

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675998	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Legacy at Town Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 2212 W Reagan St Palestine, TX 75801	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273</p> <p>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 7 of 10 residents (Residents #1, #4, #3, #9, #6, #7 and #10) reviewed for abuse and neglect.</p> <p>1. The facility failed to protect Resident #1 from abuse from Resident #2, Resident #3, Resident #4, Resident #6, and Resident #10 between 5/8/23-1/11/24. on 1/11/24 Resident #6 slapped Resident #1 on his helmet. on 11/13/23 Resident #3 grabbed Resident #1's arm causing 2 skin tears. On 10/29/23 Resident #1 was in the lobby hollering and Resident #2 went over and flipped Resident #1 out of his wheelchair causing him to fall on the floor. On 10/29/23 Resident #3 grabbed Resident #1's right arm causing skin tears to right arm. On 9/29/23 Resident #1 sitting in recliner yelling and Resident #2 went over to Resident #1 and hit him in the mouth causing his lip to bust open. on 9/19/23 Resident #1 hit Resident #10 and Resident #10 hit Resident #1 back causing a skin tear to the right forearm. on 9/4/23 Resident #3 scratched the left side of Resident #1's chin leaving 3 scratches. On 9/3/23 Resident #2 flipped Res #1 out of his wheelchair on to the floor. On 8/20/23 Resident #2 walked over to Resident #1 and slapped him in the face. on 7/21/23 with Res #1 and Res #3. Res #3 scratched Res #1 on his right lower arm. On 7/20/23 Resident #2 walked over to Resident #1 and hit him on the left cheek and chin causing redness. On 7/10/23 Resident #3 pinched and scratched Resident #1 on the right side of his neck. On 7/8/23 Resident #2 lunged over to Resident #1 and put his hands around Res #1's neck. On 7/4/23 Resident #3 scratched Resident #1 with multiple skin tears and scratches to the face, neck, right finger, and left forearm. On 6/23/23 Resident #1 pinched Resident #3, Resident #1 also received a skin tear. On 6/5/23 Resident #4 grabbed Resident #1's arm. On 5/8/23 Resident #3 scratched Resident #1's left hand.</p> <p>2. The facility failed to protect Resident #4 from abuse from Resident #1, and Resident #3 between 7/25/23-3/8/24. On 7/25/23 Resident #1 grabbed Resident #4's right wrist and lower arm. On 3/8/24 Resident #3 grabbed Resident #4 by the wrist causing a skin tear to the left wrist.</p> <p>3. The facility failed to protect Resident #3 from abuse from Resident #1 and Resident #8 between 6/23/23-5/1/24. On 6/23/23 Resident #1 pinched Resident #3, Resident #1 also received a skin tear. on 5/1/24 Resident #8 hit Resident #3 with a dinner plate causing a split between lip and nose.</p> <p>4. The facility failed to protect Resident #9 from abuse from Resident #6 on 5/22/24 Resident #6 pulled Res #9's hair and pushed her down onto the floor.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>5. The facility failed to protect Resident #6 from abuse from Resident #5 on 3/12/24. on 3/12/24 Resident #5 grabbed Resident #6 by the elbow causing a bruise.</p> <p>6. The facility failed to protect Resident #7 from abuse from Resident #3 on 3/21/24 Resident #3 grabbed Resident #7 causing a skin tear to right forearm.</p> <p>7. The facility failed to protect Resident #10 from abuse from Resident #1 on 9/19/23. on 9/19/23 Resident #1 hit Resident #10 and Resident #10 hit Resident #1 back causing a skin tear to the right forearm.</p> <p>8. The facility failed to keep residents safe following resident to resident altercations to prevent further harm.</p> <p>An Immediate Jeopardy (IJ) situation was identified on 06/05/2024 at 2:52 PM While the IJ was removed on 06/06/2024 at 05:05 PM, the facility remained out of compliance at a scope of a pattern and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of their corrective systems.</p> <p>These failures could place residents at risk for severe negative psychosocial outcomes which could prevent them from achieving their highest practicable physical, mental, and psychosocial well-being.</p> <p>Findings include:</p> <p>1. Record review of Resident #1's electronic face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included Dementia with other behavioral disturbance (problem in the brain affecting memory), schizoaffective disorder (hallucinations and mood symptoms), and sarcopenia (musculoskeletal disease in which muscle mass, strength, and performance are significantly compromised with age).</p> <p>Record review of Resident #1's quarterly MDS assessment, dated 05/27/2024, reflected a BIMS score of 03, which indicated the resident's cognition was severely impaired. Resident #1's thinking was continuously disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject).</p> <p>Record review of Resident #1's care plan, dated 4/21/2023, reflected he had the potential to be physically and verbally aggressive related to dementia and schizoaffective disorder with interventions that included: 5. Monitor/document/report as needed and signs or symptoms of resident posing danger to self and others. 6. Psychiatric/Psychogeriatric consult as indicated. Resident #1 had impaired cognitive function/dementia or impaired thought processes related to Alzheimer's dementia (disease that destroys memory and other important mental functions) with interventions that included: 3. Cue, reorient and supervise as needed. Resident #1 used psychotropic medications related to schizoaffective disorder with interventions that included: 3 .Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy.</p> <p>Record review of Resident #1's care plan dated 4/21/2023 indicated Resident #1 had the potential to be physically and verbally aggressive related to dementia and schizoaffective disorder. No new interventions were added to the care plan following aggressive incidents on 6/23/2023 and 9/19/2023.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of an incident report, dated 1/11/2024, reflected Resident #1 .was in the dining room hollering out repeatedly and another resident slapped him on his helmet.</p> <p>Record review of incident report, dated 11/13/2023, reflected Resident #1 .was in bed in his room and hollered out. Another resident wandered into his room and grabbed his arm causing him to get 2 skin tears on his left forearm.</p> <p>Record review of incident report, dated 10/29/2023, reflected Resident #1 .was in dining room at table yelling out. Another resident got frustrated with him hollering and grabbed his right arm causing skin tears.</p> <p>Record review of incident report, dated 10/29/2023, reflected Resident #1 was .in the lobby and was hollering out randomly .when another resident came over and flipped his wheelchair with him in it before staff could intervene.</p> <p>Record review of incident report, dated 9/29/2023, reflected Resident #1 was .sitting in recliner yelling, before staff could intervene another resident approached him and hit him in the mouth, busting his lip open</p> <p>Record review of incident report, dated 9/19/2023, reflected Resident #1 .hit another resident and the other resident hit him back and he received a skin tear to right forearm</p> <p>Record review of incident report, dated 9/04/2023, reflected Resident #1 .was yelling. Another resident went up to him and scratched left side of chin leaving 3 marks</p> <p>Record review of incident report, dated 9/03/2023, reflected Resident #1 was in a wheelchair .outside of dining room and another resident got mad at him because he was yelling out and dumped him out on the floor and the wheelchair fell on top of him.</p> <p>Record review of incident report, dated 8/20/2023, reflected Resident #1 .was sitting at dining room table and another resident walked up and he stated, 'What are you going to do about it?' and the other resident slapped him in the face.</p> <p>Record review of incident report, dated 7/25/2023, reflected Resident #1 .grabbed another resident by her right wrist/lower arm. Residents immediately separated</p> <p>Record review of incident report, dated 7/21/2023, reflected Resident #1 .heard yelling and found Resident #3 near resident scratching him. Residents immediately separated. Scratches noted to right lower arm</p> <p>Record review of incident report, dated 7/20/2023, reflected Resident #1 was sitting in a recliner and with Resident #2 standing over him. Resident #1 said Resident #2 hit him on the left side of chin and cheek with slight redness observed.</p> <p>Record review of incident report, dated 7/10/2023, reflected Resident #1 .was having verbal outbursts and another resident rolled up to him and pinched and scratched resident near the right side of his neck.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of incident report, dated 7/08/2023, reflected Resident #1 .was walking by another resident who was having verbal outbursts. The resident called out you son of a bitch and he lunged towards resident and put his hand around his neck, residents were immediately separated.</p> <p>Record review of incident report, dated 7/04/2023, reflected Resident #1 .was yelling out loudly. Another resident rolled up to him and she began scratching and grabbing at him .staff was unable to get to the residents in time before contact was made. Resident received multiple skin tears and scratches.</p> <p>Record review of incident report, dated 6/23/2023, reflected Resident #1 .reached out and pinched another resident while the resident was wheeling past him to go to dining room.</p> <p>Record review of incident report, dated 6/05/2023, reflected Resident #1 .was dozing in quiet area when his arm was grabbed by a fell ow resident.</p> <p>Record review of incident report, dated 5/08/2023, reflected Resident #1 .was heard yelling no you get out of the way, when staff intervened resident was noted with scratch to left hand 3.0 x 1.0, both residents were separated and assessed</p> <p>During an observation and interview on 6/03/2024 at 2:35 PM, Resident #1 was observed sitting up in wheelchair in common area in secured unit. Resident #1 was sitting at a table with 2 other residents with two building blocks on the table. Staff brought activities to the table after the State Surveyor started to interview Resident #1. Resident #1 said when asked if anyone had ever hurt him, yes. Resident #1 was alert and did not answer questions appropriately due to cognition. Resident #1 had a soft helmet in place to the top of his head with no injuries noted.</p> <p>2. Record review of Resident #2's electronic face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included Dementia with other behavioral disturbance (problem in the brain affecting memory), bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), Alzheimer's disease (disease involves parts of the brain that control thought, memory, and language), and anxiety disorder (feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).</p> <p>Record review of Resident #2's quarterly MDS assessment, dated 05/03/2024, reflected a BIMS score was not able to be obtained. Staff assessment for mental status reflected Resident #2 had short- and long-term memory problem. Resident #2's thinking was continuously disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #2's care plan, dated 7/11/2023, reflected he had potential to be physically aggressive related to bipolar disorder and dementia with actual physical aggression on 7/20/2023, 8/20/2023, 9/03/2023, 9/29/2023, 10/29/2023, 11/02/2023, 1/30/2024, 4/10/2024, 5/25/2024. Interventions: The resident's triggers for physical aggression are (the yelling out loud noises) resident's behaviors is de-escalated by (providing quiet environment redirecting attention removing from situation). Order to send to behavioral facility to evaluate and treat. Psychiatric/psychogeriatric consult as indicated. Request labs and do assessment to rule out medical reason for aggressive behaviors. When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later when possible. The resident had impaired cognitive function/dementia or impaired thought processes related to Alzheimer's with interventions that included: Cue, reorient and supervise as needed. Discuss concerns about confusion, disease process, and nursing home placement with resident/family/caregivers.</p> <p>Record review of Resident #2's care plan dated 7/11/2023 indicated Resident #2 had the potential to be physically and verbally aggressive related to dementia and bipolar disorder. No new interventions were added to the care plan following aggressive incidents on 8/20/2023, 10/29/2023, 1/30/2024, and 5/25/2024.</p> <p>Record review of incident report, dated 10/29/2023, reflected Resident #2 .came into living area and flipped another resident's wheelchair on its side before staff could intervene.</p> <p>Record review of incident report, dated 9/29/2023, indicated another resident sitting up in recliner in lounge area close to the dining room yelling when [Resident #2] approached him and hit him in the mouth</p> <p>Record review of incident report, dated 9/03/2023, reflected Resident #2 .got angry at another resident due to him yelling. He then tipped wheelchair over making resident fall into floor and wheelchair went on top of resident</p> <p>Record review of incident report, dated 8/20/2023, reflected Resident #2 .was walking by another resident who was sitting in his wheelchair at table eating. Resident stated, 'what are you going to do about it?' and resident then slapped the other resident in the face on the left cheek.</p> <p>Record review of incident report, dated 7/20/2023, reflected Resident #2 was standing over Resident #1. Resident #1 said Resident #2 hit him on the left chin and cheek with slight redness noted.</p> <p>Record review of incident report, dated 7/08/2023, reflected Resident #2 .was walking by another resident who was having verbal outbursts. The resident called out you son of a bitch and he lunged towards resident and put his hand around his neck</p> <p>During an observation and interview on 6/03/2024 at 3:08 PM, Resident #2 was observed lying in bed awake and alert in his room with his roommate present and was attempting to hang call light on the wall Resident #2's room door was closed and Resident #2 was no visible by staff. Resident #2 did not answer questions appropriately due to cognition. Resident #2 did not have any visible injuries noted.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>3. Record review of Resident #3's electronic face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), Alzheimer's disease (disease involves parts of the brain that control thought, memory, and language), and anxiety disorder (feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and schizophrenia (affects a person's ability to think, feel, and behave clearly).</p> <p>Record review of Resident #3's quarterly MDS assessment, dated 05/03/2024, reflected a BIMS score was 8, which indicated moderate cognitive impairment. Resident #3's thinking was continuously disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject).</p> <p>Record review of Resident #3's care plan, dated 5/04/2022, reflected she had potential to be physically aggressive towards another resident related to dementia with actual physical aggression on 3/21/2024, 3/08/2024, 1/06/2024, 11/13/2023, 9/04/2023, 7/19/2023, 5/25/2023, 5/19/2023, 5/06/2022, 5/05/2022. Interventions: If behavior is a threat to myself or others, immediately call for assistance. Psychiatric/psychological consult as indicated and ordered by physician. Triggers for physical aggression are other residents yelling out. The behavior is de-escalated by removing from the situation. [Resident #3] had memory loss/dementia related to schizophrenia, delusional behaviors with interventions that included: Cue, reorient, and supervise or assist me as needed. [Resident #3] had a behavior problem (including becoming physically violent toward other residents at times and refusing care at times related to advanced dementia/Alzheimer's with physical aggression on: 7/04/2023, 7/10/2023 and 8/08/2023, interventions included: monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Psych consult for medication review.