STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675900	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Pointe of Trinity Healthcare and Rehabilitat	808 S Robb Trinity, TX 75862

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38332 Based on interview and record review the facility failed to treat Resident #1 with dignity and respect of personal possessions for 1 of 4 residents (Resident #1) reviewed for resident rights in that: The facility staff packed Resident #1's belongings into trash bags and placed them in the hall of the new facility. The facility staff failed to respect Resident #1's belongings when placing everything in trash bags upon her discharge. This failure could place the residents at risk for mistreatment, uncomfortable feelings and disrespect. Findings included: Record review of Resident #1's Face Sheet, dated 5/10/24, revealed a [AGE] year-old female originally admitted on [DATE]. Her diagnoses included Muscle weakness, Type 2 diabetes mellitus without Complications [high sugar levels in the blood], Dysphagia [difficulty swallowing], Abnormalities of gait and mobility, lack of coordination, dementia [memory disorder] unspecified severity, without behavioral disturbance, psychotic disturbance (group of serious illnesses that affect the mind) mood disturbance (a mental health condition that primarily affects your emotional state) and anxiety. Record review of Resident #1's BIMS assessment dated [DATE] revealed Resident #1 had a BIMS score of 15, signifying no cognitive impairment. Record review of a document titled Notice of Proposed Transfer/ Discharge. Date of notification 3/5/24 with a 30-day notice- 4/5/24. RP notified on 3/5/24. Federal Regulations require that your transfer/ discharge be made for one of the following reasons: 2.) The transfer/ discharge is necessary for your welfare and your needs cannot be met in the facility. a) The specific needs that cannot be met are: ADL's, including shower/ bathing, medication administration. b) The facility attempts to meet the resident's needs and the resident's response, included: exhausting available staff members to provide care. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/25/24 at 8:06 a.m. Resident #1's RP said she was Resident #1's Power of Attorney. She said she felt like her and Resident #1 were retaliated against because the resident was given a 30-day discharge notice. The RP said after the meeting the resident's belongings were thrown in trash bags then Resident #1 and her belongings were taken to the new facility. The RP said the new facility staff notified her and told her everything was thrown together in the trash bags including syrup and other foods causing Resident #1's clothes to stain. She said Resident #1 told her she felt like trash and the facility threw her out with the trash bags. In an interview and observation on 5/8/24 at 11:09 a.m. with Resident #1 at the new facility. She was alert and orientated to her surroundings. She said one day she went to the doctor and when she returned to the facility her belongings were hauled off to a new facility. She stated, I felt like trash being thrown out with my belongings. In an interview on 5/8/24 at 1:20 p.m. CNA E (CNA at the new facility) said she was working the day that Resident #1 was admitted to the facility. She said the other facility dropped Resident #1 off with several, about 10 large trash bags of her belongings. She said it was wrong of the facility to leave the resident without helping her at the new facility. She said she could see that Resident #1 was bothered by the discharge. She said the resident questions often where the facility stored her belongings, and she often is asking about her crosses to be unpacked. In an interview on 5/8/24 at 1:42 p.m. the new facility's Administrator revealed Resident #1 had adjusted well to the facility. He explained when Resident #1 was discharged from the other facility they threw all of her belongings all together in about 10 large leaf size trash bags then left them in the hallway for the new facility to deal with. He explained the way the other facility discharged Resident #1 was not necessary. In an interview on 5/9/24 at 12:35 p.m. the SW said the nursing staff packed Resident #1's belongings. She said the resident had a lot of belongings to pack up. She said she watched the nursing staff pack the resident's belongings in boxes. She said the staff folded the resident's clothes neatly and placed them in bags. She said the resident tended to spill food which caused stains on her clothes. Record review of facility policy Resident Rights undated read in part .Respect and Dignity. You have the right to be treated with respect and dignity including the right to: Retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents .

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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 0607 Level of Harm - Actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38332 Based on observation, interview, and record review the facility failed to implement their written policies and procedures regarding prohibiting and preventing abuse for one (Resident #1) of 4 residents reviewed for developing and implementing abuse and neglect policies, in that: Resident #1 was provided a discharge notice on 03/05/24 after reporting CNA A shook her shoulders in the shower room on 02/29/24 and alleged MA B gave her medications she did not recognize that made her sick in January 2024. The facility failed to provide Resident #1 safety after CNA A was allowed to return to the facility on [DATE], one day after abuse allegations were made by Resident #1. These failures could place residents at risk for psychosocial harm, being fearful of staff, being uncomfortable, impaired quality of life and further abuse. Findings included: Record review of facility policy Abuse: Prevention of and Prohibition Against undated read in part .Training 1. The facility will engage in training and orienting its new and existing nursing staff on topics which relate to the delivery of care in the post-acute setting. Topics of such training will include, but not be limited to: a. Prohibiting and preventing all forms of abuse . b. identifying what constitutes abuse . h. Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect and how to respond. These symptoms, include, but are not limited to the following . iii. Resistance to care . v. Difficulty in adjusting to new routines or staff. 2. The facility will provide oversight and supervision of staff in connection with the above, to confirm that its policies prohibiting abuse are being implemented. D. Prevention: . Assuring that residents are free from neglect by having the structures and processes to provide needed care and services to all residents, which includes, but is not limited to, the completion of a Facility Assessment to determine what resources are necessary to care for its residents competently; Identifying, assessing, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect such as: .bossing around/ demanding, insulting to race or ethnic group . Residents that require extensive nursing care and/ or are totally dependent on staff for the provision of care. Reporting/ Response: . 3. The facility will ensure that all individuals who are involved in the reporting or investigation process are free from retaliation or reprisal. Record review of Resident #1's Face Sheet, dated 5/10/24, revealed a [AGE] year-old female originally admitted on [DATE]. Her diagnoses included Muscle weakness, Type 2 diabetes mellitus without Complications [high sugar levels in the blood], Dysphagia [difficulty swallowing], Abnormalities of gait and mobility, lack of coordination, dementia [memory disorder] unspecified severity, without behavioral disturbance, psychotic disturbance (group of serious illnesses that affect the mind) mood disturbance (a mental health condition that primarily affects your emotional state) and anxiety. Record review of Resident #1's BIMS assessment dated [DATE] revealed Resident #1 had a BIMS score of 15, signifying no cognitive impairment. (continued on next page)

