STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676006	A. Building B. Wing	01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Health Care Center	705 Jackson St Richmond, TX 77469

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25263 Based on observation, interview and record review the facility failed to ensure all alleged violations involving abuse were reported immediately within 2 hours to state agency for 1(Resident #1) of 6 reviewed for reporting in that: Administration failed to report to the state agency when Resident #1, who had dementia was not able to tell them how she got skin tears to both sides of her neck on 1/10/2024. This failure placed current residents at risk for abuse. Findings Included: Observation on 1/12/2024 at 10:00 a.m. of Resident #1's neck revealed a skin tear and bruise on the right side of her neck and a bandage slightly left of her throat. Record review of Resident #1 undated face sheet revealed a [AGE] year-old female that was admitted to the facility on [DATE] with diagnoses: Dementia (unspecified), Emphysema (is a chronic lung condition that cause blockage of airflow in the lungs), Traumatic subdural hemorrhage without loss of consciousness(caused by a head injury, such as a blow to the head), heart failure(a chronic condition in which the heart does not pump blood as well as it should), chronic kidney disease and age-related osteoporosis. Record review of Resident #1's MDS dated [DATE] revealed BIMS score was coded at 06 which suggests severe cognitive impairment. Functional Abilities & Goals revealed Roll left and right, sit to lying, lying to sitting, sit to stand, chair to bed transfers, and toileting transfers were all coded as (03)- which meant Partial/moderate assistance with helper did more than half the effort. Record review of the incident reports from 10/12/2023-1/12/2024 did not notate skin tears to Resident #1's neck. Record review of Resident #1 progress nursing note dated 1/11/2024 revealed Nurse A wrote: The outgoing nurse reported Resident #1 had skin tears to both left and right neck. The writer did skin assessment and noted the tears had been covered with bandages. No acute distress, shortness of breath noted. At 12:35 a. m. Resident #1 FM came into the facility to check on her wellbeing. The resident denied pain and no further concerns as of present. Plan of care ongoing and call light within reach . (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676006	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/12/2024
NAME OF PROVIDER OR SUPPLIER Richmond Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 705 Jackson St Richmond, TX 77469	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Resident #1 on 1/12/2024 at 10:03 a.m. revealed she did not know what happened to her neck. She did not recall having a fall. She said she never had visitors to come see her. She could not recall CR#2(roommates' name). She said no one told her about what happened to her. She fell asleep so the interviewed ended. An interview and observation with FM of CR#2 on 1/12/2024 at 10:15 a.m. revealed CR#2 was at a local hospital because of a medical condition. He said she was confused and sometimes combative since she had a stroke in June 2023. He said Resident was a young robust person and really needed to be in another type of facility mostly for her behaviors. He said she does use profanity at times but denied any knowledge of an altercation with Resident #1, CR#2, or her family member. He stated that he visited with her every other week. He said he was not her RP. He began to pack her personal belongings and said she would not be returning to the facility. He said he was not her RP. An interview with Nurse B on 1/12/2023 at 10:30 a.m., revealed she was not at work on 1/10/2024 or 1/11/2024, she returned to work on today (1/12/2024). She said the notes in PCC stated that it was unknown how the skin tears happened . She said that she was not aware of any altercations verbal or physical between Resident #'s 1 and 2. She stated she has been employed at the facility for 3 months and worked on this unit daily. Interviews separately with two CNA's on 1/12/2024 at 10:42 a.m. revealed they were not aware of what happened to Resident #1's neck. They said the Abuse Coordinator was the Administrator. They were able to identify types of abuse. An interview attempted with Resident #1's RP was unsuccessful on 1/12/2024 at 11:17 a.m. An interview with the DON on 1/12/2024 at 1:30 p.m., revealed Resident #1 most likely scratched herself. She said she asked Resident #1 what happened to her, and she said some man tried to kill her . She said in speaking with staff no one saw how Resident #1 got the skin tears. She said she spoke with Resident #1's RP on or about 1/11/2024 and she said she had recently (over previous weekend on or about 1/6/24), had Resident #1's nails cut. So, she did not believe that she could have scratched herself unless a hang nail was left. She stated Resident #1's RP complained that CR#2 was talking crazy recently. She said CR#2 was using profanity towards Resident #1's FM, not Resident #1. She said RP said she turned the television up to tune her out. She said RP had not reported any behavior towards her or Resident #1 prior to that incident. She said RP never implied that she suspected CR#2 of abusing Resident #1. The DON stated Nurse C had discovered the skin tears on 1/10/2024. She said a skin tear could be considered an injury of unknown origin if the resident had dementia or could not verbally tell them what happened. She said this would be considered something reportable to State agency. She said either the Administrator or herself would report an incident to State agency. She said they had no evidence of abuse by CR#2 or staff. So, it was not reported. She said she was not aware of any other incidents with CR#2 other than her wandering at night. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Resident #1's FM on 1/12/2024 at 1:50 p.m., revealed yesthe DON was made aware of the incident concerning CR#2 using profanity towards her, not Resident #1. She said she could not recall the exact date, but this incident occurred between 1/9/2024-1/10/2024. She said, she was visiting Resident #1 when CR#2 attempted to sit down on her bed. The FM stated she told her she could not sit on Resident #1's bed. She said CR#2 was about to sit on Resident #1's leg so she walked towards the bed to stop her from sitting. She said CR#2 began using profanity towards her, so she yelled for a nurse. She said she did not know the CNA's name, but she came in after hearing CR#2 cursing and asked her to reframe from using profanity. She said the CNA pulled the curtain to give FM and Resident #1 privacy, but CR#2 tried to open the curtain and continued to use profanity. She said she had not received a call about a fall, so she told the DON that she felt badly to think that CR#2 might have done this to Resident #1. But it was possible given her behavior the previous day. She denied any other incidents involving Resident #1 and CR#2. An interview with an anonymous FM on 1/12/2024 at 2:18pm, revealed Nurse C reported CR#2 was no longer at the facility because she had attacked Resident #1. An interview attempted with Nurse C on 1/12/2024 at 2:26 p.m., was unsuccessful. Record review of an undated facility responsibilities reporting allegations policy read in part: Injuries of unknown source when it is unobserved/unexplained scratches and bruises found in suspicious locations such as head, neck, upper chest or back is reportable. There was no timeframe indicated to report injuries of unknown source.