STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675811	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Gardens of Frisco	10700 Rolater Dr Frisco, TX 75035

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 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50445 Based on interviews and record reviews, the facility failed to ensure residents the right to be free of any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms for one (Resident #1) of five residents reviewed for restraints. The facility failed on 09/09/24 to ensure Resident #1 remained free of any physical restraint in that: the movement of Resident #1's head and mouth were restricted by physical force applied by the hands of OT A. The noncompliance was identified as past noncompliance (PNC). The Immediate Jeopardy (IJ) began on 09/09/24 and ended on 09/09/24. The facility had corrected the noncompliance before the state's investigation began. This failure could place residents at risk for associated risks of potential physical injury or psychological harm. Findings included: Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses of dementia, hypertension (high blood pressure), cerebrovascular accident (stroke), Parkinson's disease (brain disorder affecting movement), malnutrition, dysarthria (disorder of speech), unsteadiness on feet, weakness, abnormalities of gait and mobility, insomnia (sleep disorder), and acute cystitis (bladder infection). Section P-Restraints and Alarms reflected restraints were not used with Resident #1 in bed, in a chair, or out of chair. Section C-Cognitive Patterns reflected a Brief Interview for Mental Status (BIMS) score of 09, indicating moderately impaired cognition. Section C further noted Resident #1 has inattention and disorganized thinking that comes and goes, changes in severity. Review of Section E-Behavior reflected no physical or verbal behavioral symptoms directed towards others but did reflect behavior of rejecting evaluation or care that was necessary to achieve the resident's goals for health and well-being. (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 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Section G-Functional Abilities and Goals reflected Resident #1 normally used a walker and wheelchair in the past 7 days. Section G further reflected that Resident #1 required supervision or touching assistance with eating, partial/moderate assistance with oral hygiene, upper body dressing, and personal hygiene, as well as substantial/maximal assistance with toileting hygiene, shower/bathe self, lower body dressing, and putting on/taking off footwear. Section G reflected that Resident #1 required substantial/maximal assistance to roll left and right, change from sit to lying, change from laying to sitting on the side of the bed, change from sitting to standing, transfer from a bed to a chair, and get off and on a toilet. Resident #1 was reflected as dependent in his ability to get in and out of a tub or shower. Resident #1 was reflected as requiring partial or moderate assistance to walk 10 feet, walk 50 feet with two turns, and walking 150 feet was not applicable. Review of Resident #1's Care Plan date 08/21/24 reflected the following care areas: The resident was resistive to care, and this was initiated on 05/07/24 and revised on 06/27/24. Interventions included allowing the resident to make decisions about treatment, education for the resident and family, encourage as much participation/interaction by the resident as possible during care activities, give clear explanation of all care activities, negotiate a time for ADLs, reassure resident, leave and return 5-10 minutes later and try again, praise the resident when behavior is appropriate, provide consistency in care, and provide opportunities for choices. Resident #1 had the potential to be physically aggressive r/t hitting at staff. This was initiated on 05/07/24 and revised on 06/27/24. Interventions included administering medications as ordered, analyzing times of day, places, circumstances, triggers, and what de-escalates behavior and document, assess and address for contributing sensory deficits, assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc., to give the resident as many choices as possible, and to monitor/document/report PRN any signs of symptoms of resident posing danger to self and others. The resident had dementia. The intervention included communication techniques, avoiding overly demanding tasks. Resident #1 was at risk for falls related to deconditioning and poor balance, and interventions were identified including: educate the resident about safety reminders and what to do if a fall occurs, ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair, anticipate and meet the resident's needs, be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed, the resident needs prompt response to all requests for assistance, physical therapy evaluate and treat as ordered or as needed, review information on past falls and attempt to determine cause of falls, record possible root causes, remove any potential causes if possible, and educate the resident as to causes. Resident #1 had Parkinson's disease. Interventions included the need to encourage daily exercise and mobility as tolerated. A review of Resident #1's physician order by DR I on 08/07/24 at 10:30 a.m., indicated for occupational therapy to evaluate and treat. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 10/22/24 at 11:00 a.m., PT B reported on 09/09/24 at approximately 09:30 a.m., she entered the therapy gym where OT A had brought Resident #1 from his bedroom for his therapy session. She reported she was providing physical therapy to Resident #1 using the Omni Cycle exercise bike, at the same time that OT A was providing occupational therapy to Resident #1 using the bike. PT B reported when she first entered the gym, she noted that Resident #1 appeared to be in a bad mood and maybe wanted to go back to his room. She reported due to his dementia he was not able to clearly state his intentions, but therapy monitored his overall mood and behaviors. She stated Resident #1 often refused therapy and required a lot of prompts to participate. She reported that in prior sessions she had often given the resident snacks or tea, played music, turned on the television, changed the type of activity, gave breaks, or told stories to distract the resident or encouraged his participation in therapy. She reported Resident #1 would often bargain about his therapy and that would put him in a good mood. She reported she and OT A were able to talk to Resident #1 and bargain with him and that he was agreeable to trying therapy for about ten minutes. With Resident #1's agreement to continue therapy for another ten minutes, she and OT A squatted down and began securing Resident #1's feet into the bike's pedals. OT A was on the left side of Resident #1, and she was on the right side, when Resident #1 suddenly spit in the face of OT A three or four times. She reported that while Resident #1 required frequent interventions to participate, she had never seen him become that agitated or spit, and she had no idea what triggered him that day. She reported Resident #1 had been in the gym approximately 15 or 20 minutes when this occurred. PT B reported when Resident #1 spit in OT A's face, OT A stood up and walked behind Resident #1 who remained seated on the bike. She stated Resident #1 was still looking towards the left and that OT A grabbed Resident #1's head on the top and sides with both of his hands and abruptly forced his head to the forward-facing position and held it there. OT A held Resident #1's head so tightly that he could not move it. OT A appeared angry, and his jaw was clenched. PT B stated that Resident #1 began screaming and OT A then placed his palms over Resident #1's mouth with one hand over the other to shut him up. Resident #1's screams were muffled, and PT B told OT A to stop. Resident #1's head and mouth were held for approximately ten or fifteen seconds. PT B stated when she told OT A to stop that he released Resident #1 and went to the bathroom to wash off the spit. She reported she immediately noted a tinge of blood around a few of Resident #1's upper teeth when OT A removed his hands. She reported she noted no other signs of injury. PT B stated DOR C had been in the other gym but came when she heard Resident #1 scream. She stated that OT A was walking out of the gym door when DOR C was walking in. PT B reported that DOR C walked up behind Resident #1 and Resident #1 was scared and looking behind himself in fear. She reported that she reassured Resident #1 that it was not OT A that was behind him. PT B stated she notified DOR C of the incident, and that the DOR C notified the abuse coordinator (ADM) immediately. PT B reported that Resident #1 then took a 5-to-10-minute break in the therapy room, was given water to drink, he held her hand, she shared a story with him, and he became calm. He then continued therapy on the bike for the remainder of the session with no further agitation or spitting. PT B reported that Resident #1 was in the therapy gym for approximately 60 minutes overall and did not leave the gym during the session. PT B stated that Resident #1 was not forced to use the bike or participate in any activity. PT B stated that the entire incident was witnessed by Resident #2 who was on a nearby bike in the gym at the time. PT B stated that Resident #2 voiced no concerns and seemed unaffected. PT B reported that ADM later interviewed Resident #2. PT B stated that ADM, the abuse coordinator, came and took a statement from her at approximately 10:15 a.m. that morning (09/09/24). PT B stated that OT A was sent home immediately after she gave her statement, Resident #2 was interviewed, and OT A gave his statement. She reported that OT A had not returned to the facility since that time and has since been terminated. PT B stated that she has worked for this facility for about one year, and that she worked with OT A almost every day, Monday through Friday day shift for approximately ten months. She denied having ever previously witnessed any abuse or concerns with resident care provided by OT A or by anyone else at this facility. PT B reported that Resident #1 came back to the gym for therapy the next day and that she noted no fear or changes in his demeanor or behaviors that might indicate continued psychosocial harm. She reported that Resident #1 has continued in therapy every day since with no further aggression or incidents of spitting. PT B reported she had received abuse and neglect teaching prior to the incident and the day following the incident and that she has received training on stopping care and dealing with resident behaviors since the