</p> <p>Record review of Resident #3's care plan dated 5/04/2022 indicated Resident #3 had the potential to be physically and verbally aggressive related to dementia. No new interventions were added to the care plan following aggressive incidents on 1/6/2024 and 5/6/2022.</p> <p>Record review of incident report, dated 11/13/2023 reflected Resident #3 .went into another residents room and grabbed his arm causing 2 skin tears to left forearm</p> <p>Record review of incident report, dated 10/29/2023, reflected Resident #3 .grabbed ahold of another residents arm causing skin tears.</p> <p>Record review of incident report, dated 9/04/2023, reflected another resident was yelling and [Resident #3] went up to him and scratched left side of chin.</p> <p>Record review of incident report, dated 7/21/2023, reflected Resident #3 .was near [Resident #1] scratching him. Residents immediately separated.</p> <p>Record review of incident report, dated 7/10/2023, reflected Resident #3 .rolled up to another resident who was having verbal outbursts and pinched and scratched resident near the right side of his neck.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of incident report, dated 7/04/2023, reflected Resident #3 .rolled up to another resident who was yelling out loudly. She began scratching and grabbing at him .Staff was unable to get to the residents in time before contact was made.</p> <p>Record review of incident report, dated 6/23/2023, reflected Resident #3 .was wheeling past another resident when she yelled ouch.</p> <p>Record review of incident report, dated 5/08/2023, reflected Resident #3 .was heard shouting at other resident stating get out of way, other resident heard stating no you move, staff intervened, and other resident noted with scratch to left hand 3.0 x1.0.</p> <p>Record review of incident report, dated 5/01/2024, reflected staff heard but did not see residents arguing and possible hitting at each other. Then other resident slinging a plate leaving, then noted a split between upper lip and nose 2 x .1 centimeter. She was bleeding from area.</p> <p>Record review of incident report, dated 3/21/2024, reflected Resident #3 .went to another resident in the living area and grabbed ahold of her shirt and her right arm causing a skin tear to her lower right forearm.</p> <p>Record review of incident report, dated 3/08/2024, reflected another resident tried to grab her tray and Resident #3 grabbed ahold of the resident and caused her to get a skin tear.</p> <p>During an observation on 6/03/2024 at 3:12 PM, Resident #3 was observed sitting up in wheelchair in the secured unit common area. Resident #3 did not answer questions appropriately due to cognition.</p> <p>4. Record review of Resident #4's electronic face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a condition affecting the brain in which a person loses the ability to think, remember, learn, make decisions, and solve problems), and senile degeneration of the brain (loss of intellectual ability).</p> <p>Record review of Resident #4's quarterly MDS assessment, dated 05/17/2024, reflected a BIMS score was 8, which indicated moderate cognitive impairment. Resident #4's thinking was continuously disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject).</p> <p>Record review of Resident #4's care plan, dated 5/03/2023, reflected she had potential to be physically aggressive, and combative with staff during ADL care related to dementia with actual physical aggression on: 2/16/2024, 11/21/2023, 11/20/2023, 11/14/2023, 10/18/2023, 9/23/2023, 5/22/2023 with interventions that included: Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. Monitor/document/report PRN any signs/symptoms of resident posing danger to self and others. Psychiatric/Psychogeriatric consult as needed. Staff monitor for aggression and redirect as needed. Staff to monitor for personal space. When the resident becomes agitated: intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #4's care plan dated 5/03/2023 indicated Resident #4 had the potential to be physically and verbally aggressive related to dementia. No new interventions were added to the care plan following aggressive incidents on 11/20/2023 and 10/18/2023.</p> <p>Record review of incident report, dated 7/25/2023, reflected another resident grabbed [Resident #4] by her right wrist/lower arm</p> <p>Record review of incident report, dated 6/05/2023, reflected Resident #4 .was redirecting to a quiet area for safety when she reached out and grabbed another resident by the arm.</p> <p>Record review of incident report, dated 3/08/2024, reflected Resident #4 .was in dining room and tried to take another resident's tray of food, before staff could get there, other resident grabbed her wrist causing a skin tear to left wrist area.</p> <p>During an observation on 6/03/2024 at 3:17 PM, Resident #4 was observed sitting up in wheelchair in secured the unit common area. Resident #4 did not answer questions appropriately due to cognition. No injuries noted and no aggressive behaviors noted at that time.</p> <p>5. Record review of Resident #5's electronic face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included: unspecified dementia, unspecified severity, with other behavioral disturbance, (mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems), bipolar disorder severe with psychotic features (psychosis, including hallucinations, delusions, or jumbled thoughts) and unspecified psychosis (disconnection from reality).</p> <p>Record review of Resident #5's quarterly MDS assessment, dated 05/18/2024, reflected a BIMS score was not able to be obtained. Staff assessment for mental status reflected Resident #5 had short- and long-term memory problem. Resident #5's thinking was continuously disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject). Resident #5 had difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said.</p> <p>Record review of Resident #5's care plan, dated 01/31/2024, reflected he had potential to be physically aggressive related to poor impulse control and bipolar severe with psychotic features with actual physical aggression on 3/28/2024, 3/12/2024 and 1/22/2024. Interventions included: if behavior is a threat to themselves or others, immediately call for assistance. Observe for and immediately report to the nurse and coordinator any signs or symptoms posing a danger to self and/or others. Psychiatric/psychological consult as indicated and ordered by MD .The resident is/has potential to be verbally and physically aggressive towards staff (patient hit other patient with wet floor sign on 9/02/2023), tends to hold onto female residents, becomes angry and aggressive when redirected with interventions that included: Assess residents understanding of the situation. Allow time for the resident to express self and feelings towards the situation. Psychiatric/Psychogeriatric consult as indicated.</p> <p>Record review of incident report, dated 3/12/2024, reflected Resident #5 .went into another residents room and grabbed her left arm and elbow causing bruising.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Legacy at Town Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 2212 W Reagan St Palestine, TX 75801	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an observation on 6/03/2024 at 3:01 PM, Resident #5 was observed sitting up in bed in the room awake and alert. Resident #5 said no one had ever hurt him in any way. Resident #5 said staff did not always treat him nice but would not give any other details. Resident #5 said he took care of himself and did not let anyone treat him badly.</p> <p>6. Record review of a facility face sheet dated 6/5/24 for Resident #6 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: Alzheimer's disease, heart failure, type 2 diabetes mellitus and cerebral infarction (stroke).</p> <p>Record review of a quarterly MDS assessment dated [DATE] for Resident #6 indicated that she had a BIMS score of 5, which indicated that she had severe cognitive impairment. Section C (Cognitive Patterns) indicated that she suffered from inattention and disorganized thinking.</p> <p>Record review of a comprehensive care plan dated 4/17/23 with last revision date of 6/4/24 for Resident #6 indicated that she had the potential to be physically aggressive r/t paranoid schizophrenia with actual physical aggression on 04/04/2023, 05/03/2023, 06/29/2023, 10/22/2023, 12/12/2023, 01/09/2024, 01/11/2024, and 05/22/2024 with interventions including: .If behavior is a threat to myself or others, immediately call for assistance .; .Observe for and immediately report to the nurse and coordinator any signs or symptoms posing a danger to myself and/or others .; and .Triggers for physical aggression are (other residents in my personal space or messing with my belongings). The behavior is de-escalated by (keeping my personal space and no one messing with my belongings) . Intervention added on 5/24/24 after incident on 5/22/24 read .Send to ER for evaluation and treatment reference to behaviors .</p> <p>Record review of an incident report dated 5/22/24 for Resident #6 indicated that she .got agitated at another resident for banging on the door, pulled her hair and pushed her .</p> <p>7. Record review of a facility face sheet dated 6/5/24 for Resident #7 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: Sarcopenia (gradual loss of muscle mass, strength and function), dysphagia (trouble swallowing), bipolar disorder(a mental health condition that causes extreme mood swings between emotional highs and lows), and dementia.</p> <p>Record review of a quarterly MDS assessment dated [DATE] for Resident #7 indicated that she had a BIMS score of 2, which indicated that she had severely impaired cognition. Section C (Cognitive Patterns) indicated that she suffered from inattention and disorganized thinking.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of a comprehensive care plan for Resident #7 initiated on 6/2/22 and revised on 5/14/24 indicated that Resident #7 had physical aggressive behaviors at times r/t dementia, poor impulse control. Interventions included: .If I show signs of agitation, intervene before it escalates: remain calm, take a deep centering breath, stand out of reach, listen, and respond with empathy, guide away from source of distress; calmly engage in conversation. If response is aggressive, team member is to calmly walk away, ask others to leave the area, ensure everyone is safe, and immediately report this to nurse, discuss other approaches and approach later .; .Observe for and immediately report to the nurse and coordinator any signs or symptoms posing a danger to myself and/or others .; and .Talk with a low pitch, calm voice to decrease/eliminate undesired behavior & provide diversional activity . No new interventions were added to the care plan following incident on 3/21/24 when resident was victim of physical aggression.</p> <p>Record review of an incident report dated 3/21/24 for Resident #7 indicated that she suffered a skin tear when another resident grabbed her shirt and arm.</p> <p>8. Record review of a facility face sheet dated 6/5/24 for Resident #8 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: dementia, dysphagia (trouble swallowing), major depressive disorder, and hyperlipidemia (high cholesterol).</p> <p>Record review of an annual MDS assessment dated [DATE] for Resident #8 indicated that he had a BIMS score of 6, which indicated that he was severely cognitively impaired.</p> <p>Record review of a comprehensive care plan for Resident #8 dated 5/18/22 and revised on 5/13/24 indicated that he had the potential to be physically aggressive r/t dementia, poor impulse control and was physically aggressive with another resident on 5/17/23 and 5/1/24. Interventions included: .Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document in notes .; .Modify environment: adjust room temperature to comfortable level, reduce noise, dim lights, place familiar objects in room, keep door closed .; and .Monitor for anxiety/aggression and redirect as needed . The followig intervention was added after incident on 5/1/24: .Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document in notes .</p> <p>Record review of an incident report dated 5/1/24 for Resident #8 indicated that he was .slinging dinner plate, possibly hit another resident leaving a split between upper lip and nose 2 x 0.1 cm. She was bleeding from area .</p> <p>9. Record review of a facility face sheet dated 6/5/24 for Resident #9 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: dementia, repeated falls, osteoporosis (weak, brittle bones), and anxiety disorder.</p> <p>Record review of a quarterly MDS dated [DATE] for Resident #9 indicated that she had a BIMS score of 4, which indicated that she had severely impaired cognition. Section C (Cognitive Patterns) indicated that she suffered from inattention and disorganized thinking.</p> <p>Record review of a comprehensive care plan for Resident #9 indicated that she had potential to be physically aggressive (hitting staff and residents) r/t Dementia with physical Aggression received on 05/22/2024. No new interventions were added to the care plan following resident being a victim of aggression on 5/22/24.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of an incident report dated 5/22/24 for Resident #9 indicated that she had her hair pulled and was pushed down by another resident.</p> <p>10. Record review of a facility face sheet dated 6/5/24 for Resident #10 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: dementia, repeated falls, depression, and type 2 diabetes.</p> <p>Record review of a quarterly MDS assessment dated [DATE] for Resident #10 indicated that she had a BIMS score of 4 which indicated that she had severely impaired cognition. Section C (Cognitive Patterns) indicated that she suffered from fluctuating inattention and disorganized thinking.</p> <p>Record review of a comprehensive care plan for Resident #10 dated 9/25/23 indicated that resident had potential to be physically aggressive r/t Dementia. Interventions implemented on 9/25/23 after incident on 9/19/23 included: .Administrator medications as ordere [TRUNCATED]</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273</p> <p>Based on interview and record review the facility failed to develop and implement written policies and procedures that prohibited and prevented abuse, neglect, and exploitation of residents and misappropriation of resident property for 7 of 10 residents (Resident #1, Resident #4, Resident #3, Resident #9, Resident #6, Resident #7 and Resident #10) reviewed for abuse policies.</p> <ol style="list-style-type: none"> 1. The facility failed to implement the abuse policy by failing to protect Resident #1 from abuse from Resident #2, Resident #3, Resident #4, Resident #6, and Resident #10 between 5/8/23-1/11/24. 2. The facility failed to implement interventions after multiple incidents of resident-to-resident altercations. 3. The facility failed to implement the abuse policy by failing to protect Resident #4 from abuse from Resident #1, and Resident #3 between 7/25/23- 3/8/24. 