STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676055	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Acres Health and Rehabilitation Center	405 Shady Acres Lane Newton, TX 75966

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on interview and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 14 residents (Resident #2) reviewed for abuse. The facility failed to ensure CNA F did not verbally abuse Resident #2 when she made intimidating remarks at the resident on 08/26/24. The noncompliance was identified as PNC. The noncompliance began on 08/26/24 and ended on 08/26/2024. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for emotional distress, fear, decreased quality of life and further abuse. Findings included: Record review of Resident #2's face sheet dated 12/19/24 indicated she was a [AGE] year old female, admitted on [DATE] and her diagnoses included dementia (decline in mental abilities)and schizophrenia (mental disorder characterized by disruptions in thought process. Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated she sometimes was able to make herself understood or understood others, she had severely impaired skills for daily decision making, she had difficulty focusing attention and had disorganized or incoherent thinking, she rejected care daily, and she utilized a wheelchair for mobility. She required supervision or touching assistance or partial moderate assistance for all ADLS. Record review of Resident #2's care plan dated 08/18/20 indicated Resident #2 had ADL self-care deficit related to dementia. Interventions included assist and supervision for ADLS. Record review of Resident #2's care plan dated 08/18/20 indicated Resident #2 was dependent on staff for meeting emotional, intellectual, physical and social needs related to dementia. Interventions included simple structured activities and visiting with staff and peers. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's care plan dated 02/06/24 indicated Resident #2 had behavioral problems that included to severe delusions, moderate disrobing, moderate pacing, and sever resistance to care. Interventions included anticipate and meet Resident #2's needs. Record review of the facility's investigation dated 08/29/24 indicated the facility confirmed Resident #2 was verbally abused by CNA F. Record review of the Administrator's statement dated 08/26/24 indicated At approximately 5:00 p.m. 26 [DATE] I was doing some maintenance work in the restroom between rooms 8-16 and 8-17. I heard someone say, very loudly, I'm sick of you. Get your ass up and get to that dining room. I opened the door to room [ROOM NUMBER]-16 and saw (CNA F) at the bedside of Resident #2 attempting to get her off the bed. I recognized the voice to be (CNA F). I told her I know you were not just speaking to one of my residents like that. (CNA F) began apologizing. I told (CNA F) to clock out and go home immediately and that she was fired. I made sure CNA F left the building and then informed charge nurse of the incident and instructed to assess the resident from head to toe. Record review of CNA F's personnel file indicated she was trained on abuse and resident rights on 05/19/20. CNA F was suspended and terminated on 08/26/24. During an interview on 12/19/24 at 9:19 a.m., CNA F said she got a little loud with Resident #2. She said she did not have the intention to abuse Resident #2 but she (CNA F) was having a bad day and her tone was not a good tone. She denied saying I am sick of you. Get your ass up and get to that dining hall. to Resident #2. She said she was trying to get Resident #2 up for the supper meal. She said Resident #2 had dementia and did not want to get up and out of bed. She said she was trained on abuse and neglect and reporting when she was hired and more than once a year since she was hired. She said she was aware she should not use mean or degrading tones with the residents. During an interview on 12/18/24 at 2:46 p.m., the Administrator said he was the abuse prevention coordinator. He said he was conducting maintenance in the restroom between Resident #2's room and another resident's room. He said he heard someone say I am sick of you. Get your ass up and get to that dining hall. He opened the door and saw CNA F attempting to get Resident #2 off her bed. He said, I know you were no talking to one of my residents like that. The Administrator said he immediately directed CNA F out of the facility and told her she was terminated. He said safe-surveys were conducted and there were no additional residents identified as victims of abuse. He said staff were immediately trained on abuse and neglect and reporting on 08/26/24 and all staff that were not present in the facility were trained prior to their next scheduled shift. He said monitoring to prevent abuse was ongoing by conducting observations and interviews with residents and staff. He said he was in the facility on all shifts. He said there zero tolerance for abuse. He said staff were trained on abuse upon hire, as needed, and annually. Record review of in-service dated 08/26/24 indicated 40 out of 63 staff indicated staff were retrained on abuse and neglect prevention and reporting. Interviews conducted on 12/18/24, 12/19/24 and 12/20/24 with the Administrator, the DON, the ADON, 6 LVN, 6 CNA, 1 medication aide, 2 housekeeping staff, 2 dietary staff, 1 BOM, and 1 maintenance staff who represented all shifts indicated they were able to give examples of abuse and neglect and would report immediately to the abuse coordinator or designee. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviews conducted with 7 residents indicated there was no concerns of abuse and they would report any abuse to the administrator and DON immediately. They were not afraid of any staff. They had no complaints of staff being rude, using a mean or rude tone or using profanity towards them. Record review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program indicated Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal mental, sexual or physical abuse, and physical or chemical restraint no required to treat the resident's symptoms

