STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675940	A. Building B. Wing	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hemphill Care Center	2000 Worth St Hemphill, TX 75948

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 - Immediate jeopardy to resident health or safety 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** 36491 Based on interview and record review the facility failed to ensure residents had the right to be treated with respect and dignity for 1 of 8 residents reviewed for resident rights. (Resident #1). The facility failed to ensure CNA A respected Resident #1's rights and dignity during her shower on 5/29/24. The noncompliance was identified as PNC. The Immediate Jeopardy began on 5/29/24 and ended on 5/31/24. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of becoming distressed and feeling disrespected. Findings included: Record review of an Admission Record dated 6/4/24 indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included lymphedema (a condition that results in swelling of the leg or arm. It occurs due to blockage in the lymphatic system which is part of the immune system), hypertension (high blood pressure), diabetes (a disease that occurs when blood glucose, also called blood sugar, is too high), and peripheral vascular disease (a disorder of the blood vessels outside the heart that affects blood flow to the limbs). Record review of the most recent MDS assessment dated [DATE] indicated Resident #1 was able to make herself understood and was able to understand others. She had a BIMS score of 11, which indicated moderately impaired cognition. Resident #1 required partial to moderate assistance with showering (helper doing less than half the effort). Resident #1 had no physical, verbal, or other behavioral symptoms directed towards others Record review of a care plan with a revision date of 4/26/24 indicated Resident #1 had a self-care/mobility focus with a goal to maintain functional abilities. Interventions included, Resident #1 will maintain the ability to bathe self, including washing, rinsing, and drying self. The Resident requires assistance set up supervision with bathing/showering, as necessary. Resident #1 had bladder incontinence, with interventions to ensure Resident #1 had unobstructed pathway to the bathroom, and to monitor/document/report to physician possible medical causes of incontinence. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0557 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record Review of Resident #1's Nurses Progress Notes dated 5/29/24 at 11:23 a.m. and signed off by ADON indicated Resident #1 reportedly had an incontinent episode this morning which is unlike the resident. Resident was brought to shower per CNA A and resident was displaying weakness not able to wash self. Resident #1 is yelling/cursing at staff, crying, and not able to be consoled. This is not baseline for resident. Call placed to MD with new order for UA with C &S (urinalysis with culture and sensitivity). Will continue to monitor and assess as allowed. Record review of the facility's provider investigation report dated 6/2/24 indicated the following: date of incident 5/30/24 at 12:14 p.m. Resident #1 was independently ambulatory, interviewable and had the capacity to make informed decisions. Resident #1 had no history of combativeness, similar incidents, wandering, sexual misconduct, verbal aggression, or physical aggression. CNA A was named as the alleged perpetrator and had a history of similar allegations. The agency immediate response, Resident #1 was independent and did not want assistance in showering. Expressed to CNA A she did not want him in the shower room or in her room. Investigation findings were inconclusive. Agency action post investigation, The fact that there were two incidents that were involving CNA A, we determined that in the interest of the residents, it be best if we parted ways with CNA A. Record review of a Grievance/Complaint Report dated 4/7/24 indicated that Resident #2 had reported to a hospital case manager that CNA A was rough in the shower and when transferring her. Document indicated ADON was designated to take action on this concern. Date assigned was 4/8/24. Actions taken included Abuse and neglect in-service, for all staff and in-service CNA A on using a lighter touch when showering. Resolution of grievance/complaint included a written warning was done with CNA A regarding shower techniques, abuse, and neglect. Form signed off by Administrator/grievance officer. Record review of a Verbal Warning Record dated 4/8/24 indicated CNA A indicated ADON educated CNA A on lighter touch while in shower and also proper transfer techniques. Record review of an unnamed document provided by facility dated 4/9/24 indicated CNA A received sensitivity training on abuse and neglect (different forms of abuse), baths, attitude, transfers, and assignments. Document was signed by ADON, and CNA A. Record review of a Grievance/Complaint Report dated 5/30/24 indicated CNA A was neglecting Resident #1's rights to shower. Resident #1 expressed her feeling like her rights had been violated because CNA A would not allow her to independently bathe. Document indicated the ADON and DON were designated to take action on this concern. Date assigned was 5/30/24. Actions taken included in services on abuse and neglect, safe surveys done on residents under the care of CNA A and emotional monitoring done with Residents. Resolution of grievance/complaint included reporting incident to the State, in-services completed, safe surveys completed, emotional monitoring on Resident #1. CNA A was terminated. Document signed by Administrator/Grievance officer and dated 6/4/24. (continued on next page)

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F 0557 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a witness statement from CNA A dated 5/30/24 indicated the following, On 5/29 resident was sitting on edge of bed and had an incontinent episode, large amount of urine on the floor. Resident was confused and weak and trembling. The DON notified me of the resident and told me to take resident to the shower. Resident usually bathes self but due to confusion and weakness she could not perform task herself. Resident never stated she felt uncomfortable with me performing shower. Resident kept saying she could do it herself but was falling over in the chair. Resident was upset that she had to have help in the shower and requested this CNA not to go in her room. On 5/30 I left Resident's tray on the cart at breakfast. Resident asked nurse where her tray was. I told nurse the resident requested me not to go in her room, so I left it on the food cart. Resident said she would get it herself. Record review of a witness statement from ADON dated 5/30/24 indicated the following, This nurse heard Resident #1 hollering and cussing in the hallway. Resident #1 was upset that CNA A had to help her in the shower. This nurse tried to talk to Resident #1 and let her know that for her safety in the shower she needed assistance due to new weakness. Resident #1 remains crying and yelling that she was told she could shower alone. This nurse let her know that she always needs to be accompanied by staff in case something happens. Resident becomes more agitated stating she has been lied to that she was told before she came she did not have to be accompanied. Resident exits room to therapy yelling you can all kiss my ass. Record review of an undated form titled Associate Separation Report indicated CNA A's date of hire was 2/23/23 and date of separation was 5/31/24. Reasons for separation included violating federal or state care standards, conduct or neglect of duties determined by management to be detrimental to the welfare of patients, resident, co-workers, the workplace of employer, and must follow all resident care guidelines including but not limited to on-time meals, care and medication and accurate detailed charting. Resident #1 forged a complaint against CNA A regarding her feeling like she was treated with disrespect. CNA A was assisting in resident shower and resident had a history of being independent in showers and she did not feel she needed assistance. The resident was found to have low blood sugar and a UTI, and was not at her baseline, so CNA A expressed that it was his obligation to assist due to her instability. Once the shower was complete, Resident #1 expressed her discontent that she was unable to shower by herself. The next day she lodged a complaint with the Ombudsman regarding CNA A and stated she felt abused. The investigation resulted in showing that abuse was found. Document was signed by Administrator. (continued on next page)