4. The facility failed to implement the abuse policy by failing to protect Resident #3 from abuse from Resident #1, and Resident #8 between 6/23/23-5/1/24. 5. The facility failed to implement the abuse policy by failing to protect Resident #9 from abuse from Resident #6 on 5/22/24. 6. The facility failed to implement the abuse policy by failing to protect Resident #6 from abuse from Resident #5 on 3/12/24. 7. The facility failed to implement the abuse policy by failing to protect Resident #7 from abuse from Resident #3 on 3/21/24. 8. The facility failed to implement the abuse policy by failing to protect Resident #10 from abuse from Resident #1 on 9/19/23. 9. The facility failed to implement the abuse policy by failing to report the resident-to-resident altercations to HHSC. <p>An Immediate Jeopardy (IJ) situation was identified on 06/05/2024 at 2:52 PM. While the IJ was removed on 06/06/2024 at 05:05 PM, the facility remained out of compliance at a scope of a pattern and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of their corrective systems.</p> <p>These failures could place residents at risk of abuse which could lead to further abuse and neglect of other residents.</p> <p>Findings include:</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>1. Record review of Resident #1's electronic face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included Dementia with other behavioral disturbance (problem in the brain affecting memory), schizoaffective disorder (hallucinations and mood symptoms), and sarcopenia (musculoskeletal disease in which muscle mass, strength, and performance are significantly compromised with age).</p> <p>Record review of Resident #1's quarterly MDS assessment, dated 05/27/2024, reflected a BIMS score of 03, which indicated the resident's cognition was severely impaired. Resident #1's thinking was continuously disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject).</p> <p>Record review of Resident #1's care plan, dated 4/21/2023, reflected he had the potential to be physically and verbally aggressive related to dementia and schizoaffective disorder with interventions that included: 5. Monitor/document/report as needed and signs or symptoms of resident posing danger to self and others. 6. Psychiatric/Psychogeriatric consult as indicated. Resident #1 had impaired cognitive function/dementia or impaired thought processes related to Alzheimer's dementia (disease that destroys memory and other important mental functions) with interventions that included: 3. Cue, reorient and supervise as needed. Resident #1 used psychotropic medications related to schizoaffective disorder with interventions that included: 3 .Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy.</p> <p>Record review of Resident #1's care plan dated 4/21/2023 indicated Resident #1 had the potential to be physically and verbally aggressive related to dementia and schizoaffective disorder. No new interventions were added to the care plan following aggressive incidents on 6/23/2023 and 9/19/2023.</p> <p>Record review of an incident report, dated 1/11/2024, reflected Resident #1 .was in the dining room hollering out repeatedly and another resident slapped him on his helmet.</p> <p>Record review of incident report, dated 11/13/2023, reflected Resident #1 .was in bed in his room and hollered out. Another resident wandered into his room and grabbed his arm causing him to get 2 skin tears on his left forearm.</p> <p>Record review of incident report, dated 10/29/2023, reflected Resident #1 .was in dining room at table yelling out. Another resident got frustrated with him hollering and grabbed his right arm causing skin tears.</p> <p>Record review of incident report, dated 10/29/2023, reflected Resident #1 was .in the lobby and was hollering out randomly .when another resident came over and flipped his wheelchair with him in it before staff could intervene.</p> <p>Record review of incident report, dated 9/29/2023, reflected Resident #1 was .sitting in recliner yelling, before staff could intervene another resident approached him and hit him in the mouth, busting his lip open</p> <p>Record review of incident report, dated 9/19/2023, reflected Resident #1 .hit another resident and the other resident hit him back and he received a skin tear to right forearm</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of incident report, dated 9/04/2023, reflected Resident #1 .was yelling. Another resident went up to him and scratched left side of chin leaving 3 marks</p> <p>Record review of incident report, dated 9/03/2023, reflected Resident #1 was in a wheelchair .outside of dining room and another resident got mad at him because he was yelling out and dumped him out on the floor and the wheelchair fell on top of him.</p> <p>Record review of incident report, dated 8/20/2023, reflected Resident #1 .was sitting at dining room table and another resident walked up and he stated, 'What are you going to do about it?' and the other resident slapped him in the face.</p> <p>Record review of incident report, dated 7/25/2023, reflected Resident #1 .grabbed another resident by her right wrist/lower arm. Residents immediately separated</p> <p>Record review of incident report, dated 7/21/2023, reflected Resident #1 .heard yelling and found Resident #3 near resident scratching him. Residents immediately separated. Scratches noted to right lower arm</p> <p>Record review of incident report, dated 7/20/2023, reflected Resident #1 was sitting in a recliner and with Resident #2 standing over him. Resident #1 said Resident #2 hit him on the left side of chin and cheek with slight redness observed.</p> <p>Record review of incident report, dated 7/10/2023, reflected Resident #1 .was having verbal outbursts and another resident rolled up to him and pinched and scratched resident near the right side of his neck.</p> <p>Record review of incident report, dated 7/08/2023, reflected Resident #1 .was walking by another resident who was having verbal outbursts. The resident called out you son of a bitch and he lunged towards resident and put his hand around his neck, residents were immediately separated.</p> <p>Record review of incident report, dated 7/04/2023, reflected Resident #1 .was yelling out loudly. Another resident rolled up to him and she began scratching and grabbing at him .staff was unable to get to the residents in time before contact was made. Resident received multiple skin tears and scratches.</p> <p>Record review of incident report, dated 6/23/2023, reflected Resident #1 .reached out and pinched another resident while the resident was wheeling past him to go to dining room.</p> <p>Record review of incident report, dated 6/05/2023, reflected Resident #1 .was dozing in quiet area when his arm was grabbed by a fell ow resident.</p> <p>Record review of incident report, dated 5/08/2023, reflected Resident #1 .was heard yelling no you get out of the way, when staff intervned resident was noted with scratch to left hand 3.0 x 1.0, both residents were separated and assessed</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 6/03/2024 at 2:35 PM, Resident #1 was observed sitting up in wheelchair in common area in secured unit. Resident #1 was sitting at a table with 2 other residents with two building blocks on the table. Staff brought activities to the table after the State Surveyor started to interview Resident #1. Resident #1 said when asked if anyone had ever hurt him, yes. Resident #1 was alert and did not answer questions appropriately due to cognition. Resident #1 had a soft helmet in place to the top of his head with no injuries noted.</p> <p>2. Record review of Resident #2's electronic face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included Dementia with other behavioral disturbance (problem in the brain affecting memory), bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), Alzheimer's disease (disease involves parts of the brain that control thought, memory, and language), and anxiety disorder (feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).</p> <p>Record review of Resident #2's quarterly MDS assessment, dated 05/03/2024, reflected a BIMS score was not able to be obtained. Staff assessment for mental status reflected Resident #2 had short- and long-term memory problem. Resident #2's thinking was continuously disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject).</p> <p>Record review of Resident #2's care plan, dated 7/11/2023, reflected he had potential to be physically aggressive related to bipolar disorder and dementia with actual physical aggression on 7/20/2023, 8/20/2023, 9/03/2023, 9/29/2023, 10/29/2023, 11/02/2023, 1/30/2024, 4/10/2024, 5/25/2024. Interventions: The resident's triggers for physical aggression are (the yelling out loud noises) resident's behaviors is de-escalated by (providing quiet environment redirecting attention removing from situation). Order to send to behavioral facility to evaluate and treat. Psychiatric/psychogeriatric consult as indicated. Request labs and do assessment to rule out medical reason for aggressive behaviors. When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later when possible. The resident had impaired cognitive function/dementia or impaired thought processes related to Alzheimer's with interventions that included: Cue, reorient and supervise as needed. Discuss concerns about confusion, disease process, and nursing home placement with resident/family/caregivers.</p> <p>Record review of Resident #2's care plan dated 7/11/2023 indicated Resident #2 had the potential to be physically and verbally aggressive related to dementia and bipolar disorder. No new interventions were added to the care plan following aggressive incidents on 8/20/2023, 10/29/2023, 1/30/2024, and 5/25/2024.</p> <p>Record review of incident report, dated 10/29/2023, reflected Resident #2 .came into living area and flipped another resident's wheelchair on its side before staff could intervene.</p> <p>Record review of incident report, dated 9/29/2023, indicated another resident sitting up in recliner in lounge area close to the dining room yelling when [Resident #2] approached him and hit him in the mouth</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of incident report, dated 9/03/2023, reflected Resident #2 .got angry at another resident due to him yelling. He then tipped wheelchair over making resident fall into floor and wheelchair went on top of resident</p> <p>Record review of incident report, dated 8/20/2023, reflected Resident #2 .was walking by another resident who was sitting in his wheelchair at table eating. Resident stated, 'what are you going to do about it?' and resident then slapped the other resident in the face on the left cheek.</p> <p>Record review of incident report, dated 7/20/2023, reflected Resident #2 was standing over Resident #1. Resident #1 said Resident #2 hit him on the left chin and cheek with slight redness noted.</p> <p>Record review of incident report, dated 7/08/2023, reflected Resident #2 .was walking by another resident who was having verbal outbursts. The resident called out you son of a bitch and he lunged towards resident and put his hand around his neck</p> <p>During an observation and interview on 6/03/2024 at 3:08 PM, Resident #2 was observed lying in bed awake and alert in his room with his roommate present and was attempting to hang call light on the wall Resident #2's room door was closed and Resident #2 was no visible by staff. Resident #2 did not answer questions appropriately due to cognition. Resident #2 did not have any visible injuries noted.</p> <p>3. Record review of Resident #3's electronic face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), Alzheimer's disease (disease involves parts of the brain that control thought, memory, and language), and anxiety disorder (feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and schizophrenia (affects a person's ability to think, feel, and behave clearly).</p> <p>Record review of Resident #3's quarterly MDS assessment, dated 05/03/2024, reflected a BIMS score was 8, which indicated moderate cognitive impairment. Resident #3's thinking was continuously disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject).</p> <p>Record review of Resident #3's care plan, dated 5/04/2022, reflected she had potential to be physically aggressive towards another resident related to dementia with actual physical aggression on 3/21/2024, 3/08/2024, 1/06/2024, 11/13/2023, 9/04/2023, 7/19/2023, 5/25/2023, 5/19/2023, 5/06/2022, 5/05/2022. Interventions: If behavior is a threat to myself or others, immediately call for assistance. Psychiatric/psychological consult as indicated and ordered by physician. Triggers for physical aggression are other residents yelling out. The behavior is de-escalated by removing from the situation. [Resident #3] had memory loss/dementia related to schizophrenia, delusional behaviors with interventions that included: Cue, reorient, and supervise or assist me as needed. [Resident #3] had a behavior problem (including becoming physically violent toward other residents at times and refusing care at times related to advanced dementia/Alzheimer's with physical aggression on: 7/04/2023, 7/10/2023 and 8/08/2023, interventions included: monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Psych consult for medication review.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Legacy at Town Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 2212 W Reagan St Palestine, TX 75801	
