STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675933	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Treasure Hills Healthcare and Rehabilitation Cente	2204 Pease St Harlingen, TX 78550

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents had the right to be free from abuse, neglect and misappropriation of property for 4 of 9 residents (Residents #1, #2, #3 and #4) reviewed for abuse, in that: 1. Resident #1 and Resident #2 had a resident to resident altercation when Resident #1 struck Resident #2 on her upper shoulder and neck. 2.Resident #3 and Resident #4 had a resident to resident altercation that resulted in a skin tear with scant bleeding to Resident #3's hand. These deficient practices could affect residents and place them at risk for abuse, trauma, psychosocial harm, injuries, or hospitalization. The findings included: 1. Record review of Resident #1's face sheet, dated 06/18/25, revealed the resident was a [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses that included: schizophrenia (disorder that affects a person's ability to think, feel and behave clearly.), unspecified, bipolar disorder, (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) unspecified and unspecified dementia (a group of thinking an social symptoms that interferes with daily functioning), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. Record review of Resident #1's quarterly MDS assessment, dated 03/19/25, revealed Resident #1 had a BIMS score of 07, indicating her cognition was severely impaired. Record review of Resident #1's care plan with an initiation date of 12/12/24 reflected [Resident #1] has potential to demonstrate physical behaviors r/t (related to) another resident alleged [Resident #1] hit her with an initial date of 01/02/25, and [Resident #1] is at risk for impaired cognitive function r/t (related to) dementia, schizophrenia with an initiation date of 12/12/24. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's progress note with an effective date and time of 01/01/25 at 10:00am stated LVN A heard a loud voice coming from hallway and when arriving she noted Resident #1 was standing in the hall way and stated in Spanish, Yo no le pegue ya me [NAME] a mi cuarto which translated to, I did not hit them, I'm going to my room. As per same note LVN A redirected Resident #1 to her room and completed a full body skin assessment with no injuries or discoloration noted and Resident #1 denying any pain or discomfort. LVN A documented that she had made notifications at that time to the medical doctor (MD), Resident #1's responsible party, the DON and the Administrator. Record review of Resident #1's skin evaluation completed by LVN A on 01/01/25 revealed a full body assessment was completed after a resident to resident altercation with no injuries, no discoloration and no complaints of pain or discomfort. Record review of Resident #1's change in condition evaluation completed by LVN A on 01/01/25 stated a resident to resident altercation occurred on 01/01/25 with no changes to skin and no pain. Primary care physician was notified and provided new orders after alteration including labs and urinalysis. During an interview with Resident #1 on 06/11/25 at 4:34pm Resident #1 stated her and Resident #2 had never gotten into any fight and had never hit each other and stated she thought the two of them were friends. 2. Record review of Resident #2's face sheet, dated 06/18/25, revealed the resident was a [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses that included: unspecified dementia (a group of thinking an social symptoms that interferes with daily functioning), mild, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, and anxiety disorder (a mental health disorder characterized by feeling of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), unspecified. Record review of Resident #2's quarterly MDS assessment, dated 05/06/25, revealed Resident #2 had a BIMS score of 14, indicating her cognition was intact. Record review of Resident #2's care plan with an initiation date of 04/15/24 reflected focuses of [Resident #1] has potential for a psychosocial well- being problem r/t (related to) alleging [sic] another resident hit her in the face with an initial date of 01/02/25, and [Resident #2] is at risk for impaired thought process r/t (related to) anxiety, dementia with an initiation date of 04/15/24. Record review of Resident #2's progress note written by LVN A with an effective date and time of 01/01/25 at 10:00am stated LVN A heard a loud voice coming from hallway and when arriving Resident #2 alleged she was ambulating through the hallway and all of a sudden Resident #1 hit her in the face all of a sudden. As per note LVN A completed a skin assessment with no skin tears or discolorations noted and Resident #2 denied any pain or discomfort. LVN A documented that she had made notifications at time of altercation to the medical doctor (MD), Resident #2's responsible party, who did not answer and was left a voicemail by LVN A, the DON and the Administrator. Record review of Resident #2's skin evaluation completed by LVN A on 01/01/25 at 10:00am revealed a skin assessment was completed after a resident to resident altercation with no skin tears and no discoloration noted. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's change in condition evaluation completed by LVN A on 01/01/25 stated a resident to resident altercation occurred on 01/01/25 with no changes to skin and no pain. Primary care physician was notified and provided recommendation to monitor for any skin injuries or pain. Record review of Administrators written undated statement in facility's submitted provider investigation report gave description of video surveillance that Administrator reviewed and stated Resident #2 was observed ambulating down A wing hall when Resident #1 spontaneously emerged from her room and walked up to Resident #2 without reason or cause and raised her hand towards Resident #2 to strike her. As per statement written by the Administrator Resident #1 was able to hit Resident #2 on her upper shoulder and neck with Resident #2 making no attempt to strike back. Resident #2 was removed by staff and the Administrator interviewed Resident #1 who did not recall any incident occurring. During an interview with Resident #2 on 06/11/25 at 6:21pm she stated one day Resident #1 went at her and made contact with her shoulder. Resident #2 stated when the incident occurred nursing went to check and assess her and stated staff was right there. Resident #2 stated she did not get hurt, did not have any injury, and did not have any open areas. Resident #2 stated it was not a big a deal because Resident #1 was just raising her arm and was not aiming for anything. Resident #2 was not sure of the