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F 0557 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the complainant on 6/3/24 at 4:52 p.m. she stated she had received a call on 5/30/24 sometime between midnight and 3:00 a.m. from LVN L, night shift nurse who told her that Resident #1 was upset over the way she was manhandled by CNA A during her shower on 5/29/24. Complainant stated she could hear Resident #1 in the background crying. Complainant stated she went into the facility on [DATE] to talk with Resident #1. Complainant stated Resident #1 told her she thought she had soiled her brief and asked CNA A to help her to the bathroom. CNA A told her get up you're going straight to the shower; I am not going to change you. Resident #1 told him she did not want to be in the shower by herself with a male, and CNA A told her you don't have a choice. Resident #1 stated CNA A kept telling her you're acting crazy, you are not making logical sense. Your blood sugar is low that is why you can't think. Resident #1 then told complainant CNA A forced her into the chair and took her to the shower. Resident #1 stood up and CNA A pushed her up against the shower wall and removed her blouse. Resident #1 told him No, stop, but CNA A continued to remove her blouse. CNA A then shoved Resident #1 down into the shower chair forcefully. Complainant stated Resident #1 told her she felt very afraid and intimidated by CNA A because he was so mean and angry with her. Complainant stated Resident #1 asked for her shampoo and CNA A told her no, you're going to use the shampoo I tell you to use. Resident #1 managed to get her own shampoo and get some in her hair. Complainant stated Resident #1 was very upset, and said she felt embarrassed, and felt that she was assaulted, and did not know what to do about it. Resident #1 told complainant that she refused to go the hospital because she was concerned, they would throw her out of the facility. Resident #1 stated that she liked being there but if they did not do something about that man, she would leave and go to another facility. (continued on next page)

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F 0557 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/4/24 at 11:50 a.m. Resident #1 stated she had lived in the facility since that last week of April 2024. Resident #1 stated she loved CNA A taking care of her, up until the date of the incident. Resident #1 stated she had been warned by other residents that he was mean and could turn on you real quick. Resident #1 stated that on 5/29/24 CNA A woke her up by slamming her breakfast tray on the table and yelling her name. Resident #1 stated that it startled her and she wet herself. Resident #1 stated she was a bit confused at the time because CNA A woke her up out of a dead sleep. Resident #1 stated CNA A asked her did you pee at church?, you're not yourself. Resident #1 stated CNA A kept getting louder and louder saying I wasn't myself over and over. Resident #1 stated she told CNA A to leave her alone. Resident #1 stated that before she moved into the facility it was a top priority for her to be able to shower herself. Resident #1 stated she called the facility prior to moving in and was told she could shower herself, and it was explained to her the shower room was a separate room in the facility. Resident #1 did not remember who she had talked with. Resident #1 stated she was very modest. Resident #1 stated that CNA A said, come on we're going to the shower, and that CNA A kept twisting me to get my clothes off, and I'm trying to stop him. Resident #1 stated CNA A told her, you are not yourself. Resident #1 stated I told him I'm not getting undressed in front of you, and CNA A continued to take her clothes off. Resident #1 stated he kept trying to get her to sit in a shower chair with a hole in the middle and kept pushing her into the chair. Resident #1 stated she asked CNA A to go behind the privacy curtain and CNA stated, No. This is my job, you want to wash your rosebud by yourself? Resident #1 stated that rosebud referred to her vagina. Resident #1 stated that CNA A kept forcing her to sit in the chair. CNA A put shampoo on her head and would not let her use her own shampoo. Resident #1 stated she unwrapped her Unna boots, (compression dressings made by wrapping layers of gauze around the leg and foot. It is often used to protect an ulcer or open wound. The compression of the dressing helps improve blood flow in your lower leg. Compression also helps decrease swelling and pain), and she begged CNA A to go behind the privacy screen again. Resident #1 stated, I felt like dirt. Resident #1 stated she had always showered by herself prior to this incident. Resident #1 stated she told CNA A you are hurting me. I'm humiliated please go behind the privacy screen. Resident #1 stated she kept repeating it and begged him to go behind the privacy screen, and CNA A did not go behind the screen. Resident #1 stated she did not feel comfortable in the shower chair and that it was slippery. Resident #1 stated CNA A stated, sit there, and stop acting like this. Resident #1 stated with all the commotion, no one came in to check on her. Resident #1 stated she had some bruises on her arms, but she got them while in the hospital, and said she had not seen any other bruises. Resident #1 stated that she was a bit disoriented when she woke up, but CNA A had startled her. I was confused when he kept asking if I peed myself at church. I don't know what he was talking about. Resident #1 said when CNA A brought her back to her room, he picked out some clothes for her to wear, and she told him she did not want to wear what he picked out, and he did not listen to her. Resident #1 stated, what really pissed me off was when we got back to my room, he took my wet towel and started mopping up the floor, like I had peed all over the place. It was a small spot. Resident #1 stated after she got dressed, the ADON came in her room, and said she wanted to talk to her while she was upset. Resident #1 stated the ADON was baby talking to her asking why are you mad, and why are your unna boots off? Are you upset because we care? Resident #1 stated the ADON told her we never told you that you could shower alone, and that there was not one resident in the facility that showers by themselves. Resident #1 stated she did not know why the ADON said that because she knew a lot of Residents that showered by themselves, and that she had showered by herself 3 times a week before this incident. Resident #1 stated that she asked the ADON to leave at that time, and the ADON replied, I still want to get to the bottom of why you are mad and why your unna boots are off. Resident #1 stated she told the ADON again she wanted her to leave, and the ADON stated she did not want to leave. Resident #1 stated she got up and went to the therapy department. Resident #1 stated she would take her unna boots off when she showered, a nurse would remove them, or she was capable of removing them herself. Resident #1 stated that one day, (did not know for sure what day it was), the Administrator came in and told her we need to talk. Resident #1 stated they went into her room and the Administrator said, CNA A is over enthusiastic and means well. Resident #1 stated the Administrator promised no one would go in the shower while she was in there. Resident #1 stated the Administrator apologized for the incident, and Resident #1 told her to keep CNA A away from me. I'm humiliated. Resident stated the next day at breakfast time, CNA A was

