

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Immanuel's Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 4515 Village Creek Rd Fort Worth, TX 76119	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 45053</p> <p>Based on interview and record review, the facility failed to ensure that all alleged violations involving mistreatment, neglect, or abuse, are reported immediately to the Administrator of the facility and to other officials in accordance with Texas law no later than two hours after the allegation is made, for 1 (Resident #2) of 6 residents reviewed for abuse and neglect in that:</p> <p>1. LVN A failed to report the allegation of abuse to facility's abuse coordinator, Administrator, when Resident #2 alleged that LVN A punched her on the shoulder(date unknown).</p> <p>These failures placed residents at risk of ongoing abuse, physical and psychological harm.</p> <p>Findings include:</p> <p>Record Review of the Face Sheet for Resident #2 revealed an [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included: dementia (a chronic condition that causes a gradual decline in cognitive abilities, such as thinking, remembering, and reasoning), bipolar disorder (a mental illness that causes extreme mood swings, affecting a person's energy, activity levels, and concentration), anxiety disorder (a mental health condition that causes excessive and persistent fear or worry that can interfere with daily life), and paranoid personality disorder (a mental condition in which a person has a long-term pattern of distrust and suspicion of others).</p> <p>Record Review of Resident #2's Annual MDS dated [DATE] revealed she had a BIMS of 15 indicating her cognition is intact. Further review of the MDS revealed that she required a wheelchair for bed mobility. Resident #2 required supervision or touching assistance from one staff for toileting hygiene, shower/bath, upper body dressing, and personal hygiene.</p> <p>Record review of Resident #2's Care Plan dated 06/27/24 revealed,</p> <p>Focus: CANCELLED: [Resident #2] has potential to demonstrate verbally abusive behaviors.</p> <p>Curses and yells at staff. Multiple complaints with all attempts to resolve complaints met with more complaints. Resident states she does not know how to be respectful.</p> <p>Date Initiated: 11/18/2020</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Revision on: 09/20/2024</p> <p>Cancelled Date: 09/20/2024</p> <p>Goal: CANCELLED: [Resident #2] will demonstrate effective coping skills through the review date.</p> <p>Date Initiated: 11/18/2020</p> <p>Revision on: 09/20/2024</p> <p>Cancelled Date: 09/20/2024</p> <p>CANCELLED: The resident will verbalize understanding of the need to control verbally abusive behavior through the review date.</p> <p>Date Initiated: 11/18/2020</p> <p>Revision on: 09/20/2024</p> <p>Cancelled Date: 09/20/2024</p> <p>Interventions:</p> <p>CANCELLED: Assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc.</p> <p>Date Initiated: 11/18/2020</p> <p>Revision on: 09/20/2024</p> <p>Cancelled Date: 09/20/2024</p> <p>CANCELLED: Assess resident's understanding of the situation. Allow time for the resident to express self and feelings towards the situation.</p> <p>Date Initiated: 11/18/2020</p> <p>Revision on: 09/20/2024</p> <p>Cancelled Date: 09/20/2024</p> <p>CANCELLED: Provide positive feedback for good behavior. Emphasize the positive aspects of compliance.</p> <p>Date Initiated: 11/18/2020</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 - Few</p>	<p>In an interview with LVN A on 10/18/24 at 2:22 PM, he stated that he had been employed as the ADON at the facility for 5 months. He stated that Resident #2 received a 30-day Discharge Letter from the facility due to her behaviors of being aggressive with staff, residents, and an incident involving another resident in which she kicked him on his legs. He stated that Resident #2 was discharged from the facility at the beginning of last month (September 2024). He stated that Resident #2 did not get along with some of the staff, but she really liked LVN A. He stated that the incident occurred on his second day of employment at the facility. He stated that during the first week of his employment at the facility, he made his first rounds with the residents at the facility, he introduced himself to Resident #2 and he placed his hands on her shoulder as a friendly gesture. He stated that 2 months after Resident #2's admission, he saw Resident #2 in the hallway, and he asked her if she remembered him, and she then told him that she remembered him because he punched her on her shoulder. LVN A stated that after Resident #2 told him that he punched her on her shoulder, he told her that she was just being silly. He stated that he did not report the incident to the DON or the previous Administrator. He stated that when Resident #2 made the allegation of him punching her, another staff member was present. When asked who the staff member present was, he stated that he could not remember. He stated that after Resident #2 accused him of punching her, he always made sure that another staff member was present when he had any interactions with her. He stated that he was aware that when a resident, such as Resident #2 accused any staff member, including himself of punching her, that was considered abuse. He stated that he conducted the in-service trainings at the facility for abuse/neglect/exploitation for the staff at the facility. LVN A was asked to define abuse and neglect and he was unable to provide definitions of each. LVN A was asked the risk and harm, if any could be caused to Resident #2 or the other residents at the facility who made an allegation of abuse or neglect, and the alleged perpetrator remained at the facility. He stated that he did not know what the risk of harm could be caused to a resident if they made an allegation of abuse or neglect, and the alleged perpetrator remains at the facility and has access to other residents .</p> <p>Record review of the Nurses Progress Notes for Resident #2 for July 2024 - September 6, 2024, did not reveal any information regarding abuse of Resident #2 by LVN A.</p> <p>Record Review of the Facility's Incident log for the months of July 2024 - September 6, 2024, did not reflect an incident involving Resident #2 and ADON.</p> <p>Record Review of the facility's Resident Council Minutes for the months of April - October 2024 did not reflect any concerns regarding Resident #2.