STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675948	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Manor	810 E 13th Ave Belton, TX 76513

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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50360 Based on observation, interview, and record review, the facility failed to ensure each resident was treated with respect, dignity, and care in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for 1 of 7 residents (Resident #4) reviewed for Resident Rights. The facility failed to ensure Resident #4 was treated with respect, dignity, and care while CNA A was assisting her to attend to grooming and dressing for breakfast in the dining room. This failure could place residents at risk for a loss of dignity, decreased self- worth, and decreased self-esteem. The non-compliance was identified as PNC. The noncompliance began on 12/03/2024 and ended on 12/5/2024. The facility had corrected the non-compliance before the investigation began. Finding included: Review of the Face Sheet for Resident #4 dated 12/03/2024 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease (a brain disorder that causes a gradual decline in memory, thinking, and reasoning skills) and Need for Assistance with Personal Care. Review of the MDS assessment for Resident #4 dated 11/26/2024 reflected Resident #4 required assistance in all activities of daily living. (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 0550 Level of Harm - Actual harm Residents Affected - Few	Review of the Care Plan for Resident #4 revised 01/22/2024 reflected the following: (Resident #4) has an ADL Self Care Performance (Bed Mobility, Transfers, Eating, Bathing, Dressing, and Personal Hygiene) Deficits r/t: Activity Intolerance, Disease Process (Post-Polio Syndrome), Depression, Fatigue, Impaired balance. The resident will maintain current level of function in Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene over next 90 days. Locomotion on and off unit: Resident needs assist of 1 staff to transfer with assist of gait belt. Resident utilizes a wheelchair as adaptive device for mobility and require assist of 1 staff for mobility on and off unit. Resident is able to wheel self. Transfer: the resident is limited assistance for transfers. Provide 2 person for transfer. Encourage and remind resident to hold onto handles during transfer. Provide reassurance as needed. Observe extremities and devices during transfer and position for comfort. Ensure wheelchair is available to facilitate transfers. Personal Hygiene: the resident is limited assistance with personal hygiene. Ensure that hygiene items are available for use. Offer resident hygiene items and provide reminders, verbal cues and encouragement as needed. Do not rush, allow resident time to complete task. Provide assistance as needed to complete tasks. Check nail length and trim and clean per facility guidelines and as necessary. Report any changes to the nurse. Prior to trimming nail verify with Nurse for contraindications. Dressing: The resident requires limited assistance with dressing. Encourage and allow resident to choose weather appropriate clothing, non-slip/skid shoes/socks of choice. Provide encouragement, verbal cues and simple 1-2 step instruction as needed. Provide assistance with buttons, zippers, tying shoes etc. to compete tasks. Record review of the facility investigation report on 12/18/2024 reflected the following event: The administrator was notified by the DON on 12/3/2024 Resident #4 made an allegation of abuse against CNA A. Resident #4 informed CNA B and DON that CNA A grabbed her roughly out of bed and yanked and pulled her hair while combing it. At that time, continuous monitoring of the resident was implemented by CNA B. Record review of the Facility Investigation Reports and interviews of CNA B and DON confirmed that Resident #4 reported she was rudely awakened and treated rudely and roughly by CNA A. Record Review of the Facility Investigation and Follow Up Report and confirmed in interview with the Administrator immediate action to ensure the safety of the resident was implemented. The following observations, assessments, and interventions occurred on 12/3/24: CNA B observed Resident #4 crying and reporting abuse by CNA A. CNA B began continuous monitoring of Resident #4. The DON was notified, and she notified the Administrator that Resident #4 made an allegation of abuse against CNA A. The DON assessed Resident #4 for signs of trauma to the scalp or body. The assessment was reflected in the Record review of the documentation of the Facility Investigation, record review of the progress note submitted by the DON and confirmed per interview with the DON. There was no evidence of injury. Record review of the documentation included in the Facility Investigation Report contained a statement submitted by the SW on 12/3/24. The documentation revealed that Resident #4 stated she did not feel safe due to the treatment she received from CNA A. (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 0550 Level of Harm - Actual harm Residents Affected - Few	Record review of the facility policy, Prevention and Reporting of Suspected Resident Abuse and Neglect stated Upon identification of suspected abuse and/or neglect, provide for the immediate safety of the resident. Means of providing protection may include but are not limited to moving resident to another room or unit; provide one-on-one monitoring as appropriate; suspend suspected employee(s) pending outcome of the investigation. Based on record review of the facility investigation and confirmed in an interview with the Administrator, upon receiving notification of the allegation, the Administrator suspended CNA A. Record review of CNA A personnel file demonstrates documentation of the suspension dated 12/03/2024. The facility policy, 'Prevention and Reporting of suspected Resident Abuse and Neglect stated Investigation of all alleged violations will be done under the direction of the DON and/or Administrator. Record review of the documentation of the facility investigation and confirmed during interview with the Administrator, an investigation was initiated immediately after the report was received. The investigation was completed on 12/03/2024. Record review of staff training records demonstrated the staff were inserviced on the Abuse Policy, Resident Rights, Code of Conduct/Code of Ethics, Standard of Conduct, Suspected Abuse/Neglect Checklist was completed on 12/03/2024. Record review of CNA A employee file contained documentation of termination dated 12/05/2024. This was confirmed in interview with Administrator. A telephone interview was conducted on 12/18/2024 11:07 AM with Resident #4's family member. The family member confirmed that he was notified of the event and the actions taken afterward. The family member stated he believed the incident was handled appropriately and Resident #4 was well taken care of. Observation of Resident #4 was conducted in the Dining Room on 12/18/2024 11:12 AM. Resident #4 was clean and dressed in clothing appropriate to the situation. Resident #4 did not have any signs of fear or abuse. In an interview of Resident #4 she stated she did not remember anyone ever being rough with her. A phone interview was conducted with CNA B 12/18/2024 at 3:53pm. She stated that she went into Resident #4's room to take her tray and noticed Resident #4 was crying and jumpy. CNA B stated that Resident #4 told her she was treated badly by another staff member. CNA B stated that she went and got the DON and went back to Resident #4's room. CNA B heard Resident #4 tell the DON that she was afraid to be left alone. Record Review of the DON's statement for the Facility Investigation report and confirmed per interview with the DON revealed Resident #4 was trembling and stated please don't hurt me. Additionally, Resident #4 reported the CNA A pulled her hair and shoved and jerked her out of the bed. CNA B stated she heard from other residents that they do not receive abuse from CNA A; however, they state that sometimes she does not get them to the shower when they ask. A phone interview was conducted with CNA D 12/18/2024 at 3:58 PM. CNA D stated she walked to Resident #4's room to pick up a tray, but the door was closed. CNA D opened the door and noticed CNA B was present. CNA D stated Resident #4 was hysterical and kept asking why she did this to me. CNA D stated Resident #4 said that she was pushed in the restroom forcefully and that her hair was combed roughly by the other lady. CNA D stated she sat with Resident #4 for a while, until she calmed down. CNA D confirmed record review of inservice documentation of inservice training received on Abuse and Neglect. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	Record review of personnel file for CNA A, reflected required background checks, and orientation/training on abuse/neglect/exploitation, resident rights, and dementia care. Observed 2 different individual in-services dated 4/19/24 and 7/11/24 for Standard of Conduct, Code of Ethics, Patient Care, Resident rights. The file also contained the Verbal Warning disciplinary notice of suspension dated 12/03/2024 and the Termination Notice dated 12/05/2024. Record review of the Texas Health and Human Services/ Texas Long-Term Care Ombudsman Nursing Facility Residents [NAME] of Rights dated November 2021 revealed: Residents Rights Residents of Texas nursing facilities have all the rights, benefits, responsibilities, and privileges granted by the Constitution and laws of this state and the United States. They have the right to be free of interference, coercion, discrimination, and reprisal in exercising these rights as citizens of the United States. Dignity and Respect You have a right to be treated with dignity, courtesy, consideration, and respect.