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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 0607 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's discharge Minimum Data Set (MDS) dated [DATE] identified Section E- Behaviors revealed no potential indicators of psychosis, no behavior symptoms (physical, verbal or other), no behaviors of rejection of care. Section GG- Functional Abilities revealed Resident #1 needed only set-up assist with eating, oral hygiene and toileting. Resident #1 needed partial assist with upper body dressing and maximum assist for shower, lower body dressing and personal hygiene. Resident #1 was able to transfer with supervision. Section H- Bladder and Bowel identified Resident #1 as occasionally incontinent of urine and always continent of bowel. Record review of Resident #1's Care Plan dated 5/9/22 focus: Resident #1 has ADL self-care performance deficit related to limited mobility, impaired balance, shortness of breath and stroke. Interventions included: Requires assistance with bathing, totally dependent on staff for repositioning and turning in bed and totally dependent on staff for dressing. Care plan initiated date of 12/22/23. Focus: Resident #1 has potential for a behavior problem false allegations related to staff treatments and medication administration. Interventions included: Anticipate and meet needs, approach in a calm manner, and assist to develop more appropriate methods of coping and interacting. Encourage to express feelings appropriately. In an interview on 4/25/24 at 8:06 a.m. with Resident #1's RP said she was Resident #1's Power of Attorney. She explained the resident was discharged from the facility on 3/13/24 because the facility said they could not care for the resident's needs or give her medications. She said Resident #1 reported to the facility's Business Office Manager (BOM) on 2/29/24 the shower aide (CNA A) did her wrong, by shaking her shoulders and pushed her in the shower room. She said Resident #1 was told to go to her room and wait for someone to come and talk with her about the incident, but no one talked to her. She said she felt like Resident #1 was retaliated against because they allowed CNA A to continue to work at the facility, but the resident was given a 30-day discharge notice. The RP explained another incident happened regarding Resident #1's medication pass with MA B. She explained Resident #1 was very aware of what medications she took and knew the pills shape and size. She said a couple months ago MA B had given Resident #1 a pill she did not recognize and shortly afterwards she got sick. She explained Resident #1 refused MA B to give her medications after that. The RP said the facility told her Resident #1 exhausted all staff to care for her needs and to administer medications. She said the facility made the excuse that Resident #1 was racist and that was why she refused to take medications from MA B. The RP said she asked the SW for the paperwork regarding the incident on 2/29/24 but was told the incident was a week old and they did not investigate it. She explained Resident #1 was still bothered by the situation and talks about it often. The RP said Resident #1 still tells the same story she gave on 2/29/24. The RP said on 3/12/24 or 3/13/24 the facility had a care plan meeting regarding the resident's discharge plans. She said the Ombudsman had attended the meeting but felt like they were on the nursing facility's side and did not help Resident #1 or her. She said the Ombudsman told her she would send a form regarding the appeal process, but she never received any form or any other calls from the Ombudsman. The RP said she would have appealed the process but was not given the opportunity. The RP said after the meeting the resident's belongings were thrown in trash bags then Resident #1 and her belongings were taken to the new facility. She said Resident #1 told her she felt like trash and the facility threw her out with the trash bags. The RP said everyone loved Resident #1 and she was compliant with her care and did not like confrontation and did not understand the discharge notice. She said she was not aware of Resident #1's move until a staff from the new facility had called her a couple days later. (continued on next page)

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F 0607

Level of Harm - Actual harm

Residents Affected - Few

Record review of Provider Investigation Form 3613 completed by CO dated 2/29/24 reported an incident on 2/29/24 at approximately 11:45 a.m. in the shower room. Description of the Allegation: Resident #1 reported to the BOM that staff member CNA A, the shower aide shook her by the shoulders awhile back while waiting for the shower. Resident alleges that she requested a shower, and the aide told her she had a line of people before her. Interventions included CNA A suspended pending investigation 2/29/24. Investigation findings were unfounded. CNA A returned to work within less than 24 hours on 3/1/24 after in serviced on abuse, neglect, dealing with aggressive and manipulative residents.