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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** 25115 Based on interviews and record review, the facility failed conduct a thorough investigation and to report the results of all investigations to the Administrator or his or her designated representative and to other official in accordance with State law, including to the State Survey Agency, within 5 working days of the incident for 1 of 5 residents (Resident #3) reviewed for reporting results of all investigations. The facility failed to investigate and submit the results of their investigation within 5 days after Resident #3's fall. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: Record review of Resident #3's face sheet dated 12/19/24 indicated he was a [AGE] year old male, admitted on [DATE], and his diagnoses included Alzheimer's (a brain disorder that gradually destroys memory and thinking skills), right femur fracture, and a history of falling. Record review of Resident #3's quarterly MDS dated [DATE] indicated he had unclear speech, was sometime able to make himself understood and sometimes understood others, had severe cognitive impairment, and he did not use a mobility device. Record review of Resident #3's care plan dated 03/28/24 impaired physical mobility related to extremity fracture. Interventions included assist resident with ambulation and transfers. Record review of a progress note dated 03/24/24 at 1:13 p.m. and completed by LVN G indicated Resident #3 was seated in the lounge area. Resident #3 stood up, took a few steps and fell , Staff was not able to prevent the fall. Resident #3 landed on his right hip. Resident #3 was agitated and rolling from side to side. ROM performed and Resident yelled out in pain. The physician was notified. Resident #3 was sent to the ER for evaluation and treatment. Record review of Resident #3's x-ray report dated 03/24/25 indicated an acute impacted subcapital fracture of the right femoral neck (break in the upper part of the thigh bone that can affect the blood supply to the hip joint). Record review of TULIP intake 492332 indicated the facility reported Resident #3's fall and right hip fracture on 03/24/24 at 9:42 p.m. The allegation was noted as Resident Neglect. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an email provided by QA LVN D dated 03/24/24 at 10:18 p.m. from (identifying ticket number)(QA LVN D) Deleting Report noreply Texas Health and Human Services <noreply-hhs-salesforce@partner.hhs.texas.gov> Thank you for contacting TULIP Support Mailbox. Please save this ticket number, which is required for reference until the ticket is resolved. We are working on a resolution and will notify you soon. For enquiries regarding this ticket, please contact the TULIP Support Mailbox, including the assigned Ticket Number: (identifying ticket number) in the subject line. During an interview on 12/19/24 at 11:58 a.m., QA LVN D said the facility did not complete an investigation or submit a 5 day report because the incident was not reportable. She said she contacted TULIP/Salesforce via the portal to indicate the facility made the report in error. She said she when did not hear anything back from TULIP/Salesforce she assumed everything was taken care of the incident was no longer considered reported. She said she did not follow up with TULIP/Salesforce to ensure the self-report was deleted. During an interview on 12/19/24 at , the Administrator said Resident #3's fall was witnessed and not reportable. He said the facility followed the most current LTC provider letter 2024-14 for reporting. He said QA LVN D reported Resident #3's fall in error. He said because Resident #3's fall was witnessed and not reportable, the facility did not complete an investigation or submit a 5 day report. He said he was aware QA LVN D had contacted TULIP/Salesforce to report the error in reporting. He said he was not aware the intake was not deleted. Record review of the facility's Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigation policy dated 2001 (revised April 2021), indicated All reports of resident abuse (including injuries of unknown origin) neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical, nursing, mental, and psychosocial needs for 1 of 14 residents (Resident #1) reviewed for care plans. The facility failed to ensure Resident #1's fall risk care plan accurately addressed and included a fall mat. This failure could place residents at risk for staff not being aware of the resident needs and not receiving the care and services to attain or maintain their highest practicable physical, mental, and psychosocial outcome. Findings included: Record review of Resident #1's face sheet dated 12/19/24 indicated she was a [AGE] year old female, admitted on [DATE], and her diagnoses included Alzheimer's (brain disorder that destroys memory and thinking skills), dementia (decline in mental abilities), restless leg syndrome (neurological disorder that causes unpleasant or uncomfortable sensations in legs and an irresistible urge to move them), and Parkinson's (brain disorder that causes movement problems). Record review of Resident #1's care plan dated 05/16/24 indicated she was at high risk for falls. Interventions included anticipate and meet Resident #1's needs, ensure call light is in reach, ensure resident is wearing appropriate footwear, follow facility fall protocol, and review information on past falls and attempt to determine cause of falls, and remove any potential cause. The care plan did not include fall matt(s) as interventions. Record