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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #3's care plan dated 5/04/2022 indicated Resident #3 had the potential to be physically and verbally aggressive related to dementia. No new interventions were added to the care plan following aggressive incidents on 1/6/2024 and 5/6/2022.</p> <p>Record review of incident report, dated 11/13/2023 reflected Resident #3 .went into another residents room and grabbed his arm causing 2 skin tears to left forearm</p> <p>Record review of incident report, dated 10/29/2023, reflected Resident #3 .grabbed ahold of another residents arm causing skin tears.</p> <p>Record review of incident report, dated 9/04/2023, reflected another resident was yelling and [Resident #3] went up to him and scratched left side of chin.</p> <p>Record review of incident report, dated 7/21/2023, reflected Resident #3 .was near [Resident #1] scratching him. Residents immediately separated.</p> <p>Record review of incident report, dated 7/10/2023, reflected Resident #3 .rolled up to another resident who was having verbal outbursts and pinched and scratched resident near the right side of his neck.</p> <p>Record review of incident report, dated 7/04/2023, reflected Resident #3 .rolled up to another resident who was yelling out loudly. She began scratching and grabbing at him .Staff was unable to get to the residents in time before contact was made.</p> <p>Record review of incident report, dated 6/23/2023, reflected Resident #3 .was wheeling past another resident when she yelled ouch.</p> <p>Record review of incident report, dated 5/08/2023, reflected Resident #3 .was heard shouting at other resident stating get out of way, other resident heard stating no you move, staff intervened, and other resident noted with scratch to left hand 3.0 x1.0.</p> <p>Record review of incident report, dated 5/01/2024, reflected staff heard but did not see residents arguing and possible hitting at each other. Then other resident slinging a plate leaving, then noted a split between upper lip and nose 2 x .1 centimeter. She was bleeding from area.</p> <p>Record review of incident report, dated 3/21/2024, reflected Resident #3 .went to another resident in the living area and grabbed ahold of her shirt and her right arm causing a skin tear to her lower right forearm.</p> <p>Record review of incident report, dated 3/08/2024, reflected another resident tried to grab her tray and Resident #3 grabbed ahold of the resident and caused her to get a skin tear.</p> <p>During an observation on 6/03/2024 at 3:12 PM, Resident #3 was observed sitting up in wheelchair in the secured unit common area. Resident #3 did not answer questions appropriately due to cognition.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>4. Record review of Resident #4's electronic face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a condition affecting the brain in which a person loses the ability to think, remember, learn, make decisions, and solve problems), and senile degeneration of the brain (loss of intellectual ability).</p> <p>Record review of Resident #4's quarterly MDS assessment, dated 05/17/2024, reflected a BIMS score was 8, which indicated moderate cognitive impairment. Resident #4's thinking was continuously disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject).</p> <p>Record review of Resident #4's care plan, dated 5/03/2023, reflected she had potential to be physically aggressive, and combative with staff during ADL care related to dementia with actual physical aggression on: 2/16/2024, 11/21/2023, 11/20/2023, 11/14/2023, 10/18/2023, 9/23/2023, 5/22/2023 with interventions that included: Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. Monitor/document/report PRN any signs/symptoms of resident posing danger to self and others. Psychiatric/Psychogeriatric consult as needed. Staff monitor for aggression and redirect as needed. Staff to monitor for personal space. When the resident becomes agitated: intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later.</p> <p>Record review of Resident #4's care plan dated 5/03/2023 indicated Resident #4 had the potential to be physically and verbally aggressive related to dementia. No new interventions were added to the care plan following aggressive incidents on 11/20/2023 and 10/18/2023.</p> <p>Record review of incident report, dated 7/25/2023, reflected another resident grabbed [Resident #4] by her right wrist/lower arm</p> <p>Record review of incident report, dated 6/05/2023, reflected Resident #4 .was redirecting to a quiet area for safety when she reached out and grabbed another resident by the arm.</p> <p>Record review of incident report, dated 3/08/2024, reflected Resident #4 .was in dining room and tried to take another resident's tray of food, before staff could get there, other resident grabbed her wrist causing a skin tear to left wrist area.</p> <p>During an observation on 6/03/2024 at 3:17 PM, Resident #4 was observed sitting up in wheelchair in secured the unit common area. Resident #4 did not answer questions appropriately due to cognition. No injuries noted and no aggressive behaviors noted at that time.</p> <p>5. Record review of Resident #5's electronic face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included: unspecified dementia, unspecified severity, with other behavioral disturbance, (mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems), bipolar disorder severe with psychotic features (psychosis, including hallucinations, delusions, or jumbled thoughts) and unspecified psychosis (disconnection from reality).</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #5's quarterly MDS assessment, dated 05/18/2024, reflected a BIMS score was not able to be obtained. Staff assessment for mental status reflected Resident #5 had short- and long-term memory problem. Resident #5's thinking was continuously disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject). Resident #5 had difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said.</p> <p>Record review of Resident #5's care plan, dated 01/31/2024, reflected he had potential to be physically aggressive related to poor impulse control and bipolar severe with psychotic features with actual physical aggression on 3/28/2024, 3/12/2024 and 1/22/2024. Interventions included: if behavior is a threat to themselves or others, immediately call for assistance. Observe for and immediately report to the nurse and coordinator any signs or symptoms posing a danger to self and/or others. Psychiatric/psychological consult as indicated and ordered by MD .The resident is/has potential to be verbally and physically aggressive towards staff (patient hit other patient with wet floor sign on 9/02/2023), tends to hold onto female residents, becomes angry and aggressive when redirected with interventions that included: Assess residents understanding of the situation. Allow time for the resident to express self and feelings towards the situation. Psychiatric/Psychogeriatric consult as indicated.</p> <p>Record review of incident report, dated 3/12/2024, reflected Resident #5 .went into another residents room and grabbed her left arm and elbow causing bruising.</p> <p>During an observation on 6/03/2024 at 3:01 PM, Resident #5 was observed sitting up in bed in the room awake and alert. Resident #5 said no one had ever hurt him in any way. Resident #5 said staff did not always treat him nice but would not give any other details. Resident #5 said he took care of himself and did not let anyone treat him badly.</p> <p>6. Record review of a facility face sheet dated 6/5/24 for Resident #6 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: Alzheimer's disease, heart failure, type 2 diabetes mellitus and cerebral infarction.</p> <p>Record review of a quarterly MDS assessment dated [DATE] for Resident #6 indicated that she had a BIMS score of 5, which indicated that she had severe cognitive impairment. Section C (Cognitive Patterns) indicated that she suffered from inattention and disorganized thinking.</p> <p>Record review of a comprehensive care plan dated 4/17/23 with last revision date of 6/4/24 for Resident #6 indicated that she had the potential to be physically aggressive r/t paranoid schizophrenia with actual physical aggression on 04/04/2023, 05/03/2023, 06/29/2023, 10/22/20203, 12/12/2023, 01/09/2024, 01/11/2024, and 05/22/2024 with interventions including: .If behavior is a threat to myself or others, immediately call for assistance .; .Observe for and immediately report to the nurse and coordinator any signs or symptoms posing a danger to myself and/or others .; and .Triggers for physical aggression are (other residents in my personal space or messing with my belongings). The behavior is de-escalated by (keeping my personal space and no one messing with my belongings) . Intervention added on 5/24/24 after incident on 5/22/24 read .Send to ER for evaluation and treatment reference to behaviors .</p> <p>Record review of an incident report dated 5/22/24 for Resident #6 indicated that she .got agitated at another resident for banging on the door, pulled her hair and pushed her .</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>7. Record review of a facility face sheet dated 6/5/24 for Resident #7 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: Sarcopenia, dysphagia, bipolar disorder, and dementia.</p> <p>Record review of a quarterly MDS assessment dated [DATE] for Resident #7 indicated that she had a BIMS score of 2, which indicated that she had severely impaired cognition. Section C (Cognitive Patterns) indicated that she suffered from inattention and disorganized thinking.</p> <p>Record review of a comprehensive care plan for Resident #7 initiated on 6/2/22 and revised on 5/14/24 indicated that Resident #7 had physical aggressive behaviors at times r/t dementia, poor impulse control. Interventions included: .If I show signs of agitation, intervene before it escalates: remain calm, take a deep centering breath, stand out of reach, listen, and respond with empathy, guide away from source of distress; calmly engage in conversation. If response is aggressive, team member is to calmly walk away, ask others to leave the area, ensure everyone is safe, and immediately report this to nurse, discuss other approaches and approach later .; .Observe for and immediately report to the nurse and coordinator any signs or symptoms posing a danger to myself and/or others .; and .Talk with a low pitch, calm voice to decrease/eliminate undesired behavior & provide diversional activity . No new interventions were added to the care plan following incident on 3/21/24 when resident was victim of physical aggression.</p> <p>Record review of an incident report dated 3/21/24 for Resident #7 indicated that she suffered a skin tear when another resident grabbed her shirt and arm.</p> <p>8. Record review of a facility face sheet dated 6/5/24 for Resident #8 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: dementia, dysphagia, major depressive disorder, and hyperlipidemia.</p> <p>Record review of an annual MDS assessment dated [DATE] for Resident #8 indicated that he had a BIMS score of 6, which indicated that he was severely cognitively impaired.</p> <p>Record review of a comprehensive care plan for Resident #8 dated 5/18/22 and revised on 5/13/24 indicated that he had the potential to be physically aggressive r/t dementia, poor impulse control and was physically aggressive with another resident on 5/17/23 and 5/1/24. Interventions included: .Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document in notes .; .Modify environment: adjust room temperature to comfortable level, reduce noise, dim lights, place familiar objects in room, keep door closed .; and .Monitor for anxiety/aggression and redirect as needed . The followig intervention was added after incident on 5/1/24: .Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document in notes .</p> <p>Record review of an incident report dated 5/1/24 for Resident #8 indicated that he was .slinging dinner plate, possibly hit another resident leaving a split between upper lip and nose 2 x 0.1 cm. She was bleeding from area .</p> <p>9. Record review of a facility face sheet dated 6/5/24 for Resident #9 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: dementia, repeated falls, osteoporosis, and anxiety disorder.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of a quarterly MDS dated [DATE] for Resident #9 indicated that she had a BIMS score of 4, which indicated that she had severely impaired cognition. Section C (Cognitive Patterns) indicated that she suffered from inattention and disorganized thinking.</p> <p>Record review of a comprehensive care plan for Resident #9 indicated that she had potential to be physically aggressive (hitting staff and residents) r/t Dementia with physical Aggression received on 05/22/2024. No new interventions were added to the care plan following resident being a victim of aggression on 5/22/24</p> <p>Record review of an incident report dated 5/22/24 for Resident #9 indicated that she had her hair pulled and was pushed down by another resident.</p> <p>10. Record review of a facility face sheet dated 6/5/24 for Resident #10 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: dementia, repeated falls, depression, and type 2 diabetes.</p> <p>Record review of a quarterly MDS assessment dated [DATE] for Resident #10 indicated that she had a BIMS score of 4 which indicated that she had severely impaired cognition. Section C (Cognitive Patterns) indicated that she suffered from fluctuating inattention and disorganized thinking.</p> <p>Record review of a comprehensive care plan for Resident #10 dated 9/25/23 indicated that resident had potential to be physically aggressive r/t Dementia. Interventions implemented on 9/25/23 after incident on 9/19/23 included: .Administrator medications as ordered. Monitor/document for side effects and effectiveness ; .Assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc .; and .Psychiatric/Psychogeriatric consult as indicated .</p> <p>Record review of an incident report for Resident #10 dated 9/19/23 indicated that she was involved in a physical altercation with another resident.</p> <p>During an interview on 6/04/2024 at 2:50 PM, SW said when Resident #2 first admitted his behaviors were not that bad. SW said Resident #2 had gone to a behavioral facility in the last 4 or 5 months and had returned but had not been to a behavioral facility before April of 2024. She said when they had a resident-to-resident altercation, they always try the least invasive approach first such as redirecting, then calling psychiatric services, and a behavioral facility as a last resort. She said when there was a resident-to-resident altercation she is notified by the charge nurse or the next day in the morning meeting or nurse meeting. The SW said she tries to find the reason for the altercation and address it, she would make sure residents needs are met to see if that is why they were agitated, then possibly add activities. She said Resident #1's yelling out got to a lot of the residents at times. The SW said everyone on the secured unit was on psychiatric services. She said there was staff on the secured unit that were watching for behaviors. The SW said the Administrator was responsible for reporting resident to resident altercations to HHSC or any other appropriate agencies.</p> <p>During an interview on 6/04/2024 at 3:10 PM, the DON said she had worked at the facility since February of 2023. She said Resident #1 had a lot of anxiety and hollers out a lot but is doing better. She said that they had noticed if you occupy Resident #1's his hands or staff talks to him, he did not holler out as bad. The DON said Resident #2 got over stimulated with loud noises. The DON said Resident #2 had gone in [TRUNCATED]</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure that all alleged violations involving abuse or mistreatment were reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse, to the administrator of the facility and to other officials (including to the State Survey Agency where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 7 of 10 residents (Resident #1, Resident #4, Resident #3, Resident #9, Resident #6, Resident #7, and Resident #10) reviewed for reporting abuse.</p> <p>The facility failed to ensure that allegations of resident-to-resident abuse were reported to appropriate State Agency in that:</p> <ol style="list-style-type: none"> 1. The facility failed to protect Resident #1 from abuse from Resident #2, Resident #3, Resident #4, Resident #6, and Resident #10 between 5/8/23-1/11/24. on 1/11/24 Resident #6 slapped Resident #1 on his helmet. on 11/13/23 Resident #3 grabbed Resident #1's arm causing 2 skin tears. On 10/29/23 Resident #1 was in the lobby hollering and Resident #2 went over and flipped Resident #1 out of his wheelchair causing him to fall on the floor. On 10/29/23 Resident #3 grabbed Resident #1's right arm causing skin tears to right arm. On 9/29/23 Resident #1 sitting in recliner yelling and Resident #2 went over to Resident #1 and hit him in the mouth causing his lip to bust open. on 9/19/23 Resident #1 hit Resident #10 and Resident #10 hit Resident #1 back causing a skin tear to the right forearm. on 9/4/23 Resident #3 scratched the left side of Resident #1's chin leaving 3 scratches. On 9/3/23 Resident #2 flipped Res #1 out of his wheelchair on to the floor. On 8/20/23 Resident #2 walked over to Resident #1 and slapped him in the face. on 7/21/23 with Res #1 and Res #3. Res #3 scratched Res #1 on his right lower arm. On 7/20/23 Resident #2 walked over to Resident #1 and hit him on the left cheek and chin causing redness. On 7/10/23 Resident #3 pinched and scratched Resident #1 on the right side of his neck. On 7/8/23 Resident #2 lunged over to Resident #1 and put his hands around Res #1's neck. On 7/4/23 Resident #3 scratched Resident #1 with multiple skin tears and scratches to the face, neck, right finger, and left forearm. On 6/23/23 Resident #1 pinched Resident #3, Resident #1 also received a skin tear. On 6/5/23 Resident #4 grabbed Resident #1's arm. On 5/8/23 Resident #3 scratched Resident #1's left hand. 2. The facility failed to protect Resident #4 from abuse from Resident #1, and Resident #3 between 7/25/23-3/8/24. On 7/25/23 Resident #1 grabbed Resident #4's right wrist and lower arm. On 3/8/24 Resident #3 grabbed Resident #4 by the wrist causing a skin tear to the left wrist. 