STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675806	A. Building B. Wing	12/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurenwood Nursing and Rehabilitation	330 W Camp Wisdom Rd Duncanville, TX 75116

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50948 Based on observations, interviews, and record reviews, the facility failed to ensure resident was free from abuse and neglect for 1(Resident # 2) of 10 residents reviewed for abuse and neglect. 1. The facility failed to protect Resident # 2 from physical abuse by CNA F. Resident #2 was aggressively respositioned and hit twice in the face with an opened hand and closed fist by CNA F. Resident #2 grimaced after being hit twice in the face by CNA F. This failure could place residents at risk of abuse, injury, and emotional distress. The noncompliance was identified at PNC. The noncompliance began on 5/15/2024 and ended on 5/15/2024. CNA F was arrested by law enforcement and terminated immediately. The facility had corrected the non-compliance by conducting skin assessments on all nonverbal residents, conducted safe surveys for every verbal resident, educated staff on abuse and neglect and customer service, and the facility implemented monitoring by all departments completing guardian angel daily rounds daily for six weeks. Findings include: Record review of Resident #2 face sheet dated 12/19/2024 reflected an [AGE] year-old female who was admitted to the facility 6/24/2021 with diagnoses which included: combined systolic and diastolic heart failure, dysphasia following other cerebrovascular disease, hyperlipidemia, and Alzheimer's disease. Record review of Resident #2 quarterly MDS assessment dated [DATE] reflected a BIMS score of 99 which indicated the interview was unable to be completed. Record review of Resident #2 care plan dated 10/4/2024 reflected Resident #2 had impaired cognitive function and impaired thoughts and communication problem related to Alzheimer's, ADL self-care performance deficit related to Alzheimer's, confusion, and limited mobility, and swallowing problem related to dysphasia. (Requires total assistance with eating, bed mobility, transfers, dressing, toilet use and personal hygiene) (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of provider investigation report dated 5/22/2024 reflected video footage of CNA F slapping and hitting Resident #2 and rearranging Resident #2 forcefully. Skin assessments and x-rays were conducted and showed no results of bodily harm or bruising. CNA F was removed by law enforcement and was terminated immediately. Further investigation, documentation, and evidence confirmed the allegation. In an interview on 12/17/2024 at 4:37pm, Resident #2's representative stated Resident #2 room had video surveillance camera installed 5/14/2024. The representative stated on 5/15/24 at approximately 5:00am, she reviewed the video footage and observed a staff member hitting resident twice in the face with an open hand, and aggressively pulling Resident #2 from the top of the head to the other side of the bed. Resident #2's representative stated after viewing the video footage she notified law enforcement. She stated law enforcement visited the facility and arrested CNA F. Observation and interview on 12/18/2024 at 12:28pm. Resident #2 were observed sitting up staring at the ceiling. The state surveyor attempted to interview Resident #2 but Resident #2 could not verbally communicate. In an interview on 12/18/2024 at 1:00pm, the DON stated Resident #2 is nonverbal and require total care and is dependent on staff for ADL's. She stated on 5/14/2024 at approximately 5:00pm or 6:00pm, resident # 2 had video surveillance camera installed in her with approval from the facility. She stated on 5/15/2024 at approximately 6:00am, she was contacted by staff and informed law enforcement showed up to the facility with video footage of CNA F hitting Resident #2 twice in the face. She stated staff told her law enforcement addressed the incident with CNA F and then arrested CNA F. She stated immediately following the arrest, CNA F was terminated. She stated there were no witnesses present during the incident. She stated following the incident, the resident was treated off site, and a skin assessment and X-rays were conducted. She stated no injuries were founded. She stated on 5/15/2024, the facility started their investigation and initiated skin assessments on all non-verbal residents, safe surveys on all verbal residents, in services on abuse and neglect and customer service, and Angel rounds were conducted and completed by all department heads daily for six weeks. Attempted interview on 12/19/2024 at 12:55pm, the state surveyor attempted to contact CNA F via phone. The attempt was unsuccessful, the state surveyor left a message requesting a call back. In an interview on 12/20/2024 at 4:37am, RN D stated on 5/15/2024, she was the nurse on duty during the 10pm-6am shift. She stated at approximately 5:00am, law enforcement showed up to the facility and approached the nurse's station. She stated the officer asked who provided care to Resident # 2. She stated CNA F was standing at the nurse's station and responding to the officer stating she provided care to Resident # 2. She stated the officer asked CNA F if she physically assaulted Resident #2 and CNA F denied physically assaulting Resident # 2. She stated the officer showed CNA F video footage of CNA F physically assaulting Resident # 2. She stated after the officer showed CNA F the video footage, she still denied physically assaulting Resident # 2. She stated the officer handcuffed CNA F and escorted CNA F out of the facility. She stated the officer showed her the video footage. She stated in the video footage she identified CNA F and observed CNA F pulling Resident # 2 roughly and slapping Resident #2 on her forehead. She stated she notified the ADM and the DON immediately. She stated she was in serviced on abuse and neglect. She stated the risks of staff not reporting abuse or neglect to the abuse coordinator could allow the abuse to continue. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 12/20/2024 at 5:17am, CNA G stated she worked full time during the 10pm-6am at the facility. She stated the night the incident between CNA F and Resident # 2 took place, she was off. She stated she was in serviced on abuse and neglect. She stated the risks of staff failing to report abuse or neglect could put the residents a harm for continued abuse. In an interview on 12/20/2024 at 8:07am, the ADM stated she was not employed at the facility when the incident between CNA F and Resident # 2 occurred. She stated she was hired in September 2024. She stated after reviewing the PIR, she was informed there was video footage of CNA F physically hitting Resident # 2 twice to the face. She stated the PIR indicated law enforcement arrested CNA F at the facility. She stated the PIR revealed CNA F was terminated immediately and the facility-initiated safety and prevention measures. She stated the facility initiated in services on abuse and neglect and customer service. She stated skin assessments were conducted on all non-verbal residents, and safe surveys conducted on all verbal residents. She stated the facility's monitoring plan included angel rounds conducted daily for 6 weeks by all department heads. She stated the risks of staff failing to report abuse or neglect could put the residents at risks of getting hurt and having adverse effects. Observation and interview on 12/20/2024 at 9:00am with the ADM and the DON, the state surveyor revealed she received the video footage of the incident between CNA F and Resident # 2 on 12/20/2024. Surveyors reviewed the video with the ADM and the DON. The video revealed at 5/15/24 at 2:26am, CNA F was observed in Resident #2 room whipping Resident #2 chin with a towel. CNA F was observed slapping Resident # 2 on her forehead with a right open hand causing loud noise. CNA F was then observed aggressively grabbing Resident #2 by the head and pulling Resident #2 to the other side of the bed as she positioned Resident #2. CNA was then observed hitting Resident #2 on the forehead with a right closed fist. Resident #2 was observed with a grimacing face after being hit in the face. After watching the video, the DON was able to identify the CNA as CNA F. The DON stated after she was informed about the incident, the facility terminated the CNA F immediately. She stated she tried to contact CNA F, but the attempt was unsuccessful. Record review revealed a skin assessment performed on 5/15/2024 on Resident # 2 with no adverse physical findings. Record review revealed skin assessments performed on 5/15/2024 on all non-verbal residents. Record review of in-service training record dated 5/15/2024 revealed nurses, CNAs, and CMAs were in serviced by nursing management on abuse and neglect and customer service. Dietary staff was in serviced on customer service. Record review of safe surveys dated 5/15/2024 revealed departments heads conducted safe surveys on verbal residents. Record review of Guardian Angel Daily Rounds revealed department heads conducted angel rounds. The angel rounds were initiated on 5/15/2024 and completed on 7/16/2024. Record review of Police Report dated 5/15/2024, reflected law enforcement dispatched to the facility. The video footage was provided to the responding officer. Due to the video evidence CNA F was taken into custody for the offense of injury to elderly. The disposition of the police report was cleared by arrest. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's policy titled Risk Management: Abuse, neglect, exploitation, mistreatment of resident, or misappropriation of resident property dated December 2023, Policy statement: The facility has designated and implemented processes which strive to reduce the risk of abuse, neglect, exploitation, mistreatment, and misappropriation of residents' property. Definitions: Abuse means the willful infliction of injury, unreasonable confinement/involuntary seclusion, or separation of a resident from other residents or from their room or other area against the resident's will or the will of the resident's legal representative. Intimidation with resulting physical harm, or pain, or mental anguish. Punishment with resulting physical harm, or pain, or mental anguish. 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. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment. 1. Residents must bit be subject to abuse by anyone including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, or other individuals.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070 Based on observations, record reviews and interviews, the facility failed to ensure the resident environment remains as free of accident hazards as is possible and that residents received adequate supervision to prevent accidents for one (Resident #1) resident of three residents reviewed for elopement. 