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	PT B noted that some residents are dementia patients and can scratch and spit at staff, but that staff do not react. She stated, we defend ourselves by walking away. She reported that the risk to Resident #1 having his head held and mouth held included the possibility of accidently occluding the resident's nose and affecting his breathing, damaging his teeth or mouth, and possibly causing injury by turning his neck. In an interview on 10/22/24 at 11:33 a.m., DOR C reported that on 09/09/24 she responded to a loud yell in the therapy department in a separate gym. She reported when she walked into the other gym, she saw Resident #1 and PT B. She stated she did not yet know what had happened and that she walked up behind Resident #1 and placed her hand on his shoulder and that he jumped and looked behind himself, and that PT B reassured him because he seemed fearful. She reported that within a few minutes PT B came out and told her about the incident in which Resident #1 was spitting and OT A grabbed him. DOR C reported that nursing later completed an injury assessment of Resident #1 and that at the time she saw Resident #1 she did not note any redness, bleeding around his teeth, or other obvious sign of injury. DOR C stated that she interviewed Resident #2, the resident who witnessed the incident. Resident #2 reported to her that Resident #1 had behaviors and that the staff had handled him the best they could. DOR C reported that Resident #2 told her that OT A had put Resident #1 in a headlock. He denied that he himself was injured or upset due to the incident. DOR C reported that she immediately removed OT A from resident care and that he sat up front during the interviews. She reported she notified ADM of a possible abuse situation, that ADM interviewed OT A and PT B, and that OT A was immediately suspended, never returned to the facility, and was later terminated. She denied that prior to this incident OT A had ever had any allegations, issues or demonstrated issues or concerns for abuse. DOR C further reported that holding a resident head or mouth as alleged to her was, inappropriate contact no matter what, because Resident #1 is in a wheelchair, and you can always step away. She reported that the expectation of her staff is that they will move or walk away and not pursue therapy during periods of resident aggression and agitation. She states that holding a resident's head or mouth in the manner alleged could place the resident at risk for physical or psychological harm. DOR C denied having ever witnessed abuse at this facility since she was employed about 2.5 years ago. DOR C reported that she conducted immediate in-service training with her staff including abuse and neglect training and dealing with difficult behaviors. She reported that she assigned Resident #1 to be cared for by female staff only as he seemed to do well with female staff. Review of Admission MDS reflected that Resident #2 was a [AGE] year-old male resident admitted to the facility on [DATE]. Section C-Cognitive Patterns reflected a BIMS score of 11 indicating moderately impaired cognition. In an interview on 10/22/24 at 12:07 p.m., Resident #2 stated that a few weeks back he was in the therapy room sitting on an exercise bike and noted OT A encouraging a male resident (name not known) to participate. Resident #2 stated that the male resident began swinging his arms and he thinks he spit on OT A. Resident #2 stated, that was the straw that broke the camel's back. OT A reached around him and grabbed him by the head and the mouth. He immobilized him by grabbing his whole head so the guy couldn't move. It only lasted a few seconds. I was surprised he did that. Resident #2 stated that prior to this incident he has never witnessed this type of behavior or any abuse or neglect at this facility. He stated that if he did, he would notify someone at the nurse's station or ADM. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 10/22/24 at 12:25 p.m., ADM reported that on 09/09/24 PT B had reported to him that she had felt uncomfortable with what she observed was done to Resident #1 by OT A and that he immediately investigated. ADM reported the resident was examined and there were no physical signs of injury, although OT A had reported seeing a tinge of blood. He reported that he interviewed Resident #2 who witnessed the event and said that he did not think the interaction was inappropriate and that OT A was doing his best to get Resident #1 to participate in therapy. ADM reported he unsubstantiated the findings but that he did not feel comfortable keeping OT A either, or as a contract employee he decided that he would not return to the building. OT A did not work at the facility following the incident on 