STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675853	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hansford County Hospital District Dba Lakeridge Nu	4403 74th St Lubbock, TX 79424

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344 Based on interviews and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours if the alleged violation involved abuse or neglect and resulted in bodily injury, to other officials (including the State Agency) and the Abuse Coordinator for 3 of 6 residents (Resident #1, #2, and #3) reviewed for abuse. A. The ADM failed to follow the facility's abuse policy by not reporting the allegation of abuse to HHSC regarding Resident #1 being fed forcibly by CNA A on an unknown date. B. The ADM failed to follow the facility's abuse policy by not reporting the allegation of abuse to HHSC regarding Resident #2 being transferred in a rough manner (chucked in the bed) by CNA A on an unknown date. C. The ADM failed to follow the facility's abuse policy by not reporting the allegation of abuse to HHSC regarding Resident #3 being changed improperly by CNA B on an unknown date. These failures could place residents as risk for abuse and neglect. Findings included: Resident #1 Record Review of Resident #1's face sheet, dated 1/28/25, revealed a [AGE] year-old female that was admitted to the facility on [DATE], with a diagnosis of dementia (memory loss) and anxiety (increased worry). Record Review of Resident #1's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 00, indicating the resident was severely cognitively impaired. Section E revealed Resident #1 did not exhibit physical behavior (hitting, kicking, pushing, scratching, grabbing, and abusing) during the review period [E0200]. Section GG revealed Resident #1 was dependent on staff for all her eating needs [GG0130]. Section K revealed that Resident #1 had the following swallowing disorder: coughing or choking during meals [K0100.]. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675853	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's progress notes dated from 10/27/24- 1/28/25 did not reveal any information regarding choking or allegation of abuse between the dates of 1/01/25-1/28/25. Record review of Resident #1's care plan, dated 1/21/25, revealed a focused area, initiated on 12/13/23, Resident #1 had an ADL self-care performance deficit r/t dementia. The goal initiated on 12/13/23, was Resident #1 would maintain current level of function through the review date review date (02/06/24-01/21/25). The interventions initiated 12/13/23 included while eating Resident #1 would be fed for all meals. During an interview on 1/28/25 at 2:50 PM, Resident #1 was unable to answer any questions about the staff's feeding technique. She lay in bed and was nonverbal at the time of the attempted interview. Resident #2 Record Review of Resident #2's face sheet, dated 1/28/25, revealed a [AGE] year-old female that was admitted to the facility on [DATE], with a diagnosis of dementia (memory loss), pain in unspecified joint and anxiety (increased worry). Record Review of Resident #2's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 03, indicating the resident was severely cognitively impaired. Section GG revealed Resident #2 requires partial or moderate assistance when it comes to chair/bed to chair transfer. Record review of Resident #2's progress notes dated from 10/27/24- 1/28/25 did not reveal any information regarding improper transfer or allegation of abuse between the dates of 1/01/25-1/28/25. Record review of Resident #2's care plan, dated 6/14/24, revealed a focused area, initiated on 6/17/24, Resident #2 had an ADL self-care performance deficit r/t left hip and sacrum fracture. The goal initiated on 6/17/24, was Resident #2 would maintain current level of function through the review date review date (08/15/24-06/20/25). The interventions initiated 6/17/24 included Resident #2 required extensive assistance by 1 staff to move between surfaces. During an interview on 1/28/25 at 4:15 PM, Resident #2 stated she could not remember if staff had been rough with her. When asked about transfers, she said she could not remember anything. Resident #3 Record Review of Resident #3's face sheet, dated 1/28/25, revealed a [AGE] year-old female that was admitted to the facility on [DATE], with a diagnosis of Alzheimer's (memory loss) and anxiety (increased worry). Record Review of Resident #3's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 03, indicating the resident was severely cognitively impaired. Section E revealed Resident #1 did exhibit verbal behavior (threatening, screaming and cursing at others) during the review period [E0200]. Section GG revealed that Resident #3 requires substantial/maximal assistance regarding toileting hygiene [GG0130]. Section H revealed Resident #3 was always incontinent of bowel and urinary [H0300-0400]. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's progress notes dated from 10/27/24- 1/28/25 did not reveal any information regarding improper perineal care or allegation of abuse between the dates of 1/01/25-1/28/25. Record review of Resident #3's care plan, dated 3/08/24, revealed a focused area, initiated on 3/18/24, Resident #3 had bladder incontinence r/t Alzheimer's. The goal initiated on 3/18/24, was Resident #3 was at risk for septicemia (life threatening bacterial disease) will be minimized/prevented via prompt recognition and treatment of symptoms of UTI through review date (4/30/24-06/20/25). The interventions initiated 3/18/24 did not include instruction to staff on what to do regarding incontinence care. Record review of Resident #3's care plan, dated 3/08/24, revealed a focused area, initiated on 3/18/24, Resident #3 had an ADL Self Care performance deficit r/t