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F 0557 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/4/24 at 12:40 p.m. Resident #2 was lying in her bed. Resident #2 stated she had received care from CNA A. Resident #2 stated CNA A was yelling and was rough when moving me in bed. Resident #2 stated she did not remember when this occurred, and that she did not report it to anyone. During an interview on 6/4/24 at 12:50 p.m. Resident #3 was sitting outside in the smoking area. Resident #3 stated she had lived in the facility since December 2, 2023. Resident #3 stated CNA A was obnoxious and acted like a bully. Resident #3 stated CNA A talked very loud and had hurt her feelings a couple of times and made her cry. Resident #3 stated he mocked her in the hall in front of another employee. Resident #3 stated CNA A was a smart ass and very unprofessional, and it had gotten out of hand. Resident #3 stated CNA A was not very nice and was a smart ass bully. Resident #3 stated it was so bad, she checked herself out of the facility for a week and went to her family member's house just to get away. Resident #3 stated she checked out about 3 weeks after she had come to the facility, and then came back. Resident #3 stated CNA A hurt her feelings by making fun of her needing her medications. Resident #3 stated there was a day CNA A told her never raise your voice like that to me ever again yelling at the top of his lungs in front of all the smokers. Resident #3 did not remember all the details of the event. Resident #1 stated she did not report this to anyone but should have. During an interview on 6/4/24 at 1:24 p.m. MA B sated he had worked in the facility since November 2023. CMA B stated that CNA A was a hard worker, but horse-played (engaging in activities not related to task at hand) a lot. MA B sated CNA A was rude and arrogant to residents as well as other staff. MA B stated on the day of the incident with Resident #1, CNA A had called for help to stand her up. MA B stated Resident #1 had a look of disgust on her face like, I can't believe this is happening. Resident #1 told MA B that she was told by the facility that she could shower by herself. MA B stated Resident #1 had told CNA A to stand behind the privacy curtain, and he did not. Resident #1 was crying when she came out of the shower, and her face was red. Resident #1 stated CNA A had hurt her feelings. CMA B stated what ever happened in that shower room, CNA A never looked the same . CNA A could not make eye contact with Resident #1. MA B stated CNA A had no respect for his peers or for any woman. MA B stated CNA A had said things to other staff such as your mom is a whore, and you are a crack baby. MA B stated he told CNA A that he had victimized Resident #1. MA B stated that looking at Resident #1, he could see so many emotions in the lady's face. MA B stated he knew that CNA A had been banned from a lot of facilities around the area. MA B stated CNA A told him, I don't know if this job is for me. Every facility I go to I get fired. I don't know what I want to do. During an interview on 6/4/24 at 2:30 p.m. CNA E said he had worked with CNA A a few times. CNA E stated he personally had no problems with CNA A, but he had heard from some residents that CNA A was rough with them . CNA E stated the only resident he could remember was Resident #6. (continued on next page)

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F 0557 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/4/24 at 2:42 p.m. Resident #4 stated she had been in the facility for about a month. Resident #4 stated she had known CNA A for many years when he was working at another facility. Resident #4 stated she felt CNA A had caused a lot of problems in the facility. Resident #4 stated CNA A had inappropriately touched some ladies. Resident #4 stated Resident #1 was one of them. Resident #4 stated she could not remember any other names and that most of the ladies that he had touched had left the facility because of him. Resident #4 stated CNA A grabs the top and in the middle during showers. Resident #4 stated CNA A did not belong giving ladies showers, and Resident #1 was very upset. Resident #4 stated CNA A tried to do it with ladies because he can get away with it. CNA A has cursed at women and was very disrespectful. CNA A had never touched me as he knows better. Some ladies need help with their showers, but not by him. Resident #4 stated she showered by herself. During an interview on 6/6/24 at 10:55 a.m. Resident #5 stated that she showered by herself. Resident #5 stated CNA A acted like a child. Resident #5 stated she had never witnessed any abuse with him but wouldn't doubt it. Resident #5 stated CNA A was mean to other staff bullying them, and his mouth was always running and he talked very loud. Resident #5 stated she got mad at CNA A because every time she would be walking around in the facility, CNA A kept saying we're going to find you a boyfriend. He would say how bout that one, or that one, and kept pointing at different men. Resident #5 stated she asked him to please not do that as I was embarrassed. During an interview on 6/6/24 at 10:15 a.m. Rehab employee G stated CNA A did not have a good bedside manner. CNA A would joke a lot and did not realize it could hurt feelings. Rehab employee G stated she felt CNA A meant well and was always in a joking mood. Rehab employee G stated she had become close to Resident #1 and helped her get into the facility. Rehab employee G stated she told Resident #1 that therapy would always be a safe place for her to come to if she needed to. Rehab employee G stated Resident #1 told her CNA A had been rough in the shower, and that she was leaning forward in her chair and CNA A grabbed her around the chest area to sit her up, as he was afraid she was going to fall. Rehab employee G stated Resident #1 told her that CNA A put his arms across her chest to sit her up and hurt her ribs when pulling her back in the chair. Rehab employee G stated Resident #1 talked to her the day of the incident. Rehab employee G stated Resident #1 was hysterical when she came to the department, to the point they closed the door for her privacy. Rehab employee G stated Resident #1 was crying. Rehab employee G stated that Resident #1 stayed in the department for about 2 hours. Rehab employee G stated they let her lay down and gave her a heating pad for her back and applied Bio freeze to her shoulders. Rehab employee G stated the day after the incident Resident #1 had told her that CNA A would not bring her breakfast tray to her, and that she could get her own damn tray. Rehab employee G stated she had heard hearsay that CNA A had touched women prior to coming here, but it was just hearsay and she had never witnessed it. During an interview on 6/6/24 at 10:48 a.m. CNA H stated she had worked in the facility since 2012. CNA H said she would sometimes pick up a shift on CNA A's rotation but did not like to work with him. CNA H stated CNA A was different but could not explain how. CNA H stated she had never witnessed any abuse by CNA A. CNA H stated Resident #1 had always showered by herself. CNA H stated Resident #1 told her CNA A roughed her up and that she did not want him in the shower with her, and that he kept pulling her shirt off and pulled her sports bra down. During an interview on 6/6/24 at 11:24 a.m CNA I stated CNA A was very rude, and played too much to be in the field he is in. CNA I stated she had worked with CNA A in another facility and that he acted the same way. CNA I stated if a resident needed anything CNA A had an attitude and would be mouthy (verbally disrespectful). (continued on next page)