An interview on 5/8/24 at 3:05 p.m. the SW said Resident #1 exhibited behaviors of accusing others of poisoning her food, only provided with Mexican food, and she said she was told in IDT meeting that Resident #1 accused MA B of choking her because it was a whole three minutes later after Resident #1 began to cough after MA B gave her medications. She said Resident #1 did not like MA B because of her race. She said MA B was removed from assisting Resident #1. She said Resident #1 got very angry because the meds were not given at an exact time and she demanded the nursing staff to give her medications. SW said She was running the nurses ragged because MA B could not give her medications anymore and Resident #1 would make the nurses stop and give her medications immediately. SW revealed she did not create the discharge notice and that it was provided by the legal staff. She said the Administrator (CO) recommended initiating the discharge. She said residents are admitted to Long Term Care because the families can not do the care that was needed and safe for the resident. She said Resident #1 was a very independent resident and she could have probably lived in an assisted living. She explained there was a care plan meeting on 3/13/24 regarding Resident #1 and the Ombudsmen was also at the facility. She said she had found placement for Resident #1 and the resident agreed to move to the new facility that day.

An interview on 5/8/24 at 3:38 p.m. with CNA A said she was one of the shower aides in February and March. She said she recently transferred back to the floor as a CNA. She said she did not know too much about the allegation Resident #1 made. She said one day Resident #1 requested her shower and she reported that I picked her up and shook her. She said she did not understand why Resident #1 made the allegations because they got along, and she never had any problems. She said there were typically 2 shower aides, and she was told by management to not give Resident #1 a shower alone because she made false allegations. She said occasionally she still gave Resident #1 a shower alone. She said she was told that Resident #1 told BOM that she shook Resident #1. She said she was placed on suspension until the investigation was completed.

Record review of CNA A's Counseling/ Disciplinary Notice dated 2/29/24. Action taken: suspension, pending investigation. Reason: resident accusation. 3. Corrective action, suspend pending investigation. No signature for CNA A on Employee's Signature line. Signed by ADON on 2/29/24. [Form was placed in employee file after surveyor identified corrective action was not filed].

An interview on 5/9/24 at 11:50 a.m. the BOM (Business Office Manager) said Resident #1 came to her and ABOM office. She said Resident #1 became upset and as she was walking out of the office she said, CNA A did me wrong. BOM said she did not believe CNA A would treat Resident #1 wrong because she goes above and beyond for Resident #1. She said she reported the allegation to CO, the assigned Abuse Coordinator immediately after the resident left the office.