3. The facility failed to protect Resident #3 from abuse from Resident #1 and Resident #8 between 6/23/23-5/1/24. On 6/23/23 Resident #1 pinched Resident #3, Resident #1 also received a skin tear. on 5/1/24 Resident #8 hit Resident #3 with a dinner plate causing a split between lip and nose. 4. The facility failed to protect Resident #9 from abuse from Resident #6 on 5/22/24 Resident #6 pulled Res #9's hair and pushed her down onto the floor. 5. The facility failed to protect Resident #6 from abuse from Resident #5 on 3/12/24. on 3/12/24 Resident #5 grabbed Resident #6 by the elbow causing a bruise. <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6. The facility failed to protect Resident #7 from abuse from Resident #3 on 3/21/24. on 3/21/24 Resident #3 grabbed Resident #7 causing a skin tear to right forearm.</p> <p>7. The facility failed to protect Resident #10 from abuse from Resident #1 on 9/19/23. on 9/19/23 Resident #1 hit Resident #10 and Resident #10 hit Resident #1 back causing a skin tear to the right forearm.</p> <p>8. The facility failed to keep residents safe following resident to resident altercations to prevent further harm.</p> <p>.</p> <p>The facility failed to implement their abuse policy which stated .The Health Care Center will report all allegations and substantiated occurrences of abuse .to the state agency and to all other agencies as required by law .</p> <p>These failures could place residents at risk for continued alleged violations, diminished quality of life and harm due to allegations not being reported.</p> <p>Findings included:</p> <p>1.Record review of Resident #1's electronic face sheet revealed an [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Dementia with other behavioral disturbance (problem in the brain affecting memory), schizoaffective disorder (hallucinations and mood symptoms), and sarcopenia (musculoskeletal disease in which muscle mass, strength, and performance are significantly compromised with age).</p> <p>Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 03, which indicated residents' cognition was severely impaired. Resident #1's thinking was continuously disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject).</p> <p>Record review of Resident #1's care plan dated 4/21/2023 revealed he had the potential to be physically and verbally aggressive related to dementia and schizoaffective disorder with interventions that included: . 5. Monitor/document/report as needed and signs or symptoms of resident posing danger to self and others. 6. Psychiatric/Psychogeriatric consult as indicated. Resident #1 had impaired cognitive function/dementia or impaired thought processes related to Alzheimer's dementia with interventions that included: . 3. Cue, reorient and supervise as needed. Resident #1 used psychotropic medications related to schizoaffective disorder with interventions that included: .3.Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy.</p> <p>Record review of an incident report dated 1/11/2024 indicated Resident #1 .was in the dining room hollering out repeatedly and another resident slapped him on his helmet.</p> <p>Record review of incident report dated 11/13/2023 indicated Resident #1 .was in bed in his room and hollered out. Another resident wandered into his room and grabbed his arm causing him to get 2 skin tears on his left forearm.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of incident report dated 10/29/2023 indicated Resident #1 .was in dining room at table yelling out. Another resident got frustrated with him hollering and grabbed his right arm causing skin tears.</p> <p>Record review of incident report dated 10/29/2023 indicated Resident #1 was .in the lobby and was hollering out randomly, .when another resident came over and flipped his wheelchair with him in it before staff could intervene.</p> <p>Record review of incident report dated 9/29/2023 indicated Resident #1 was .sitting in recliner yelling, before staff could intervene another resident approached him and hit him in the mouth, busting his lip open .</p> <p>Record review of incident report dated 9/19/2023 indicated Resident #1 .hit another resident and the other resident hit him back and he received a skin tear to right forearm .</p> <p>Record review of incident report dated 9/04/2023 indicated Resident #1 .was yelling. Another resident went up to him and scratched left side of chin leaving 3 marks .</p> <p>Record review of incident report dated 9/03/2023 indicated Resident #1 was in wheelchair .outside of dining room and another resident got mad at him because he was yelling out and dumped him out on the floor and the wheelchair fell on top of him.</p> <p>Record review of incident report dated 8/20/2023 indicated Resident #1 .was sitting at dining room table and another resident walked up and he stated, What are you going to do about it? and the other resident slapped him in the face.</p> <p>Record review of incident report dated 7/25/2023 indicated Resident #1 .grabbed another resident by her right wrist/lower arm. Residents immediately separated .</p> <p>Record review of incident report dated 7/21/2023 indicated Resident #1 .heard yelling and found Resident #3 near resident scratching him. Residents immediately separated. Scratches noted to right lower arm .</p> <p>Record review of incident report dated 7/20/2023 indicated Resident #1 was sitting in recliner and with Resident #2 standing over him. Resident #1 said Resident #2 hit him on the left side of chin and cheek with slight redness observed.</p> <p>Record review of incident report dated 7/10/2023 indicated Resident #1 .was having verbal outbursts and another resident rolled up to him and pinched and scratched resident near the right side of his neck.</p> <p>Record review of incident report dated 7/08/2023 indicated Resident #1 .was walking by another resident who was having verbal outbursts. The resident called out you son of a bitch and he lunged towards resident and put his hand around his neck, residents were immediately separated.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of incident report dated 7/04/2023 indicated Resident #1 .was yelling out loudly. Another resident rolled up to him and she began scratching and grabbing at him .staff was unable to get to the residents in time before contact was made. Resident received multiple skin tears and scratches.</p> <p>Record review of incident report dated 6/23/2023 indicated Resident #1 .reached out and pinched another resident while the resident was wheeling past him to go to dining room.</p> <p>Record review of incident report dated 6/05/2023 indicated Resident #1 .was dozing in quiet area when his arm was grabbed by a fell ow resident.</p> <p>Record review of incident report dated 5/08/2023 indicated Resident #1 .was heard yelling no you get out of the way, when staff intervned resident was noted with scratch to left hand 3.0 x 1.0, both residents were separated and assessed .</p> <p>During an observation and interview on 6/03/2024 at 2:35 PM, Resident #1 was observed sitting up in wheelchair in common area in secured unit. Resident #1 was sitting at a table with 2 other residents with two building blocks on the table. Staff brought activities to the table after surveyor had started to interview Resident #1. Resident #1 said yes when asked if anyone had ever hurt him, Resident #1 was alert and did not answer additional questions appropriately due to cognition. Resident #1 had a soft helmet in place to the top of his head.</p> <p>2.Record review of Resident #2's electronic face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Dementia with other behavioral disturbance (problem in the brain affecting memory), bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), Alzheimer's disease (disease involves parts of the brain that control thought, memory, and language), and anxiety disorder (feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).</p> <p>Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS score was not able to be obtained. Staff assessment for mental status revealed Resident #2 had short- and long-term memory problem. Resident #2's thinking was continuously disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject).</p> <p>Record review of Resident #2's care plan dated 7/11/2023 revealed he had potential to be physically aggressive related to bipolar disorder and dementia with actual physical aggression on 7/20/2023, 8/20/2023, 9/03/2023, 9/29/2023, 10/29/2023, 11/02/2023, 1/30/2024, 4/10/2024, 5/25/2024. Interventions: The resident's triggers for physical aggression are (the yelling out loud noises) resident's behaviors is de-escalated by (providing quiet environment redirecting attention removing from situation). Order to send to behavioral facility to evaluate and treat. Psychiatric/psychogeriatric consult as indicated. Request labs and do assessment to rule out medical reason for aggressive behaviors. When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later when possible. The resident had impaired cognitive function/dementia or impaired thought processes related to Alzheimer's with interventions that included: Cue, reorient and supervise as needed. Discuss concerns about confusion, disease process, and nursing home placement with resident/family/caregivers.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of incident report dated 10/29/2023 indicated Resident #2 .came into living area and flipped another resident's wheelchair on its side before staff could intervene.</p> <p>Record review of incident report dated 9/29/2023 indicated another resident sitting up in recliner in lounge area close to the dining room yelling when Resident #2 approached him and hit him in the mouth .</p> <p>Record review of incident report dated 9/03/2023 indicated Resident #2 .got angry at another resident due to him yelling. He then tipped wheelchair over making resident fall into floor and wheelchair went on top of resident .</p> <p>Record review of incident report dated 8/20/2023 indicated Resident #2 .was walking by another resident who was sitting in his wheelchair at table eating. Resident stated, what are you going to do about it? and resident then slapped the other resident in the face on the left cheek.</p> <p>Record review of incident report dated 7/20/2023 indicated Resident #2 was standing over Resident #1. Resident #1 said Resident #2 hit him on the left chin and cheek with slight redness noted.</p> <p>Record review of incident report dated 7/08/2023 indicated Resident #2 .was walking by another resident who was having verbal outbursts. The resident called out you son of a bitch and he lunged towards resident and put his hand around his neck .</p> <p>During an observation and attempted interview on 6/03/2024 at 3:08 PM, Resident #2 was observed lying in bed awake and alert. Resident #2 was attempting to hang call light on the wall. Resident #2 did not answer questions appropriately due to cognition.</p> <p>3. Record review of Resident #3's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), Alzheimer's disease (disease involves parts of the brain that control thought, memory, and language), and anxiety disorder (feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and schizophrenia (affects a person's ability to think, feel, and behave clearly).</p> <p>Record review of Resident #3's quarterly MDS assessment dated [DATE] revealed a BIMS score was 8 which indicated moderate cognitive impairment. Resident #3's thinking was continuously disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject).</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #3's care plan dated 5/04/2022 revealed She had potential to be physically aggressive towards another resident related to dementia with actual physical aggression on 3/21/2024, 3/08/2024, 1/06/2024, 11/13/2023, 9/04/2023, 7/19/2023, 5/25/2023, 5/19/2023, 5/06/2022, 5/05/2022. Interventions: If behavior is a threat to myself or others, immediately call for assistance. Psychiatric/psychological consult as indicated and ordered by physician. Triggers for physical aggression are other residents yelling out. The behavior is de-escalated by removing from the situation. Resident #3 had memory loss/dementia related to schizophrenia, delusional behaviors with interventions that included: Cue, reorient, and supervise or assist me as needed. Resident #3 had a behavior problem (including becoming physically violent toward other residents at times and refusing care at times related to advanced dementia/Alzheimer's with physical aggression on: 7/04/2023, 7/10/2023 and 8/08/2023, interventions included: monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Psych consult for medication review.</p> <p>Record review of incident report dated 11/13/2023 indicated Resident #3 .went into another residents room and grabbed his arm causing 2 skin tears to left forearm .</p> <p>Record review of incident report dated 10/29/2023 indicated Resident #3 .grabbed ahold of another residents arm causing skin tears.</p> <p>Record review of incident report dated 9/04/2023 indicated another resident was yelling and Resident #3 went up to him and scratched left side of chin.</p> <p>Record review of incident report dated 7/21/2023 indicated Resident #3 .was near Resident #1 scratching him. Residents immediately separated.</p> <p>Record review of incident report dated 7/10/2023 indicated Resident #3 .rolled up to another resident who was having verbal outbursts and pinched and scratched resident near the right side of his neck.</p> <p>Record review of incident report dated 7/04/2023 indicated Resident #3 .rolled up to another resident who was yelling out loudly. She began scratching and grabbing at him .Staff was unable to get to the residents in time before contact was made.</p> <p>Record review of incident report dated 6/23/2023 indicated Resident #3 .was wheeling past another resident when she yelled ouch.</p> <p>Record review of incident report dated 5/08/2023 indicated Resident #3 .was heard shouting at other resident stating get out of way, other resident heard stating no you move, staff intervened, and other resident noted with scratch to left hand 3.0 x1.0.</p> <p>Record review of incident report dated 5/01/2024 indicated staff heard but did not see residents arguing and possible hitting at each other. Then other resident slinging a plate leaving, then noted a split between upper lip and nose 2 x .1cm. She was bleeding from area.</p> <p>Record review of incident report dated 3/21/2024 indicated Resident #3 .went to another resident in the living area and grabbed ahold of her shirt and her right arm causing a skin tear to her lower right forearm.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of incident report dated 3/08/2024 indicated another resident tried to grab her tray and Resident #3 grabbed ahold of the resident and caused her to get a skin tear.