exact date of the altercation with Resident #1 but stated she felt safe in the facility and stated no other similar incident had occurred since. During an interview with LVN A on 06/18/25 at 2:01pm she stated she was the responding nurse to the altercation between Resident #1 and Resident #2 on 01/01/25, LVN A stated she had heard Resident #2 screaming and responded but when she got there Resident #1 was already in her room and stated she then took Resident #2 to her room to complete a full body assessment and then she went to Resident #1 who did not recall anything. LVN A stated she did not witness any contact between Resident #1 and Resident #2 and stated Resident #2 told her that she was walking in the hallway when Resident #1 came out of her room and tried to slap Resident #2 in the face and then then went back to her room after she hit Resident #2. LVN A stated there were no injuries noted on Resident #1 or Resident #2. LVN A stated she had been trained over resident to resident altercations and stated as soon as she was able to separate and assess the residents she would report within 1 hour to the Administrator, LVN A stated she notified the Administrator shortly after the incident with Resident #1 and #2 but did not recall the exact time of notification. LVN A stated the Administrator went to the facility and LVN A was able to review the surveillance footage of the incident. LVN A stated that they zoomed into the video which was very blurry and stated they saw Resident #1 swipe at Resident #2 but were unable to tell if there was contact made. LVN A stated neither Residents #1 or #2 had similar previous incidents and stated they had not had any similar incidents since either. LVN A stated she did not consider the altercation between Residents #1 and #2 abuse because Resident #1 was not fully alert or there. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Administrator on 06/18/25 at 6:04pm she stated LVN A was the responding nurse to the altercation between Resident #1 and Resident #2. The Administrator stated LVN A did not witness any contact between Resident #1 and Resident #2 and stated Resident #2 told her that she was hit all of a sudden by Resident #1. The Administrator stated she did review the surveillance footage at time of the incident and stated she saw Resident #1 extend her arm but did not see Resident #1 hit Resident #2 on her face area and saw her only make contact with Resident #2's shoulder. The Administrator stated staff removed residents and completed change in condition, progress note, made notifications and skin assessments that revealed no injuries noted on Resident #1 or Resident #2. The Administrator stated Resident #2 had poor cognition and her ability to make decisions was extremely poor. The Administrator stated she was not aware of neither Resident #1 or #2 having similar incident prior this incident and stated they had not had any similar incidents since either. The Administrator stated staff had been trained over resident to resident altercations, behavioral management and what their procedures and policy required them to do and stated staff were to notify her of any resident to resident altercations as soon as staff did everything to keep the resident safe. The Administrator stated she was notified of the resident to resident altercation immediately after the incident by nursing but did not recall the exact date or time of incident occurring or of being notified. The Administrator stated she did not consider the altercation between Resident #1 and Resident #2 abuse. The Administrator stated she reported the incident to HHSC within 24 hours and stated she was previously following a QSO but was not able to recall exactly which one and stated her understanding was that she had 24 hours because there was no major physical injury. The Administrator stated according to the guidelines she learned recently it should have been reported in 2 hours, the Administrator stated she had not received any training on the guidance of reporting abuse allegations within 2 hours. The Administrator stated the facility abuse policy did not give a specific time frame for reporting and stated to follow the regulation and report anything with major injury within 2 hours. The Administrator stated in this situation she and her staff followed the facility policy based on the time frame she was aware of. Administrator stated how resident to resident altercations negatively impact residents was dependent on a case by case bases on residents' cognition and ability to recall the event. The Administrator stated reporting allegations of abuse within 2 hours was important to ensure patients were safe and that staff responded appropriately and timely. 3. Record review of Resident #3's face sheet, dated 06/18/25, revealed the resident was a [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses that included: unspecified dementia (a group of thinking an social symptoms that interferes with daily functioning), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, other Alzheimer's disease (most common cause of dementia - progressive decline in memory, thinking and behavior.) and hemiplegia (paralysis on one side) and hemiparesis (weakness of one side) following unspecified cerebrovascular disease (conditions that affect blood flow to brain) affecting left non -dominant side Record review of Resident #3's quarterly MDS assessment, dated 03/20/25, revealed Resident #1 had a BIMS score of 03, indicating her cognition was severely impaired. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's care plan with an initiation date of 10/25/2019 reflected focuses of 1/4/25 [Resident #3] has potential for a behavior problem r/t (related to) SN (staff nurse) heard loud voices from dining room upon arrival noted resident sitting in w/c (wheelchair), both residents pulling same towel. SN (staff nurse) pulled both residents apart from altercation immediate. Resident voiced she has my towel with an initial date of 01/06/25, and [Resident #3] is at risk for impaired cognitive function/dementia or impaired though process r/t (related to) Dementia, ALZHEIMERS [sic] with an initiation date of 01/26/2020. Record review of Resident #3's progress note with an effective date and time of 01/04/25 at 9:45am stated LVN A heard loud voices coming from dining room and upon arrival noted resident #3 sitting in w/c (wheelchair), LVN A's note stated both residents were pulling the same towel and she immediately pulled both residents apart from altercation with Resident #3 stating she has my towel. LVN A completed a full body skin assessment on Resident #3 and noted a scratch to right hand with scant bleeding, area was cleaned with normal saline and band aide put in place. Resident #3 had no signs or symptoms of pain or