Alzheimer's. The goal initiated on 3/18/24, was Resident #3 was to maintain current level of function in eating through the review date (4/30/24-06/20/25). The interventions initiated 3/18/24 stated Resident #3 was totally dependent on staff for toilet use. Record review of Resident #3's care plan, dated 3/08/24, revealed a focused area, initiated on 3/18/24, Resident #3 was resistive to care and would refuse to be changed r/t Alzheimer's. The goal initiated on 3/18/24, was Resident #3 would cooperate with care through review date (4/30/24-06/20/25). The interventions initiated 3/18/24 did not include if Resident #3 resisted with ADLs, negotiate a time so that the resident can participate in the decision making process. During an interview on 1/28/25 at 4:00 PM, Resident #3 did not provide any pertinent information related to the deficient practice. During an interview on 1/28/25 at 12:14 PM, Student C stated that she reported allegations of abuse when she was completing her clinical at the NF. She said she was not in a place where she could talk but could give the information later to the investigator. She said she did write a statement and reported the allegations of abuse to the ADON and the ADM that she had witnessed abuse and neglect at the facility. During an interview on 1/28/25 at 1:15 PM, CNA A stated she was unsure of the exact day and time but that Student C had alleged that she was doing something wrong. The CNA stated she did not do anything wrong. She stated that she was asked to write a statement and was addressed about the allegations immediately. She said she focused on providing care for her residents and would not abuse them. During an interview on 1/28/25 at 2:00 PM, the DON stated that she was unsure of the date and time but that Student C did not make a report of abuse to her. She said the report was made to the ADON. She said she was not clear on all the allegations, but it was her understanding that CNA A force-fed someone and threw someone on their bed. She said it was her understanding that an investigation was done, the facility cameras were watched, and none of the findings were valid. She stated she was unsure of which resident was force-fed but that she believed the resident who was thrown in bed was Resident #2. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/28/25 at 2:20 PM, the ADON stated she was unsure of the date and time, but Student C came to her at least three weeks ago with another employee (CNA D). She stated that she was told by CNA D that Student C needed to speak with her. The ADON stated that she was told by Student C that she (Student C) had an abuse case that she wanted to report. The ADON stated that the DON was off on that day, and as a result, she went to the ADM. She stated she did not want to take a statement regarding abuse by herself. She stated that in the presence of the ADM, CNA Student C stated that CNA A fed a resident with a spoon with too much food, making the resident choke. The ADON stated that Student C reported that CNA B performed perineal care incorrectly. The ADON stated that she could not fully remember what Student C alleged. She stated they had Student C write a statement, which was submitted to the ADM. The ADON stated it was her understanding that the information gathered was submitted to their corporate. She stated that it was told to her that what was told to her (the ADON) and what was on the statement were different. She stated they educated staff on what to do if residents are choking and how to conduct perineal care. She stated that they asked nurses if they had witnessed anything and that no one had reported anything. The ADON stated that after she, the DON, and the ADM got statements and consulted with corporate, it was concluded that Student C was a new CNA and everything was a first for Student C in the nursing home environment. The ADON stated she had been trained on the facility's abuse policy. She stated that failure to report allegations of abuse to HHSC could result in the nursing facility being shut down. She said abuse could continue if it is not reported correctly. She stated that the purpose of reporting allegations of abuse to HHSC was to ensure that residents are treated fairly and keep them free from abuse and that all allegations of abuse are investigated on a higher level. She stated she was unaware that the allegations had not been reported to HHSC. She stated she was unaware that the incident with Student C was supposed to be reported to HHSC. She stated that their system to monitor and ensure that the abuse policy was being followed was that all allegations of abuse should be reported to the abuse coordinator, the ADM. The ADON stated that in-services and education on expectations are conducted. She stated they are trained and train the staff to report anything that seems unjust and anything they would not want to their family members. She said the ADM and the DON will conduct the investigation and report the appropriate information to HHSC. She stated that she expected all allegations of abuse to be reported to the abuse coordinator (ADM), the abuse policy followed, and all staff educated accordingly. The ADON stated that the ADM and DON were responsible for reporting allegations of abuse to HHSC. She said she was unsure of the reason the allegations of abuse reported by Student C were not to HHSC. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/28/25 at 3:00 PM, the ADM stated he was unsure of the specific date and time, but Student C reported that she had concerns about how staff at the NF were taking care of the residents. He stated he had her write a statement. He stated that during their interview, Student C reported that a staff (CNA B) was rough with a resident, and the resident was screaming out. He said that he was told by Student C that another staff member (CNA A) had chucked another resident into bed. He said Student C stated that a staff (CNA A) overfed a resident and caused her to choke. The ADM said he took Student C's statement and sent it to his corporate staff. He stated he was instructed to conduct a 1:1 with both staff members, assess all residents, in-service all staff on customer care, and conduct safe surveys with residents. The ADM stated that Student C did not mention the term abuse or neglect. The ADM stated that he interpreted the student's statement that she had concerns but was not alleging abuse. He stated that he felt the student was bringing to his attention that the staff were rushing. He stated he would hope that his staff, when reporting serious incidents, would be specific and use the actual word abuse and neglect. She stated that she did not disclose the resident's names when Student C reported the incident. He stated that in the process of their investigation, they concluded that it was Resident #1 regarding the feeding incident, Resident #2 who was allegedly chucked on the bed, and Resident #3 involved in the perineal care. The ADM stated that because Student C did not provide names, he could not be 100 percent sure those were the residents involved. The ADM stated he did not report the allegations to HHSC because he did not perceive them as allegations of abuse but thought it was a concern in all three instances where staff may have been rushing and needed additional education. He stated that the purpose of reporting allegations to HHSC was to prevent abuse and to ensure that the resident's rights were being taken care of. The ADM stated that the potential negative outcome of not reporting all allegations of abuse to HHSC was that residents could endure abuse. He stated he was familiar with the facility's abuse policy and had been trained on the policy. He stated he was aware that he did not report the concerns to HHSC. He said their system for monitoring the implementation of the facility's abuse policy was to consult with corporate staff to see if they have enough evidence to report the allegation. He stated he had been trained to report all allegations of abuse to HHSC, and he expected all allegations of abuse. He stated he was responsible for reporting allegations of abuse to HHSC. During an interview on 1/28/25 at 3:30 PM, CNA D stated that she could not remember the date or the time, but a few weeks before her interview with the investigator, Student C came to her and stated she had observed abuse and neglect in the facility. She stated that she stopped Student C before she could report anything to her and explained to her that she could not take that type of report. She stated she took her to the Administrator's office. She stated they knocked, and he did not answer. CNA D stated she took Student C to the ADON. She stated that after that, she did not know what had happened with the abuse reporting process. During an interview on 1/28/25 at 3:40 PM, the DON stated that she had been trained on the facility's abuse policy and was familiar with it. She said she had been trained that all allegations of abuse had to be reported to HHSC. She said the purpose of reporting to HHSC was to protect residents from abuse while the investigations were being conducted. She said the potential negative outcome for the resident is that abuse can continue if not appropriately addressed. She said she was aware that the allegations from Student C were not reported to HHSC, but it was not reported because there were no findings that substantiated what Student C reported. The DON said she expected all allegations of abuse to be reported to HHSC. She said that she and the ADM were responsible for reporting allegations of HHSC. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/29/25 at 10:06 AM, CNA B stated she did not remember the exact date and time but had been asked to change Resident #3 with the assistance of student aides. She said that after she changed Resident #3, management asked her to write a statement because it was alleged that she was rough with Resident #3. CNA B told the students that Resident #3 was sensitive. She said that while changing Resident #3, she forgot that Resident #3 needed cream and had intended to tell the night shift to put cream on her. CNA B stated that one of the students (name unknown to her) went and retrieved the cream. She said, Thank you, and put the cream on her. She said she was unaware of any issues or concerns from the student aides at the time of the incident. She said she was given a warning about the incident. During an interview on 1/29/25 at 10:12 AM, the Regional Clinical director stated she received an email from the ADM (the email date was not disclosed during the interview). She stated that the email from the ADM stated that he (the ADM) had a grievance from one of the CNA students (she did not disclose which CNA student by name). She said she read Student C's statement that was attached to the email and advised the ADM to investigate, in-service, and conduct safe surveys. She stated that after reading Student C's statement, she considered what she reported to be a concern, not an allegation of abuse. She stated that this instruction was given because there was no merit to the concerns that the CNA student disclosed. The Regional Clinical Director stated that the ADM never stated that there was an allegation of abuse. The Regional Clinical Director stated that if there is a complaint of abuse, it is customary for them to investigate and immediately notify HHSC. She stated she was unaware if the term abuse was used when the concerns were made. She stated that the ADM had been trained on the abuse policy and is the abuse