</p> <p>During an observation on 6/03/2024 at 3:12 PM, Resident #3 was observed sitting up in wheelchair in secured unit common area. Resident #3 did not answer questions appropriately due to cognition.</p> <p>4. Record review of Resident #4's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a condition affecting the brain in which a person loses the ability to think, remember, learn, make decisions, and solve problems), and senile degeneration of the brain (loss of intellectual ability).</p> <p>Record review of Resident #4's quarterly MDS assessment dated [DATE] revealed a BIMS score was 8 which indicated moderate cognitive impairment. Resident #4's thinking was continuously disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject).</p> <p>Record review of Resident #4's care plan dated 5/03/2023 revealed She had potential to be physically aggressive, and combative with staff during ADL care related to dementia with actual physical aggression on: 2/16/2024, 11/21/2023, 11/20/2023, 11/14/2023, 10/18/2023, 9/23/2023, 5/22/2023 with interventions that included: Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. Monitor/document/report PRN any signs/symptoms of resident posing danger to self and others. Psychiatric/Psychogeriatric consult as needed. Staff monitor for aggression and redirect as needed. Staff to monitor for personal space. When the resident becomes agitated: intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later.</p> <p>Record review of incident report dated 7/25/2023 indicated another resident grabbed Resident #4 by her right wrist/lower arm .</p> <p>Record review of incident report dated 6/05/2023 indicated Resident #4 .was redirecting to a quiet area for safety when she reached out and grabbed another resident by the arm.</p> <p>Record review of incident report dated 3/08/2024 indicated Resident #4 .was in dining room and tried to take another resident's tray of food, before staff could get there, other resident grabbed her wrist causing a skin tear to left wrist area.</p> <p>During an observation on 6/03/2024 at 3:17 PM, Resident #4 was observed sitting up in wheelchair in secured unit common area. Resident #4 did not answer questions appropriately due to cognition.</p> <p>5. Record review of Resident #5's electronic face sheet revealed an [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: unspecified dementia, unspecified severity, with other behavioral disturbance, (mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems), bipolar disorder severe with psychotic features (psychosis, including hallucinations, delusions, or jumbled thoughts) and unspecified psychosis (disconnection from reality).</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #5's quarterly MDS assessment dated [DATE] revealed a BIMS score was not able to be obtained. Staff assessment for mental status revealed Resident #5 had short- and long-term memory problem. Resident #5's thinking was continuously disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject). Resident #5 had difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said.</p> <p>Record review of Resident #5's care plan dated 01/31/2024 revealed he had potential to be physically aggressive related to poor impulse control and bipolar severe with psychotic features with actual physical aggression on 3/28/2024, 3/12/2024, and 1/22/2024. Interventions included: if behavior is a threat to themselves or others, immediately call for assistance. Observe for and immediately report to the nurse and coordinator any signs or symptoms posing a danger to self and/or others. Psychiatric/psychological consult as indicated and ordered by MD. The resident is/has potential to be verbally and physically aggressive towards staff (patient hit other patient with wet floor sign on 9/02/2023), tends to hold onto female residents, becomes angry and aggressive when redirected with interventions that included: Assess residents understanding of the situation. Allow time for the resident to express self and feelings towards the situation. Psychiatric/Psychogeriatric consult as indicated.</p> <p>Record review of incident report dated 3/12/2024 indicated Resident #5 .went into another residents room and grabbed her left arm and elbow causing bruising.</p> <p>During an observation and interview on 6/03/2024 at 3:01 PM, Resident #5 was Observed sitting up in bed in room awake and alert. Resident #5 said no one had ever hurt him in any way. Resident #5 said staff did not always treat him nice but would not give any other details. Resident #5 said he took care of himself and did not let anyone treat him badly.</p> <p>6. Record review of a facility face sheet dated 6/5/24 for Resident #6 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: Alzheimer's disease, heart failure, type 2 diabetes mellitus and cerebral infarction (stroke).</p> <p>Record review of a quarterly MDS assessment dated [DATE] for Resident #6 indicated that she had a BIMS score of 5, which indicated that she had severe cognitive impairment. Section C (Cognitive Patterns) indicated that she suffered from inattention and disorganized thinking.</p> <p>Record review of a comprehensive care plan dated 4/17/23 with last revision date of 6/4/24 for Resident #6 indicated that she had the potential to be physically aggressive r/t paranoid schizophrenia with actual physical aggression on 04/04/2023, 05/03/2023, 06/29/2023, 10/22/20203, 12/12/2023, 01/09/2024, 01/11/2024, and 05/22/2024 with interventions including: .If behavior is a threat to myself or others, immediately call for assistance .; .Observe for and immediately report to the nurse and coordinator any signs or symptoms posing a danger to myself and/or others .; and .Triggers for physical aggression are (other residents in my personal space or messing with my belongings). The behavior is de-escalated by (keeping my personal space and no one messing with my belongings) .</p> <p>Record review of an incident report dated 5/22/24 for Resident #6 indicated that she .got agitated at another resident for banging on the door, pulled her hair and pushed her .</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a quarterly MDS dated [DATE] for Resident #9 indicated that she had a BIMS score of 4, which indicated that she had severely impaired cognition. Section C (Cognitive Patterns) indicated that she suffered from inattention and disorganized thinking.</p> <p>Record review of a comprehensive care plan for Resident #9 indicated that she had potential to be physically aggressive (hitting staff and residents) r/t Dementia with physical Aggression received on 05/22/2024.</p> <p>Record review of an incident report dated 5/22/24 for Resident #9 indicated that she had her hair pulled and was pushed down by another resident.</p> <p>10. Record review of a facility face sheet dated 6/5/24 for Resident #10 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: dementia, repeated falls, depression, and type 2 diabetes.</p> <p>Record review of a quarterly MDS assessment dated [DATE] for Resident #10 indicated that she had a BIMS score of 4 which indicated that she had severely impaired cognition. Section C (Cognitive Patterns) indicated that she suffered from fluctuating inattention and disorganized thinking.</p> <p>Record review of a comprehensive care plan for Resident #10 dated 9/25/23 indicated that resident had potential to be physically aggressive r/t Dementia. Interventions included: .Administrator medications as ordered. Monitor/document for side effects and effectiveness .; .Assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc .; and .Psychiatric/Psychogeriatric consult as indicated .</p> <p>Record review of an incident report for Resident #10 dated 9/19/23 indicated that she was involved in a physical altercation with another resident.</p> <p>During an interview on 6/04/2024 at 2:50 PM, SW said when there was a resident-to-resident altercation she would be notified by the charge nurse or the next day in the morning meeting or nurse meeting. SW said everyone on the secured unit was on psychiatric services. She said there was staff on the secured unit that were watching for behaviors. SW said Administrator was responsible for reporting resident to resident altercations to HHSC or any other appropriate agencies.</p> <p>During an interview on 6/04/2024 at 3:10 PM, DON said she had worked at the facility since February of 2023. DON said Administrator was responsible for reporting and was not sure what the last incident was that got reported.</p> <p>During an interview on 6/04/2024 at 3:26 PM, Administrator said she had worked at the facility since January of 2023. She said she was the abuse coordinator. Administrator said she made the determination of what incidents got reported to HHSC and she was responsible for the reporting. She said resident-to-resident altercations when the residents have a diagnosis of dementia were not reportable because there was not a willful intent behind their actions. Administrator said she was looking at the incidents as the residents did not have the cognition to make a willful decision and that is why she did not realize that they were reportable.</p> <p>Record review of TULIP for facility account indicated that there were no self-reports for above incidents.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Legacy at Town Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 2212 W Reagan St Palestine, TX 75801	

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a f [TRUNCATED]

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273</p> <p>Based on observation, interview, and record review the facility failed to have evidence violations were thoroughly investigated to prevent further abuse for 7 of 10 residents (Resident #1, Resident #4, Resident #3, Resident #9, Resident #6, Resident #7, and Resident #10) reviewed for investigating abuse.</p> <p>The facility failed to ensure a thorough investigation of allegations of resident-to-resident abuse in that:</p> <ol style="list-style-type: none"> 1. The facility failed to implement the abuse policy by failing to investigate the incidents involving Resident #1 receiving abuse from Resident #2, Resident #3, Resident #4, Resident #6, and Resident #10 between 5/8/23-1/11/24. 2. The facility failed to investigate multiple incidents of resident-to-resident altercations. 3. The facility failed to implement the abuse policy by failing to investigate Resident #4 receiving abuse from Resident #1, and Resident #3 between 7/25/23- 3/8/24. 4. The facility failed to implement the abuse policy by failing to investigate Resident #3 receiving abuse from Resident #1, and Resident #8 between 6/23/23-5/1/24. 5. The facility failed to implement the abuse policy by failing to investigate Resident #9 receiving abuse from Resident #6 on 5/22/24. 6. The facility failed to implement the abuse policy by failing to investigate Resident #6 receiving abuse from Resident #5 on 3/12/24. 7. The facility failed to implement the abuse policy by failing to investigate Resident #7 receiving abuse from Resident #3 on 3/21/24. 8. The facility failed to implement the abuse policy by failing to investigate Resident #10 receiving abuse from Resident #1 on 9/19/23. 9. The facility failed to implement the abuse policy by failing to investigate the resident-to-resident altercations. <p>The facility failed to implement their abuse policy which stated .The Health Care Center will conduct an investigation of all alleged or suspected cases of abuse, neglect or misappropriation of property, and will provide notifications and information to the proper authorities according to state and federal regulations .</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An IJ was identified on 6/5/24. The IJ template was provided to the facility on [DATE] at 2:52 pm. While the IJ was removed on 6/6/24, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate threat due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.</p> <p>These failures placed residents at risk of not having allegations of abuse/neglect investigated.</p> <p>Findings included:</p> <p>1.Record review of Resident #1's electronic face sheet revealed an [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Dementia with other behavioral disturbance (problem in the brain affecting memory), schizoaffective disorder (hallucinations and mood symptoms), and sarcopenia (musculoskeletal disease in which muscle mass, strength, and performance are significantly compromised with age).</p> <p>Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 03, which indicated residents' cognition was severely impaired. Resident #1's thinking was continuously disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject).</p> <p>Record review of Resident #1's care plan dated 4/21/2023 revealed he had the potential to be physically and verbally aggressive related to dementia and schizoaffective disorder with interventions that included: 5. Monitor/document/report as needed and signs or symptoms of resident posing danger to self and others. 6. Psychiatric/Psychogeriatric consult as indicated. Resident #1 had impaired cognitive function/dementia or impaired thought processes related to Alzheimer's dementia with interventions that included: 3. Cue, reorient and supervise as needed. Resident #1 used psychotropic medications related to schizoaffective disorder with interventions that included: 3.Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy.</p> <p>Record review of an incident report dated 1/11/2024 indicated Resident #1 .was in the dining room hollering out repeatedly and another resident slapped him on his helmet.</p> <p>Record review of incident report dated 11/13/2023 indicated Resident #1 .was in bed in his room and hollered out. Another resident wandered into his room and grabbed his arm causing him to get 2 skin tears on his left forearm.</p> <p>Record review of incident report dated 10/29/2023 indicated Resident #1 .was in dining room at table yelling out. Another resident got frustrated with him hollering and grabbed his right arm causing skin tears.</p> <p>Record review of incident report dated 10/29/2023 indicated Resident #1 was .in the lobby and was hollering out randomly, .when another resident came over and flipped his wheelchair with him in it before staff could intervene.</p> <p>Record review of incident report dated 9/29/2023 indicated Resident #1 was .sitting in recliner yelling, before staff could intervene another resident approached him and hit him in the mouth, busting his lip open .</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of incident report dated 9/19/2023 indicated Resident #1 .hit another resident and the other resident hit him back and he received a skin tear to right forearm .</p> <p>Record review of incident report dated 9/04/2023 indicated Resident #1 .was yelling. Another resident went up to him and scratched left side of chin leaving 3 marks .</p> <p>Record review of incident report dated 9/03/2023 indicated Resident #1 was in wheelchair .outside of dining room and another resident got mad at him because he was yelling out and dumped him out on the floor and the wheelchair fell on top of him.</p> <p>Record review of incident report dated 8/20/2023 indicated Resident #1 .was sitting at dining room table and another resident walked up and he stated, What are you going to do about it? and the other resident slapped him in the face.</p> <p>Record review of incident report dated 7/25/2023 indicated Resident #1 .grabbed another resident by her right wrist/lower arm. Residents immediately separated .