe surveys were completed.<br><br>7. Record review of Resident #10's face sheet dated [DATE] indicated an [AGE] year-old male who admitted to the facility on [DATE] and discharged on [DATE]. Resident #10 had diagnoses of metabolic encephalopathy (a disorder that affects brain function), acute respiratory failure (condition that occurs when the lungs cannot adequately exchange gases, leading to insufficient oxygen in blood), dementia (memory loss) and diabetes (condition that results in too much sugar in the blood).<br><br>Record review of Resident #10's admission MDS assessment dated [DATE], indicated he was able to be understood and understand others. Resident #10 had a BIMS score of 7, which indicated his cognition was severely impaired. Resident #10 did not have behaviors. Resident #10 required substantial/maximal assistance with toileting, showering, and personal hygiene.<br><br>Record review of Resident #10's comprehensive care plan dated [DATE], indicated Resident #10's [family member] slapped him in the face when he refused to discharge the facility AMA per her demand. The care plan interventions included: 1. Police called, and resident's [family member] was removed from the facility. 2. Resident's [family member] is not allowed on facility premises-no trespassing issued. 3. Resident's [other family member] contacted. 4. APS notified. 5. HHSC self-report filed.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of resident #10's progress note dated [DATE] at 5:18PM and signed by LVN Q indicated . Residents [family member] approached the nurse's station and communicated that she would like to sign him out to go home. SN communicated that Resident was his own RP and would need to sign the paperwork himself. [Family member] agreed and SN filled out and approached Resident with the paperwork for AMA and explained to him the paperwork itself. Resident states that he did not feel comfortable leaving with [family member] at this time. [Family member] asked the nurse if they could have a moment to talk about the AMA form and him coming with her. SN stepped out of the room, after approx 20 min later [family member] approached the nurse's station again and resident said he wanted to see how well he walked on his own before signing the papers and leaving with [family member]. Resident was able to walk about five steps and states he felt faint, resident was assisted back to his WC and a sitting position. Resident then stated he did not wish to DC at this time. [Family member] then attempted to grab the clipboard from SN and stated, I will sign the Damn papers, he is my [significant other], SN explained that I understand that he is her [significant other] but without POA paperwork in place he is his own RP. [family member] then attempted to grab WC and push him outside himself. [Family member] was told that resident could not be taken from the facility against his will. [Family member] then open handed assaulted the resident in the face causing bleeding from her fingernails and a red area on his left cheek at this point resident is moved back from [family member] and [family member] is asked to leave. [Family member] attempted to slap SN and SN stopped her by blocking her hand and asking the [family member] to exit the building. [Family member] refused to leave until she was told that police officers were in route, she was escorted out of the building by staff then police approached her in the parking lot. She began yelling at the police officers that she did not assault her [significant other] she just slapped him . police officer [name and badge number] of [name of town] PD alerted the [family member]. She was CT from the building and not allowed to return or she would be arrested. [Family member] verbalized understanding per [police officer]. Resident was assisted back to bed and stated he was not in pain nor felt that he was in need of any assistance per paramedics. DON [name] was contacted as well as [Resident #10's other family member], who spoke with resident and gave his information to be added as a first contact. [Police officer]was given the name of [Administrator] and his contact info.<br><br>Record review of the facility's PIR dated [DATE] with an incident category of abuse indicated Resident #10 was the alleged victim and Resident #10's family member was the alleged perpetrator. The report indicated . [Resident #10's family member came in facility trying to discharge resident, [Resident #10] did not want to go with her. Resident stated he wanted to stay and do some more therapy as he was not ready to go home. [Resident #10's family member] got upset and slapped [Resident #10] on left cheek. [LVN Q] intervened and separated resident from his [family member] she did skin assessment, resident reddened area and superficial abrasions to left cheek. Resident state he was in no pain. [police department] notified they caught [Resident #10's family member] in the parking lot and criminally trespassed as [family member] is not allowed on premises or she will be arrested. [Family member] told police officer 'I didn't abuse him, I slapped him. [Resident #10 other family member] was notified and agreed with criminal trespass and taking over care of [Resident #10's]. Adult protective services notified and visited with resident [DATE]. [ombudsman] notified and visited with resident [DATE]. Physician notified. The PIR reflected Resident #10's progress noted dated [DATE], Resident #10's updated care plan regarding psychosocial well-being, APS referral, and staff was in-serviced on banned family member and what to do if she was a the facility completed [DATE].<br><br>(continued on next page) |

