STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675886	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coryell Health Rehabliving at the Meadows	110 Chicktown Rd Gatesville, TX 76528

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44700 Based on interview and record review, the facility failed to implement their written policies and procedures regarding prohibiting and preventing abuse for one (Resident #1) of six residents reviewed for developing and implementing abuse and neglect policies, in that: Facility staff failed to report to the Administrator, who was the Abuse Prevention Coordinator, potential incidents of abuse that occurred on 4/23/2024 when: 1. RN B was allegedly heard making a derogatory statement about Resident #1 to CNA A. 2. RN B was allegedly heard making a derogatory statement about Resident #1 to CSM C. 3. RN-B was allegedly heard making a derogatory statement about Resident #1 in front of CSM D This failure placed residents at risk of abuse, neglect, or exploitation. Findings included: Review of Resident #1 undated face sheet reflected an [AGE] year-old female with an unknown admitted with diagnoses that included: Diabetes mellitus Type II (blood sugar disorder), Hypertension (high blood pressure), Hyperlipidemia (high cholesterol) Congestive Heart Failure (chronic condition in which the heart doesn't pump blood correctly) Mild Asthma, Generalized Anxiety Disorder, Chronic Pain Syndrome, Disorder of the Connective Tissue (inflammation of connective tissue like collagen and elastin), and Osteoarthritis . (Degeneration of joint cartilage) Review of Resident #1's Quarterly MDS assessment dated [DATE]., reflected Resident had a BIMS score of 15 suggesting Resident # 1 had no cognitive impairments. Review of Resident #1's care plan dated 5/6/2024 reflected a plan of LTC Falls with outcome: free from falls and interventions including: low bed, ensure glasses worn, evaluate room for clutter, use of assistive devices, adequate room lighting, call light tin reach and non -slip footwear. (continued on next page)

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/2/2024 at 1:30 pm, CNA -A stated they were at work on 4/23/2024 and they received a call from another CNA that Resident #1 had an unwitnessed fall , and their help was needed. On their way to that hall, CNA - A stated they encountered RN-B in the hall and RN-B stated that Resident #1 had fallen. CNA-A asked RN-B if they were sending Resident #1 out to the hospital and RN-B stated no it was a boy who cried wolf scenario. CNA-A stated at the time they did not think RN-B's derogatory comment about Resident #1 was abuse so they did not report it. CNA-A stated they had received training on abuse and neglect and was able to identify the Administrator as the Abuse Coordinator. CNA-A stated later after talking with Resident #1 they called and spoke to the ADON and told her what RN-B has said to them about Resident #1 crying wolf about the fall. During an interview on 5/2/2024 at 2:43 pm, RN-B stated she had been at work on 4/23/2024 when Resident #1 sustained an unwitnessed fall. She stated she assessed the resident and had not seen any injuries but Resident #1 wanted to be sent to the ER, so she had gone back to the nurse's desk to start the process. She stated Resident #1 has Generalized Anxiety Disorder and can be hyper-sensitive. She stated she never told Resident #1 that she would not send her out to the ER. She also stated that she had not said anything to anyone about the resident being overly dramatic or crying wolf. She stated when she provided information at the nurse's station at shift change she did not say Resident #1 was faking it or being overly dramatic. She stated she did not remember that she said anything to CNA-A in the hall about the fall. RN-B stated Resident #1 had a history of making false accusations and has had frequent somatic complaints. She said, the thought entered my mind that she had not fallen because the resident could not tell me how she got to sitting on the floor by her recliner. She stated Resident #1 had made accusations in the past that are not quite accurate from my viewpoint. RN-B She stated she had received training on ANE and how to recognize and report ANE. She stated they are supposed to report all ANE to the Abuse Coordinator who is the AD. RN-B denied any ANE of Resident #1. During an interview on 5/2/2024 at 3:49 pm, the ADON stated she had received a call from CNA-A after Resident #1 had fallen. She stated nothing was reported to her as abuse