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F 0600 Level of Harm - Actual harm 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** 50360 Based on observation, interview, and record review, the facility failed to ensure the resident had the right to be free from physical abuse for 1 of 7 residents (Resident #4) reviewed for abuse. CNA A awakened Resident #4 abruptly, was rude and rough with her. The resident stated CNA A dug the comb in her scalp while combing her hair. Resident #4 was crying, shaking, and stated she did not feel safe. The non-compliance was identified as PNC. The noncompliance began on 12/03/2024 and ended on 12/5/2024. The facility had corrected the non-compliance before the investigation began. This failure placed residents at risk of fear and physical/psychosocial injury. Findings included: Review of the Face Sheet for Resident #4 dated 12/03/2024 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease (a brain disorder that causes a gradual decline in memory, thinking, and reasoning skills) and Need for Assistance with Personal Care. Review of the MDS assessment for Resident #4 dated 11/26/2024 reflected . Resident #4 required assistance in all activities of daily living. Review of the Care Plan for Resident #4 revised 01/22/2024 reflected the following: (Resident #4) has an ADL Self Care Performance (Bed Mobility, Transfers, Eating, Bathing, Dressing, and Personal Hygiene) Deficits r/t: Activity Intolerance, Disease Process (Post-Polio Syndrome), Depression, Fatigue, Impaired balance. The resident will maintain current level of function in Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene over next 90 days. Locomotion on and off unit: Resident needs assist of 1 staff to transfer with assist of gait belt. Resident utilizes a wheelchair as adaptive device for mobility and require assist of 1 staff for mobility on and off unit. Resident is able to wheel self. Transfer: the resident is limited assistance for transfers. Provide 2 person for transfer. Encourage and remind resident to hold onto handles during transfer. Provide reassurance as needed. Observe extremities and devices during transfer and position for comfort. Ensure wheelchair is available to facilitate transfers. Personal Hygiene: the resident is limited assistance with personal hygiene. Ensure that hygiene items are available for use. Offer resident hygiene items and provide reminders, verbal cues and encouragement as needed. Do not rush, allow resident time to complete task. Provide assistance as needed to complete tasks. Check nail length and trim and clean per facility guidelines and as necessary. Report any changes to the nurse. Prior to trimming nail verify with Nurse for contraindications. Dressing: The resident requires limited assistance with dressing. Encourage and allow resident to choose weather appropriate clothing, non-slip/skid shoes/socks of choice. Provide encouragement, verbal cues and simple 1-2 step instruction as needed. Provide assistance with buttons, zippers, tying shoes etc. to compete tasks. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of the facility investigation report on 12/18/2024 reflected the following event: The administrator was notified by the DON on 12/3/2024 Resident #4 made an allegation of abuse against CNA A. Resident #4 informed CNA B and DON that CNA A grabbed her roughly out of bed and yanked and pulled her hair while combing it. At that time, continuous monitoring of the resident was implemented by CNA B. Record Review of the Facility Investigation and Follow Up Report and confirmed in interview with the Administrator immediate action to ensure the safety of the resident was implemented. The following observations, assessments, and interventions occurred on 12/3/24: CNA B observed Resident #4 crying and reporting abuse by CNA A. CNA B began continuous monitoring of Resident #4. The DON was notified, and she notified the Administrator that Resident #4 made an allegation of abuse against CNA A. The DON assessed Resident #4 for signs of trauma to the scalp or body. The assessment was reflected in the Record review of the documentation of the Facility Investigation, record review of the progress note submitted by the DON and confirmed per interview with the DON. There was no evidence of injury. The Administrator implemented an investigation beginning with an interview of Resident #4. Next, the Administrator interviewed CNA A and asked her to write a statement regarding the incident. Record review of the statement demonstrated that the resident was upset about getting hair combed and did not want to get up like ever morning. There was no admission/denial of abuse to the resident. Interview with the Administrator confirmed CNA A denied the allegation and responded by stating what else do you want me to write? when invited to add to her statement. The Administrator suspended CNA A immediately. The Administrator then administered the facility Resident Abuse/Neglect Questionnaire to Resident #4. Record review of the Questionnaire demonstrated that Resident #4 understood what it meant to be abused or neglected, a statement that this was the first time Resident #4 had been abused or neglected by a staff member, Resident #4 stated she would notify the Head Nurse if feeling she had been abused or neglected, and that she had nothing else she wanted to share. Per Record Review of the Facility Investigation report and confirmed by interview with the Administrator Safety Rounds were immediately implemented. Confirmed per Record review of the safety rounds and Administrator interview, all other residents assessed denied having been mistreated or harmed by any staff. Following this, the Administrator interviewed staff present to include the DON, other CNA's and the Social Worker. After the interviews were completed, the Administrator notified the Chief of Operations and Clinical Director. The DON notified the resident's responsible party and the physician. Inservice training on the following was implemented: Abuse Policy, Resident Rights, Code of Conduct/Code of Ethics, Standard of Conduct, and suspected Abuse Checklist. The Administrator performed safety rounds on residents who also resided on the same hallway where CNA A was