STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675958	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Care Center	1008 Citizens Trail Texarkana, TX 75501

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 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** 45643 Based on interview and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 (Resident #1) of 7 residents reviewed for abuse and/or neglect. The facility failed to prevent CNA A from physically and verbally abusing Resident #1 when she intentionally shoved and used derogatory language towards Resident # 1. The noncompliance was identified as PNC. The IJ noncompliance began on 10/7/23 and ended on 10/8/23. The facility had corrected the noncompliance before the investigation began. This failure could place residents at risk of abuse and neglect. Findings included: Record review of Resident #1's face sheet, dated 07/17/2024, indicated she was admitted to the facility on [DATE] with diagnoses including, Hypertension (A condition in which the force of the blood against the artery walls is too high), Gastro-esophageal reflux disease without esophagitis (a common condition in which the stomach contents move up into the esophagus and inflammation of the esophagus), Gastrostomy infection (a surgical operation for making an opening in the stomach). Record review of Resident #1's Quarterly MDS assessment, dated 10/16/23, reflected Resident #1 usually made herself understood and usually understood others. Resident #1 had severe cognitive impairment with a (BIMS score of 0. Resident #1 had no physical or verbal behaviors symptoms directed towards herself or others. Resident #1 had no behavior of rejecting care. Resident #1 was dependent on staff for all activities of daily living and was always incontinent of bowel and bladder. Record review of Resident #1's care plan dated 4/24/24, reflected Resident #1 was incontinent of bowel and bladder. Staff were to provide incontinent care after each episode. The care plan reflected that Resident #1 was totally dependent on staff for all of her activities of daily living. Record review of the facility's provider investigation report dated 10/8/23, reflected CNA B reported she witnessed CNA A shove (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Resident # 1, tell Resident #1 to, Turn your ass over, don't touch me you be playing in your pussy, and shut the hell up. It was indicated that the police were notified. Record review of CNA A's signed statement, dated 10/8/2023, reflected, I CNA A was taking to the nurse and She was saying that milk was every were in Resident #1 and her roommate She ask who got them I said another CNA had them I was looking for them could not fine them so I got CNA B to help clean them up when I come out I said them to fat motherfucker got them so by ther another CNA and who are you taking to I did not say not me and another CNA going back and for and I told another CNA did you here me call any by name out she no but we the only to white girl her I apologize if they thank I was toke to them.(Sic) Record review of CNA B's signed statement, dated 10/9/23, reflected I CNA B is stating that on 10/7/2023 at approximately 9:45 p.m I witness CNA A actually go in to Resident #1's room and went to the left side of the bed while I was standing on the right side of the bed CNA A actually pushed Resident #1 and told her to turn her ass over as CNA A begin to clean Resident # 1 she reached out to touch CNA A she made a statement don't touch me you be playing in your pussy Resident #1 moaned and CNA A told Resident # 1 to shut the hell up. During an interview on 7/16/24 at 10:35 a.m., Resident #1 said she did not remember someone by the name of CNA A. She said that no one has been mean to her. She said that she cannot remember if anyone had harmed her or said disrespectful words to her. She said she cannot say if anyone has hurt her feeling here. During an interview on 7/16/24 at 11:15 p.m., with the DON she said CNA A came back after the incident and gave a statement, but it had nothing to do with the actual incident. She said CNA A would not talk about the allegations CNA B made. She said the former ADM was in charge during this incident and the current ADM is only acting ADM until one is hired. She said CNA A was terminated as it was confirmed this incident took place. She said CNA B notified her on 10/8/2023 at 1:15 p.m. that on 10/7/2023 at 9:50 p.m. she witnessed CNA A shove and use verbally abusive language to Resident # 1 . She said that she was the first person that the incident was reported to. During an interview on 7/16/24 at 1:34 p.m. with CNA B she said that she remembered the incident with Resident #1 and CNA A. She said she witnessed CNA A shove Resident # 1 hard when turning her over to do peri care. She said she heard CNA A tell Resident # 1 to turn her ass over. She said then Resident # 1 touched CNA A and she told Resident # 1 to not touch her because she plays with her pussy. She said she heard CNA A then tell Resident # 1 to shut the hell up after Resident # 1 made a groaning noise. She said she reported this incident to the DON. During an attempted interview on 7/16/2024 at 2:50 p.m. CNA A was contacted via telephone. A voicemail was not left as the number was disconnected. During an interview on 7/16/2024 