discomfort. LVN A stated she made notifications to the DON, responsible party for Resident #3 and the MD who gave new orders for urinalysis and labs, LVN A documented that she notified the Administrator of the altercation. Record review of Resident #3's progress note with an effective date and time of 01/04/25 at 9:18am stated LVN B noted discoloration to left shin of Resident #3 measuring 2.0 x 7.0 x 0, (unit of measurement was not included) with no complaint of pain to site. Record review of Resident #3's skin evaluation completed by LVN B on 01/04/25 at 9:22pm revealed greenish discoloration to left shin that measured 2.0x7.0 (unit of measurement not included) Resident #3 had no complaint of pain and was unable to recall if/when she bumped self. Record review of Resident #3's change in condition evaluation completed by LVN B on 01/04/25 at 9:32pm had check placed on skin wound or ulcer and stated it started on 01/04/25 that noted a discoloration to front of left lower leg measuring 2 x 7 x 0 with no unit of measurement noted. Primary care physician was notified and provided recommendation to monitor. Record review of Resident #3's change in condition evaluation completed by LVN A on 01/04/25 at 9:45am stated resident to resident altercation occurred on 01/04/25 with no changes to skin other than skin tear to right arm and no pain. Primary care physician was notified and provided new orders after alteration including labs and urinalysis and to clean skin tear with normal saline and apply triple antibiotic ointment and leave open to air. Record review of Resident #3's skin evaluation completed by LVN A on 01/04/25 at 2:35pm revealed skin tear to back of right hand measuring 1.2 x 0.2 (unit of measurement not included) with scant bleeding, resident denied pain or discomfort. During an interview with Resident #3 on 06/11/25 at 3:58 PM Resident #3 stated her she had never been hit, grabbed, kicked, or abused in anyway at the facility and stated she knew who resident #4 was and denied any arguments or incident had occurred with Resident #4. Resident #3 denied Residents #4 ever swinging at her or kicking her and stated she did not recall any incident with a towel. Resident #3 stated Resident #4 was nice to her, had never abused her and stated they liked to go and play with one another. Resident #3 stated she felt safe at the facility. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Record review of Resident #4's face sheet, dated 06/18/25, revealed the resident was a [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses that included: paranoid schizophrenia, schizophrenia (disorder that affects a person's ability to think, feel and behave clearly.), unspecified, bipolar disorder, (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) unspecified, unspecified intellectual disabilities, (condition that limits intelligence and disrupts abilities necessary for living independently) not otherwise specified. Record review of Resident #4's quarterly MDS assessment, dated 05/20/25, revealed Resident #4 had a BIMS score of 11, indicating her cognition was moderately impaired. Record review of Resident #4's care plan with an initiation date of 04/27/22 reflected focus's of [Resident #4] has potential for a behavior problem r/t bickering heard from down the hall to be coming from the small dining room. upon arrival, resident noted to be sitting in her wheelchair pulling on a towel that another resident [Resident #3] had in her hands and was pulling as well. With an initiation date of 01/06/25. [Resident #4] is at risk for impaired cognitive function/dementia or impaired thought processes [sic] BIMS scored 8 with an initiation fate of 04/27/22. Record review of Resident #4's progress note written by RN C with an effective date and time of 01/04/25 at 9:45am stated RN C heard bickering from down the hall coming from the small dining room, upon arrival RN C noted Resident #4 to be sitting in her wheelchair pulling on a towel that another resident had in her hands and was pulling as well with resident stating, she had my stuff and scratched my arm while gesturing towards her upper left arm. Both residents were immediately separated, and skin assessment was conducted with no visible injuries noted. Left arm was assessed with no redness noted and skin intact with no swelling. MD was made aware, DON and administrator. Record review of Resident #4's skin evaluation completed by RN C on 01/04/25 at 9:45am revealed a skin assessment was completed after a resident to resident altercation with Resident #4 reporting she was scratched to upper left arm however area was free of redness, swelling and had no open areas, no new skin injuries noted, and Resident #4 denied pain or discomfort. Record review of Resident #4's change in condition evaluation completed by RN C on 01/04/25 stated resident to resident altercation occurred on 01/04/25 with no changes to skin and no pain. Primary care physician was notified and provided no new orders. During an interview with Resident #4 on 06/11/25 at 4:58pm she stated she did not know who Resident #3 was and stated she not been abused by anyone in the facility and stated she had not had any incidents involving a towel, swinging a wallet or kicking a resident chair or legs. Record review of Administrators written undated statement in facility's submitted provider investigation report gave description of video surveillance that Administrator reviewed and stated Resident #3 was seated in the small dining room folding towels when Resident #4 approached her and started pulling at the towel she had in hand. Once Resident #4 had pulled the towel away from Resident #3 she processed to pursue Resident #4 requesting her towel back. Resident #3 then took a hold of another residents wallet and began swinging it while another resident swung the towel at Resident #3, resident proceeded to kick Resident #3's chair and leg resulting in Resident #3 taking hold of her arm and attempted to raise it. Nursing intervened and separated both residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with RN C on 06/17/25 at 1:53 pm she stated she and LVN A were the responding nurses to the altercation between Resident #3 and Resident #4 , RN C stated she heard arguing so she entered the small dining room and stated Resident #3 and #4 were arguing over a towel that Resident #3 had with Resident #4 saying Resident #3 had her towel. RN C stated she did not see any contact between Resident #3 and Resident #4 and stated she did not see any kicking. RN C stated Resident #4 stated Resident #3 scratched her hand. RN C stated she completed a skin assessment on Resident #4 and did not note any injuries and did not recall any scant bleeding to her hand. RN C stated Resident #4 had no discoloration to legs, and stated