assigned. The Social Worker performed an assessment to assess for negative emotional outcomes. She also notified the Resident's Representative of the event and notified him that CNA A will no longer be employed at the facility. On 12/5/2024, CNA A was terminated. (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 - Actual harm Residents Affected - Few	Record review of the facility policy, Prevention and Reporting of Suspected Resident Abuse and Neglect stated Upon identification of suspected abuse and/or neglect, provide for the immediate safety of the resident. Means of providing protection may include but are not limited to: moving resident to another room or unit; provide one-on-one monitoring as appropriate; suspend suspected employee(s) pending outcome of the investigation. Based on record review of the facility investigation and confirmed in an interview with the Administrator, upon receiving notification of the allegation, the Administrator suspended CNA A. Record review of CNA A personnel file demonstrates documentation of the suspension dated 12/03/2024. The facility policy, 'Prevention and Reporting of suspected Resident Abuse and Neglect stated Investigation of all alleged violations will be done under the direction of the DON and/or Administrator. Record review of the documentation of the facility investigation and confirmed during interview with the Administrator, an investigation was initiated immediately after the report was received. The investigation was completed on 12/03/2024. Record review of staff training records demonstrated the staff were inserviced on the Abuse Policy, Resident Rights, Code of Conduct/Code of Ethics, Standard of Conduct, Suspected Abuse/Neglect Checklist was completed on 12/03/2024. Record review of CNA A employee file contained documentation of termination dated 12/05/2024. This was confirmed in interview with Administrator. Record Review of Psychological Services progress note dated 12/04/2024 at 12:12pm revealed that Resident #4 did not express any particular complaints or ongoing concerns about the issue. A telephone interview was conducted on 12/18/2024 11:07AM with Resident #4's family member. The family member confirmed that he was notified of the event and the actions taken afterward. The family member stated he believed the incident was handled appropriately and Resident #4 was well taken care of. Resident #4 was observed in the Dining Room on 12/18/2024 11:12AM. Resident #4 was clean and dressed in clothing appropriate to the situation. Resident #4 did not have any signs of fear or abuse. In an interview of Resident #4 she stated she did not remember anyone ever being rough with her. A phone interview was conducted with CNA B 12/18/2024 at 3:53pm. She stated that she went into Resident #4's room to take her tray and noticed Resident #4 was crying and jumpy. CNA B stated that Resident #4 told her she was treated badly by another staff member. CNA B stated that she went and got the DON and went back to Resident #4's room. CNA B heard Resident #4 tell the DON that she was afraid to be left alone. Record Review of the DON's statement for the Facility Investigation report and confirmed per interview with the DON revealed Resident #4 was trembling and stated please don't hurt me. Additionally, Resident #4 reported the CNA A pulled her hair and shoved and jerked her out of the bed. CNA B stated she heard from other residents that they do not receive abuse from CNA A; however, they state that sometimes she does not get them to the shower when they ask. A phone interview was conducted with CNA D 12/18/2024 at 3:58 PM. CNA D stated she walked to Resident #4's room to pick up a tray, but the door was closed. CNA D opened the door and noticed CNA B was present. CNA D stated Resident #4 was hysterical and kept asking why she did this to me. CNA D stated Resident #4 said that she was pushed in the restroom forcefully and that her hair was combed roughly by the other lady. CNA D stated she sat with Resident #4 for a while, until she calmed down. CNA D confirmed record review of inservice documentation of inservice training received on Abuse and Neglect. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview with LVN F was conducted at 12/18/2024 4:30 PM . LVN F verbally confirmed she received training regarding Abuse Policy, Resident Rights, code of Conduct/Code of Ethics, Standards of Conduct, and Education on Suspected Abuse and Neglect Checklist on 12/3/2024 as documented on the Inservice Sheet for that date. Interview with LVN G was conducted at 12/18/2024 4:40 PM. LVN G verbally confirmed she received training regarding Abuse Policy, Resident Rights, code of Conduct/Code of Ethics, Standards of Conduct, and Education on Suspected Abuse and Neglect Checklist on 12/3/2024 as documented on the Inservice Sheet for that date. Record Review of in-service for 12/03/2024 revealed training on Abuse Policy, Resident Rights, Code of Conduct/Code of Ethics, Standards of Conduct, and Education on Suspected Abuse and Neglect Checklist received by direct care staff, housekeeping, dietary, and nonclinical staff . There were a total of 41 signatures on the inservice record. Review of personnel file for CNA A, reflected required background checks, and orientation/training on abuse/neglect/exploitation, resident rights, and dementia care. Observed 2 different individual in-services dated 4/19/24 and 7/11/24 for Standard of Conduct, Code of Ethics, Patient Care, Resident rights. The file also contained the Verbal Warning disciplinary notice of suspension dated 12/03/2024 and the Termination Notice dated 12/05/2024. Review of facility policy titled Prevention and Reporting of Suspected Resident Abuse and Neglect on 12/18/2024 11:07 AM reflected the following: this facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect. This facility has implemented the follow processes in an effort to provide resident and staff a comfortable and safe environment. The administrator and Director of Nursing are responsible for the implementation and ongoing monitoring of abuse policies and procedures. Implementation and ongoing monitoring consist of the following policies: Screening, Training, Prevention, Identification, Protection, Investigation and Reporting.