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F 0557 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/6/24 at 11:50 a.m. CNA K stated she had not worked with CNA A very often but that he was playful, arrogant, rude to coworkers and a smart butt. During an interview on 6/6/24 at 12:20 p.m. the DON stated she had worked in the facility since April 1 of this year. DON stated Resident #1 was under the impression that she could shower alone, and due to Resident #1's state of mind, all showers had to be supervised. DON stated Resident #1 had a fall on 5/31/24 and complained of rib pain the next day and did not want x-rays done. DON stated that when Resident #1 was in the shower with CNA A , when Resident #1 said stop, CNA A should have stopped. DON stated the Ombudsman came to visit that day and was told of the situation. During an interview on 6/6/24 at 1:00 p.m. the Administrator stated that when Resident #1 said stop, CNA A should have stopped. Administrator stated she did grievances and had not received any from any staff member regarding CNA A. Administrator stated she did not have a copy of the provider investigator report that was submitted with all training documentation. During an interview on 6/6/24 at 1:00 p.m. ADON stated she talked with Resident #1 the day of her incident with CNA A. ADON stated Resident #1 was crying and stating, I'm humiliated. ADON told Resident #1 she could not take a shower by herself. ADON stated Resident #1 did not want to speak with her and wanted her out of her room. ADON stated every resident is to have assistance in the shower, and she had instructed the staff about it. ADON said she spoke to CNA A after the incident and wrote up what had happened. DON stated CNA A said Resident #1 felt humiliated that he had to bath her, and CNA A told Resident #1 that for her safety he needed to be there. ADON stated that when Resident #1 said stop, he should have stopped. ADON stated she got a statement from CNA A on 5/30/24 and CNA A was sent home during the investigation and was terminated. ADON said she had not received any grievances from staff regarding CNA A. During an interview on 6/6/24 at 2:11 p.m. Resident #6 stated she had lived in the facility for 8 years. Resident #6 stated CNA A had provided care to her and was rough with her when helping her out of the bed. Resident #6 stated she told CNA A it hurt, and he said, so what. Resident #6 said she did not tell anyone, and when asked why Resident #6 stated, I don't know. Resident #6 stated CNA A had helped her with her showers, and never had a problem. Resident #6 stated she had heard CNA A say mean and hateful things. Resident #6 stated she did not remember who he was talking to at the time. On 6/6/24 at 2:21 p.m. and 4:11 p.m. two attempts were made to contact LVN L. No response was received to voicemail left. During an interview on 6/10/24 at 9:45 a.m. the DON stated she was working as a floor nurse on the day of Resident #1's incident on 5/29/24. DON stated she had talked with Resident #1 after the incident and said Resident #1 apologized for being so upset. Resident #1 stated she did not want CNA A in the shower with her. CNA A was out doing a transport at that time but was suspended as soon as he returned to the facility. DON stated she had not had any staff or resident come to her with any concerns with CNA A. DON stated she was not aware of any write-ups on CNA A since she had started working in the facility in April of this year. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Hemphill Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 Worth St Hemphill, TX 75948	

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/10/24 at 9:56 a.m. the ADON stated that on 5/29/24, she had gone to talk with Resident #1 after the incident. ADON stated Resident #1 was crying and would not talk with her. ADON stated she had looked at Resident #1's ribs, and there were no bruises. ADON stated the DON told her that she had sent CNA A to take Resident #1 to the shower after an incontinent episode. ADON stated Resident #1 was weak and needed assistance. ADON was asked if there were any specific documents she could provide regarding what was covered in the abuse trainings that were done or any documents that talked about what was discussed. ADON stated the abuse/neglect in-service was generic and covered the abuse policy. During a follow up interview on 6/10/24 at 10:16 a.m. Resident #1, stated that on the date of the incident with CNA A, she did not request that a female showered her, she just told CNA A you are not going into the shower with me. You are a kid and a male. Resident #1 stated she thought that was enough. Resident #1 stated CNA A stated, you're not yourself, you don't know what you are saying. Resident #1 stated she was so upset she did not remember if CNA A had helped wash her, but he must have washed some parts because he asked if I wanted to wash my own rosebud. Resident #1 stated she felt CNA A forced her to have that shower. Resident #1 stated she felt at peace now that CNA A was gone, and won't be doing this to anyone else, but I am not at peace after what happened and why it happened. Resident #1 stated, he made me feel so disgraced, and the more I think about it the madder I get. Resident #1 stated she did not feel bad that CNA A got fired. Resident #1 stated, at the time of the incident I kept thinking why isn't there a female in here. I was so busy thinking what is happening and why, I was not able to take the next step of getting him out of the shower. Everything happened so fast, and I was worried about getting covered up and getting him out. I told CNA A to stop and get out, over and over. Resident #1 stated she had chronic back pain and CNA A kept twisting and pulling under her arms and she thought he had broken her ribs which he didn't. Resident #1 stated CNA A lifted her from her rollator walker. (rollators have wheels on all legs, making them easier to push without lifting)to a shower chair, and she had always stood to take her showers. Resident #1 stated today was the first day I could take a shower. I was afraid to go into the shower since the incident. Resident #1 stated that she was a logical person, and knew it would not happen again, but it's kind of like PTSD. Resident #1 stated that she hated that she was still thinking about this incident and did not want to keep bringing it up. Resident #1 stated she felt that she can eventually put it out of her mind, and that it will just take a while. Resident #1 stated she was able to shower on this date by herself, and that two employees checked on her. Resident #1 stated it felt good to get a shower. Resident #1 stated, I know logically, CNA A is not here, but I still have thoughts of my shorts, underwear, shirt and sports bra all being removed by CNA A. Resident #1 stated she felt absolutely comfortable talking with the Administrator and DON if she felt she needed any counseling. Resident #1 stated, despite this incident, I am very happy to be here. On 6/10/24 at 1:50 p.m. an attempt to reach CNA A by phone was made. The phone number had been disconnected or was no longer in service Record review of a document titled Protecting Resident Rights In Nursing Facilities with a date of 2018 stated .All individuals have the right to be treated with dignity and respect . Record review of the facility's steps taken regarding the incident with completion dates included: All items listed will be completed by 6/11/24 3:00 pm with continued follow up for scheduled staff. (continued on next page)