at 3:02 p.m., LVN C said that any type of abuse was to be reported immediately to the abuse coordinator, charge nurse, or DON. She said that she has been in-serviced on this topic as well as their abuse policy multiple times including immediately after the incident with Resident #1. She said she would also need to ensure the resident that was allegedly abused was safe after the allegation and remove the alleged perpetrator for access to any resident. (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 7/16/2024 at 3:04 p.m., CNA D said if a resident made an allegation that they were abused then she would need to ensure the resident was safe, report to the abuse coordinator and any other management that was working, keep the resident safe, and prevent the person who allegedly did the abuse away from other residents. She said she has been in-serviced on all these principals multiple times. During an interview on 7/16/2024 at 3:07 p.m., LVN E said that she has been in-services on the facility abuse policy several times. She said that if an allegation of abuse is made, they are to immediately report the allegation to the abuse coordinator. She said she can also report to the charge nurse and the DON as well as call the abuse coordinator. She said that she would also need to ensure that the person who did the abuse did not have access to any resident and have them leave the building. During an interview on 7/16/2024 at 3:09 p.m., LVN F said that the abuse coordinator should be notified immediately after an allegation of abuse is made. She said that she can tell the abuse coordinator in person or call them. She said that she can also tell other management of an allegation of abuse. She said that she has been trained in this topic multiple times. She said the abuse policy is a topic that is trained frequently. She said that when abuse allegedly occurs she would also need to ensure that the resident and other residents are kept safe from the person who allegedly did the abuse. During an interview on 7/16/2024 at 3:20 p.m., with the former ADM he said he vaguely remembers this incident. He said he immediately suspended CNA A on 10/8/2023 before she came back to work. He said he then investigated the incident. He said he doesn't recall any type of statement from CNA A other than what is in the PIR. He said he doesn't recall the resident needing any counseling or showing any type of emotional response to the incident. He said he doesn't remember what time this was reported by CNA B but it will be located on the PIR. He said these were typically reported immediately to himself or the DON. He said he does not recall when he got the self-report for this incident. During an interview on 7/17/24 at 12:53 p.m., the Administrator said CNA A was immediately upon learning of the incident on 10/8/2024 at 1:15 p.m. suspended pending the investigation results. He said CNA A was terminated when it was determined that the allegations made against CNA A were true. He said that all staff were in-serviced over abuse, neglect and exploitation. The Administrator said abuse of residents would not be tolerated at the facility. Record review of a facility in-service dated 10/8/2023 revealed that CNA B was in-services for the facilities abuse policy. Abuse policy educates staff on identifying abuse and neglect as well as timeframes associated with reporting abuse and neglect to the State Agency. Record review of CNA A's personnel file on 07/17/24 indicated hire date of 9/5/23. The facility had performed background check and employee misconduct search. No concerns were identified. Record review of CNA A's Employee Disciplinary Report, dated 10/10/23, indicated she was terminated on 10/10/2023 for misconduct regarding allegations of Abuse and was not eligible for rehire. The administrator was notified of IJ PNC on 07/16/2024 at 5:16 p.m. due to the above failures. The administrator was provided with the IJ template on 07/16/2024 at 5:17 p.m. (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	The noncompliance was identified as PNC. The IJ noncompliance began on 10/7/23 and ended on 10/8/23 . The facility had corrected the noncompliance before the investigation began. The surveyor confirmed the following actions had been implemented sufficiently to remove the immediacy by: Facility notification of abuse incident to responsible party, MD, Ombudsman and HHSC on 10/8/2023. Completion of in-services on abuse. Abuse policy educates staff on identifying abuse and neglect as well as timeframes associated with reporting abuse and neglect to the State Agency. Termination of confirmed perpetrator on 10/10/2023. Residents of facility interviewed did not indicate that they had been abused and were safe. Safe surveys were conducted with residents and no resident reported feeling unsafe. Record review of the facility's policy and procedure dated January 10th, 2017, titled Abuse/Reportable Events All residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents should not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants, or volunteers, staff of other agencies serving the resident, family members or legal guardians . Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish . Mental Abuse: Includes, but is not limited to, humiliation, harassment, threats of punishment and deprivation.