Resident #4 had any injuries. RN C stated she had to see what really happened to see if Resident #4 scratched Resident #3 intentionally and if so, then yes she could consider that abuse. RN C stated she had been trained over resident to resident altercations and stated she would report to the Administrator as soon as possible and stated they only have 2 hours to report. RN C stated she and LVN A notified the Administrator shortly after the incident with Resident #3 and #4 but did not recall the exact time of incident or notification. RN C stated neither Residents #3 or #4 had similar previous incidents and stated they had not had any similar incidents since either. During an interview with LVN A on 06/18/25 at 2:01pm she stated she and RN C were the responding nurses to the altercation between Resident #3 and Resident #4 , LVN A stated she was the nurse for Resident #3 and stated at time of the incident she was called by RN C when she was on the floor. LVN A stated RN C told her that Resident #3 and #4 were fighting over something but LVN A did not recall what Resident #3 and #4 were fighting about and stated she saw Resident #3 on one table and Resident #4 on another. LVN A stated she did not see any contact between Resident #3 and Resident #4 and stated she did not remember if she saw the video surveillance of incident. LVN A stated neither resident had any injuries. LVN A stated she had been trained over resident to resident altercations and stated as soon as she was able to separate and assess the residents she would report within 1 hour to the Administrator, LVN A stated she notified the Administrator shortly after the incident with Resident #3 and #4 but did not recall the exact time of notification. LVN A stated neither Residents #3 or #4 had similar previous incidents and stated they had not had any similar incidents since either. LVN A stated she did not consider the altercation between Residents #3 and #4 abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Administrator on 06/18/25 at 6:04pm she thought LVN A was the responding nurse to the altercation between Resident #3 and Resident #4. The Administrator stated nursing staff did not witness any contact between Resident #3 and Resident #4. The Administrator stated she did review the surveillance footage at the time of the incident and stated she saw Resident #3 and #4 fighting over a towel that Resident #3 was initially folding at the table and then Resident #4 wanted and stated both residents then had a tug of war with the towel and Resident #4 yelled that Resident #3 hit her. The Administrator stated when she reviewed the camera that did not happen and stated Resident #3 was kicking her feet while in her wheelchair but it was slow and did not reach Resident #4, as per the Administrators observation of the video surveillance she did not see any contact between Residents #3 and #4 and only saw them hitting the chair and Resident #4 trying to raise Resident #3's arm. The Administrator stated staff completed skin assessments, change in condition documentation, and made notifications. The Administrator stated both Residents were noted to have no injuries. The Administrator stated Resident #3 and Resident #4 had poor cognition and their ability to make decisions was poor. The Administrator stated she was not aware of neither Resident #3 or #4 having similar incidents prior to this incident and stated they had not had any similar incidents since either. The Administrator stated staff had been trained over resident to resident altercations, behavioral management and what their procedures and policy required them to do and stated staff were to notify her of any resident to resident altercations as soon as staff did everything to keep the resident safe . The Administrator stated she was notified of the resident to resident altercation immediately after the incident by nursing but did not recall the exact date or time of incident occurring or of being notified. The Administrator stated she did not consider the altercation between Resident #3 and Resident #4 abuse. The Administrator stated she reported the incident to HHSC within 24 hours and stated she was previously following a QSO but was not able to recall exactly which one and stated her understanding was that she had 24 hours because there was no major physical injury. The Administrator stated according to the guidelines she learned recently it should have been reported in 2 hours, the Administrator stated she had not received any training on the guidance of reporting abuse allegations within 2 hours. The Administrator stated the facility abuse policy did not give a specific time frame for reporting and stated to follow the regulation and report anything with major injury within 2 hours. The Administrator stated in this situation she and her staff followed the facility policy based on the time frame she was aware of. the Administrator stated how resident to resident altercations negatively impact residents was dependent on a case by case bases on residents' cognition and ability to recall the event. The Administrator stated not reporting allegations of abuse within 2 hours was important to ensure patients were safe and that staff respond appropriately and timely. Record review of facility Inservice dated 06/09/25 that was provided by the DON and the Administrator covered, Abuse and neglect Coordinator - [Administrator], Behavior Management, Abuse and Neglect, Physical, Sexual, Verbal, Psychological, Misappropriation signs and symptoms - unexplained discolorations, injuries, refusing to eat, crying, isolation, missing items, withdrawal, depression, avoidance, poor hygiene, etc. revealed LVN A and RN C had received the training. Record review of LVN A's training transcript revealed she completed a training titled Abuse, Neglect and Exploitation Self -Paced on 10/22/24. Record review of RN C's training transcript revealed she completed a training titled Abuse, Neglect and Exploitation Self -Paced on 10/27/24. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility policy with a revision date of 4/2025 and titled, Abuse: Prevention of and Prohibition Against stated, Physical Abuse includes but is not limited to hitting, slapping, pinching, and kicking. And stated, allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the facility and to the appropriate State or Federal agencies in the applicable time frames, as per this policy and applicable regulations,

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Treasure Hills Healthcare and Rehabilitation Cente	2204 Pease St Harlingen, TX 78550