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F 0557 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. An Inservice regarding the Dignity policy and procedure was initiated with all staff on 6/7/24 by the assistant admin and the ADON. < [TRUNCATED]

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 36491 Based on interview and record review, the facility failed to ensure residents the right to be free from abuse and/or neglect for 1 of 8 residents reviewed for abuse and/or neglect. (Resident #1) The facility failed to prevent CNA A from verbally, physically and mentally abusing Resident #1 while giving Resident #1 a shower on 5/29/24. The noncompliance was identified as PNC. The Immediate Jeopardy began on 5/29/24 and ended on 5/31/24. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of emotional harm, abuse/neglect, humiliation, intimidation, fear, shame, agitation, degradation, and decreased quality of life. Findings included: Record review of an Admission Record dated 6/4/24 indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included lymphedema (a condition that results in swelling of the leg or arm. It occurs due to blockage in the lymphatic system which is part of the immune system), hypertension (high blood pressure), diabetes (a disease that occurs when blood glucose, also called blood sugar, is too high), and peripheral vascular disease (a disorder of the blood vessels outside the heart that affects blood flow to the limbs). Record review of the most recent MDS assessment dated [DATE] indicated Resident #1 was able to make herself understood and was able to understand others. She had a BIMS score of 11, which indicated moderately impaired cognition. Resident #1 required partial to moderate assistance with showering (helper doing less than half the effort). Resident #1 had no physical, verbal, or other behavioral symptoms directed towards others. Record review of a care plan with a revision date of 4/26/24 indicated Resident #1 had a self-care/mobility focus with a goal to maintain functional abilities. Interventions included, Resident #1 will maintain the ability to bathe self, including washing, rinsing, and drying self. The Resident requires assistance set up supervision with bathing/showering, as necessary. Resident #1 had bladder incontinence, with interventions to ensure Resident #1 had unobstructed pathway to the bathroom, and to monitor/document/report to physician possible medical causes of incontinence. Record Review of Resident #1's Nurses Progress Notes dated 5/29/24 at 11:23 a.m. and signed off by ADON indicated Resident #1 reportedly had an incontinent episode this morning which is unlike the resident. Resident was brought to shower per CNA A and resident was displaying weakness not able to wash self. Resident #1 is yelling/cursing at staff, crying, and not able to be consoled. This is not baseline for resident. Call placed to MD with new order for UA with C &S (urinalysis with culture and sensitivity). Will continue to monitor and assess as allowed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's provider investigation report dated 6/2/24 indicated the following: date of incident 5/30/24 at 12:14 p.m. Resident #1 was independently ambulatory, interviewable and had the capacity to make informed decisions. Resident #1 had no history of combativeness, similar incidents, wandering, sexual misconduct, verbal aggression, or physical aggression. CNA A was named as the alleged perpetrator and had a history of similar allegations. The agency immediate response, Resident #1 was independent and did not want assistance in showering. Expressed to CNA A she did not want him in the shower room or in her room. Investigation findings were inconclusive. Agency action post investigation, The fact that there were two incidents that were involving CNA A, we determined that in the interest of the residents, it be best if we parted ways with CNA A. Record review of a Grievance/Complaint Report dated 4/7/24 indicated that Resident #2 had reported to a hospital case manager that CNA A was rough in the shower and when transferring her. Document indicated ADON was designated to take action on this concern. Date assigned was 4/8/24. Actions taken included Abuse and neglect in-service, for all staff and in-service CNA A on using a lighter touch when showering. Resolution of grievance/complaint included a written warning was done with CNA A regarding shower techniques, abuse, and neglect. Form signed off by Administrator/grievance officer. Record review of a Verbal Warning Record dated 4/8/24 indicated CNA A indicated ADON educated CNA A on lighter touch while in shower and also proper transfer techniques. Record review of an unnamed document provided by facility dated 4/9/24 indicated CNA A received sensitivity training on abuse and neglect (different forms of abuse), baths, attitude, transfers, and assignments. Document was signed by ADON, and CNA A. Record review of a Grievance/Complaint Report dated 5/30/24 indicated CNA A was neglecting Resident #1's rights to shower. Resident #1 expressed her feeling like her rights had been violated because CNA A would not allow her to independently bathe. Document indicated the ADON and DON were designated to take action on this concern. Date assigned was 5/30/24. Actions taken included in services on abuse and neglect, safe surveys done on residents under the care of CNA A and emotional monitoring done with Residents. Resolution of grievance/complaint included reporting incident to the State, in-services completed, safe surveys completed, emotional monitoring on Resident #1. CNA A was terminated. Document signed by Administrator/Grievance officer and dated 6/4/24. Record review of a witness statement from CNA A dated 5/30/24 indicated the following, On 5/29 resident was sitting on edge of bed and had an incontinent episode, large amount of urine on the floor. Resident was confused and weak and trembling. The DON notified me of the resident and told me to take resident to the shower. Resident usually bathes self but due to confusion and weakness she could not perform task herself. Resident never stated she felt uncomfortable with me performing shower. Resident kept saying she could do it herself but was falling over in the chair. Resident was upset that she had to have help in the shower and requested this CNA not to go in her room. On 5/30 I left Resident's tray on the cart at breakfast. Resident asked nurse where her tray was. I told nurse the resident requested me not to go in her room, so I left it on the food cart. Resident said she would get it herself. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a witness statement from ADON dated 5/30/24 indicated the following, This nurse heard Resident #1 hollering and cussing in the hallway. Resident #1 was upset that CNA A had to help her in the shower. This nurse tried to talk to Resident #1 and let her know that for her safety in the shower she needed assistance due to new weakness. Resident #1 remains crying and yelling that she was told she could shower alone. This nurse let her know that she always needs to be accompanied by staff in case something happens. Resident becomes more agitated stating she has been lied to that she was told before she came she did not have to be accompanied. Resident exits room to therapy yelling you can all kiss my ass. Record review of an undated form titled Associate Separation Report indicated CNA A's date of hire was 2/23/23 and date of separation was 5/31/24. Reasons for separation included violating federal or state care standards, conduct or neglect of duties determined by management to be detrimental to the welfare of patients, resident, co-workers, the workplace of employer, and must follow all resident care guidelines including but not limited to on-time meals, care and medication and accurate detailed charting. Resident #1 forged a complaint against CNA A regarding her feeling like she was treated with disrespect. CNA A was assisting in resident shower and resident had a history of being independent in showers and she did not feel she needed assistance. The resident was found to have low blood sugar and a UTI, and was not at her baseline, so CNA A expressed that it was his obligation to assist due to her instability. Once the shower was complete, Resident #1 expressed her discontent that she was unable to shower by herself. The next day she lodged a complaint with the Ombudsman regarding CNA A and stated she felt abused. The investigation resulted in showing that abuse was found. Document was signed by Administrator. Record review of an undated online training report indicated CNA A received training on preventing, recognizing, and reporting abuse on 2/26/23 when hired. During an interview with the complainant on 6/3/24 at 4:52 p.m. she stated she had received a call on 5/30/24 sometime between midnight and 3:00 a.m. from LVN L, night shift nurse who told her that Resident #1 was upset over the way she was manhandled by CNA A during her shower on 5/29/24. Complainant stated she could hear Resident #1 in the background crying. Complainant stated she went into the facility on [DATE] to talk with Resident #1. Complainant stated Resident #1 told her she thought she had soiled her brief and asked CNA A to help her to the bathroom. CNA A told her get up you're going straight to the shower; I am not going to change you. Resident #1 told him she did not want to be in the shower by herself with a male, and CNA A told her you don't have a choice. Resident #1 stated CNA A kept telling her you're acting crazy, you are not making logical sense. Your blood sugar is low that is why you can't think. Resident #1 then told complainant CNA A forced her into the chair and took her to the shower. Resident #1 stood up and CNA A pushed her up against the shower wall and removed her blouse. Resident #1 told him No, stop, but CNA A continued to remove her blouse. CNA A then shoved Resident #1 down into the shower chair forcefully. Complainant stated Resident #1 told her she felt very afraid and intimidated by CNA A because he was so mean and angry with her. Complainant stated Resident #1 asked for her shampoo and CNA A told her no, you're going to use the shampoo I tell you to use. Resident #1 managed to get her own shampoo and get some in her hair. Complainant stated Resident #1 was very upset, and said she felt embarrassed, and felt that she was assaulted, and did not know what to do about it. Resident #1 told complainant that she refused to go the hospital because she was concerned, they would throw her out of the facility. Resident #1 stated that she liked being there but if they did not do something about that man, she would leave and go to another facility. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/4/24 at 11:50 a.m. Resident #1 stated she had lived in the facility since that last week of April 2024. Resident #1 stated she loved CNA A taking care of her, up until the date of the incident. Resident #1 stated she had been warned by other residents that he was mean and could turn on you real quick. Resident #1 stated that on 5/29/24 CNA A woke her up by slamming her breakfast tray on the table and yelling her name. Resident #1 stated that it startled her and she wet herself. Resident #1 stated she was a bit confused at the time because CNA A woke her up out of a dead sleep. Resident #1 stated CNA A asked her did you pee at church?, you're not yourself. Resident #1 stated CNA A kept getting louder and louder saying I wasn't myself over and over. Resident #1 stated she told CNA A to leave her alone. Resident #1 stated that before she moved into the facility it was a top priority for her to be able to shower herself. Resident #1 stated she called the facility prior to moving in and was told she could shower herself, and it was explained to her the shower room was a separate room in the facility. Resident #1 did not remember who she had talked with. Resident #1 stated she was very modest. Resident #1 stated that CNA A said, come on we're going to the shower, and that CNA A kept twisting me to get my clothes off, and I'm trying to stop him. Resident #1 stated CNA A told her, you are not yourself. Resident #1 stated I told him I'm not getting undressed in front of you, and CNA A continued to take her clothes off. Resident #1 stated he kept trying to get her to sit in a shower chair with a hole in the middle and kept pushing her into the chair. Resident #1 stated she asked CNA A to go behind the privacy curtain and CNA stated, No. This is my job, you want to wash your rosebud by yourself? Resident #1 stated that rosebud referred to her vagina. Resident #1 stated that CNA A kept forcing her to sit in the chair. CNA A put shampoo on her head and would not let her use her own shampoo. Resident #1 stated she unwrapped her Unna boots, (compression dressings made by wrapping layers of gauze around the leg and foot. It is often used to protect an ulcer or open wound. The compression of the dressing helps improve blood flow in your lower leg. Compression also helps decrease swelling and pain), and she begged CNA A to go behind the privacy screen again. Resident #1 stated, I felt like dirt. Resident #1 stated she had always showered by herself prior to this incident. Resident #1 stated she told CNA A you are hurting me. I'm humiliated please go behind the privacy screen. Resident #1 stated she kept repeating it and begged him to go behind the privacy screen, and CNA A did not go behind the screen. Resident #1 stated she did not feel comfortable in the shower chair and that it was slippery. Resident #1 stated CNA A stated, sit there, and stop acting like this. Resident #1 stated with all the commotion, no one came in to check on her. Resident #1 stated she had some bruises on her arms, but she got them while in the hospital, and said she had not seen any other bruises. Resident #1 stated that she was a bit disoriented when she woke up, but CNA A had startled her. I was confused when he kept asking if I peed myself at church. I don't know what he was talking about. Resident #1 said when CNA A brought her back to her room, he picked out some clothes for her to wear, and she told him she did not want to wear what he picked out, and he did not listen to her. Resident #1 stated, what really pissed me off was when we got back to my room, he took my wet towel and started mopping up the floor, like I had peed all over the place. It was a small spot. Resident #1 stated after she got dressed, the ADON came in her room, and said she wanted to talk to her while she was upset. Resident #1 stated the ADON was baby talking to her asking why are you mad, and why are your unna boots off? Are you upset because we care? Resident #1 stated the ADON told her we never told you that you could shower alone, and that there was not one resident in the facility that showers by themselves. Resident #1 stated she did not know why the ADON said that because she knew a lot of Residents that showered by themselves, and that she had showered by herself 3 times a week before this incident. Resident #1 stated that she asked the ADON to leave at that time, and the ADON replied, I still want to get to the bottom of why you are mad and why your unna boots are off. Resident #1 stated she told the ADON again she wanted her to leave, and the ADON stated she did not want to leave. Resident #1 stated she got up and went to the therapy department. Resident #1 stated she would take her unna boots off when she showered, a nurse would remove them, or she was capable of removing them herself. Resident #1 stated that one day, (did not know for sure what day it was), the Administrator came in and told her we need to talk. Resident #1 stated they went into her room and the Administrator said, CNA A is over enthusiastic and means well. Resident #1 stated the Administrator promised no one would go in the shower while she was in there. Resident #1 stated the Administrator apologized for the incident, and Resident #1 told her to keep CNA A away from me. I'm humiliated. Resident stated the next day at breakfast time, CNA A was