coordinator. She stated she felt comfortable with the ADM interpreting if there was an allegation of abuse. She stated that the ADM received the basic abuse training that all staff receive, but she was unaware of any additional training he may have received as the abuse coordinator. The Regional Clinical director stated she read Student C's statement and considered it a grievance. She stated that it was a strange situation because she is unsure if something is going on in the facility where the staff may be against CNA A. She stated that the ADM was responsible for reporting to HHSC. She said the purpose of reporting all allegations to HHSC was so they (HHSC) could come out and ensure that the facility followed the correct protocol to prevent abuse. She stated the reason the allegations of abuse were not reported was because they were considered a grievance and not an allegation of abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/29/25 at 11:17 AM, Student C stated that 1/10/25 she graduated from CNA school. She stated that her experience at the NF was challenging. She stated that on the previous Tuesday (01/7/25) before graduation, she observed CNA B perform perineal care on Resident #3. She stated she observed her partially clean and not put cream on her buttocks. She stated that CNA B would not put the cream on Resident #3, so she retrieved the cream. She stated that CNA B thanked her, and when she went to put the cream on Resident #3, it appeared that CNA B forcibly put the cream in Resident #3 buttocks, and when she removed her hand, there was feces on CNA B's gloves, indicating that Resident #3 was not clean. Student C said CNA B did not attempt to reclean Resident #3. She stated that the next day (1/08/25), while she was feeding Resident #1, CNA A took over feeding Resident #1. Student C stated that she observed CNA A provide at least two large spoonful of mashed potatoes and other unknown sauces and feed them to Resident #1. Student C stated that when CNA A attempted to give her another heaping spoonful of food, Resident #1 appeared to start choking and spit the food out on her clothing protector. Student C stated she provided Resident #1 with a drink, which seemed to help her. She stated that CNA A was feeding Resident #1 all the while eating her own lunch in between providing Resident #1 bites of food. She stated that CNA A threw Resident #2 in the bed the same day. She stated she felt bad for the residents at the NF. She stated that Resident #2 told CNA A she was moving too fast and was crying. Student C stated she felt bad for all the residents at the NF because of the treatment she saw. She stated she went to CNA D, who told her she would have to report what she observed and showed her where to go. She stated she went to the ADON office on her first day. She stated that she made herself clear that she wanted to report abuse. She said the ADON told her she would have to get the ADM as she could not take a statement of that nature herself. She stated that when the ADON retrieved the ADM, they passed CNA A and told her, After this, we will need to talk. She stated that CNA A attempted to walk with the ADON and ADM, but the ADON stopped her. Student C said this made her feel uncomfortable as this would make it obvious that she was the one making the report of abuse. She stated they went to the office, and she reported what she had experienced, including the alleged allegations of abuse with Resident #1 ,#2, and #3. She stated that in the presence of the ADM and ADON, she made herself clear that she was alleging that Resident #1, #2, and #3 had been abused. She stated that she was asked to write a statement. She stated she was placed in the room next to the ADM office and could hear him sucking his teeth and breathing hard as if he was irritated. She stated that this treatment caused her not to focus on her statement as much. She stated that staff were coming in and out, and the ADM would come and ask her if she was done frequently. She stated that she did not include names or the words abuse or neglect because she was instructed by the ADM to only write what she observed. She stated that the tone of the environment set by the ADON and ADM made her rush and forget that she had another incident to report about CNA A. She said that CNA A had made an inappropriate comment to an unknown resident while showering him but did not want to say anything further because she already felt she had caused enough trouble. She stated that while reporting what she observed with Resident #1, #2, and #3, she (Student C) had become emotional and started crying. She stated that no one followed up with her about what she reported. She said she did not consider what she reported a grievance. She said she had received training on ANE during certified nurses aide training from the school but only attended the NF for hands on training with the residents. Record review of the email, dated 1/29/25, forwarded by the Regional Clinical Director revealed the following: Student C's witness statement was attached. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The ADM emailed Student C's witness statement to Regional Clinical Director and reported that a student had complaints about staff care. Record review of Student C's handwritten statement, dated 1/9/25, revealed the following: December 7, 2025 I witness CNA B not cleaning the patient (Resident #3) in room private area right. She also did not use diaper rash medicine and when I brought it to her and told her to use it she placed it on her hand and forcefully shoved her hand in the lady's legs. The lady was in so much pain she yelled. January 8, 2025 I witnessed CNA A put a over amount of food into the mouth of a patient (Resident #1) who couldn't move and was rushing feeding her. The lady choked so I gave her kool-laid. January 9, 2025 I witnessed CNA A chuck Resident #2 on the bed. CNA A was in a hurry due to trying to leave early. Record review of CNA A's handwritten statement, dated 1/08/25, revealed the following: I, CNA A, was feeding residents and it was said I over feed, but I truly feel that I over did it, but I will be careful and safe. Record review of CNA A's handwritten statement, dated 1/09/25, revealed the following: I, CNA A, had 4 students with me to put Resident #2 to bed as asked by my nurse. As I stood her up I smelled her, so I got her brief and wipes and changed her while she was standing when I assisted her to bed. There were no provider investigation reports available for review that involved Resident #1, #2 or #3 as of 1/28/25. Record review of CNA B's handwritten statement, dated 1/07/25, revealed the following: Tuesday January 7th the students asked me for help with Resident #3, so I came to help. I let them know as I was helping that she's (Resident #3) sensitive so when you move her even just a little it hurts her. She (Resident #3) was a little red. It was the last round. I didn't have cream so I was gonna let night shift know she was red so they could put some on her but one of the student aids went and got some cream so I did put dome on her after she was changed. Record review of the facility's investigation report, dated 1/11/25, revealed the following: The investigation from the student was completed and the conclusion did not show any abuse or neglect. The staff need to be in-serviced on taking their time and more personal care when caring for residents. Safe surveys were completed by the Licensed Social Worker on other residents down the hall and no complaint made at this time. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The staff (CNA B) that was in question about her perineal care technique: had stated to the student before they went in that the resident will scream out when you touch her in any manner. The staff (CNA A) that put Resident #2 to bed, stated she did not chuck as stated or do any type of transfer that would be considered abuse at that time. It may have seemed rough to the student. The staff (CNA A) that was feeding the resident (Resident #1) stated she was giving her large spoons, but that was normal for the resident (Resident #1) and she did not choke; and if so the nurse would have intervened. Record review of LVN E's handwritten statement, dated 1/09/25, revealed the following: Head to toe skin assessment performed on Resident #2. One old bruise noted to back of right arm, measuring 1 cm by 1.5 cm , and greenish in color. Residents skin is warm/dry to touch. Skin turgor elastic (ability to stretch and return to normal). No abnormalities noted, no other skin breakdown noted. No rashes/lesions noted to skin. Record review of facility's inservice overview, dated 1/10/25, revealed that staff were inserviced on the following: Customer service: Respect resident's rights, respect their privacy and show compassion with care Direct care Staff: Take your time with personal care, be gentle and use caution with care during transferring, assisting with meals and bathing. Record review of a total of 6 safe surveys, dated 1/10/25, revealed the following: No resident reported feeling unsafe, abused or handled roughly. Record review of facility employee training, dated 1/10/25, revealed the following: CNA B was trained on perineal care technique. Record review of facility employee training, dated 1/10/25, revealed the following: CNA A was trained on transfer technique and assisting residents with feeding. Record review of the facility policy, Filing Grievances, revised December 2024, revealed: Policy Statement Our facility will assist residents, their representatives (sponsors), other interested family members, or resident advocates in filing grievances or complaints when such requests are made. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675853	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hansford County Hospital District Dba Lakeridge Nu	4403 74th St Lubbock, TX 79424

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Any resident, his or her representative (sponsor), family member, or appointed advocate may file a grievance or complaint concerning treatment, medical care, behavior of other residents, staff members, theft of property, etc., without fear of threat or reprisal in any form. The resident, or person filing the grievance and/or complaint in behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. Such report will be made orally by the administrator, or his or her designee, within 3 working days of the filing of the grievance or complaint with the facility. A written summary of the report will also be provided to the resident, and a copy will be filed in the business office. Record review of the facility grievance log dated from November 2024-January 2025 did not include a concern involving Resident #1, #2 or Resident #3. Record review of the facility policy, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigation, revised April 2021, revealed: Policy Statement All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations). Policy Interpretation and Implementation If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to tl1e following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility; Immediately is defined as: within two hours of an allegation involving abuse or result in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Reporting Results of Investigations The administrator, or his/her designee, provide the appropriate agencies or individuals listed above witl1 a written report of the findings of the investigation within five (5) working days of the occurrence of the incident.