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F 0607 Level of Harm - Actual harm Residents Affected - Few	In an interview on 5/9/24 at 11:56 a.m. with ABOM (Assisted Business Office Manager) said she had been working at the facility for about 7 months. She said for the last few months Resident #1 stayed in her room all the time except when she got a shower. She explained Resident #1 liked routine and she expected staff to accommodate to her first. She said one day she had came into the office and she was upset because she was wanting her shower and she could not get one. She said she could not remember if Resident #1 said CNA A shook her on that day or if it happened days before. She said Resident #1 reported to her and the BOM that CNA A shook her on the shoulders. She said she immediately wrote a statement and reported to the Abuse Coordinator. She said we know that shower aide and she was good with the residents. We did not believe her. She said discrediting a resident could lead to more physical or emotional harm and the resident might withdraw and feel embarrassed which could lead to not voicing concerns. Record review of ABOM's witness statement Today, February 29, 2024 Resident #1 walked into the business office. She sat down on her walker and began talking with myself and BOM. When Resident #1 was ready to leave, she stood and said, CNA A did me wrong the other day. BOM then asked Resident #1 what she meant. Resident #1 sat back down and began to say that CNA A made her wait for a long time because she had so many other people to shower. She then stated that She shook me. BOM asked her who, CNA A? Resident #1 said yes. BOM told Resident #1, CNA A has never done you wrong, why would she shake you? Resident #1 didn't answer and looked out the door, then later stood and said she was leaving. Record review of BOM witness statement undated Resident #1 came in my office on 2/29/24 and was saying that CNA A the shower aide did her wrong awhile back and she made her wait to get shower because she had so many people to shower. I asked her well did you get a shower and she said yes but she shook me. I asked her what she meant because I did not believe that CNA A would ever hurt her and she said well I have to go now. Signed by BOM. Further interview on 5/9/24 at 12:35 p.m. the SW said when there was a facility initiated discharge the facility staff try whatever they can to prevent the discharge, this was the last resort. She said she was unsure if Resident #1's RP wanted to appeal the discharge. She said the RP was on the phone during the care plan meeting when she became upset and began to cuss the staff out then hung up the phone. She said the Ombudsmen was involved simply because facility staff wanted to be fair to family and to be the mediator during the meeting. The SW said every single avenue had been exhausted and there was nothing else that they could have done. She said every allegation a resident makes should be believed and reported immediately to the Abuse Coordinator who was the Administrator, CO. The SW said staff should respond to a resident's abuse allegation by listening to the resident and reporting to the Administrator and DON. She said she was not aware that BOM's statement read I did not believe that CNA A would ever hurt her and she said well I have to go now. She said a comment like that could make a resident withdraw she said her role at the facility was to be an advocate for the residents and for the facility. She said BOM was a distant relative and maybe she forgot her role as a staff member and forgot what she should have done. Record review of Resident #1's discharge summary dated 3/5/24 by the SW read in part .RP then wanted to know why she had not received paperwork on the investigation on the shower aide. Explained the allegation was called into the state and they have not been to the facility as of yet . Notified resident she would be moved today to new facility . (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few	In an interview on 5/9/24 at 1:38 p.m. with CO said Resident #1 had a facility-initiated discharge on 3/5/24. He said the discharge had been discussed in IDT meetings for awhile before the notice was given. He said the IDT made schedule changes to accommodate Resident #1's showers and medication administration. He also said 2 staff were supposed to go into Resident #1's room to care for her. He said he probably was the one who made the recommendation to discharge Resident #1. He explained Resident #1 started to use resources that the facility could not provide, and it started to affect other residents. He explained the problem was Resident #1 exhausted the staff because she made comments and accusations. He said the facility was pulling staff from other areas to care for Resident #1. He said they were shuffling staff to accommodate her needs and we tried to explain that to Resident #1 and her RP. He said he notified the RP that the facility would have to discharge Resident #1. CO said he was the facility's Abuse Coordinator, and he does at least a monthly in-service on abuse, neglect, and exploitation. He said he did read BOM's statement. He said BOM was questioning Resident #1 as like a RP. He said if a resident's allegations were not taken seriously, it could cause a resident to fear reporting, not feel heard or not report in the future. CO said a nurse did an assessment on Resident #1. He said he completed the investigation and could not find anything to validate the allegation. He said he followed the facility's process immediately and it was very thorough. He said there was no other avenues, and they would not have done anything differently with the investigation. He said CNA A was brought back to work when we thought it was reasonable. He said CNA A was allowed to come back to work on 3/1/24 because they fully investigated the allegation. The CO said there was no other avenues to look at. He said when he was informed of the allegation, he immediately initiated the investigation by interviewing Resident #1, suspended CNA A, safe surveys completed, and talked to other staff. He said quite frankly that Resident #1 liked CNA A. He said there were no further abuse allegations on CNA A and she was not a shower aide currently. Record review of Resident #1's progress note by CO dated 3/5/24 at 11:23 a.m. read Notified resident and RP of discharge from facility. A 30 discharge has been issued to resident due to the facility being unable to provide care for the resident such as medication administration and showering/ bathing. Resident has exhausted all available staff members to provide care. Resident stated she did not want to go and it was explained in detail with kindness by the Administrator that the discharge to another facility was in the best interest of the resident as the facility was no longer able to provide care appropriately for the resident. It was explained to resident that the facility will reach out and find placement for resident in a facility that can provide care for her. Called RP and let her know a letter was being sent in the mail via certified mail notifying her of a 30 discharge for the resident today. Informed RP that facility would help with placement for resident. RP hung up on Administrator. A copy of the discharge notice was emailed to the ombudsman as well. Record review of Resident #1's progress note by DON dated 3/5/24 at 12:47 p.m. read Late entry: Resident is unable to be showered by the shower tech/ CNA A. 2 Nurse aides was pulled from floor to shower the resident and management assisted with covering the floor during the shower. Record review of Resident #1's document titled Notice of Proposed Transfer/ Discharge. Date of notification 3/5/24 with a 30 day notice- 4/5/24. RP notified on 3/5/24. Federal Regulations require that your transfer/ discharge be made for one of the following reasons: 2.) The transfer/ discharge is necessary for your welfare and your needs cannot be met in the facility. a) The specific needs that cannot be met are: ADL's, including shower/ bathing, medication administration. b) The facility attempts to meet the resident's needs and the resident's response, included: exhausting available staff members to provide care. If you believe that the proposed transfer/ discharge is inappropriate in your case, and is involuntary, you have the right to appeal Signed by Chief of Operations on 3/5/24. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few	In an interview on 5/9/24 at 2:19 p.m. with DON said Resident #1 made allegations about staff and the facility had exhausted staff. She said after Resident #1 made allegations about CNA A she pulled CNA A from giving her showers and had to delegate another CNA. The DON said the Abuse Coordinator was the Nursing Facility Administrator, (CO). The DON said she was in training the day Resident #1 made the allegation but assisted with the self-report. She said abuse trainings were initiated, safe surveys were done, CNA A was brought in and questioned, a nursing assessment was completed. The DON said the facility did not find anything and they had a thorough investigation. The DON said CNA A was allowed to come back to work the next day on 3/1/24. She said CNA A did have prior allegations while she was a shower aide and disciplinary actions were taken. Record review of Resident #1's Physician Discharge Summary revealed resident was admitted on [DATE] and discharged on [DATE]. Recapitulation of stay: Custodial/ long-term care services and skilled nursing provided. Final Diagnosis: Transferred to. In an interview on 5/11/24 at 12:50 p.m. MA B said Resident #1 did not want her to give her medications anymore. She said in January Resident #1 took her pill but said a small white pill was taking her breathe away. She said she tried to explain to Resident #1 that it could be the big multivitamin tablet, but the resident told her does not want that girl to give her medicine after that. Record review of Resident #1's Progress Note dated 1/15/24 read in part .ER visit . vomited x 1 during medication administration, medications, crushed, resident requesting meds be pulled then she be allowed to look at them and then they may be crushed for administration to prevent coughing/ choking during administration . one episode of vomiting or complaints of nausea observed appeared as stomach acid and green/ brown . In an interview on 5/8/24 at 10:06 a.m. with the Ombudsman said she attended Resident #1's discharge care plan meeting. She explained the RP attended the meeting over the phone and overpowered the meeting by not allowing anyone else to talk and the resident seemed reserved. She said the RP became angry during the meeting and hung the phone up. She said after the RP hung up Resident #1 looked more relaxed and then started talking. She said the nursing facility had exhausted all implemented care needs for Resident #1. She said the facility told her that Resident #1 exhausted all staff to care for the resident because the resident had a history of making allegations against staff. She said she was told by facility staff that Resident #1 was racist and did not want black people to come into her room or care for her. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few	In an interview and observation on 5/8/24 at 11:09 a.m. with Resident #1 at the new facility. She was alert and orientated to her surroundings, independent ambulating with a walker, and independent with using the toilet. Resident #1 explained on her assigned shower day she had went into the shower room, sat down on a chair and started to remove her shirt. She said CNA A came up to her and shook her shoulders hard that her head went back and forth for a long time then the CNA refused to give her a shower. She said the next time CNA A gave her a shower she sprayed water in her face and caused her to have difficulty breathing. Resident #1 began to cry and said, CNA A treated me wrong. She said she cried and cried after that because she did not understand why CNA A did that to her. Resident #1 said she was always aware of which medications she took and the color and size. She explained a couple months back MA B gave her a pill that she did not recognize and shortly afterwards her stomach began to [NAME] and vomited green stuff. She said MA B gave her that pill three different times and caused her to get sick, so she refused to have MA B give her medications. Resident #1 began to cry again and said, nobody would listen to her. She said she reported the shower aide to the BOM, but nothing was done. She said then one day she went to the doctor and when she returned to the facility her belongings were hauled off to the new facility. She stated, I felt like trash being thrown out with my belongings. She said the staff told her she would have to go if she had a problem. Resident #1 said she did not understand why she was discharged . She said she did not refuse care by staff or because of a staff's race. Resident #1 said she did not want to move back to. In an interview on 5/8/24 at 1:20 p.m. with CNA E at the new facility said she was working the day that Resident #1 was admitted to the facility. She said the other facility dropped Resident #1 off with several, about 10 large trash bags of her belongings. She said it was wrong of the facility to leave the resident without helping her at the new facility. She said she could see that Resident #1 was bothered by the discharge. She said Resident #1 was independent with a lot of her care including toileting herself. CNA E said Resident #1 had not refused care from her or other staff. She said Resident #1 showed no indication of being racist towards her or other coworkers. In an interview on 5/8/24 at 1:42 p.m. with the new facility's Administrator revealed Resident #1 had adjusted well to the facility. He explained when Resident #1 was discharged from the other facility they threw all of her belongings all together in about 10 large leaf trash bags then left them in the hallway for the new facility to deal with. He explained the way the other facility discharged Resident #1 was not necessary. In an interview on 5/8/24 at 2:12 p.m. with unnamed med aide said Resident #1 took her medications without problems. The med aide said she knew Resident #1 because she had worked at the other nursing facility. She said she never had Resident #1 refuse her medications at the other facility either. She said Resident #1 was alert and she wanted the med aide to go over each pill before she took it. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER River Pointe of Trinity Healthcare and Rehabilitat		STREET ADDRESS, CITY, STATE, ZIP CODE 808 S Robb Trinity, TX 75862	