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|---|---|---|---|
| | 675668 | A. Building<br>B. Wing | 04/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Wood Memorial Nursing and Rehabilitation Center | 320 Greenville Highway<br>Mineola, TX 75773 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of the in-service sign in sheet dated [DATE] indicated 21 staff members were in-serviced on banned family member. Staff was advised not to allow admittance into the facility of Resident #10's family member. Staff was instructed to call police and have family member removed from the premises and Resident #10 was not allowed to leave with her.<br><br>Record review of the police report dated [DATE], indicated a disturbance call with description of [facility] reporting party advised a resident is being actively assaulted by his [family member] . yelling was heard in the background of call . The report narrative indicated . On Saturday, [DATE], at approximately 16:43 (4:43PM) hours I, [Officer Name], and [Officer Name] of the [Town] Police Department Patrol Division were dispatched to [facility's name and address] on report of a disturbance . I asked [ Resident #10's family member] what was going on today to which she stated she wanted [Resident #10] to leave the nursing facility and come home. [Family member] stated [Resident #10] wouldn't leave with her and wanted to stay at the facility so she slapped him. I contacted [LVN Q] who advised me [Resident #10's family member] arrived at the facility to see [ Resident #10] and stated she wanted him to come home with her. [LVN Q] stated [Resident #10] advised he did not want to go with her and stated he wanted to stay in the facility at which time [Resident #10's family member slapped [Resident t #10] with an open hand to the left side of his face, causing bruising. [LVN Q] stated she separated [Resident #10's family member] from [Resident #10] and contacted the Police Department. [LVN Q] stated to me that [Resident #10] is at their facility for rehab and advised me that he has all medical control over himself. I contacted [Resident #10] who advised me that he does not wish to leave the facility and does not feel safe with [family member]. [Resident #10] stated that when he told [family member] he did not want to go with her she slapped him in the face, causing pain. While speaking to [Resident #10] I noticed bruising under his left eye from the slap. [Resident #10] stated multiple times that he did not wish to press charges on [family member] and would not comply with filing any paperwork for an assault case. [LVN Q] advised me the facility wanted [family member] criminally trespassed from the facility. [Family member] was issued a criminal trespass from this location and advised that the [Town] Police Department Criminal Investigation Division and the Adult Protective Service [TRUNCATED] |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928<br><br>Based on observation, interview, and record review, the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain grooming and personal hygiene for 1 of 10 residents reviewed for ADLs. (Resident #35)<br><br>The facility failed to ensure Resident #12 received his shower as scheduled.<br><br>This failure could place residents at risk of not receiving services/care, decreased quality of life, and decreased self-esteem.<br><br>Findings included:<br><br>Record review of Resident #12's face sheet dated 04/10/25, indicated an [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #12 had diagnoses of myocardial infarction (heart attack), essential hypertension (high blood pressure), muscle weakness, and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe).<br><br>Record review of Resident #12's quarterly MDS assessment dated [DATE], indicated he was able to make himself understood and understood others. The MDS assessment indicated Resident #12 had a BIMS score of 15, which indicated his cognition was intact. Resident #12 did not refuse care and was independent with showers/baths.<br><br>Record review of Resident #12's comprehensive care plan revised 04/09/25 indicated he had an ADL function/rehabilitation potential, at risk for further decline, and a failure to have needs met related to ADL self-performance deficit. The care plan interventions indicated he required bathing/hygiene assist x 1. The care plan also indicated Resident #12 needed assistance with ADLs with interventions he preferred to have his bath/shower on Tuesday, Thursday, Saturday by hall aide between 6:00 AM- 6:00 PM.<br><br>Record review Resident #12's point of history report dated 04/01/25-04/09/25, indicated Resident #12 preferred to have his showers/baths on Tuesday, Thursday, Saturday between 6:00 AM - 6:00 PM. The report revealed the following:<br><br>04/01/25 shower was not provided.<br><br>04/02/25 shower completed at 3:26 AM by CNA DD.<br><br>04/03/25 shower completed at 2:31 AM by CNA Y.<br><br>04/04/25 shower completed at 2:05 PM by CNA CC.