09/09/24. ADM reported he interviewed OT A and that he reported he covered Resident #1's mouth because he was spitting. ADM reported that OT A demonstrated covering Resident #1's mouth with one hand laid over the mouth with the palm down. ADM reported that OT A did not state how long he covered Resident #1's mouth. OT A denied that he held Resident #1's head. ADM reported that he immediately did training with all staff on abuse and neglect and when to stop care and that DOR C did the same for the therapy staff. ADM reported he started working at this facility in June of 2024 and that had been no reports or observations regarding concerns with OT A's behaviors-no grievances or complaints. ADM reported that Resident #1 was observed for any emotional distress or behavioral changes and that none were observed. He reported that Resident #1 was typically easily redirected and had not demonstrated aggressive behaviors or spitting prior to this incident to the best of his knowledge. ADM reported that the facility is restraint free and that annual in-services regarding restraints were conducted. In a telephone interview on 10/22/24 at 02:04 p.m., OT A reported that regarding the incident with Resident #1, he was providing therapy in the gym to Resident #1 who became unhappy when set on the exercise bike. Resident #1 twice became agitated and was trying to hit, requiring a break from care and space. He reported he asked PT B for assistance and that when Resident #1 was okay, they went to secure the straps on the bike and Resident #1 became agitated again and he was given a snack. When Resident #1 was calm again, they tried to secure the pedal straps when Resident #1 began trying to hit and push OT A and suddenly spit in his face multiple times. OT A reported he tried to block himself from the spit and was holding up his hand and, got his (Resident #1's) mouth. OT A stated, I should not have done that. I just should have gotten out or ran away. I wish I could not have made people uncomfortable. That was something my reflex did. I apologize to all the people. OT A did not answer when asked if he held Resident #1's mouth. He denied having ever grabbed or held Resident #1. OT A reported that he worked at the facility for about two years and denied he had ever previously had any allegation of abuse against himself. He reported that he had received abuse and neglect training in-service prior to the incident and was familiar with the facility's policy on abuse. He reported that a physical restraint is something that restricts the patient's own will. A review of OT A employee file revealed licensure information, criminal history name search verification, a signed job description dated 03/27/24, a Baseline Risk Assessment Questionnaire, and an Employment Eligibility Verification Form. OT A employee file did not reveal any indication of any former complaint, allegation, or disciplinary actions. A review of facility records indicated that the facility conducted a criminal history name search for OT A on 03/22/24 and conducted an occupational therapy licensure verification which reflected a current license with no disciplinary action and an expiration date of 11/30/25. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 10/22/24 at 03:00 p.m., NP D reported that she assessed Resident #1 on 09/12/24 and that she did not note any bruising, redness, bleeding teeth/gums, or other signs of injuries to Resident #1. She denied she observed any psychological changes which might have indicated resident harm or injury. She did state that Resident #1 could be aggressive due to his dementia. A review of a weekly Body Audit Results dated 09/12/24 at 09:30 a.m., reflected Resident #1's skin was noted as intact with no issues. A review of a Nursing Progress Noted dated 09/09/24 at 01:57 p.m. and created by LVN G stated that, At about 11:30 am, the director of therapy (DOR C) reported to the nurse that when resident was doing therapy with one of the therapists, resident keep spitting on the therapist, then the therapist trying to dodge the spit covers the resident mouth with his hand. On assessment VSWNL, no bruise, injures at this time, resident denies having any pain at this time. Administrator, physician, and family notified. A review of Progress Note for Resident #1 dated 09/09/24 at 02:01 p.m. and created by ADON reflected a head-to-toe skin assessment was completed and no issues or injuries were noted, and Resident #1 denied any pain. A nursing incident note dated 09/09/24 at 11:33 a.m., created by the DON noted that Resident #1 was comfortable, with no pain, no open skin, or bleeding and that a mouth assessment was completed. Review of records reflect that Resident #1 was followed by psychiatric services. The most recent evaluation was dated 10/02/24. In an observation on 10/22/24 at 10:00 a.m., three different therapy staff were observed providing physical therapy to residents in the hallway. Each of the therapy staff were noted using a gait belt with the resident they were assisting. The staff interactions with these three residents were noted as calm, encouraging, patient, and appropriate. The dignity of each resident was noted as maintained