</p> <p>Record review of incident report dated 7/21/2023 indicated Resident #1 .heard yelling and found Resident #3 near resident scratching him. Residents immediately separated. Scratches noted to right lower arm .</p> <p>Record review of incident report dated 7/20/2023 indicated Resident #1 was sitting in recliner and with Resident #2 standing over him. Resident #1 said Resident #2 hit him on the left side of chin and cheek with slight redness observed.</p> <p>Record review of incident report dated 7/10/2023 indicated Resident #1 .was having verbal outbursts and another resident rolled up to him and pinched and scratched resident near the right side of his neck.</p> <p>Record review of incident report dated 7/08/2023 indicated Resident #1 .was walking by another resident who was having verbal outbursts. The resident called out you son of a bitch and he lunged towards resident and put his hand around his neck, residents were immediately separated.</p> <p>Record review of incident report dated 7/04/2023 indicated Resident #1 .was yelling out loudly. Another resident rolled up to him and she began scratching and grabbing at him .staff was unable to get to the residents in time before contact was made. Resident received multiple skin tears and scratches.</p> <p>Record review of incident report dated 6/23/2023 indicated Resident #1 .reached out and pinched another resident while the resident was wheeling past him to go to dining room.</p> <p>Record review of incident report dated 6/05/2023 indicated Resident #1 .was dozing in quiet area when his arm was grabbed by a fell ow resident.</p> <p>Record review of incident report dated 5/08/2023 indicated Resident #1 .was heard yelling no you get out of the way, when staff intervened resident was noted with scratch to left hand 3.0 x 1.0, both residents were separated and assessed .</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 6/03/2024 at 2:35 PM, Resident #1 was observed sitting up in wheelchair in common area in secured unit. Resident #1 was sitting at a table with 2 other residents with two building blocks on the table. Staff brought activities to the table after surveyor had started to interview Resident #1. Resident #1 said when asked if anyone had ever hurt him, yes. Resident #1 was alert and did not answer questions appropriately due to cognition. Resident #1 had a soft helmet in place to the top of his head.</p> <p>2.Record review of Resident #2's electronic face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Dementia with other behavioral disturbance (problem in the brain affecting memory), bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), Alzheimer's disease (disease involves parts of the brain that control thought, memory, and language), and anxiety disorder (feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).</p> <p>Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS score was not able to be obtained. Staff assessment for mental status revealed Resident #2 had short- and long-term memory problem. Resident #2's thinking was continuously disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject).</p> <p>Record review of Resident #2's care plan dated 7/11/2023 revealed he had potential to be physically aggressive related to bipolar disorder and dementia with actual physical aggression on 7/20/2023, 8/20/2023, 9/03/2023, 9/29/2023, 10/29/2023, 11/02/2023, 1/30/2024, 4/10/2024, 5/25/2024. Interventions: The resident's triggers for physical aggression are (the yelling out loud noises) resident's behaviors is de-escalated by (providing quiet environment redirecting attention removing from situation). Order to send to behavioral facility to evaluate and treat. Psychiatric/psychogeriatric consult as indicated. Request labs and do assessment to rule out medical reason for aggressive behaviors. When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later when possible. The resident had impaired cognitive function/dementia or impaired thought processes related to Alzheimer's with interventions that included: Cue, reorient and supervise as needed. Discuss concerns about confusion, disease process, and nursing home placement with resident/family/caregivers.</p> <p>Record review of incident report dated 10/29/2023 indicated Resident #2 .came into living area and flipped another resident's wheelchair on its side before staff could intervene.</p> <p>Record review of incident report dated 9/29/2023 indicated another resident sitting up in recliner in lounge area close to the dining room yelling when Resident #2 approached him and hit him in the mouth .</p> <p>Record review of incident report dated 9/03/2023 indicated Resident #2 .got angry at another resident due to him yelling. He then tipped wheelchair over making resident fall into floor and wheelchair went on top of resident .</p> <p>Record review of incident report dated 8/20/2023 indicated Resident #2 .was walking by another resident who was sitting in his wheelchair at table eating. Resident stated, what are you going to do about it? and resident then slapped the other resident in the face on the left cheek.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of incident report dated 7/20/2023 indicated Resident #2 was standing over Resident #1. Resident #1 said Resident #2 hit him on the left chin and cheek with slight redness noted.</p> <p>Record review of incident report dated 7/08/2023 indicated Resident #2 .was walking by another resident who was having verbal outbursts. The resident called out you son of a bitch and he lunged towards resident and put his hand around his neck .</p> <p>During an observation and interview on 6/03/2024 at 3:08 PM, Resident #2 was observed lying in bed awake and alert. Resident #2 was attempting to hang call light on the wall. Resident #2 did not answer questions appropriately due to cognition.</p> <p>3.Record review of Resident #3's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), Alzheimer's disease (disease involves parts of the brain that control thought, memory, and language), and anxiety disorder (feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and schizophrenia (affects a person's ability to think, feel, and behave clearly).</p> <p>Record review of Resident #3's quarterly MDS assessment dated [DATE] revealed a BIMS score was 8 which indicated moderate cognitive impairment. Resident #3's thinking was continuously disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject).</p> <p>Record review of Resident #3's care plan dated 5/04/2022 revealed She had potential to be physically aggressive towards another resident related to dementia with actual physical aggression on 3/21/2024, 3/08/2024, 1/06/2024, 11/13/2023, 9/04/2023, 7/19/2023, 5/25/2023, 5/19/2023, 5/06/2022, 5/05/2022. Interventions: If behavior is a threat to myself or others, immediately call for assistance. Psychiatric/psychological consult as indicated and ordered by physician. Triggers for physical aggression are other residents yelling out. The behavior is de-escalated by removing from the situation. Resident #3 had memory loss/dementia related to schizophrenia, delusional behaviors with interventions that included: Cue, reorient, and supervise or assist me as needed. Resident #3 had a behavior problem (including becoming physically violent toward other residents at times and refusing care at times related to advanced dementia/Alzheimer's with physical aggression on: 7/04/2023, 7/10/2023 and 8/08/2023, interventions included: monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Psych consult for medication review.</p> <p>Record review of incident report dated 11/13/2023 indicated Resident #3 .went into another residents room and grabbed his arm causing 2 skin tears to left forearm .</p> <p>Record review of incident report dated 10/29/2023 indicated Resident #3 .grabbed ahold of another residents arm causing skin tears.</p> <p>Record review of incident report dated 9/04/2023 indicated another resident was yelling and Resident #3 went up to him and scratched left side of chin.</p> <p>Record review of incident report dated 7/21/2023 indicated Resident #3 .was near Resident #1 scratching him. Residents immediately separated.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of incident report dated 7/10/2023 indicated Resident #3 .rolled up to another resident who was having verbal outbursts and pinched and scratched resident near the right side of his neck.</p> <p>Record review of incident report dated 7/04/2023 indicated Resident #3 .rolled up to another resident who was yelling out loudly. She began scratching and grabbing at him .Staff was unable to get to the residents in time before contact was made.</p> <p>Record review of incident report dated 6/23/2023 indicated Resident #3 .was wheeling past another resident when she yelled ouch.</p> <p>Record review of incident report dated 5/08/2023 indicated Resident #3 .was heard shouting at other resident stating get out of way, other resident heard stating no you move, staff intervened, and other resident noted with scratch to left hand 3.0 x1.0.</p> <p>Record review of incident report dated 5/01/2024 indicated staff heard but did not see residents arguing and possible hitting at each other. Then other resident slinging a plate leaving, then noted a split between upper lip and nose 2 x .1cm. She was bleeding from area.</p> <p>Record review of incident report dated 3/21/2024 indicated Resident #3 .went to another resident in the living area and grabbed ahold of her shirt and her right arm causing a skin tear to her lower right forearm.</p> <p>Record review of incident report dated 3/08/2024 indicated another resident tried to grab her tray and Resident #3 grabbed ahold of the resident and caused her to get a skin tear.</p> <p>During an observation on 6/03/2024 at 3:12 PM, Resident #3 was observed sitting up in wheelchair in secured unit common area. Resident #3 did not answer questions appropriately due to cognition.</p> <p>4.Record review of Resident #4's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a condition affecting the brain in which a person loses the ability to think, remember, learn, make decisions, and solve problems), and senile degeneration of the brain (loss of intellectual ability).</p> <p>Record review of Resident #4's quarterly MDS assessment dated [DATE] revealed a BIMS score was 8 which indicated moderate cognitive impairment. Resident #4's thinking was continuously disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject).</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #4's care plan dated 5/03/2023 revealed She had potential to be physically aggressive, and combative with staff during ADL care related to dementia with actual physical aggression on: 2/16/2024, 11/21/2023, 11/20/2023, 11/14/2023, 10/18/2023, 9/23/2023, 5/22/2023 with interventions that included: Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. Monitor/document/report PRN any signs/symptoms of resident posing danger to self and others. Psychiatric/Psychogeriatric consult as needed. Staff monitor for aggression and redirect as needed. Staff to monitor for personal space. When the resident becomes agitated: intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later.</p> <p>Record review of incident report dated 7/25/2023 indicated another resident grabbed Resident #4 by her right wrist/lower arm .</p> <p>Record review of incident report dated 6/05/2023 indicated Resident #4 .was redirecting to a quiet area for safety when she reached out and grabbed another resident by the arm.</p> <p>Record review of incident report dated 3/08/2024 indicated Resident #4 .was in dining room and tried to take another resident's tray of food, before staff could get there, other resident grabbed her wrist causing a skin tear to left wrist area.</p> <p>During an observation on 6/03/2024 at 3:17 PM, Resident #4 was observed sitting up in wheelchair in secured unit common area. Resident #4 did not answer questions appropriately due to cognition.</p> <p>5.Record review of Resident #5's electronic face sheet revealed an [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: unspecified dementia, unspecified severity, with other behavioral disturbance, (mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems), bipolar disorder severe with psychotic features (psychosis, including hallucinations, delusions, or jumbled thoughts) and unspecified psychosis (disconnection from reality).</p> <p>Record review of Resident #5's quarterly MDS assessment dated [DATE] revealed a BIMS score was not able to be obtained. Staff assessment for mental status revealed Resident #5 had short- and long-term memory problem. Resident #5's thinking was continuously disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject). Resident #5 had difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said.</p> <p>Record review of Resident #5's care plan dated 01/31/2024 revealed he had potential to be physically aggressive related to poor impulse control and bipolar severe with psychotic features with actual physical aggression on 3/28/2024, 3/12/2024, and 1/22/2024. Interventions included: if behavior is a threat to themselves or others, immediately call for assistance. Observe for and immediately report to the nurse and coordinator any signs or symptoms posing a danger to self and/or others. Psychiatric/psychological consult as indicated and ordered by MD. The resident is/has potential to be verbally and physically aggressive towards staff (patient hit other patient with wet floor sign on 9/02/2023), tends to hold onto female residents, becomes angry and aggressive when redirected with interventions that included: Assess residents understanding of the situation. Allow time for the resident to express self and feelings towards the situation. Psychiatric/Psychogeriatric consult as indicated.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of incident report dated 3/12/2024 indicated Resident #5 .went into another residents room and grabbed her left arm and elbow causing bruising.</p> <p>During an observation and interview on 6/03/2024 at 3:01 PM, Resident #5 was Observed sitting up in bed in room awake and alert. Resident #5 said no one had ever hurt him in any way. Resident #5 said staff did not always treat him nice but would not give any other details. Resident #5 said he took care of himself and did not let anyone treat him badly.</p> <p>6. Record review of a facility face sheet dated 6/5/24 for Resident #6 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: Alzheimer's disease, heart failure, type 2 diabetes mellitus and cerebral infarction (stroke).</p> <p>Record review of a quarterly MDS assessment dated [DATE] for Resident #6 indicated that she had a BIMS score of 5, which indicated that she had severe cognitive impairment. Section C (Cognitive Patterns) indicated that she suffered from inattention and disorganized thinking.</p> <p>Record review of a comprehensive care plan dated 4/17/23 with last revision date of 6/4/24 for Resident #6 indicated that she had the potential to be physically aggressive r/t paranoid schizophrenia with actual physical aggression on 04/04/2023, 05/03/2023, 06/29/2023, 10/22/2023, 12/12/2023, 01/09/2024, 01/11/2024, and 05/22/2024 with interventions including: .If behavior is a threat to myself or others, immediately call for assistance .; .Observe for and immediately report to the nurse and coordinator any signs or symptoms posing a danger to myself and/or others .; and .Triggers for physical aggression are (other residents in my personal space or messing with my belongings). The behavior is de-escalated by (keeping my personal space and no one messing with my belongings) . Intervention added on 5/24/24 after incident on 5/22/24 read .Send to ER for evaluation and treatment reference to behaviors .