<br><br>04/05/25 shower completed at 2:20 AM by CNA AA, 4:31 PM by CNA BB and 10:03 PM by CNA Z.<br><br>04/06/25 shower completed at 8:23 AM and 8:21 PM by CNA Z.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 04/07/25 shower completed at 11:39 AM by CNA D and 11:01 PM by CNA Y.<br><br>04/08/25 shower completed at 11:45 AM by CNA D.<br><br>During an observation and interview on 04/08/25 at 10:30 AM Resident #12 was in his bed. He said he had not received a shower in over a week. He said his showers were scheduled for Tuesday, Thursday, Saturday. He said it made him feel bad not receiving his showers regularly.<br><br>During an interview on 04/09/25 at 11:35 AM, Resident #12 said he did not receive a shower yesterday (04/08/25).<br><br>During an interview 04/09/25 at 11:43 AM, CNA D said she worked from 6a-6p on 04/08/25 and was assigned to Resident #12. CNA D said she did not give Resident #12 a shower on 04/08/25 because she did not have time. CNA D said she was busy answering call lights and residents needing this or that. CNA D said the last time she saw resident receive a shower was on Thursday of last week (04/03/25). CNA D said the CNAs were responsible for ensuring the residents received their showers as scheduled. She said failure to provide showers would place the residents at risk for skin breakdown and health issues.<br><br>During an interview on 04/09/25 at 1:11 PM, CNA E said Resident #12's showers were scheduled on Tuesday, Thursday, and Saturday. CNA E said Resident #12 did not refuse his showers. CNA E said Resident #12 was usually assigned to her. CNA E said the last time she remembered Resident #12 receiving a shower was on Tuesday of last week (04/01/25). CNA E said she was off for a week after that. CNA E said CNAs and nurses were responsible for ensuring the residents received their showers as scheduled. She said failure to provide showers would place the residents at risk for wounds and infections.<br><br>During an interview on 04/09/25 at 2:33 PM, the ADON said the shower documentation comes up daily for the aides to document and they were consistently telling them to please read what they were documenting. The ADON said the point of care documentation was monitored daily during their morning meeting and for the most part was accurate. The ADON said she has reminded the nurses to document any refusals . The ADON said Resident #12 was not one who refused his showers. The ADON said the CNAs were responsible for ensuring the residents received their showers as scheduled. She said failure to provide showers would place the residents at risk for skin issues.<br><br>During an interview on 04/09/24 at 2:49 PM, the Administrator said he expected showers/baths to be provided as per the resident's preference. He said the charge nurse, DON or designee were responsible for ensuring the residents received their showers/baths. The Administrator said failure to provide showers/baths placed the resident at risk for smells.<br><br>Record review of the facility's policy Bath, Shower/Tub revised February 2018, indicated . The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin .<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of the facility's policy Activities of daily Living, ADLs, Supporting revised March 2018, indicated . Residents will provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). 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 ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care) . |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892<br><br>Based on interview and record review, the facility failed to maintain an effective pest control program to keep the facility free from pests for 4 of 18 (Resident #3 Resident #4, Resident #9 and Resident #14) residents reviewed for pest control.<br><br>The facility did not maintain an effective pest control program to ensure the facility was free of roaches and water bugs.<br><br>This failure could place residents at risk for an unsanitary environment and a decreased quality of life.<br><br>Findings included:<br><br>1. Record review of a face sheet dated 04/09/2025 indicated Resident #3 was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on ,d+[DATE]//2024 with diagnoses which included dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life without behaviors), and anxiety and chronic obstructive pulmonary disease (chronic inflammatory lung condition that affects the respiratory system).<br><br>Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #3 understood others and was understood. The MDS assessment indicated Resident #3 had a BIMS score of 15, which indicated his cognition was intact.<br><br>During an interview on 04/08/2025 at 11:28 AM, Resident #3 said there were roaches and water bugs in the dining room and rooms. Resident #3 said the last time he had seen them was about 2 days ago. Resident #3 said he saw the roaches and water bugs in the mornings around 6 am by the area where the coffee was served in the dining room when he went and turned the lights on. Resident #3 said he had reported it to the housekeepers, the CNAs, and the nurses. Resident #3 said they told him they would report it and get it taken care of.<br><br>2. Record review of a face sheet dated 04/10/2025 indicated Resident # 4 was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (weakness and paralysis of one site of the body following a stroke).