review of an incident report dated 10/16/24, completed by LVN B, indicated Resident #1 was found lying on her fall mat. She sustained a small 1 cm skin tear above her right eye. She was assessed with no additional injuries. A steri-strip was applied. The physician was notified. Record review of Resident #1's Fall Risk assessment dated [DATE] indicated she was at high risk for falling. Record review of Resident #1's annual MDS assessment dated [DATE] indicated she had unclear speech, was sometimes able to make herself understood, and usually understood others. She had severe impaired cognitive skills. She was inattentive and had disorganized thinking. She had hallucinations and delusions. She utilized a wheelchair for mobility. Record review of an incident report dated 11/08/24, completed by LVN A, indicated Resident #1 was found on the floor, bleeding from a laceration above her right eye on the brow area. She was assessed with no additional injuries or sign of pain. Resident #1 was transferred to the hospital for evaluation and treatment. The physician, RP and DON were notified. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of hospital records dated 11/08/24 indicated Resident #1 sustained a 3 cm laceration above her right eye. She received 5 sutures. Record review of facility investigation dated 11/12/24 indicated Resident #1's the facility would update Resident #1's care plan to include fall mat. During an interview on 12/19/24 at 9:45 a.m., the ADON said Resident #1's diagnoses included Parkinson's. She said Resident #1 was able to roll herself while lying in bed. She said Resident #1 was at risk for falls. She said she thought Resident #1's care plan included a fall mat due to previous falls. She said Resident #1's care plan should have included a fall mat to prevent serious injuries. She said she did not know why Resident #1's fall risk care plan did not include a fall mat. She said residents were at risk of serious injuries if fall mats were not in place. During an interview on 12/19/24 at 11:07 a.m., CNA C said she was aware Resident #1 was supposed to have a fall mat place adjacent to her bed when she was lying in bed. She said she was trained on which residents were at risk for falls and who required fall mats. She said Resident #1's fall mat was moved away from her bed when Resident #1 was transferred to her Geri-chair because the Geri-chair was hard to move over the fall mat. She said she transferred Resident #1 to bed on 11/08/24 and forgot to put the fall mat next to the bed. She said the fall mat was moved away from the bed but was available. She said residents were at risk of serious injuries if fall mats were not in place. During an interview on 12/19/24 at 12:02 p.m., LVN A said Resident #1 had fallen from her bed on 11/08/24 and sustained a 3 cm laceration above her right eye. She said Resident #1 was assessed with no additional injuries. She said Resident #1 was transferred to the hospital for evaluation and treatment. She said the fall mat was folded up at the end of the bed. She said the fall matt was supposed to be on the floor when Resident #1 was lying in bed. She said Resident #1 returned to the facility with 5 sutures above her right eye. She said residents were at risk of serious injuries if fall mats were not in place. During an interview on 12/20/14 at 8:42 a.m., QA LVN D said Resident #1's care plan was not updated to include a fall mat. She said she did not know the care plan was not updated to include a fall mat. She said she took over updating care plans June 2024 and Resident #1's care plan update was missed. She said residents were at risk of serious injuries if fall mats were not in place. During an interview on 12/20/24 at 11:01 a.m., the Administrator said Resident #1's care plan should have been updated to include a fall mat. He said it was probably a miscommunication that Resident #1's care plan update to include a fall matt was missed. He said residents were at risk of serious injury if the fall mat interventions were not in place as required per the resident care plan. Record review of the facility's Safety and Supervision of Resident Policy dated 2001 (revised July 2017) indicated Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. 4. Implementing interventions to reduce accident risks and hazards shall include the following: a. Communicating specific interventions to all relevant staff; b. Assigning responsibility for carrying out interventions; c. Providing training as necessary; d. Ensuring all interventions are implemented; and e. documenting interventions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's Managing Falls and Fall Risk policy dated 2001 (revised March 2018) indicated: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try and minimize complications from falling. 6. If underlying causes cannot be readily identified or corrected, staff will try various interventions, . 7. In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try and minimize serious consequences of falling. Record review of the facility's Care Planning-Interdisciplinary Team policy dated 2001 (revised March 2022) indicated 1. Resident care plans are developed according to the timeframes and criteria established by S483. 21. 2. Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT). 3. The IDT includes but is not limited to: a. the resident's attending physician; b. a registered nurse with responsibility for the resident; c. a nursing assistant with responsibility for the resident; d. a member of the food and nutrition services staff; e. to the extent practicable, the resident and/or the resident's representative; and f. other staff as appropriate or necessary to meet the needs of the resident, or as requested by the resident. 4. The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. 5. Care plan meetings are scheduled at the best time of the day for the resident and family when possible. 