1. The facility failed to ensure Resident #1 was adequately supervised to prevent her from leaving the facility unsupervised. Resident #1 had severely cognitive impairment and lacked safety awareness. Resident #1 eloped from the facility rolling in her wheelchair across a four-lane busy residential street arriving at the fire station across the street 50 yards away. It was determined these failures placed Resident #1 in a non-compliance Immediate Jeopardy (IJ) situation from 07/01/24-07/02/24. The facility corrected the noncompliance before the survey began. This failure placed residents at risk for harm and /or serious injury. Findings included: Record review of Resident #1's other MDS assessment, dated 07/11/2024 reflected the Resident was an [AGE] year-old-female who admitted to the facility on [DATE] and readmission on 05/31/2023 and discharged on [DATE]. The resident had diagnosis which included: Malignant Neoplasm of colon (cancer of the colon), intestinal obstruction (mass in the intestine), dementia (confusion and forgetfulness), functional decline, generalized weakness, anxiety (restlessness) and lack of coordination (unable to walk). The MDS reflected he had a BIMs score of 4, which indicated severe cognitive impairment and the resident was ambulatory with a wheelchair and required assist of one staff for activities of daily living. The MDS did not reflect any wandering behavior. Record review of Resident #1's care plan, dated with an review date of 07/01/2024, addressed the resident's impaired cognition due to short term memory loss (unable to remember after 5 minutes), and assistance required for activities of daily living. Further review of the clinical record reflected, the resident's moderate risk for elopement was not addressed, until 07/01/2024. Record review of Resident #1's Elopement [NAME] Assessment completed 06/05/2023 scored Resident #1 as no risk for elopement. Further review of Resident #1's elopement risk dated 06/04/2024 reflected Resident #1 as no risk for elopement. Record review of the clinical record reflected an Elopement Risk Assessment completed on 07/01/2024, indicating a high risk for elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Provider Investigation Report dated 07/01/2024 reflected a finding of Unfounded for Neglect. Review of the External/Internal/Systemic Approach Investigation Summary dated 07/01/2024 completed on 07/05/2024 reflected: . An emergency QAPI meeting was held on 07/02/2024 with Medical Director in attendance . all residents had a new elopement assessment to identify any current patients that are imminent risk for elopement (no other residents were found to be at imminent risk of elopement) . (who was responsible: Nurse Management . who will monitor: Regional Director of Clinical Services/Director of Nursing.elopement assessment will be completed upon admission and quarterly by the charge nurse and/or nurse managers and for any resident that triggers an imminent risk for elopement, the elopement response protocol will be initiated Any patient that triggers elopement risk will be placed on 1:1 monitoring until no longer deemed necessary. DON will monitor for compliance for 4 weeks until 08/08/2024 and then monthly on an ongoing basis .Who will monitor: Regional Nurse of Clinical Services Until alternative and or safe living arrangements are made, they will be placed on one-one-supervision with facility staff. The resident's picture and face sheet will be placed in an elopement binder. Resident care plans will also be updated. The Director of Nursing and/or Nurse Manager will monitor weekly for compliance by completing an audit of the elopement assessments and the elopement binders. Audits will be completed weekly for 4 weeks until 08/08/2024 and monthly on an ongoing basis The Regional Director of Clinical Services will review the documentation each week for compliance The Executive Director will monitor daily to ensure compliance for four weeks and will review . Further review of the Providers Investigation Report reflected monitoring and audits by the designated staff (DON Nurse Managers and Regional Nurse consultant) had occurred. Record review of progress notes reflected Resident #1 on 06/01/2024 through 07/01/2024 had previously indicated she had no behaviors of wandering or attempting to exit the facility. Further review of the progress note reflected Resident #1 had a diagnosis of anxiety, that had increased on 06/17/2024, The nursing staff contacted the physician, who came and visited the resident who as not sleeping well at night and stating she did not know what to do with herself anymore. The physician medications changes increased the anxiety medication. Record review of the Medication Administration Records for Resident #1 reflected the Lorazepam 05mg two time a day had been increased to three times a day on 06/17/2024. Record review of progress notes reflected Resident #1 on 07/01/2024 she was observed by LVN A, who was the MDS coordinator at the time, in her wheelchair mobilizing across a busy four lane residential road. Record review of In-service dated 07/01/2024 reflected all staff attended and the subject matter was regarding Facility policy on elopement and reducing the risk for elopement: initiating a frequent monitoring form, communicating any related changes in any resident immediately to the charge nurse, if you notice a residents exhibiting exit seeking behavior to notify the charge nurse immediately and do not leave the resident alone, and to be aware where the elopement binders are located at each nurses station. and updating the care plan. Record review of the In-serviced dated 07/02/2024 reflected an all-staff elopement drill. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 12/18/2024 at 10:00 am with the ADON revealed she was working on the day that Resident #1 left the facility, she did not know which door she went out of. ADON stated, A code was called and everyone went running, I stayed inside to assist the other nurse to make sure all the other residents were accounted for and were safe. The ADON said she did not know the resident that well, she had not worked here long. Resident #1 was pleasant and she had never been told by staff that she would elope, she did not wear a wander guard. The ADON stated at times the resident was anxious, but not exit seeking. In an interview on 12/18/2024 with LVN A at 10:53 a.m. revealed he was looking at the window and he thought he saw the resident crossing the street in her wheelchair, going towards the old fire station. LVN A said, I could not believe my eyes; I called a code pink and ran out telling he receptionist to tell everyone. By the time I got to her she was already across the street and in the parking lot of the fire station. LVN A stated the traffic had stopped on both sides of the street as she crossed. Resident #1 told me she was coming to see about the fireman, the DON was right behind me and a whole lot of staff. She was brought back to the facility and the DON assessed her; she was not injured. Resident #1 never mentioned about leaving, the LVN stated he saw her every day and she was always out of her room and she was wheeling around in her wheelchair, but not trying to leave. The LVN stated Resident #1 goes to all activities and she will sit at the nurse's station and talk to other residents. An observation on 12/18/2024 at 4:00 p.m. revealed the surrounding outside area, parking lot, and streets adjacent to the facility. The facility was in a residential/business area with multiple car lots, multiple restaurants, a large shopping center, and multiple businesses. The street in front of the facility was very busy with cars. There was a popular highway less than a quarter of a mile away, as well as a very busy main four lane street that leads to residential areas, and large shopping centers, that has heavy traffic on the road all times of the day and night. Where the resident was found (in the parking lot of the old fire station) is approximately 150-200 feet away across busy streets. In an interview on 12/18/2024 with Social Worker at 11:10 a.m. revealed she had worked here since December 2017 there had not been any elopements. The Social Worker stated she had been in-served by the new Administrator. The staff is supposed to report any exit seeking behaviors, that would include a resident talking about leaving. The resident is immediately replaced on 1:1 until they can locate a safe place for them to reside. The Social Worker stated she assisted in locating several secured units for the family to tour and pick from. The Social Worker stated Resident #1 had never had any exit seeking behaviors. The Social Worker stated the facility had an in-service about elopement and conducted an elopement drill. In an interview on 12/18/2024 at 11:15 a.m. with CNA B revealed she was working the day that Resident #1 left the facility. CNA B stated she had been in the dining area around 12:30 p.m. and Resident #1 had been in the dining room, ate her lunch and left the dining area. The CNA stated she did not say anything about leaving and she did not notice any unusual behavior related to Resident #1. The CNA stated the resident came into the dining area ate her lunch and left, came as she has always done. CNA B stated when she came back inside, I got the feeling she was not eloping, she was just going to introduce herself to the fireman, like she was their neighbor. The CNA stated the facility had in-service on elopement and we had an elopement drill also. CNA B stated Resident #1 had a wander guard placed on her and staff was asked to do 1:1 monitoring her 24 hours a day until she left the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 12/18/2024 with CNA E at 12:00 p.m. revealed she knew where the wander guard binders were at the nurse's station. CNA E stated she had taken care of Resident #1; she was very busy resident and would sit for awhile if you gave her an activity book. CNA E stated Resident #1 attended all the activities. The resident never said anything about leaving the facility. The CNA stated she had been in-serviced on elopement and had attended a drill for elopement and knew what to do. In an interview/observation on 12/18/2024 with the Maintenance Director at 12:10 p.m. revealed the wander guard system was checked once a week. The Maintenance Director and the Surveyor revealed the maintenance logs together the last check had been on 12/16/2024. Further view revealed the wander guard system had been checked the morning of 07/01/2024. The Maintenance Director stated the doors were easy release doors that if you hold them, they will release in 15 seconds and if you wear a wander guard the doors will alarm. The maintenance