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/4/24 at 12:40 p.m. Resident #2 was lying in her bed. Resident #2 stated she had received care from CNA A. Resident #2 stated CNA A was yelling and was rough when moving me in bed. Resident #2 stated she did not remember when this occurred, and that she did not report it to anyone. During an interview on 6/4/24 at 12:50 p.m. Resident #3 was sitting outside in the smoking area. Resident #3 stated she had lived in the facility since December 2, 2023. Resident #3 stated CNA A was obnoxious and acted like a bully. Resident #3 stated CNA A talked very loud and had hurt her feelings a couple of times and made her cry. Resident #3 stated he mocked her in the hall in front of another employee. Resident #3 stated CNA A was a smart ass and very unprofessional, and it had gotten out of hand. Resident #3 stated CNA A was not very nice and was a smart ass bully. Resident #3 stated it was so bad, she checked herself out of the facility for a week and went to her family member's house just to get away. Resident #3 stated she checked out about 3 weeks after she had come to the facility, and then came back. Resident #3 stated CNA A hurt her feelings by making fun of her needing her medications. Resident #3 stated there was a day CNA A told her never raise your voice like that to me ever again yelling at the top of his lungs in front of all the smokers. Resident #3 did not remember all the details of the event. Resident #3 stated she did not report this to anyone but should have. During an interview on 6/4/24 at 1:24 p.m. MA B sated he had worked in the facility since November 2023. CMA B stated that CNA A was a hard worker, but horse-played (engaging in activities not related to task at hand) lot. MA B sated CNA A was rude and arrogant to residents as well as other staff. MA B stated on the day of the incident with Resident #1, CNA A had called for help to stand her up. MA B stated Resident #1 had a look of disgust on her face like, I can't believe this is happening. Resident #1 told MA B that she was told by the facility that she could shower by herself. MA B stated Resident #1 had told CNA A to stand behind the privacy curtain, and he did not. Resident #1 was crying when she came out of the shower, and her face was red. Resident #1 stated CNA A had hurt her feelings. MA B stated, whatever happened in that shower room, CNA A never looked the same ., and could not make eye contact with Resident #1. MA B stated CNA A had no respect for his peers or for any woman. MA B stated CNA A had said things to other staff such as your mom is a whore, and you are a crack baby. MA B stated he told CNA A that he had victimized Resident #1. MA B stated that looking at Resident #1, he could see so many emotions in the lady's face. MA B stated he knew that CNA A had been banned from a lot of facilities around the area. MA B stated CNA A told him, I don't know if this job is for me. Every facility I go to I get fired. I don't know what I want to do. During an interview on 6/4/24 at 2:30 p.m. CNA E said he had worked with CNA A a few times. CNA E stated he personally had no problems with CNA A, but he had heard from some residents that CNA A was rough with them. CNA E stated the only resident he could remember was Resident #6. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Hemphill Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 Worth St Hemphill, TX 75948	

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/4/24 at 2:42 p.m. Resident #4 stated she had been in the facility for about a month. Resident #4 stated she had known CNA A for many years when he was working at another facility. Resident #4 stated she felt CNA A had caused a lot of problems in the facility. Resident #4 stated CNA A had inappropriately touched some ladies . Resident #4 stated Resident #1 was one of them. Resident #4 stated she could not remember any other names and that most of the ladies that he had touched had left the facility because of him. Resident #4 stated CNA A grabs the top and in the middle during showers. Resident #4 stated CNA A did not belong giving ladies showers, and Resident #1 was very upset. Resident #4 stated CNA A tried to do it with ladies because he can get away with it. CNA A has cursed at women and was very disrespectful. CNA A had never touched me as he knows better. Some ladies need help with their showers, but not by him. Resident #4 stated she showered by herself. During an interview on 6/6/24 at 9:10 a.m. LVN F stated she had worked in the facility for 3 years. LVN F stated she was not working the day of Resident #1's incident, but that Resident #1 had told her CNA A had startled her on the morning of the incident waking her up, and that CNA A told her she had to go take a shower and she told him no, as she tried to keep her shirt down as he was pulling it off and hurt her ribs. LVN F stated CNA A had a tendency to blow up verbally and slam doors and had no problems getting in your face . During an interview on 6/6/24 at 10:55 a.m. Resident #5 stated that she showered by herself. Resident #5 stated CNA A acted like a child. Resident #5 stated she had never witnessed any abuse with him but wouldn't doubt it. Resident #5 stated CNA A was mean to other staff bullying them, and his mouth was always running and he talked very loud. Resident #5 stated she got mad at CNA A because every time she would be walking around in the facility, CNA A kept saying we're going to find you a boyfriend. He would say how bout that one, or that one, and kept pointing at different men. Resident #5 stated she asked him to please not do that as I was embarrassed. During an interview on 6/6/24 at 10:15 a.m. Rehab employee G stated CNA A did not have a good bedside manner. CNA A would joke a lot and did not realize it could hurt feelings. Rehab employee G stated she felt CNA A meant well and was always in a joking mood. Rehab employee G stated she had become close to Resident #1 and helped her get into the facility. Rehab employee G stated she told Resident #1 that therapy would always be a safe place for her to come to if she needed to. Rehab employee G stated Resident #1 told her CNA A had been rough in the shower, and that she was leaning forward in her chair and CNA A grabbed her around the chest area to sit her up, as he was afraid she was going to fall. Rehab employee G stated Resident #1 told her that CNA A put his arms across her chest to sit her up and hurt her ribs when pulling her back in the chair. Rehab employee G stated Resident #1 talked to her the day of the incident. Rehab employee G stated Resident #1 was hysterical when she came to the department, to the point they closed the door for her privacy. Rehab employee G stated Resident #1 was crying. Rehab employee G stated that Resident #1 stayed in the department for about 2 hours. Rehab employee G stated they let her lay down and gave her a heating pad for her back and applied Bio freeze to her shoulders. Rehab employee G stated the day after the incident Resident #1 had told her that CNA A would not bring her breakfast tray to her, and that she could get her own damn tray. Rehab employee G stated she had heard hearsay that CNA A had touched women prior to coming here, but it was just hearsay and she had never witnessed it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675940	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2024