</p> <p>Record review of an incident report dated 5/22/24 for Resident #6 indicated that she .got agitated at another resident for banging on the door, pulled her hair and pushed her .</p> <p>7. Record review of a facility face sheet dated 6/5/24 for Resident #7 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: Sarcopenia (gradual loss of muscle mass, strength and function), dysphagia (trouble swallowing), bipolar disorder(a mental health condition that causes extreme mood swings between emotional highs and lows), and dementia.</p> <p>Record review of a quarterly MDS assessment dated [DATE] for Resident #7 indicated that she had a BIMS score of 2, which indicated that she had severely impaired cognition. Section C (Cognitive Patterns) indicated that she suffered from inattention and disorganized thinking.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of a comprehensive care plan for Resident #7 initiated on 6/2/22 and revised on 5/14/24 indicated that Resident #7 had physical aggressive behaviors at times r/t dementia, poor impulse control. Interventions included: .If I show signs of agitation, intervene before it escalates: remain calm, take a deep centering breath, stand out of reach, listen, and respond with empathy, guide away from source of distress; calmly engage in conversation. If response is aggressive, team member is to calmly walk away, ask others to leave the area, ensure everyone is safe, and immediately report this to nurse, discuss other approaches and approach later .; .Observe for and immediately report to the nurse and coordinator any signs or symptoms posing a danger to myself and/or others .; and .Talk with a low pitch, calm voice to decrease/eliminate undesired behavior & provide diversional activity . No new interventions were added to the care plan following incident on 3/21/24 when resident was victim of physical aggression.</p> <p>Record review of an incident report dated 3/21/24 for Resident #7 indicated that she suffered a skin tear when another resident grabbed her shirt and arm.</p> <p>8. Record review of a facility face sheet dated 6/5/24 for Resident #8 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: dementia, dysphagia (trouble swallowing), major depressive disorder, and hyperlipidemia (high cholesterol).</p> <p>Record review of an annual MDS assessment dated [DATE] for Resident #8 indicated that he had a BIMS score of 6, which indicated that he was severely cognitively impaired.</p> <p>Record review of a comprehensive care plan for Resident #8 dated 5/18/22 and revised on 5/13/24 indicated that he had the potential to be physically aggressive r/t dementia, poor impulse control and was physically aggressive with another resident on 5/17/23 and 5/1/24. Interventions included: .Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document in notes .; .Modify environment: adjust room temperature to comfortable level, reduce noise, dim lights, place familiar objects in room, keep door closed .; and .Monitor for anxiety/aggression and redirect as needed . The followig intervention was added after incident on 5/1/24: .Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document in notes .</p> <p>Record review of an incident report dated 5/1/24 for Resident #8 indicated that he was .slinging dinner plate, possibly hit another resident leaving a split between upper lip and nose 2 x 0.1 cm. She was bleeding from area .</p> <p>9. Record review of a facility face sheet dated 6/5/24 for Resident #9 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: dementia, repeated falls, osteoporosis (weak, brittle bones), and anxiety disorder.</p> <p>Record review of a quarterly MDS dated [DATE] for Resident #9 indicated that she had a BIMS score of 4, which indicated that she had severely impaired cognition. Section C (Cognitive Patterns) indicated that she suffered from inattention and disorganized thinking.</p> <p>Record review of a comprehensive care plan for Resident #9 indicated that she had potential to be physically aggressive (hitting staff and residents) r/t Dementia with physical Aggression received on 05/22/2024. No new interventions were added to the care plan following resident being a victim of aggression on 5/22/24.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of an incident report dated 5/22/24 for Resident #9 indicated that she had her hair pulled and was pushed down by another resident.</p> <p>10. Record review of a facility face sheet dated 6/5/24 for Resident #10 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: dementia, repeated falls, depression, and type 2 diabetes.</p> <p>Record review of a quarterly MDS assessment dated [DATE] for Resident #10 indicated that she had a BIMS score of 4 which indicated that she had severely impaired cognition. Section C (Cognitive Patterns) indicated that she suffered from fluctuating inattention and disorganized thinking.</p> <p>Record review of a comprehensive care plan for Resident #10 dated 9/25/23 indicated that resident had potential to be physically aggressive r/t Dementia. Interventions implemented on 9/25/23 after incident on 9/19/23 included: .Administrator medications as ordered. Monitor/document for side effects and effectiveness .; .Assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc .; and .Psychiatric/Psychogeriatric consult as indicated .</p> <p>Record review of an incident report for Resident #10 dated 9/19/23 indicated that she was involved in a physical altercation with another resident.</p> <p>During an interview on 6/04/2024 at 2:50 PM SW said when there was a resident-to-resident altercation she would normally be notified by the charge nurse, or the next day in the morning meeting or nurse meeting. The SW said she would try to find the reason for the altercation and address it, she would make sure residents needs were met to see if that was why they were agitated, then possibly add activities. The SW said Administrator was responsible for reporting resident to resident altercations to HHSC or any other appropriate agencies, and they (administrative staff) worked together to ensure that allegations were investigated.</p> <p>During an interview on 6/04/2024 at 3:10 PM, the DON said she had worked at the facility since February of 2023 She said that when the CNA's were making rounds, the nurse and med aid were watching other residents. The DON said the staff would notify the unit manager, DON, or the Administrator of any resident-to-resident altercations. The DON said Administrator does all the reporting and she was not sure what the last incident was that got reported. She said they all work together to investigate incidents during the investigation process.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273</p> <p>Based on interview, and record review, the facility failed to provide adequate supervision and assistance devices to prevent accidents for 1 of 10 residents reviewed for accidents. (Resident #27).</p> <p>On [DATE] CNA A failed to ensure a safe transfer for Resident #27 by transferring with only 1 staff member when she required 2 staff members for transfers which led to Resident #27 suffering a 4 cm toe laceration requiring sutures.</p> <p>The noncompliance was identified as PNC (past non-compliance). The non-compliance began on [DATE] and ended [DATE]. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place residents who required supervision at risk of injury or accidents and hospitalization .</p> <p>Findings included:</p> <p>Record review of a facility face sheet dated [DATE] indicated that Resident #27 was a [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: dementia, sarcopenia (gradual loss of muscle mass, strength, and function) and dysphagia (trouble swallowing).</p> <p>Record review of a quarterly MDS assessment dated [DATE] for Resident #27 indicated that she was unable to complete the Brief Interview of Mental Status interview. Section C (Cognitive Patterns) indicated that she had severe cognitive impairment. Section GG (Functional Abilities and Goals) indicated that she required extensive assistance of 2+ persons with transfers.</p> <p>Record review of a comprehensive care plan for Resident #27 dated [DATE] indicated that she was at risk for falls and interventions included .Provide a safe environment: clutter free; support/assistive devices are available and in good repair .</p> <p>Record review of an ADL task documentation sheet for Resident #27 for the month of [DATE] indicated that she was a 2 person transfer and on [DATE] CNA A documented transfer with Resident #27 with a ,d+[DATE] on flow sheet: 3 indicated that she required extensive assistance and 2 indicated 1-person physical assist.</p> <p>Record review of a progress note dated [DATE] at 10:58 am for Resident #27 indicated that she was observed by staff .with a large amount of blood on sock .noted with a large slit from inside of great toe around the back of toe. Laceration measures 4cm in length. Area cleansed with NS and pressure dressing applied. [physician name] notified received order to send her to ER for eval. Administrator, DON, ADON, RP, all notified . signed by LVN AD.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a witness statement dated [DATE] and signed by CNA A read .After breakfast, I laid [Resident #27 name] in a recliner shortly after she was done eating. She did not complain of any pain or signs distress. [Resident] was anxious to lay down. Did not notice any blood on sock or on floor .</p> <p>Record review of hospital records for Resident #27 dated [DATE] indicated that she was seen in the emergency room for a laceration of the great toe, received sutures, and was returned to the facility the same day with an order to remove sutures in ,d+[DATE] days.</p> <p>Record review of a proficiency form titled Gait Belt Transfer Proficiency dated [DATE] indicated that CNA A received training on gait belt transfers on [DATE] and passed the proficiency check off with 1 and 2 person transfers on [DATE]. No prior trainings were provided.</p> <p>Record review of a form titled Employee Disciplinary/Counseling Action Notice dated [DATE] for CNA A read . suspension pending investigation of injury to a resident by transferring with only one staff when resident is care planned for 2 staff during transfers . Form was signed by CNA A, Administrator, and DON.</p> <p>Record review of Resident #27's electronic medical record indicated that she expired in facility on [DATE] due to unrelated causes. Therefore, Resident #27 was not observed or interviewed.</p> <p>During a joint interview on [DATE] at 5:30 pm Administrator and DON said CNA A expressed that he just did not realize Resident #27 was always to be a 2-person transfer. He was suspended pending investigation and written up for an unsafe transfer. He returned to work on [DATE] after education and training and had no further incidents with unsafe transfers or resident injuries. Administrator said she expected her staff to follow protocol by checking the Kardex (documentation system that enables nurses to write, organize, and easily reference key patient information that shapes their nursing care plan) and to keep residents safe. Both said residents could be at risk of injuries if transferred improperly.</p> <p>Attempted telephone interview with CNA A on [DATE] at 1:35 pm, there was no answer. A voicemail was left requesting a return phone call. No return call received before exiting facility.</p> <p>Record review of a proficiency check off titled Gait Belt Transfer Proficiency with revision date of ,d+[DATE] read .5. Obtain assistance, if needed .9. Safely transfer resident .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273</p> <p>Based on observations, interviews, and record reviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 3 residents (Resident #31) reviewed for infection control.</p> <p>The facility failed to ensure CNA B performed proper hand hygiene when providing incontinent care to Resident #31 on 6/3/2024.</p> <p>This failure could place residents at risk of exposure to communicable diseases and infections.</p> <p>Findings include:</p> <p>Record review of a facility face sheet dated 6/5/24 for Resident #31 indicated that he was an [AGE] year-old male admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), depression, dementia, and hypertension (high blood pressure).</p> <p>Record review of a comprehensive MDS assessment dated [DATE] for Resident #31 indicated that he had a BIMS score of 4, which indicated that he had severely impaired cognition. Section H (Bowel and Bladder) indicated that he was always incontinent of bowel and bladder.</p> <p>Record review of a comprehensive care plan dated 5/27/23 for Resident #31 indicated that he was incontinent of bladder and bowel and included an intervention to clean peri-area after each incontinent episode.</p> <p>During an observation on 6/3/24 at 2:20 pm CNA B was observed inside the room of Resident #31. Resident #31 was observed lying in bed. CNA B was observed to lay a plastic bag on the bed for dirty brief, wipes, and trash. She was then observed to put on gloves and proceeded to undo resident's brief. She wiped the resident's peri area and then, keeping on same gloves, she rolled resident over to clean bottom area. Once bottom was cleaned, she removed the brief and placed it and used wipes in the plastic bag. She kept on the same gloves and put a clean brief on the resident and secured it. She then removed her gloves and exited the room without washing her hands.</p> <p>During an interview on 6/3/24 at 2:29 pm CNA B was observed at clean linen cart getting clean trash bags. She said she did not wash her hands yet because she still had to take the dirty linens out. She said she would wash them after that.</p> <p>During an interview on 6/3/24 at 3:30 pm DON said that she would expect her CNAs providing incontinent care to wash their hands before, during and after providing incontinent care to a resident. She said this was an agency CNA and she would ensure she got training today.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/4/24 at 8:30 am the Administrator said that CNA B would not be returning to facility. She said the DON was checking her off on female peri care and CNA B did not pass the proficiency. She said they had placed CNA B on a do not return list.</p> <p>During a joint interview on 6/6/24 at 5:30 pm DON and Administrator said they expect their staff to follow proper procedure during incontinent care and perform handwashing appropriately. They both said that residents could be at risk of infection if staff were not properly washing their hands.</p> <p>Record review of a facility policy titled Handwashing/Hand Hygiene dated 2001 and revised August 2015 read .All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, resident, and visitors . and use an alcohol-based hand rub containing at least 62% alcohol; or, alternately, soap (antimicrobial or non-antimicrobial) and water for the following situations: . h. before moving to a contaminated body site to a clean body site during resident care; .m. after removing gloves . and .Hand hygiene is the final step after removing and disposing of personal protective equipment .</p> <p>Record review of a facility policy titled Infection Control Guidelines for All Nursing Procedures dated 2001 and revised in August 2015 read .Employees must wash their hands for ten (10) to fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: a. before and after direct contact with residents .d. After removing gloves; e. After handling items potentially contaminated with blood, body fluids, or secretions .</p>		