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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 0607 Level of Harm - Actual harm Residents Affected - Few	Record Review of Facility Assessment Tool original date of 10/1/21 and last updated on 4/1/24 read in part . 1.7 Services we provide include the following . Long-Term Care, Behavioral/ Dementia Care [GEM- designed for employees, students, and volunteers to recognize each other for their professional behavior and for Going the Extra Mile in their daily activities] . Other [psychiatry, psychology] . 1.8 The residents we serve have, or may develop, the following common diseases, conditions, physical and cognitive disabilities, or combination of conditions that require complex medical care and management. Disease type: Psychiatric/ Mood Disorders: Psychosis, impaired cognition, mental disorder, depression, bipolar disorder, Schizophrenia, post-traumatic Stress Disorder, Anxiety Disorder, Behavior that needs interventions. Actions and Additional or Competency Needed: Staff training on: 1. Cognitive impairment/ Dementia Care, 2. How to Handle Aggressive Behaviors 3. Recognizing Change of Condition . ADL Data identified 37 residents needed assist of 1-2 staff with bathing and 18 residents were dependent on staff for bathing. 47 residents needed assist of 1-2 staff for dressing and 8 residents were dependent on staff to dress. 2.1 The general types of care that our resident population requires and that we provide, and additional considerations relative to the provisions of that care, include the following: Activities of Daily Living [Bathing, showers] . Mental Health and Behavior . identify and implement interventions to help support individuals with issues such as dealing with anxiety . Medications: Awareness of any limitations administering medications . 3.2 We are committed to having sufficient staff to meet the needs of our residents at any given time. Our general approach to staffing, in light of our resident population and their needs for care and support, is to consider the number of residents in the facility and the existing level of resident acuity for purposes of computing and scheduling nursing hours . 3.4 We are committed to ensuring that our staff have and receive the necessary training and education to provide the level and types of support and care needed for our resident population.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38332 Based on observation, interview, and record review, the facility did not ensure residents were permitted to remain in the facility, and not transfer or discharge the resident from the facility, unless the transfer or discharge was necessary for the resident's welfare and the resident's needs could not be met in the facility and failed to ensure a resident was not transferred or discharged while the appeal was pending for 1 of 3 residents (Resident #1) reviewed for discharges, in that: Resident #1 was given a discharge letter after reporting an incident of abuse by an aide that listed shower administration on the form. The facility discharged Resident #1 prior to her 30-day notice date of 4/6/24 and did not give the RP the opportunity to appeal the discharge decision. This failure could place residents at risk of being discharged /transferred improperly. Findings included: Record review of a facility policy titled, Transfer or Discharge, Facility Initiated, dated October 2022, revealed the following: Each resident will be permitted to remain in the facility, and not be transferred or discharged unless: a. the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in this facility; b. the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs services provided by this facility; c. the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; d. the health of individuals in the facility would otherwise be endangered; e. the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at this facility . f. the facility ceases to operate. A resident's declination of treatment is not grounds for discharge, unless the facility is unable to meet the needs of the resident or protect the health and safety of others . Residents have the right to appeal a facility-initiated transfer or discharge through the state agency that handles appeals . If a resident exercises his or her right to appeal a transfer or discharge he or she will not be transferred or discharge while the appeal is pending, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. Record review of Resident #1's Face Sheet, dated 5/10/24, revealed a [AGE] year-old female originally admitted on [DATE]. Her diagnoses included Muscle weakness, Type 2 diabetes mellitus without Complications [high sugar levels in the blood], Dysphagia [difficulty swallowing], Abnormalities of gait and mobility, lack of coordination, dementia [memory disorder] unspecified severity, without behavioral disturbance, psychotic disturbance (group of serious illnesses that affect the mind) mood disturbance (a mental health condition that primarily affects your emotional state) and anxiety. Record review of Resident #1's BIMS assessment dated [DATE] revealed Resident #1 had a BIMS score of 15, signifying no cognitive impairment. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's discharge Minimum Data Set (MDS) dated [DATE] identified Section E- Behaviors revealed no potential indicators of psychosis, no behavior symptoms (physical, verbal, or other), no behaviors of rejection of care. Section GG- Functional Abilities revealed Resident #1 needed only set-up assist with eating, oral hygiene, and toileting. Resident #1 needed partial assist with upper body dressing and maximum assist for shower, lower body dressing and personal hygiene. Resident #1 was able to transfer with supervision. Section H- Bladder and Bowel identified Resident #1 as occasionally incontinent of urine and always continent of bowel. Signed by Social Worker on 3/4/24, MDS RN 3/5/24, MDS Coordinator on 3/8/24 and verified by DON on 3/8/24. (RAI Assessment protocol read in part . Discharge Assessment Must be completed when the resident is discharged from the facility . Completed within 14 days after discharge date . Record review of Resident #1's Care Plan dated 5/9/22 revealed Resident #1 has ADL self-care performance deficit related to limited mobility, impaired balance, shortness of breath and stroke. Interventions included: Requires assistance with bathing, totally dependent on staff for repositioning and turning in bed and totally dependent on staff for dressing. Care plan initiated date of 12/22/23 revealed Resident #1 has potential for a behavior problem false allegations related to staff treatments and medication administration. Interventions included: Anticipate and meet needs, approach in a calm manner, and assist to develop more appropriate methods of coping and interacting. Encourage to express feelings appropriately. Record review of a document titled Notice of Proposed Transfer/ Discharge, completed by CO. Date of notification 3/5/24 with a 30-day notice- 4/5/24. RP notified on 3/5/24. Federal Regulations require that your transfer/ discharge be made for one of the following reasons: . 2.) The transfer/ discharge is necessary for your welfare and your needs cannot be met in the facility. a) The specific needs that cannot be met are: ADL's, including shower/ bathing, medication administration. b) Record review of progress notes The facility attempts to meet the resident's needs and the resident's response, included: exhausting available staff members to provide care. If you believe that the proposed transfer/ discharge is inappropriate in your case, and is involuntary, you have the right to appeal Signed by Chief of Operations on 3/5/24. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/25/24 at 8:06 a.m. Resident #1's RP said she was Resident #1's Power of Attorney. She explained the resident was discharged from the Nursing facility on 3/13/24 because the facility said they could not care for the resident's needs or give her medications. She said Resident #1 reported to the facility's Business Office Manager (BOM) on 2/29/24 the shower aide (CNA A) did her wrong, by shaking her shoulders and pushed her in the shower room. She said Resident #1 was told to go to her room and wait for someone to come down and talk with her about the incident, but no one talked to her. She said she felt like her and Resident #1 were retaliated against because the facility allowed CNA A to continue to work at the facility, but the resident was given a 30-day discharge notice. The RP explained another incident happened regarding Resident #1's medication passes with MA B. She explained Resident #1 was very aware of what medications she took and knew the pills shape and size. She said a couple months ago MA B had given Resident #1 a pill she did not recognize and shortly afterwards she got sick. She explained Resident #1 refused MA B to give her medications after that. She said the facility made the excuse that Resident #1 was racist and that was why she refused to take medications from MA B. The RP said the facility told her and Resident #1 that she exhausted all staff to care for her needs and to administer medications. The RP said on 3/12/24 or 3/13/24 the facility had a care plan meeting regarding the resident's discharge plans. She said the Ombudsman had attended the meeting but felt like they were on the nursing facility's side and did not help her with her concern. She said the Ombudsman told her she would send a form regarding the appeal process, but she never received any form or any other calls from the Ombudsman. The RP said she would have appealed the process but was not given the opportunity. The RP said after the meeting the resident's belongings were thrown in trash bags then Resident #1 and her belongings were taken to the new facility. She said Resident #1 told her she felt like trash and the facility threw her out with the trash bags. The RP said everyone loved Resident #1 and she was compliant with her care and did not like confrontation and did not understand the discharge notice. She explained Resident #1 was still bothered by the situation and talks about it often. In an interview on 5/11/24 at 12:50 p.m. with MA B said Resident #1 did not want her to give her medications anymore. She said in January Resident #1 took her pill but said a small white pill was taking her breathe away. She said she tried to explain to Resident #1 that it could be the big multivitamin tablet but the resident told her does not want that girl to give her medicine after that. Record review of Resident #1's Progress Note dated 1/15/24 read in part .ER visit . vomited x 1 during medication administration, medications, crushed, resident requesting meds be pulled then she be allowed to look at them and then they may be crushed for administration to prevent coughing/ choking during administration . one episode of vomiting or complaints of nausea observed appeared as stomach acid and green/ brown . Record review of Provider Investigation Form 3613 dated 2/29/24 reported an incident on 2/29/24 at approximately 11:45 a.m. in the shower room. Description of the Allegation: Resident #1 reported to the BOM that staff member CNA A, the shower aide shook her by the shoulders awhile back while waiting for the shower. Resident alleges that she requested a shower, and the aide told her she had a line of people before her. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's progress note by CO dated 3/5/24 at 11:23 a.m. read Notified resident and RP of discharge from facility. A 30 discharge has been issued to resident due to the facility being unable to provide care for the resident such as medication administration and showering/ bathing. Resident has exhausted all available staff members to provide care. Resident stated she did not want to go and it was explained in detail with kindness by the Administrator that the discharge to another facility was in the best interest of the resident as the facility was no longer able to provide care appropriately for the resident. It was explained to resident that the facility will reach out and find placement for resident in a facility that can provide care for her. Called RP and let her know a letter was being sent in the mail via certified mail notifying her of a 30 discharge for the resident today. Informed RP that facility would help with placement for resident. RP hung up on Administrator. A copy of the discharge notice was emailed to the Ombudsman as well. Record review of Resident #1's progress note dated 3/5/24 at 12:47 p.m. read Late entry: Resident was unable to be showered by the shower tech/ CNA A. 2 Nurse aides was pulled from floor to shower the resident and management assisted with covering the floor during the shower. Record review of Resident #1's Physician Discharge Summary revealed resident was admitted on [DATE] and discharged on [DATE]. Recapitulation of stay: Custodial/ long-term care services and skilled nursing provided. Final Diagnosis: Transferred to new facility. An interview on 5/8/24 at 3:05 p.m. the SW said she was told in IDT meeting that Resident #1 accused MA B of choking her because it was a whole three minutes later after Resident #1 began to cough after MA B gave her medications. She said Resident #1 did not like MA B because of her race. She said MA B was removed from assisting Resident #1. She said Resident #1 got very angry because the meds were not given at an exact time and she demanded her medications. The SW said She was running the nurses ragged because MA B could not give her medications anymore and Resident #1 would make the nurses stop and give her medications immediately. The SW revealed she did not create the discharge notice and that it was provided by the legal staff. She said the Administrator (CO) recommended initiating the discharge. She said residents are admitted to Long Term Care because the families can not do the care that was needed and safe for the resident. She said Resident #1 was a very independent resident and she could have probably lived in an assisted living. She explained there was a care plan meeting on 3/13/24 regarding Resident #1 and the Ombudsmen was also at the facility. She said she had found placement for Resident #1 and the resident agreed to move to the new facility that day. Further interview on 5/9/24 at 12:35 p.m. the SW said when there was a facility initiated discharge the facility staff try whatever they can to prevent the discharge, it was the last resort. She said Resident #1's RP wanted to appeal the discharge. She said the RP was on the phone and during the meeting she became upset and began to cuss the staff out then hung up the phone. She said the Ombudsmen was involved simply because facility staff wanted to be fair to the family and to be the mediator during the meeting. The SW said every single avenue had been exhausted and there was nothing else that they could have done. (continued on next page)