throughout these sessions and there was no abuse or neglect observed. Review of facility Policy Statement titled, Use of Restraints, copyrighted 2001 Medi-Pass (Revised April 2017) reflected the policy states, Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptoms(s) and never for discipline or staff convenience, or for the prevention of falls. Review of facility Policy Statement titled, Resident Rights, copyrighted 2001 Med-Pass (Revised October 4, 2022) reflected the policy states, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include resident's right to: a. a dignified existence, b. be treated with respect, kindness, and dignity; c. be free from abuse, neglect, misappropriate of property, and exploitation; d. be free from corporal punishment or involuntary seclusion, and physical or chemical restraints not required to treat the resident's symptoms, e. self-determination; . Review of facility Policy Statement titled, Abuse Prevention Program, copyrighted 2001 Med-Pass (Revised October 2022) reflect the policy states, Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. (continued on next page)

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Victoria Gardens of Frisco	10700 Rolater Dr Frisco, TX 75035

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 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 10/23/24 at 15:49, the SLP M reported that she had worked at this facility since Monday. She reported that in onboarding this past week she received training in Resident Rights and Abuse and Neglect and dealing with behaviors as part of the dementia training. She reported she learned that if a resident is agitated, to step away, give them a break, make sure they are not in danger or a danger to anyone else. The SLP M stated if a resident was being aggressive with her, she would step back and not put her hands on them. She stated if there were some difficult behaviors, she might try to redirect them or distract them, or use knowledge of their personal interest to distract them and changes their mood. She stated that based on the individuals needs she would give them a short break and possibly try again later or even try the activity in a different location. She stated that if a resident was spitting at her she would move out of the range of the spit. She stated she would not hold or turn a resident's head as an intervention to spitting and would not cover a resident's mouth. She stated that would be a physical restraint and that the resident could experience fear or anxiety and could have physical injuries. In an interview on 10/23/24 02:30 p.m., ADM reported that on 09/09/24 angel rounds which are conducted each morning by department heads, began specifically including assessment of residents for any issues or concerns related to abuse and restraint. Resident council meetings were increased from monthly to a frequency of twice monthly so that any resident concerns could be shared and monitored. Behavioral monitor sheets for Resident #1 were reviewed and monitored during morning meetings. In addition to angel rounds, the ADM made daily rounds of the facility including the therapy gyms Monday through Friday, to monitor staff and therapy staff interactions with residents. Monthly QAPI meetings now include discussions of any concerns of difficult resident behaviors and abuse. In an interview on 10/23/24 at 02:52 p.m., DOR C reported that she walks through the building multiple times in the morning and multiple times in the evening (instead of once or twice a day) and that she goes back and forth between the two gyms intentionally monitoring for the appropriateness of interactions between therapy and residents, including monitoring for how staff deal with difficult resident behaviors. DOR C reported she meets with administration every morning in morning meetings Monday through Friday, and they address concerns they are having with any resident, and they share any concerns that have been noted or that a resident has expressed. DOR C reported that starting 09/09/24, weekly Wednesday meetings with therapy staff began including intentional questions regarding resident behaviors as well as resident triggers. She reported this is so that she can know ahead of time and help staff to address any issues. She reported that since this is a group meeting all staff now become aware of resident behaviors and triggers and are encouraged to ask for assistance. In an interview on 10/23/24 at 1:36 p.m., DON reported that since the incident on 09/09/24, the facility has continued monthly in-service trainings with staff but that in-service trainings for abuse and restraints are followed with questions to monitor for staff understanding and allow for immediate reteaching as needed. DON reported that Town Hall meetings which are conducted every Friday, now includes specifically asking the staff if they are experiencing any issues with residents with difficult behaviors. DON report that on 09/09/24 herself and the ADON decided that in addition to rounding each morning, they would perform, pop-in in which they assist staff with hands on resident care as a means of monitoring staff and resident interactions and providing