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643 Based on interview and record review the facility failed to implement written policies and procedures that prohibit and prevent abuse of residents for 1 of 7 Residents (Resident #1) whose records were reviewed for abuse. CNA B failed to report an allegation of resident abuse within 2 hours after learning about the allegation per facility policy. The facility failed to conduct a thorough investigation when the DON completed only 4 safe surveys and did not interview the resident. The facility failed to prevent CNA A from physically and verbally abusing Resident #1 when she intentionally shoved and used derogatory language towards Resident # 1. The noncompliance was identified as PNC. The IJ noncompliance began on 10/7/23 and ended on 10/8/23. The facility had corrected the noncompliance before the investigation began. This deficient practice could affect any resident and contribute to further resident abuse. The findings were: Record review of the facility's policy and procedure dated January 10th, 2017, titled Abuse/Reportable Events All residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents should not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants, or volunteers, staff of other agencies serving the resident, family members or legal guardians . Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish . Mental Abuse: Includes, but is not limited to, humiliation, harassment, threats of punishment and deprivation . Reporting: Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report the allegation to HHSC. If the allegations involve abuse or result in serious bodily Injury, the report Is to be made within 2 hours of the allegation. Record review of Resident #1's face sheet, dated 07/17/2024, indicated she was admitted to the facility on [DATE] with diagnoses including, Hypertension (A condition in which the force of the blood against the artery walls is too high), Gastro-esophageal reflux disease without esophagitis (a common condition in which the stomach contents move up into the esophagus), Gastrostomy infection (a surgical operation for making an opening in the stomach). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the Resident #1's Quarterly MDS assessment, dated 10/16/23, reflected Resident #1 usually made herself understood and usually understood others. Resident #1 had severe cognitive impairment with a BIMS score of 0. Resident #1 had no physical or verbal behaviors symptoms directed towards herself or others. Resident #1 had no behavior of rejecting care. Resident #1 was dependent on staff for all activities of daily living and was always incontinent of bowel and bladder. Record review of Resident #1's care plan dated 4/24/24, reflected Resident #1 was incontinent of bowel and bladder. Staff were to provide incontinent care after each episode. The care plan reflected that Resident #1 was totally dependent on staff for all of her activities of daily living. Record review of the facility's provider investigation report dated 10/8/23, reflected CNA B reported she witnessed CNA A shove Resident # 1, tell Resident #1 to, Turn your ass over, don't touch me you be playing in your pussy, and shut the hell up. It was indicated that the police were notified. Record review of CNA B's signed statement, dated 10/9/23, reflected I CNA B is stating that on 10/7/2023 at approximately 9:45 p.m., I witness CNA A actually go in to Resident #1's room and went to the left side of the bed while I was standing on the right side of the bed CNA A actually pushed Resident #1 and told her to turn her ass over as CNA A begin to clean Resident # 1 she reached out to touch CNA A she made a statement don't touch me you be playing in your pussy Resident #1 moaned and CNA A told Resident # 1 to shut the hell up Record review of CNA A's signed statement, dated 10/8/2023, reflected, I CNA A was taking to the nurse and She was saying that milk was every were in Resident #1 and her roomate She ask who got them I said another CNA had them I was looking for them could not fine them so I got CNA B to help clean them up when I come out I said them to fat motherfucker got them so by ther another CNA and who are you taking to I did not say not me and another CNA going back and for and I told another CNA did you here me call any by name out she no but we the only to white girl her I apologize if they thank I was toke to them.(Sic) During an interview on 7/16/24 at 10:35 a.m., Resident #1 said she did not remember someone by the name of CNA A. She said that no one has been mean to her. She said that she cannot remember if anyone had harmed her or said disrespectful words to her. She said she cannot say if anyone has hurt her feeling here. During an interview on 7/16/24 at 11:15 p.m., with the DON she said CNA A came back after the incident and gave a statement, but it had nothing to do with the actual incident. She said CNA A would not talk about the allegations CNA B made. She said the former ADM was in charge during this incident and the current ADM is only acting ADM until one is hired. She said CNA A was terminated as it was confirmed this incident took place. She said CNA B notified her on 10/8/2023 at 1:15 p.m. that on 10/7/2023 at 9:50 p.m. she witnessed CNA A shove and use verbally abusive language to Resident # 1. She said that she was the first person that the incident was reported to. During an interview on 7/16/24 at 1:34 p.m. with CNA B she said that she remembered the incident with Resident #1 and CNA A. She said she witnessed CNA A shove Resident # 1 hard when turning her over to do peri care. She said she heard CNA A tell Resident # 1 to turn her ass over. She said then Resident # 1 touched CNA A and she told Resident # 1 to not touch her because she plays with her pussy. She said she heard CNA A then tell Resident # 1 to shut the hell up after Resident # 1 made a groaning noise. She said she reported this incident to the DON. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 7/16/2024 at 2:41 p.m., with the DON she said that all safe surveys were completed during the investigation of the allegations. She said that the safe surveys were also called psychosocial assessments. She said she was the first person the incident was reported to. She said that she thought 4 safe surveys was sufficient to determine if facility residents felt safe. She said that Resident # 1 was not interviewed after the incident, and she did not receive a safe survey. During an interview on 7/16/2024 at 3:02 p.m., LVN C said that any type of abuse was to be reported immediately to the abuse coordinator, charge nurse, or DON. She said that she has been in-serviced on this topic as well as their abuse policy multiple times including immediately after the incident with Resident #1. She said she would also need to ensure the resident that was allegedly abused was safe after the allegation and remove the alleged perpetrator for access to any resident. During an interview on 7/16/2024 at 3:04 p.m., CNA D said if a resident made an allegation that they were abused then she would need to ensure the resident was safe, report to the abuse coordinator and any other management that was working, keep the resident safe, and prevent the person who allegedly did the abuse away from other residents. She said she has been in-serviced on all these principals multiple times. During an interview on 7/16/2024 at 3:07 p.m., LVN E said that she has been in-services on the facility abuse policy several times. She said that if an allegation of abuse is made, they are to immediately report the allegation to the abuse coordinator. She said she can also report to the charge nurse and the DON as well as call the abuse coordinator. She said that she would also need to ensure that the person who did the abuse did not have access to any resident and have them leave the building. During an interview on 7/16/2024 at 3:09 p.m., LVN F said that the abuse coordinator should be notified immediately after an allegation of abuse is made. She said that she can tell the abuse coordinator in person or call them. She said that she can also tell other management of an allegation of abuse. She said that she has been trained in this topic multiple times. She said the abuse policy is a topic that is trained frequently. She said that when abuse allegedly occurs she would also need to ensure that the resident and other residents are kept safe from the person who allegedly did the abuse. During an interview on 7/16/2024 at 3:20 p.m., with the former ADM he said he vaguely remembers this incident. He said he immediately suspended CNA A on 10/8/2023 before she came back to work. He said he then investigated the incident. He said he doesn't recall any type of statement from CNA A other than what is in the PIR. He said he doesn't recall the resident needing any counseling or showing any type of emotional response to the incident. He said he doesn't remember what time this was reported by CNA B but it will be located on the PIR. He said these were typically reported immediately to himself or the DON. He said he does not recall when he got the self-report for this incident. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 7/16/24 at 4:26 p.m., with the Administrator, he said that he was the acting Administrator until a new Administrator was hired. He said if he became aware of abuse, he would be required to report it within two hours to the state. He said that as soon as he found out there was an alleged perpetrator, he would suspend the alleged perpetrator and remove their access to residents. He said when he is called, he will ask the person who called him to ensure that the resident was safe, what they were currently doing to ensure the safety of the resident and he will then give guidance if additional measures were needed. He said if it was necessary, he would then call the police. He said that he would then ensure there was an assessment completed for the resident to identify any potential issues. He said if the resident can speak, they would be interviewed and safe surveys would be completed, he would talk to family, talk to the physician, and police if necessary. He said if the resident could not tell what occurred, they would then rely on safe surveys and witness statements. He said that the number of residents that they have complete safe surveys depend on what happened, and the residents would be picked at random. During an interview on 7/17/24 at 12:53 p.m., the Administrator said CNA A was immediately suspended pending the investigation results. He said CNA A was terminated when it was determined that the allegations made against CNA A were true. He said that all staff were in-serviced over abuse, neglect and exploitation. The Administrator said abuse of residents would not be tolerated at the facility. He said that all allegations of abuse are reported within two hours after the incident occurred. Record review of CNA A's personnel file on 07/17/24 indicated hire date of 9/5/23. The facility had performed background check and employee misconduct search. No concerns were identified. Record review of CNA A's Employee Disciplinary Report, dated 10/10/23, indicated she was terminated for misconduct regarding allegations of Abuse and was not eligible for rehire. The administrator was notified of IJ PNC on 07/16/2024 at 5:16 p.m. due to the above failures. The administrator was provided with the IJ template on 07/16/2024 at 5:17 p.m. The surveyor confirmed the following actions had been implemented sufficiently to remove the immediacy by: facility notification of abuse incident to responsible party, MD, Ombudsman and HHSC. Completion of in-services on abuse on 10/8/2023. Abuse policy educates staff on identifying abuse and neglect as well as timeframes associated with reporting abuse and neglect to the State Agency. Staff and management recognizing the steps to report abuse and neglect. ADM and DON being able to articulate the steps of an investigation on 7/17/2024. Termination of confirmed perpetrator. The noncompliance was identified as PNC. The IJ noncompliance began on 10/7/23 and ended on 10/8/23. The facility had corrected the noncompliance before the investigation began.