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and observation on 5/8/24 at 11:09 a.m. with Resident #1 at the new facility. She was alert and orientated to her surroundings, independent ambulating with a walker, and independent with using the toilet. Resident #1 explained on her assigned shower day she had gone into the shower room, sat down on a chair and started to remove her shirt. She said CNA A came up to her and shook her shoulders hard that her head went back and forth for a long time then the CNA refused to give her a shower. She said the next time CNA A gave her a shower she sprayed water in her face and caused her to have difficulty breathing. Resident #1 began to cry and said, CNA A treated me wrong. She said she cried and cried after that because she did not understand why CNA A did that to her. Resident #1 said she was always aware of which medications she took and the color and size. She explained a couple months back MA B gave her a pill that she did not recognize and shortly afterwards her stomach began to [NAME] and vomited green stuff. She said MA B gave her that pill three different times and caused her to get sick, so she refused to have MA B give her medications. Resident #1 began to cry again and said, nobody would listen to her. She said she reported the shower aide to the BOM, but nothing was done. She said then one day she went to the doctor and when she returned to the facility her belongings were hauled off to the new facility. She stated, I felt like trash being thrown out with my belongings. She said the staff told her she would have to go if she had a problem. Resident #1 said she did not understand why she was discharged . She said she did not refuse care by staff or because of a staff's race. Resident #1 said she did not want to move back. In an interview on 5/8/24 at 1:20 p.m. with CNA E (CNA at the new facility) said she was working the day that Resident #1 was admitted to the facility. She said the other facility dropped Resident #1 off with several, about 10 large trash bags of her belongings. She said it was wrong of the facility to leave the resident without helping her at the new facility. She said she could see that Resident #1 was bothered by the discharge. She said the resident questions often where the facility stored her belongings, and she often is asking about her crosses to be unpacked. She said Resident #1 was independent with a lot of her care including toileting herself. CNA E said Resident #1 had not refused care from her or other staff. She said Resident #1 showed no indication of being racist towards her or other coworkers. In an interview on 5/8/24 at 1:42 p.m. with the new facility's Administrator revealed Resident #1 had adjusted well to the facility. He explained when Resident #1 was discharged from the other facility they threw all of her belongings all together in about 10 large leaf size trash bags then left them in the hallway for the new facility to deal with. He explained the way the other facility discharged Resident #1 was not necessary because she was just left at the new facility with all her personal belongings left in the hallway for the new staff to help her unpack. In an interview on 5/9/24 at 1:38 p.m. the CO said Resident #1 had a facility-initiated discharge on 3/5/24. He said the discharge had been discussed in an IDT meetings for a while before the notice was given. He said he probably was the one who made the recommendation to discharge Resident #1. He explained Resident #1 started to use resources that the facility could not provide, and it started to affect other residents. He explained the problem was Resident #1 exhausted the staff because she made comments and accusations. He said there were only MA and CNA's who could care for the resident. He said the facility was pulling staff from other areas to care for Resident #1. He said they were shuffling staff to accommodate her needs and we tried to explain that to Resident #1 and her RP. He said he notified the RP that the facility would have to discharge Resident #1. He said he assumed the Ombudsman sent the appeal letter process to the RP and the RP decided not to appeal because that was apart of the facility's discharge policy. (continued on next page)