demonstrated that the wander guard worked with a loose wander guard that had been engaged. The maintenance Director explained if the wander guard bracelet was engaged it was blinking. In an interview on 12/18/2024 with LVN C at 12:45 p.m. revealed LVN C had seen Resident #1 on 07/01/2024 coming out of the dining room. LVN C stated it was after she had eaten lunch. Resident #1 was not her resident, but she knew her because she mobilized all around in her wheelchair. LVN C stated that Resident #1 had never said anything about wanting to leave that day or any other day. LVN C stated she was working that day. She stayed inside and made sure all the other residents were accounted for. The LVN stated the facility had an in-service on elopement and had an elopement drill. In an interview on 12/18/2024 at 3:45 p.m. with primary care physician revealed Resident #1 was his resident. The physician stated the resident could be confused at times due to the cancer that had spread to her brain. He stated Resident #1 did not have history of wandering. Resident #1 anxiety medications had been changed prior to her leaving the facility, when the nurses had called me informing me that her anxiety had increased. I came to see her around June the 17th 2024 and she was more anxious, but she never mentioned to me about leaving or wanting to go home. I was concerned about her pain making her more anxious, but she said she did not hurt, so I made sure her pain medication was scheduled since she did not have to ask for it. The facility informed me when she left the building and then when she was back inside. I told them she needed to be moved to a secured unit, since she was so mobile still in her wheelchair. I spoke to the family about her moving, they did not want her to, since she had lived there for so long, but I assured them this was the right thing to do for her safety, The facility was offered several options, and moved her. The physician stated that Resident #1 had never tried to leave the facility before and he had not had other occurrences of elopement. In an interview on 12/20/204 at 4:45 a.m. with RN D revealed she was surprised when she heard about Resident #1 leaving the facility. RN D stated she would get up at night and roll around the facility, but never tried to leave. She did not sleep that much at nighttime, but she was not disruptive. RN D stated Resident #1 was more restless at times than others and would ask what she should do, but she was easily redirected and she would go back to bed most of the time. The physician had changed the anxiety medicine sometime in June I cannot recall, the increase settled her down some. Resident #1 never went into other resident's rooms and she always recalled where her room was. The RN stated she had an in-serviced on elopement a drill and on abuse/neglect after this happened. Resident #1 had a 1:1 staff member on the night shift until she transferred to another facility with a secured unit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 12/20/2024 at 8:45 a.m. with DON revealed Resident #1 did leave the facility on 07/01/2024. The DON stated she was in the medication room when the code was called and went out the side door and ran out to the street. The MDS nurse was already there with Resident #1 in the old fire station parking lot. The DON stated that it really scared me, Resident #1 had no history of exit seeking behavior, and never tried to leave before, we immediately placed a wander guard on here and I called the family and told them she needed to be relocated to a secured unit for her safety. The family did not want her to move, but only agreed that it was best for her. The DON stated Resident #1 was placed on 1:1 monitoring until she transferred. The DON stated Resident #1 tried one time when she was on 1:1 to leave again, that was when I told the Social Worker the family had to decide right away. The Social Worked called the family again and she left the next day. The DON stated that she had an all-staff elopement drill on 07/02/2024 and had an in-service on 07/01/2024. In an interview on 12/20/2024 at 10:15 a.m. with the Administrator revealed she was not the administrator at that time and there had been no elopements since she had been at the facility. The Administrator stated she had been informed of the elopement when she first came to work at the facility. The DON had informed me that in-services had been conducted as well as an elopement drill. There is a wander guard system on the doors and the maintenance director checks it once a week and the nurses are required to check the wander guards each shift to make sure they are working correctly. Attempts were made to contact the previous administrator on 12/18/2024, 12/19/2024 and 12/20/2024 with no return calls. Record review of the Facility's Policy titled Elopements revised December 2023 reflected: 1. Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing .2. I an employee observes a resident leaving the premises, he/she should: a. attempt to prevent the departure in a courteous manner; b. get help from other staff members in the immediate vicinity, if necessary; and c. instruct another staff member to inform the Charge Nurse or the Director of Nursing Services that a resident has left the premissies.3. When a departing individual returns to the facility, the Director of Nursing Services or Charge Nurse shall; a. examine, the resident; b. Notify the attending physician; c. Notify the resident's legal representative (sponsor) of the incident; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675806	A. Building B. Wing	12/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurenwood Nursing and Rehabilitation	330 W Camp Wisdom Rd Duncanville, TX 75116