</p> <p>Record Review of the facility's Grievances from June 2024 - October 2024 did not reflect any concerns regarding Resident #2.</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 - Few</p>	<p>In an interview on 10/18/24 at 2:50 PM, with the DON, she stated that she would speak with Resident #2 daily, and she would talk to her about her complaints or concerns. She stated that Resident #2 never made an outcry of abuse to her alleging that LVN A punched her. She stated that she was unaware that Resident #2 made an allegation of abuse, stating that LVN A punched her 2 months ago. She stated that Resident #2 had some behaviors and received a Notice of Recommended Discharge from the facility on 08/15/24 due to her being involved in a resident-to-resident altercation with another resident. She stated that Resident #2 was verbally and physically abusive to staff on several occasions. She was advised that although Resident #2 had been involved in incidents at the facility, she made an allegation of being abused by LVN A, the incident should have been reported to the state within 2 hours and investigated by the facility. The DON agreed that the allegation of LVN A punching Resident #2 should have been reported to the Administrator, the facility abuse coordinator, and stated that the risk to Resident #2 making an allegation of abuse and the facility not investigation the allegation placed the other residents at the facility at risk of harm due to LVN A remaining at the facility after the allegation was made by Resident #2. She stated that the harm to the residents at the facility due to LVN A remaining at the facility after the allegation was made by Resident #2 could be physical, mental and emotional abuse.</p> <p>In an Interview with the Administrator on 10/18/24 at 3:21 PM, he stated that he had only been at the facility for 4 days. He stated that he was unaware about Resident #2 making an allegation to LVN A alleging that he punched her approximately 2 months ago. He stated that if there was any time a resident made an allegation against a staff member stating that the staff hit them, he would consider that as an abuse allegation. He stated that he submit a self-report to the State, and he would have 5 days to investigate the allegation of abuse. He stated that he would ensure the resident's safety by having his staff perform a head to toe assessment on the resident to see if the resident has any bruises, marks, discoloration on their body. He stated that he would contact the resident's responsible party and doctor to advise them of the situation. He stated that he would immediately suspend the alleged perpetrator pending the facility's investigation of the incident. He said that he was the Abuse Coordinator He stated the incident occurred prior to his employment at the facility. He said that he was not informed about the incident until it was brought to his attention by State Surveyor on 10/18/24. He agreed that it was an incident that should have been reported to the State. He stated that the risk of Resident #2 making an allegation of abuse by LVN A put all the residents in the facility at risk of harm.</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 - Few</p>	<p>In an interview with the Owner on 10/18/24 at 3:35 PM, he stated that he was not aware that Resident #2 made an allegation of abuse to LVN A until the State Surveyor notified him on 10/18/24. He stated that anytime a resident made an allegation of abuse by any staff, the staff member would be suspended immediately pending the facility's investigation. He stated that LVN A would need to write a statement about the incident so that it could be investigated by the facility. He stated that LVN A would receive a 1 on 1 training by the DON and he would ensure that all staff were reeducated and retrained on abuse/neglect/exploitation and via in-service trainings as soon as possible. He stated that LVN A would be suspended immediately pending the facility's Investigation and he would make a self-report to the State regarding Resident #2's allegation that LVN A punched her. He stated that there was a huge risk to the residents at the facility when any resident made an allegation of abuse and neglect involving staff which was safety of the residents. He stated that LVN A should have reported the incident to the DON and the previous Administrator should have made a self-report to the State. He stated the due to LVN A not reporting the allegation of abuse by a resident to administration, family and the resident's physician it could potentially cause harm to the resident that made the allegation of abuse and the other residents at the facility. He stated that due to the abuse allegation from Resident #2 not being reported to the State harm could be caused if they ignored the allegation and the alleged perpetrator (LVN A) remained at the facility with access to other residents, abuse could happen to other residents, which could potentially cause harm to the other residents.</p> <p>In an Interview with LVN A on 10/18/24 at 3:44 PM, he stated that he needed a minute to think about the incident involving Resident #2's allegation of abuse. He stated that he was able to provide definitions of abuse and neglect. He stated that was the risk for him remaining at the facility with Resident #2 and the other residents after an allegation of abuse was made by Resident #2 would be that he would remain around the residents. He stated that Resident #2 and himself had a great relationship and she allowed him to remain in her room and assist her with packing her belongings when she was being discharged from the facility. LVN A stated that he should have reported the allegation of abuse by Resident #2 to administration, so that the facility and the State could have investigated it.</p> <p>Record Review of the facility's In-Service Training Attendance Roster for 07/19/24, 07/27/24 and 08/24/2024 for Abuse/Neglect/Exploitation reflected that LVN A did sign the in-service training Attendance Roster for the in-service training on Abuse, Neglect and Exploitation.</p> <p>Record review of the Facility's policy for Abuse/Neglect revised 10/04/2022 revealed,</p> <p>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.</p> <p>The facility will provide ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility.</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 - Few</p>	<p>The facility will appoint and train an Abuse Preventionist that will act as the designated contact for staff, residents, family or visitors to report any concerns related to abuse, neglect, misappropriation, or exploitation. The Abuse Preventionist will be responsible for receiving, leading the appropriate investigation, assure that required reporting is completed timely, assures that any additional staff training is assigned, and reports the above and any other measures indicated to the Quality Assurance program. Situations of abuse, neglect, misappropriation of resident property, and exploitation will be communicated to the center QAA committee. The QAA committee will track these incidents and will review and validate any necessary corrective actions have occurred.</p> <p>1. Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Resident to resident altercations will be reviewed as potential abuse not assumed as abuse. Resident to resident altercations must include any willful action that results in physical injury mental anguish or pain .</p> <p>5. Physical Abuse: Includes, hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment. Abuse as defined in 40 TAC 19.101(1).</p> <p>C. Prevention</p> <p>The facility will provide the residents, families, and staff an environment free from abuse and neglect.</p> <p>3. All reports of abuse or suspicion of abuse/neglect or potentially criminal behavior will be investigated as per facility protocol. Investigations will be reviewed by the facility administrator and/or Abuse Preventionist within 24 hours of complaint. Appropriate notification to state and home office will be the responsibility of the administrator and per policy.</p> <p>4. The facility will be responsible to identify, correct, and intervene in situations of possible abuse/neglect. The facility has in place a method to identify events such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse. All occurrences of potential abuse or criminal behavior will be investigated by the Abuse Preventionist and/or designee.</p> <p>D. Identification</p> <p>1. The facility will identify and investigate events that may constitute abuse/neglect. The facility will determine the direction of the investigation based on a thorough examination of events. Opportunities to prevent abuse/neglect will be managed accordingly.</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 - Few</p>	<p>2. Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect or exploitation must report this to the DON, administrator, state and/or adult protective services. State law mandates that citizens report all suspected cases of abuse, neglect or financial exploitation of the elderly and incapacitated persons.</p> <p>3. Facility employees must report all allegations of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property to the facility administrator. The facility administrator or designee will report the allegation to the Health and Human Services (HHSC).</p> <p>a. If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation</p> <p>b. If the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation.</p> <p>E. Investigation</p> <p>Comprehensive investigations will be the responsibility of the administrator and/or Abuse Preventionist. All allegations of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property will be investigated.</p> <p>1. The administrator in consultation with the Risk Management Department will be responsible for investigating and reporting cases to the HHSC.</p> <p>2. The administrator in consultation with the Risk Management Department will report any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility to local law enforcement.</p> <p>3. After receipt of the allegation the Abuse Preventionist and administrator in conjunction with Risk Management will immediately evaluate the resident's situation using the criteria as stated in this policy. Determination will be made for required reporting to HHSC per reporting guidelines.</p> <p>4. A report to the appropriate agency will include the following:</p> <p>c. The name and address of the suspected victim.</p> <p>d. The name and address of the suspected victim's care giver, if known.</p> <p>e. The nature and extent of any injuries resulting from the suspected abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property</p> <p>f. Other pertinent information as available.</p> <p>The written report must be sent to HHSC no later than the fifth working day after the initial report. The facility will use the designated state reporting form.</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 - Few</p>	<p>5. With an allegation of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property, the employee(s) will immediately be suspended pending an investigation. The employee will have an opportunity to present a written statement to answer the allegation(s) of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. The employee will have the opportunity to be advised of the outcome of the investigation in the determination of disciplinary action and/or reinstatement.</p> <p>6. Abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property of residents by employees of any facility will be grounds for immediate termination.</p> <p>7. The Abuse Preventionist and/or administrator will conduct a thorough investigation of the incident(s). A copy of the written report will accompany any personnel action deemed necessary. If a personnel action occurs, a copy of all pertinent documents will be placed in the employee's personnel file.</p> <p>8. The facility will report and cooperate with all investigations concerning reports of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property by the company's employees as set forth in state law (including to the state survey and certification agency).</p> <p>F. Protection</p> <p>The facility will take necessary measures to protect residents and employees from harm during and following an abuse, neglect, and exploitation, mistreatment of residents or misappropriation of resident property investigation.</p> <p>1. Allegations of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property will remain confidential.</p> <p>2. If fear of reprisal cannot be relieved, an individual who reports suspected abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property may not be required to identify himself. All allegations will be investigated regardless of identification of caller.</p> <p>3. Harassment and interfering with an investigation will result in disciplinary action up to and including termination. Prosecution of civil offenses will be pursued to the fullest extent of the law.</p>		