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River Pointe of Trinity Healthcare and Rehabilitat	808 S Robb Trinity, TX 75862

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of Facility Assessment Tool original date of 10/1/21 and last updated on 4/1/24 read in part . 1.7 Services we provide include the following . Long-Term Care, Behavioral/ Dementia Care [GEM- designed for employees, students, and volunteers to recognize each other for their professional behavior and for Going the Extra Mile in their daily activities] . Other [psychiatry, psychology] . 1.8 The residents we serve have, or may develop, the following common diseases, conditions, physical and cognitive disabilities, or combination of conditions that require complex medical care and management. Disease type: Psychiatric/ Mood Disorders: Psychosis, impaired cognition, mental disorder, depression, bipolar disorder, Schizophrenia, post-traumatic Stress Disorder, Anxiety Disorder, Behavior that needs interventions. Actions and Additional or Competency Needed: Staff training on: 1. Cognitive impairment/ Dementia Care, 2. How to Handle Aggressive Behaviors 3. Recognizing Change of Condition . ADL Data identified 37 residents needed assist of 1-2 staff with bathing and 18 residents were dependent on staff for bathing. 47 residents needed assist of 1-2 staff for dressing and 8 residents were dependent on staff to dress. 2.1 The general types of care that our resident population requires and that we provide, and additional considerations relative to the provisions of that care, include the following: Activities of Daily Living [Bathing, showers] . Mental Health and Behavior . identify and implement interventions to help support individuals with issues such as dealing with anxiety . Medications: Awareness of any limitations administering medications . 3.2 We are committed to having sufficient staff to meet the needs of our residents at any given time. Our general approach to staffing, in light of our resident population and their needs for care and support, is to consider the number of residents in the facility and the existing level of resident acuity for purposes of computing and scheduling nursing hours . 3.4 We are committed to ensuring that our staff have and receive the necessary training and education to provide the level and types of support and care needed for our resident population.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 38332 Based on observation, interview, and record review, the governing body failed to appoint an Administrator who is licensed by the State for 1 of 4 Facility Administrators reviewed for governing body. The Interim Administrator was not licensed in Texas. This failure could place residents at risk of not being provided care and services by licensed and unlicensed staff being overseen by an Administrator who was not licensed by the State of Texas and familiar with Texas rulles and regulations for nursing facilities. Findings include: Observations and interview between 5/8/24 at 9:10 a.m. and 5/9/24 at 6:30 p.m. revealed the CO was the only acting Administrator. During entrance conference the CO identified himself as the Administrator. During an interview on 5/8/24 at 3:48 p.m. CNA B identified CO as the Administrator and Abuse Coordinator. She said she was unsure who the Administrator was. She said she works full-time and she has not seen the Administrator. During an interview on 5/9/24 at 11:29 a.m. LVN A identified CO as the Administrator and Abuse Coordinator. She said CO was the only Administrator she was aware of. During an interview on 5/9/24 at 1:38 p.m. revealed CO had been employed at the facility since 11/28/23. CO said the Administrator was the Executive Director and he was working under his license. He explained he was an Administrator in Training and his Administrator preceptor worked in a different building. CO explained he completed his Administrator in Training hours and filed an application with the state to get his Administration license. During an interview on 5/10/24 at 4:17 p.m. the Administrator said he was also the Regional Administrator for the company. He said he was at the facility once a week if not more. He explained CO was working as an interim Administrator. He said CO had sent state all of his documentation and was waiting for his certificate. Record review of LTC Incident Report, Provider Self-reporting of LTC incidents dated 2/29/24 at 1:48 p.m. revealed Your Information, Name: CO, Title: Administrator. Record review of the CO's personnel file reviewed on 5/9/24 at 4:32 p.m. read in part .It appears his internship request was approved to complete his hours under preceptor Administrator C at another facility . No request to change preceptor nor facility has been received since the above approval . A Governing Body policy was requested on 5/13/24 at 8:47 a.m. from the CO and DON. The facility policy was not provided prior to exit.