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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** Based on interviews and record reviews the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (which included to the State Survey Agency) in accordance with State law through established procedures for 4 of 9 residents (Resident #1, #2, #3, #4) reviewed for reporting alleged allegation of abuse. 1.The facility did not report, within 2 hours, when Resident #1 and Resident #2 had a resident to resident altercation on 01/02/25. 2. The facility did not report, within 2 hours, when Resident #3 and Resident #4 had a resident to resident altercation that resulted in a skin tear to Resident #3's hand on 01/04/25. This failure could place residents at risk for undetected abuse, neglect and/or decline in feelings of safety and well-being. The findings included: 1. Record review of Resident #1's face sheet, dated 06/18/25, revealed the resident was a [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses that included: schizophrenia (disorder that affects a person's ability to think, feel and behave clearly.), unspecified, bipolar disorder, (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) unspecified and unspecified dementia (a group of thinking an social symptoms that interferes with daily functioning), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. Record review of Resident #1's quarterly MDS assessment, dated 03/19/25, revealed Resident #1 had a BIMS score of 07, indicating her cognition was severely impaired. Record review of Resident #1's care plan with an initiation date of 12/12/24 reflected [Resident #1] has potential to demonstrate physical behaviors r/t (related to) another resident alleged [Resident #1] hit her with an initial date of 01/02/25, and [Resident #1] is at risk for impaired cognitive function r/t (related to) dementia, schizophrenia with an initiation date of 12/12/24. Record review of Resident #1's progress note with an effective date and time of 01/01/25 at 10:00am stated LVN A heard a loud voice coming from hallway and when arriving she noted Resident #1 was standing in the hall way and stated in Spanish, Yo no le pegue ya me [NAME] a mi cuarto which translated to, I did not hit them, I'm going to my room. As per same note LVN A redirected Resident #1 to her room and completed a full body skin assessment with no injuries or discoloration noted and Resident #1 denying any pain or discomfort. LVN A documented that she had made notifications at that time to the medical doctor (MD), Resident #1's responsible party, the DON and the Administrator. (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 #1's skin evaluation completed by LVN A on 01/01/25 revealed a full body assessment was completed after a resident to resident altercation with no injuries, no discoloration and no complaints of pain or discomfort. Record review of Resident #1's change in condition evaluation completed by LVN A on 01/01/25 stated a resident to resident altercation occurred on 01/01/25 with no changes to skin and no pain. Primary care physician was notified and provided new orders after alteration including labs and urinalysis. During an interview with Resident #1 on 06/11/25 at 4:34pm Resident #1 stated her and Resident #2 had never gotten into any fight and had never hit each other and stated she thought the two of them were friends. 2. Record review of Resident #2's face sheet, dated 06/18/25, revealed the resident was a [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses that included: unspecified dementia (a group of thinking an social symptoms that interferes with daily functioning), mild, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, and anxiety disorder (a mental health disorder characterized by feeling of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), unspecified. Record review of Resident #2's quarterly MDS assessment, dated 05/06/25, revealed Resident #2 had a BIMS score of 14, indicating her cognition was intact. Record review of Resident #2's care plan with an initiation date of 04/15/24 reflected focuses of [Resident #1] has potential for a psychosocial well- being problem r/t (related to) alleging [sic] another resident hit her in the face with an initial date of 01/02/25, and [Resident #2] is at risk for impaired thought process r/t (related to) anxiety, dementia with an initiation date of 04/15/24. Record review of Resident #2's progress note written by LVN A with an effective date and time of 01/01/25 at 10:00am stated LVN A heard a loud voice coming from hallway and when arriving Resident #2 alleged she was ambulating through the hallway and all of a sudden Resident #1 hit her in the face all of a sudden. As per note LVN A completed a skin assessment with no skin tears or discolorations noted and Resident #2 denied any pain or discomfort. LVN A documented that she had made notifications at time of altercation to the medical doctor (MD), Resident #2's responsible party, who did not answer and was left a voicemail by LVN A, the DON and the Administrator. Record review of Resident #2's skin evaluation completed by LVN A on 01/01/25 at 10:00am revealed a skin assessment was completed after a resident to resident altercation with no skin tears and no discoloration noted. Record review of Resident #2's change in condition evaluation completed by LVN A on 01/01/25 stated a resident to resident altercation occurred on 01/01/25 with no changes to skin and no pain. Primary care physician was notified and provided recommendation to monitor for any skin injuries or pain. Record Review of TULIP (HHSC online incident reporting application) on 06/12/25 at 9:30 AM revealed a self-report received by the facility on 01/02/25 at 12:38pm more than 2 hours after Resident #1 and Resident #2's had an altercation on 01/01/25. (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 Administrators written undated statement in facility's submitted provider investigation report gave description of video surveillance that Administrator reviewed and stated Resident #2 was observed ambulating down A wing hall when Resident #1 spontaneously emerged from her room and walked up to Resident #2 without reason or cause and raised her hand towards Resident #2 to strike her. As per statement written by the Administrator Resident #1 was able to hit Resident #2 on her upper shoulder and neck with Resident #2 making no attempt to strike back. Resident #2 was removed by staff and the Administrator interviewed Resident #1 who did not recall any incident occurring. During an interview with Resident #2 on 06/11/25 at 6:21pm she stated one day Resident #1 went at her and made contact with her shoulder. Resident #2 stated when the incident occurred nursing went to check and assess her and stated staff was right there. Resident #2 stated she did not get hurt, did not have any injury, and did not have any open areas. Resident #2 stated it was not a big a deal because Resident #1 was just