<br><br>Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #4 was understood and understood others. The MDS assessment indicated #4 had a BIMS score of 15, which indicated his cognition was intact.<br><br>During an interview on 04/08/2025 at 3:23 PM, Resident #4 said there were huge water bugs and a lot of cockroaches everywhere and in the dining room by the coffee. Resident #4 said he had to be careful when he went to get coffee to make sure there was not a roach in his cup.<br><br>(continued on next page) |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3. Record review of an undated face sheet indicated Resident #14 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included focal traumatic brain injury (injury to the brain) and schizoaffective disorder bipolar type (a condition that can make you feel detached from reality with mood swings).<br><br>Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #14 was usually understood and usually understood others. The MDS assessment indicated Resident #14 had a BIMS score of 15, which indicated her cognition was intact.<br><br>During an interview on 04/08/2025 at 3:30 PM, Resident #14 said she had seen water bugs and roaches in her room, and she had reported it to the staff.<br><br>4. Record review of Resident #9's face sheet dated 04/08/2025, indicated a [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses of cerebral ischemia (insufficient blood flow to the brain), dementia (memory loss), major depression (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and anxiety.<br><br>Record review of Resident #9's annual MDS assessment dated [DATE], indicated she was usually understood and usually understood others. The MDS assessment indicated Resident #9 had a BIMS score of 12, which indicated her cognition was moderately impaired.<br><br>During an interview on 04/08/2025 at 3:40 PM, Resident #9 said when she turned the light on in her room and bathroom the big bugs come out. Resident #9 said the staff were aware of the bugs in her room.<br><br>During an interview on 04/09/2025 at 1:04 PM, CNA E said she had noticed roaches in the shower room about 2 weeks ago.<br><br>During an interview on 04/09/2025 at 1:22 PM, CNA F said there were gigantic water bugs and house roaches everywhere. CNA F said they got on the ceilings and the residents complained about them. CNA F said he had seen some today (04/09/2025). CNA F said he did not log it in the pest control binder but he verbally told the Maintenance Director.<br><br>During an interview on 04/10/2025 at 8:48 AM, the Maintenance Director said the staff was supposed to write in the pest control binder if they saw anything. The Maintenance Director said he had told the staff to write in the binder, but when he went to check the binders the staff also verbally told him. The Maintenance Director said the staff reported to him that they saw water bugs, but for a while he had not hear anything about roaches. The Maintenance Director said he did not have all the visits from the pest control, but there were binders on the east and west side of the building where the pest control person signed when he went to the facility. The Maintenance Director said it was important for there not to be any roaches or water bugs because nobody wanted the bugs, and it was important for the quality of life of the residents.<br><br>(continued on next page) |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 04/10/2025 at 9:37 AM, the Pest Control Technician said he last visited the facility on 03/26/2025 and was going to the facility twice a month. The Pest Control Technician said the facility had American roaches and water bugs, and they were coming out of the plumbing areas in the residents' rooms. He said the kitchen had German roaches, but the German roaches were almost resolved.<br><br>During an interview on 04/10/2025 at 10:51 AM, Housekeeper M said she saw roaches on the unit today (04/10/2025), and she had reported it to her supervisor. Housekeeper M said it was important for there not to be any roaches because they could get in the residents' clothes or get in the bed with them.<br><br>During an interview on 04/10/2025 at 11:18 AM, the Administrator said they had switched pest control companies in December 2024, and the pest control company had been perfect. The Administrator said he was not aware that the residents and staff were still seeing roaches and water bugs. The Administrator said he expected for the staff to document in the pest control book if they saw any roaches and water bugs so the facility could be treated accordingly. The Administrator said the facility staff were responsible for monitoring for any pests, and they should be documenting in the pest control books. The Administrator said having roaches and water bugs could affect the residents because it was nasty and dirty.<br><br>Record review of the east and west pest control binders for the building did not indicate any facility staff entries for pests sighted.<br><br>Record review of the facility's policy titled, Pest Control, revised May 2008, indicated, Our facility shall maintain an effective pest control program .Maintenance services assist, when appropriate and necessary, in providing pest control services . |