NAME OF PROVIDER OR SUPPLIER Hemphill Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 Worth St Hemphill, TX 75948	

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/6/24 at 10:48 a.m. CNA H stated she had worked in the facility since 2012. CNA H said she would sometimes pick up a shift on CNA A's rotation but did not like to work with him. CNA H stated CNA A was different but could not explain how. CNA H stated she had never witnessed any abuse by CNA A. CNA H stated Resident #1 had always showered by herself. CNA H stated Resident #1 told her CNA A roughed her up and that she did not want him in the shower with her, and that he kept pulling her shirt off and pulled her sports bra down. During an interview on 6/6/24 at 11:50 a.m. CNA K stated she had not worked with CNA A very often but that he was playful, arrogant, rude to coworkers and a smart butt. During an interview on 6/6/24 at 12:20 p.m. the DON stated she had worked in the facility since April 1 of this year. DON stated Resident #1 was under the impression that she could shower alone, and due to Resident #1's state of mind, all showers had to be supervised. DON stated Resident #1 had a fall on 5/31/24 and complained of rib pain the next day and did not want x-rays done. DON stated that when Resident #1 was in the shower with CNA A , when Resident #1 said stop, CNA A should have stopped. DON stated the Ombudsman came to visit that day and was told of the situation. During an interview on 6/6/24 at 1:00 p.m. the Administrator stated that when Resident #1 said stop, CNA A should have stopped. Administrator stated she did grievances and had not received any from any staff member regarding CNA A. Administrator stated she did not have a copy of the provider investigator report that was submitted with all training documentation . During an interview on 6/6/24 at 1:00 p.m. ADON stated she talked with Resident #1 the day of her incident with CNA A. ADON stated Resident #1 was crying and stating, I'm humiliated. ADON told Resident #1 she could not take a shower by herself. ADON stated Resident #1 did not want to speak with her and wanted her out of her room. ADON stated every resident is to have assistance in the shower, and she had instructed the staff about it. ADON said she spoke to CNA A after the incident and wrote up what had happened. DON stated CNA A said Resident #1 felt humiliated that he had to bathe her, and CNA A told Resident #1 that for her safety he needed to be there. ADON stated that when Resident #1 said stop, he should have stopped. ADON stated she got a statement from CNA A on 5/30/24 and CNA A was sent home during the investigation and was terminated. ADON said she had not received any grievances from staff regarding CNA A. During an interview on 6/6/24 at 2:11 p.m. Resident #6 stated she had lived in the facility for 8 years. Resident #6 stated CNA A had provided care to her and was rough with her when helping her out of the bed. Resident #6 stated she told CNA A it hurt, and he said, so what. Resident #6 said she did not tell anyone, and when asked why Resident #6 stated, I don't know. Resident #6 stated CNA A had helped her with her showers, and never had a problem. Resident #6 stated she had heard CNA A say mean and hateful things. Resident #6 stated she did not remember who he was talking to at the time. On 6/6/24 at 2:21 p.m. and 4:11 p.m. two attempts were made to contact LVN L. No response was received to voicemail left. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/10/24 at 9:45 a.m. the DON stated she was working as a floor nurse on the day of Resident #1's incident on 5/29/24. DON stated she had talked with Resident #1 after the incident and said Resident #1 apologized for being so upset. Resident #1 stated she did not want CNA A in the shower with her. CNA A was out doing a transport at that time but was suspended as soon as he returned to the facility. DON stated she had not had any staff or resident come to her with any concerns with CNA A. DON stated she was not aware of any write-ups on CNA A since she had started working in the facility in April of this year. During an interview on 6/10/24 at 9:56 a.m. the ADON stated that on 5/29/24, she had gone to talk with Resident #1 after the incident. ADON stated Resident #1 was crying and would not talk with her. ADON stated she had looked at Resident #1's ribs, and there were no bruises. ADON stated the DON told her that she had sent CNA A to take Resident #1 to the shower after an incontinent episode. ADON stated Resident #1 was weak and needed assistance. ADON was asked if there were any specific documents she could provide regarding what was covered in the abuse trainings that were done or any documents that talked about what was discussed. ADON stated the Abuse/Neglect in-service was generic and covered the abuse policy. During a follow up interview on 6/10/24 at 10:16 a.m. Resident #1, stated that on the date of the incident with CNA A, she did not request that a female showered her, she just told CNA A you are not going into the shower with me. You are a kid and a male. Resident #1 stated she thought that was enough. Resident #1 stated CNA A stated, you're not yourself, you don't know what you are saying. Resident #1 stated she was so upset she did not remember if CNA A had helped wash her, but he must have washed some parts because he asked if I wanted to wash my own rosebud. Resident #1 stated she felt CNA A forced her to have that shower. Resident #1 stated she felt at peace now that CNA A was gone, and won't be doing this to anyone else, but I am not at peace after what happened and why it happened. Resident #1 stated, he made me feel so disgraced, and the more I think about it the madder I get. Resident #1 stated she did not feel bad that CNA A got fired. Resident #1 stated, at the time of the incident I kept thinking why isn't there a female in here. I was so busy thinking what is happening and why, I was not able to take the next step of getting him out of the shower. Everything happened so fast, and I was worried about getting covered up and getting him out. I told CNA A to stop and get out, over and over. Resident #1 stated she had chronic back pain and CNA A kept twisting and pulling under her arms and she thought he had broken her ribs which he didn't. Resident #1 stated CNA A lifted her from her rollator walker. (rollators have wheels on all legs, making them easier to push without lifting) to a shower chair, and she had always stood to take her showers. Resident #1 stated today was the first day I could take a shower. I was afraid to go into the shower since the incident. Resident #1 stated that she was a logical person, and knew it would not happen again, but it's kind of like PTSD . Resident #1 stated that she hated that she was still thinking about this incident and did not want to keep bringing it up. Resident #1 stated she felt that she can eventually put it out of her mind, and that it will just take a while. Resident #1 stated she was able to shower on this date by herself, and that two employees checked on her. Resident #1 stated it felt good to get a shower. Resident #1 stated, I know logically, CNA A is not here, but I still have thoughts of my shorts, underwear, shirt and sports bra all being removed by CNA A. Resident #1 stated she felt absolutely comfortable talking with the Administrator and DON if she felt she needed any counseling. Resident #1 stated, despite this incident, I am very happy to be here. On 6/10/24 at 1:50 p.m. an attempt to reach CNA A by phone was made. The phone number had been disconnected or was no longer in service. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's policy, Abuse and Neglect C [TRUNCATED]