raising her arm and was not aiming for anything. Resident #2 was not sure of the exact date of the altercation with Resident #1 but stated she felt safe in the facility and stated no other similar incident had occurred since. During an interview with LVN A on 06/18/25 at 2:01pm she stated she was the responding nurse to the altercation between Resident #1 and Resident #2 on 01/01/25, LVN A stated she had heard Resident #2 screaming and responded but when she got there Resident #1 was already in her room and stated she then took Resident #2 to her room to complete a full body assessment and then she went to Resident #1 who did not recall anything. LVN A stated she did not witness any contact between Resident #1 and Resident #2 and stated Resident #2 told her that she was walking in the hallway when Resident #1 came out of her room and tried to slap Resident #2 in the face and then then went back to her room after she hit Resident #2. LVN A stated there were no injuries noted on Resident #1 or Resident #2. LVN A stated she had been trained over resident to resident altercations and stated as soon as she was able to separate and assess the residents she would report within 1 hour to the Administrator, LVN A stated she notified the Administrator shortly after the incident with Resident #1 and #2 but did not recall the exact time of notification. LVN A stated the Administrator went to the facility and LVN A was able to review the surveillance footage of the incident. LVN A stated that they zoomed into the video which was very blurry and stated they saw Resident #1 swipe at Resident #2 but were unable to tell if there was contact made. LVN A stated neither Residents #1 or #2 had similar previous incidents and stated they had not had any similar incidents since either. LVN A stated she did not consider the altercation between Residents #1 and #2 abuse because Resident #1 was not fully alert or there. (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 with the Administrator on 06/18/25 at 6:04pm she stated LVN A was the responding nurse to the altercation between Resident #1 and Resident #2. The Administrator stated LVN A did not witness any contact between Resident #1 and Resident #2 and stated Resident #2 told her that she was hit all of a sudden by Resident #1. The Administrator stated she did review the surveillance footage at time of the incident and stated she saw Resident #1 extend her arm but did not see Resident #1 hit Resident #2 on her face area and saw her only make contact with Resident #2's shoulder. The Administrator stated staff removed residents and completed change in condition, progress note, made notifications and skin assessments that revealed no injuries noted on Resident #1 or Resident #2. The Administrator stated Resident #2 had poor cognition and her ability to make decisions was extremely poor. The Administrator stated she was not aware of neither Resident #1 or #2 having similar incident prior this incident and stated they had not had any similar incidents since either. The Administrator stated staff had been trained over resident to resident altercations, behavioral management and what their procedures and policy required them to do and stated staff were to notify her of any resident to resident altercations as soon as staff did everything to keep the resident safe. The Administrator stated she was notified of the resident to resident altercation immediately after the incident by nursing but did not recall the exact date or time of incident occurring or of being notified. The Administrator stated she did not consider the altercation between Resident #1 and Resident #2 abuse. The Administrator stated she reported the incident to HHSC within 24 hours and stated she was previously following a QSO but was not able to recall exactly which one and stated her understanding was that she had 24 hours because there was no major physical injury. The Administrator stated according to the guidelines she learned recently it should have been reported in 2 hours, the Administrator stated she had not received any training on the guidance of reporting abuse allegations within 2 hours. The Administrator stated the facility abuse policy did not give a specific time frame for reporting and stated to follow the regulation and report anything with major injury within 2 hours. The Administrator stated in this situation she and her staff followed the facility policy based on the time frame she was aware of. Administrator stated how resident to resident altercations negatively impact residents was dependent on a case by case bases on residents' cognition and ability to recall the event. The Administrator stated reporting allegations of abuse within 2 hours was important to ensure patients were safe and that staff responded appropriately and timely. 3. Record review of Resident #3's face sheet, dated 06/18/25, revealed the resident was a [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses that included: unspecified dementia (a group of thinking an social symptoms that interferes with daily functioning), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, other Alzheimer's disease (most common cause of dementia - progressive decline in memory, thinking and behavior.) and hemiplegia (paralysis on one side) and hemiparesis (weakness of one side) following unspecified cerebrovascular disease (conditions that affect blood flow to brain) affecting left non -dominant side Record review of Resident #3's quarterly MDS assessment, dated 03/20/25, revealed Resident #1 had a BIMS score of 03, indicating her cognition was severely impaired. (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 care plan with an initiation date of 10/25/2019 reflected focuses of 1/4/25 [Resident #3] has potential for a behavior problem r/t (related to) SN (staff nurse) heard loud voices from dining room upon arrival noted resident sitting in w/c (wheelchair), both residents pulling same towel. SN (staff nurse) pulled both residents apart from altercation immediate. Resident voiced she has my towel with an initial date of 01/06/25, and [Resident #3] is at risk for impaired cognitive function/dementia or impaired though process r/t (related to) Dementia, ALZHEIMERS [sic] with an initiation date of 01/26/2020. Record review of Resident #3's progress note with an effective date and time of 01/04/25 at 9:45am stated LVN A heard loud voices coming from dining room and upon arrival noted resident #3 sitting in w/c (wheelchair), LVN A's note stated both residents were pulling the same towel and she immediately pulled both residents apart from altercation with Resident #3 stating she has my towel. LVN A completed a full body skin assessment on Resident #3 and noted a scratch to right hand with scant bleeding, area was cleaned with