

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675729	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER Stonecreek Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 451 S El Camino Crossing San Augustine, TX 75972	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40124</p> <p>Based on observation, interview and record review, the facility failed to ensure residents were free from abuse for 1 of 3 residents (Resident #1) reviewed for abuse.</p> <p>The facility failed to prevent CNA A, on 9/04/24, from abusing Resident #1 when she purposefully tossed water on her.</p> <p>The noncompliance was identified as PNC. The noncompliance began on 09/04/24 and ended on 09/04/24. The facility had corrected the noncompliance before the survey began.</p> <p>The failure could place residents at risk for emotional distress, fear, decreased quality of life and further abuse.</p> <p>Findings included:</p> <p>Review of the face sheet for Resident #1 reflected she was admitted to the facility on [DATE] with diagnoses of schizoaffective disorder (mental illness), need for assistive personal care, lack of coordination and communication deficient (unable to communicate).</p> <p>Review of a Significant Change MDS Assessment for Resident #1 dated 7/4/24 indicated a BIMS score of 2 reflecting severe cognitive impairment. Resident #1 had physical behavioral symptoms directed toward others daily such as hitting, kicking, pushing, scratching, grabbing almost daily.</p> <p>Review of the Care Plan for Resident #1 with revisions dated 9/12/24 reflected focus of Resident #1 was at risk for psychosocial well-being related to incident with caregiver.</p> <p>Review of Nurses notes from 9/04/24 until this investigation indicated no changes in the actions, demeanor, or behaviors for Resident #1.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675729
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/25/24 at 9:45 am the DON said she received a call from Witness B needing to speak with her as soon as possible. Witness B came to her office and reported while Resident #1 was sitting at the dining table in the locked unit, CNA A walked by Resident #1 and tossed about a 1/2 cup of water from a Styrofoam cup onto the blanket Resident #1 was wrapped up in with some water splashing on her face. The DON asked when this occurred, she said it occurred right before CNA A left for the day, at 12:45pm to 1:00pm. The DON said she immediately went to the locked unit to perform a head-to-toe assessment on Resident #1. The DON said Witness B had already cleaned the water from Resident #1 when she arrived and was providing care to another resident. The DON said Witness C gave her statement regarding CNA A purposefully tossing water on Resident #1. The DON then reported the incident to the Administrator who is the Abuse Coordinator. The DON said she immediately completed head to toe assessments on the residents in the locked unit. She said that psychosocial assessments were completed as well that afternoon.</p> <p>During an interview on 9/25/24 at 10:00 am the Administrator stated Witness B and Witness C had confirmed CNA A had tossed water on Resident #1 on 9/04/24 at approximately 12:45 pm. The Administrator stated she was notified by the DON after Witness A and Witness B had reported the incident to the DON when she arrived back from lunch on 9/04/24 at 1:00pm to 1:15 pm. the facility investigation confirmed abuse and CNA A was suspended by phone, since she had left for the day immediately after the incident. The Administrator said Resident #1's representative and medical doctor were notified of the incident immediately. The Administrator stated ongoing assessments had confirmed Resident #1 had no negative outcome from the incident and was unable to determine if Resident #1 was aware that the incident had occurred. The Administrator said in-services were conducted on ANE, Dignity and dementia care on 9/04/24.</p> <p>During a phone interview on 9/25/24 at 11:58 am CNA A said she was terminated from employment at the facility after the incident on 09/04/24. CNA A said that Resident #1 was at the dining room table in the locked unit. CNA A said Resident #1 had grabbed her arm as she was walking by, and she unintentionally spilled the water on herself and the resident. CNA A said that she was not assigned care of Resident #1 due to the resident was difficult and Resident #1 preferred to be assigned ADLs by another CNA working at the facility. CNA A said she had been educated on ANE numerous times and she knew better than to mistreat any resident. She said she felt the witnesses did not see the whole incident as Witness B was standing behind her and Witness C was standing at the exit door.</p> <p>During an observation and interview on 9/25/24 at 12:15 pm, Witness B revealed Resident #1 was sitting at the dining table in the locked unit with a blanket wrapped around her with just her face in view. Witness B said that was how she was covered on 9/4/24 when CNA A intentionally tossed 1/2 cup of water from white foam cup onto the front of her blanket with some water getting on her face. Resident #1 looked up and smiled when her name was called. Resident #1 was unable to answer any questions about the incident involving CNA A.</p> <p>On 9/25/24 at 10:05 am 11:18 am and 1:00 PM three attempts were made to interview Witness C but the attempts were unsuccessful. Unable to leave a message.</p> <p>Record review of the facility investigation reflected the incident was reported on 9/04/24 and occurred on the afternoon of 9/04/24 as reported during interview with the DON and Administrator.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a witness statement dated 09/04/24 signed by Witness B indicated Witness B had walked back onto the secured unit to clean the dining room. The statement reflected Witness B had just entered the dining room when CNA A was walking towards the exit door to the outside area holding a cup in her hand. As she was walking by Resident # 1, she gestured as if she was throwing the cup towards her and tossed water all over the resident and kept walking towards the door. Witness B documented that they reported what they saw to the DON.</p> <p>Record review of a witness statement dated 09/04/24 signed by Witness C indicated Witness C was standing at the smoking area door facing inside the dining room when she saw CNA A walk by Resident #1 and tossed water on her. Witness C immediately went to check on the resident and clean her up. Afterwards she called the DON to have her come to the unit.</p> <p>Record review of CNA A's Termination Statement dated 09/04/24 revealed CNA A was suspended per phone call on 09/04/24 and terminated on 09/04/24.</p> <p>Record review of the facility policy titled Dignity with revision date 2/2021 . indicated: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.</p> <p>Record review of the Facility Policy titled Abuse Neglect dated 3/29/2018 indicated .the resident has a right to be free from abuse, neglect and misappropriation. "Abuse is define 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, and 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 enabled through the use of technology.</p> <p>Review of Abuse, Neglect and Exploitation In-service dated 09/04/24 revealed staff were in-serviced on abuse, neglect and exploitation, dementia care and dignity.</p> <p>Review of CNA A's employee record reflected she was hired 4/13/2023 and background checks were completed. Her last abuse prevention training was done 5/08/24 and there were no disciplinary actions.</p> <p>During an observation on 09/25/2024 at 9:35 AM revealed staff interacting at the facility respectfully with residents.</p> <p>During an interview on 09/25/2024 at 1:35 PM Resident #2 stated he thought the staff were competent and felt safe at the facility. He denied any abuse.</p> <p>During an interview on 09/25/2024 at 1:45 PM Resident #3 stated she felt safe and had no concerns for abuse or neglect.</p> <p>During interviews with staff present on morning and evening shifts 09/25/24 from 10:00 am until 3:15 pm, the staff were able to identify the abuse coordinator was the Administrator. The staff said that they would report any abuse immediately and had been trained on dignity and dementia care.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/25/2024 at 11:00 AM Witness B stated she was educated regarding the facility abuse and neglect policy and would notify their abuse coordinator, the Administrator. If she did not feel the situation was addressed by the abuse coordinator, she would notify HHSC.</p> <p>Review of Satisfaction Rounds by the Administrator dated 09/04/2024 revealed the DON completed satisfaction rounds with all residents with no additional concerns revealed.</p> <p>Review of Resident #1's Care plan dated 06/25/2024 revealed Resident #1's care plan was updated for recent trauma related to abuse for incident involving CNA A.</p> <p>The noncompliance was identified as PNC. The noncompliance began on 09/04/24 and ended on 09/04/24. The facility had corrected the noncompliance before the survey began.</p>		