or neglect, there was just a concern that RN-B was not going to send Resident to ER. She stated she received no statements from staff stating RN-B stated Resident #1 was faking her fall or crying wolf. She stated if she had, she would have reported it to the Administrator. During an interview on 5/2/2024 at 4:13 pm, the AD stated she was aware of the fall incident with Resident #1 on 4/23/2024. She stated staff thought RN-B wasn't going to send Resident #1 out, but that staff didn't understand protocol for sending a resident to the ER. She stated she had no concerns about ANE and no concerns with how the incident was handled. During an interview on 5/3/2024 at 1:57 pm, CSM-C stated they were at work on 4/23/2024 and had been sitting at the nurse's station at shift change and heard CNA staff come up to the desk and tell RN-B that Resident #1 had fallen. RN-B stated that Resident #1 was faking it and CSM-C heard RN B say She's always crying wolf, there's nothing wrong with her, she didn't hit her head and I'm not sending her out.' CSM-C stated Resident #1 is the type of resident that will say things sometimes that staff think are not true. During another interview on 5/5/2024 at 1:36pm, CSM-C stated they had received training on abuse and neglect and was able to identify the AD as the person to report any ANE. CSM-C stated that it did not cross my mind that it might be abuse, referring to what she heard RN-B had said on 4/23/2024 and that RN-B wasn't being malicious about it, that's how they talk about Resident #1. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/3/2024 at 2:19 pm, CSM-D stated they had been working on 4/23/2024 and was at the nurse's desk about 5:15 pm. RN-B told her that Resident #1 had fallen and you know she's faking it, she did one of her fake falls,. CSM - D asked if Resident #1 had hit her head and RN-B stated, she says she did. CSM-D asked RN-B if she was going to send Resident #1 out and RN-B said no. CSM-D stated later that evening the DON called them and asked what happened at the nurse's desk earlier that day and CSM-D stated they told the DON that RN-B told me that Resident #1 fake fell and that she wasn't sending her to the ER. During another interview on 5/3/2024 at 4:09 pm, CSM-D stated at the time they did not think what RN-B said was abuse or neglect but looking back now they think that it was , and they should have reported it to the AD who is the abuse coordinator. CSM-D stated, I wanted to get out of the situation because of RN-B's attitude at the time. I know that's wrong, and I have been beating myself up over it. She stated the facility policy stated any concerns with ANE are to be reported to the abuse coordinator who is the administrator. During an interview on 5/3/2024 at 4:59 pm, the DON stated she was aware of the fall incident with Resident #1 and that staff thought RN-B was not going to send Resident #1 out to the ER. She stated she does not recall any staff telling her that RN-B said it was a fake fall or that Resident #1 was crying wolf., I'm not saying they didn't, I don't recall, I don't remember; not to my recollection. She stated there was no reason to believe that there was any abuse or neglect going on by RN-B. She stated the events were reported to the AD in the morning meeting the next day on 4/24/24 and there was nothing reported in the morning meeting about RN-B refusing to send Resident #1 out to the ER. She stated she did have an informal discussion with RN-B on 4/24/24 at the nurse's station face to face to remind her if a resident wants to be sent out we have to send them out. Review of undated facility policy Prevention and Reporting of Suspected Resident Abuse and Neglect reflected: This facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect. This facility has implemented the following processes in an effort to provide residents and staff a comfortable and safe environment. The Administrator and Director of Nursing are responsible for the implementation and ongoing monitoring of abuse policies and procedures. Implementation and ongoing monitoring consist of the following policies: Screening, Training, Prevention, Identification, Protection, Investigation and Reporting .4. B. Any person with the knowledge or suspicion of suspected violations must report, immediately, without fear of reprisal. Notification will be to the Unit Charge Nurse (UCN) for the resident involved. The UCN is identified as responsible for initiating the reporting process and will notify the Director of Nursing and/or Administrator.