normal saline and band aide put in place. Resident #3 had no signs or symptoms of pain or discomfort. LVN A stated she made notifications to the DON, responsible party for Resident #3 and the MD who gave new orders for urinalysis and labs, LVN A documented that she notified the Administrator of the altercation. Record review of Resident #3's progress note with an effective date and time of 01/04/25 at 9:18am stated LVN B noted discoloration to left shin of Resident #3 measuring 2.0 x 7.0 x 0, (unit of measurement was not included) with no complaint of pain to site. Record review of Resident #3's skin evaluation completed by LVN B on 01/04/25 at 9:22pm revealed greenish discoloration to left shin that measured 2.0x7.0 (unit of measurement not included) Resident #3 had no complaint of pain and was unable to recall if/when she bumped self. Record review of Resident #3's change in condition evaluation completed by LVN B on 01/04/25 at 9:32pm had check placed on skin wound or ulcer and stated it started on 01/04/25 that noted a discoloration to front of left lower leg measuring 2 x 7 x 0 with no unit of measurement noted. Primary care physician was notified and provided recommendation to monitor. Record review of Resident #3's change in condition evaluation completed by LVN A on 01/04/25 at 9:45am stated resident to resident altercation occurred on 01/04/25 with no changes to skin other than skin tear to right arm and no pain. Primary care physician was notified and provided new orders after alteration including labs and urinalysis and to clean skin tear with normal saline and apply triple antibiotic ointment and leave open to air. Record review of Resident #3's skin evaluation completed by LVN A on 01/04/25 at 2:35pm revealed skin tear to back of right hand measuring 1.2 x 0.2 (unit of measurement not included) with scant bleeding, resident denied pain or discomfort. During an interview with Resident #3 on 06/11/25 at 3:58 PM Resident #3 stated her she had never been hit, grabbed, kicked, or abused in anyway at the facility and stated she knew who resident #4 was and denied any arguments or incident had occurred with Resident #4. Resident #3 denied Residents #4 ever swinging at her or kicking her and stated she did not recall any incident with a towel. Resident #3 stated Resident #4 was nice to her, had never abused her and stated they liked to go and play with one another. Resident #3 stated she felt safe at the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Record review of Resident #4's face sheet, dated 06/18/25, revealed the resident was a [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses that included: paranoid schizophrenia, schizophrenia (disorder that affects a person's ability to think, feel and behave clearly.), unspecified, bipolar disorder, (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) unspecified, unspecified intellectual disabilities, (condition that limits intelligence and disrupts abilities necessary for living independently) not otherwise specified. Record review of Resident #4's quarterly MDS assessment, dated 05/20/25, revealed Resident #4 had a BIMS score of 11, indicating her cognition was moderately impaired. Record review of Resident #4's care plan with an initiation date of 04/27/22 reflected focus's of [Resident #4] has potential for a behavior problem r/t bickering heard from down the hall to be coming from the small dining room. upon arrival, resident noted to be sitting in her wheelchair pulling on a towel that another resident [Resident #3] had in her hands and was pulling as well. With an initiation date of 01/06/25. [Resident #4] is at risk for impaired cognitive function/dementia or impaired thought processes [sic] BIMS scored 8 with an initiation fate of 04/27/22. Record review of Resident #4's progress note written by RN C with an effective date and time of 01/04/25 at 9:45am stated RN C heard bickering from down the hall coming from the small dining room, upon arrival RN C noted Resident #4 to be sitting in her wheelchair pulling on a towel that another resident had in her hands and was pulling as well with resident stating, she had my stuff and scratched my arm while gesturing towards her upper left arm. Both residents were immediately separated, and skin assessment was conducted with no visible injuries noted. Left arm was assessed with no redness noted and skin intact with no swelling. MD was made aware, DON and administrator. Record review of Resident #4's skin evaluation completed by RN C on 01/04/25 at 9:45am revealed a skin assessment was completed after a resident to resident altercation with Resident #4 reporting she was scratched to upper left arm however area was free of redness, swelling and had no open areas, no new skin injuries noted, and Resident #4 denied pain or discomfort. Record review of Resident #4's change in condition evaluation completed by RN C on 01/04/25 stated resident to resident altercation occurred on 01/04/25 with no changes to skin and no pain. Primary care physician was notified and provided no new orders. During an interview with Resident #4 on 06/11/25 at 4:58pm she stated she did not know who Resident #3 was and stated she not been abused by anyone in the facility and stated she had not had any incidents involving a towel, swinging a wallet or kicking a resident chair or legs. Record review of Administrators written undated statement in facility's submitted provider investigation report gave description of video surveillance that Administrator reviewed and stated Resident #3 was seated in the small dining room folding towels when Resident #4 approached her and started pulling at the towel she had in hand. Once Resident #4 had pulled the towel away from Resident #3 she processed to pursue Resident #4 requesting her towel back. Resident #3 then took a hold of another residents wallet and began swinging it while another resident swung the towel at Resident #3, resident proceeded to kick Resident #3's chair and leg resulting in Resident #3 taking hold of her arm and attempted to raise it. Nursing intervened and separated both residents. (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 TULIP (HHSC online incident reporting application) on 06/12/25 at 9:30 AM revealed a self-report received by the facility on 01/05/25 at 8:19am more than 2 hours after Resident #3 and Resident #4's had an altercation on 01/04/25. During an interview with RN C on 06/17/25 she stated she and LVN A were the responding nurses to the altercation between Resident #3 and Resident #4 , RN C stated she heard arguing so she entered the small dining room and stated Resident #3 and #4 were arguing over a towel that Resident #3 had with Resident #4 saying Resident #3 had her towel. RN C stated she did not see any contact between Resident #3 and Resident #4 and stated she did not see any kicking. RN C stated Resident #4 stated Resident #3 scratched her hand. RN C stated she completed a skin assessment on Resident #4 and did not note any injuries and did not recall any scant bleeding to her hand. RN C stated Resident #4 had no discoloration to legs, and stated Resident #4 had any injuries. RN C stated she had to see what really happened to see if Resident #4 scratched Resident #3 intentionally and if so, then yes she could consider that abuse. RN C stated she had been trained over resident to resident altercations and stated she would report to the Administrator as soon as possible and stated they only have 2 hours to report. RN C stated she and LVN A notified the Administrator shortly after the incident with Resident #3 and #4 but did not recall the exact time of incident or notification. RN C stated neither Residents #3 or #4 had similar previous incidents and stated they had not had any similar incidents since either. During an interview with LVN A on 06/18/25 at 2:01pm she stated she and RN C were the responding nurses to the altercation between Resident #3 and Resident #4 , LVN A stated she was the nurse for Resident #3 and stated at time of the incident she was called by RN C when she was on the floor. LVN A stated RN C told her that Resident #3 and #4 were fighting over something but LVN A did not recall what Resident #3 and #4 were fighting about and stated she saw Resident #3 on one table and Resident #4 on another. LVN A stated she did not see any contact between Resident #3 and Resident #4 and stated she did not remember if she saw the video surveillance of incident. LVN A stated neither resident had any injuries. LVN A stated she had been trained over resident to resident altercations and stated as soon as she was able to separate and assess the residents she would report within 1 hour to the Administrator, LVN A stated she notified the Administrator shortly after the incident with Resident #3 and #4 but did not recall the exact time of notification. LVN A stated neither Residents #3 or #4 had similar previous incidents and stated they had not had any similar incidents since either. LVN A stated she did not consider the altercation between Residents #3 and #4 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 with the Administrator on 06/18/25 at 6:04pm she thought LVN A was the responding nurse to the altercation between Resident #3 and Resident #4. The Administrator stated nursing staff did not witness any contact between Resident #3 and Resident #4. The Administrator stated she did review the surveillance footage at the time of the incident and stated she saw Resident #3 and #4 fighting over a towel that Resident #3 was initially folding at the table and then Resident #4 wanted and stated both residents then had a tug of war with the towel and Resident #4 yelled that Resident #3 hit her. The Administrator stated when she reviewed the camera that did not happen and stated Resident #3 was kicking her feet while in her wheelchair but it was slow and did not reach Resident #4, as per the Administrators observation of the video surveillance she did not see any contact between Residents #3 and #4 and only saw them hitting the chair and Resident #4 trying to raise Resident #3's arm. The Administrator stated staff completed skin assessments, change in condition documentation, and made notifications. The Administrator stated both Residents were noted to have no injuries. The Administrator stated Resident #3 and Resident #4 had poor cognition and their ability to make decisions was poor. The Administrator stated she was not aware of neither Resident #3 or #4 having similar incidents prior to this incident and stated they had not had any similar incidents since either. The Administrator stated staff had been trained over resident to resident altercations, behavioral management and what their procedures and policy required them to do and stated staff were to notify her of any resident to resident altercations as soon as staff did everything to keep the resident safe . The Administrator stated she was notified of the resident to resident altercation immediately after the incident by nursing but did not recall the exact date or time of incident occurring or of being notified. The Administrator stated she did not consider the altercation between Resident #3 and Resident #4 abuse. The Administrator stated she reported the incident to HHSC within 24 hours and stated she was previously following a QSO but was not able to recall exactly which one and stated her understanding was that she had 24 hours because there was no major physical injury. The Administrator stated according to the guidelines she learned recently it should have been reported in 2 hours, the Administrator stated she had not received any training on the guidance of reporting abuse allegations within 2 hours. The Administrator stated the facility abuse policy did not give a specific time frame for reporting and stated to follow the regulation and report anything with major injury within 2 hours. The Administrator stated in this situation she and her staff followed the facility policy based on the time frame she was aware of. the Administrator stated how resident to resident altercations negatively impact residents was dependent on a case by case bases on residents' cognition and ability to recall the event. The Administrator stated not reporting allegations of abuse within 2 hours was important to ensure patients were safe and that staff respond appropriately and timely. Record review of facility Inservice dated 06/09/25 that was provided by the DON and the Administrator covered, Abuse and neglect Coordinator - [Administrator], Behavior Management, Abuse and Neglect, Physical, Sexual, Verbal, Psychological, Misappropriation signs and symptoms - unexplained discolorations, injuries, refusing to eat, crying, isolation, missing items, withdrawal, depression, avoidance, poor hygiene, etc. revealed LVN A and RN C had received the training. Record review of LVN A's training transcript revealed she completed a training titled Abuse, Neglect and Exploitation Self -Paced on 10/22/24. Record review of RN C's training transcript revealed she completed a training titled Abuse, Neglect and Exploitation Self -Paced on 10/27/24. (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 facility policy with a revision date of 4/2025 and titled, Abuse: Prevention of and Prohibition Against stated, Physical Abuse includes but is not limited to hitting, slapping, pinching, and kicking. And stated, allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the facility and to the appropriate State or Federal agencies in the applicable time frames, as per this policy and applicable regulations,