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's policy titled Risk Management: Abuse, neglect, exploitation, mistreatment of resident, or misappropriation of resident property dated December 2023, Policy statement: The facility has designated and implemented processes which strive to reduce the risk of abuse, neglect, exploitation, mistreatment, and misappropriation of residents' property Definitions: Abuse means the willful infliction of injury, unreasonable confinement/involuntary seclusion, or separation of a resident from other residents or from their room or other area against the resident's will or the will of the resident's legal representative. Intimidation with resulting physical harm, or pain, or mental anguish. Punishment with resulting physical harm, or pain, or mental anguish. 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. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment. 1. Residents must be subject to abuse by anyone including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, or other individuals

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50948 Based on interviews and record review, the facility failed to ensure sufficient nursing staff with appropriate competencies and skills set to provide nursing and related services for 1 (CNA F) of 11 employees reviewed for staff qualifications. 1. The facility failed to ensure CNA F had a current nurse aide certification while employed at the facility while actively providing care for residents. This failure could result in residents being provided care by staff who have not provided documentation of training and competency in providing care. Findings include: Record review of CNA F's personnel file revealed her date of hire was [DATE]. Record review of CNA F's NAR, Certificate registry date [DATE], revealed CNA F's certification expired on [DATE]. Record review of CNA F's Timecard Report for [DATE]-[DATE], revealed CNA F worked a total of 9 shifts scheduled 10:00pm-6:00am. Record review of CNA F's Timecard Report for [DATE]-[DATE], revealed CNA F worked a total of 21 shifts scheduled 10:00pm-6:00am. Record review of CNA F's Timecard Report for [DATE]-[DATE] , revealed CNA F worked a total of 9 shifts scheduled 10:00pm-6:00am. The record review revealed CNA F last day worked was [DATE]. Record review of CNA F's New Hire/Termination Form revealed CNA F was terminated [DATE]. Record review of Tulip Credentialing Transition Grace Period dated [DATE], revealed HHS extended the grace period to [DATE]st for aides to allow users additional time to learn and understand the new credentialing system. Attempted interview on [DATE] at 12:55pm, the state surveyor attempted to contact CNA F via phone. The attempt was unsuccessful, the state surveyor left a message requesting a call back. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 10:26am, HR stated she has worked for the facility since 2014. She stated she transitioned into the HR role in [DATE]. She stated HR is responsible for completing background checks and registry checks prior to hire and annually once hired. She stated when she transitioned into her role, she was trained on how to complete background and registry checks. She stated she completed background checks once a year and registry checks ,d+[DATE] times a year. She stated completing checks annually is how she monitors criminal history and expired licenses and certifications. She stated if an aide's certification was close to expiring, it is her responsibility to remind the aide to renew their certification. She stated she would inform the aide as soon as possible. She stated if an aide's certification is expired, an aide cannot perform duties until their certification is renewed. She stated CNA F's certification expiration date was [DATE]. She stated she informed CNA F, her certification was expiring however, HR did not follow up with CNA F regarding the status of the certification renewal. She stated the risks of staff working with an expired license or certification while working with residents can cause a lack of skills and affect the quality of care the resident will receive. In an interview on [DATE] at 1:02pm, the Regional Nurse Consultant stated HR is expected to complete background and registry checks routinely. She stated background checks and registry checks should be completed prior to hire and annually once hired. She stated HR is responsible to have communication when notifying staff about certification expiration. She stated HHS sent out a memo regarding a waiver. The wavier extended the grace period for certification renewal twice. She stated the first grace period was extended to [DATE]st then extended to [DATE]th. However, a copy of the waiver application was not provided. She stated the risks of staff working with an expired license of certification can result in incompetent staff and put residents at risk for abuse and neglect and a lack of quality of care. The state surveyor requested a policy for nurse aide registry verification and was informed the facility did not have a policy for nurse aide registry verification .