6. If it is determined that participation of the resident or representative is not practicable for development of the care plan, an explanation is documented in the medical record.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on interview and record review the facility failed to provide adequate supervision and assistance devices to prevent accidents for 1 of 14 (Resident #1)residents reviewed for accidents/supervision. The facility failed to ensure Resident #1's fall matt was adjacent to her bed on 11/08/24. Resident #1 fell had an unwitnessed fall and sustained a 3 cm laceration above her right eye. This failure could place residents at risk of severe injuries. Findings included: Record review of Resident #1's face sheet dated 12/19/24 indicated she was a [AGE] year old female, admitted on [DATE], and her diagnoses included Alzheimer's (brain disorder that destroys memory and thinking skills), dementia (decline in mental abilities), restless leg syndrome (neurological disorder that causes unpleasant or uncomfortable sensations in legs and an irresistible urge to move them), and Parkinson's (brain disorder that causes movement problems). Record review of Resident #1's care plan dated 05/16/24 indicated she was at high risk for falls. Interventions included anticipate and meet Resident #1's needs, ensure call light is in reach, ensure resident is wearing appropriate footwear, follow facility fall protocol, and review information on past falls and attempt to determine cause of falls, and remove any potential cause. The care plan did not include fall matt(s) as interventions. Record review of an incident report dated 10/16/24, completed by LVN B, indicated Resident #1 was found lying on her fall mat. She sustained a small 1 cm skin tear above her right eye. She was assessed with no additional injuries. A steri-strip was applied. The physician was notified. Record review of Resident #1's Fall Risk assessment dated [DATE] indicated she was at high risk for falling. Record review of Resident #1's annual MDS assessment dated [DATE] indicated she had unclear speech, was sometimes able to make herself understood, and usually understood others. She had severe impaired cognitive skills. She was inattentive and had disorganized thinking. She had hallucinations and delusions. She utilized a wheelchair for mobility. She was dependent on staff for all ADLS. Record review of an incident report dated 11/08/24, completed by LVN A, indicated Resident #1 was found on the floor, bleeding from a laceration above her right eye on the brow area. She was assessed with no additional injuries or sign of pain. Resident #1 was transferred to the hospital for evaluation and treatment. The physician, RP and DON were notified. Record review of hospital records dated 11/08/24 indicated Resident #1 sustained a 3 cm laceration above her right eye. She received 5 sutures. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of facility investigation dated 11/12/24 indicated the facility would update Resident #1's care plan to include fall mat. During an interview on 12/18/24 at 9:45 a.m., the ADON said Resident #1's diagnoses included Parkinson's. She said Resident #1 was able to roll herself while lying in bed. She said Resident #1 was at risk for falls. She said she thought Resident #1's care plan included a fall mat due to previous falls. She said Resident #1's care plan should have included a fall mat to prevent serious injuries. She said she did not know why Resident #1's fall risk care plan did not include a fall mat. She said residents were at risk of serious injuries if fall mats were not in place. During an interview on 12/19/24 at 11:07 a.m., CNA C said she was aware Resident #1 was supposed to have a fall mat place adjacent to her bed when she was lying in bed. She said she was trained on which residents were at risk for falls and who required fall mats. She said Resident #1's fall mat was moved away from her bed when Resident #1 was transferred to her Geri-chair because the Geri-chair was hard to move over the fall mat. She said she transferred Resident #1 to bed on 11/08/24 and forgot to put the fall mat next to the bed. She said the fall mat was moved away from the bed but was available. She said residents were at risk of serious injuries if fall mats were not in place. During an interview on 12/19/24 at 12:02 p.m., LVN A said Resident #1 had fallen from her bed on 11/08/24 and sustained a 3 cm laceration above her right eye. She said Resident #1 was assessed with no additional injuries. She said Resident #1 was transferred to the hospital for evaluation and treatment. She said the fall mat was folded up at the end of the bed. She said the fall matt was supposed to be on the floor when Resident #1 was lying in bed. She said Resident #1 returned to the facility with 5 sutures above her right eye. She said residents were at risk of serious injuries if fall mats were not in place. During an interview on 12/20/14 at 8:42 a.m., QA LVN D said Resident #1's care plan was not updated to include a fall mat. She said she did not know why the care plan was not updated to include a fall mat. She said she took over updating care plans June 2024 and Resident #1's care plan update was missed. She said residents were at risk of serious injuries if fall mats were not in place. During an interview on 12/20/24 at 11:01 a.m., the Administrator said Resident #1's care plan should have been updated to include a fall mat. He said it was probably a miscommunication that Resident #1's care plan update to include a fall matt was missed. He said residents were at risk of serious injury if the fall mat interventions were not in place as required per the resident care plan. Record review of the facility's Safety and Supervision of Resident Policy dated 2001 (revised July 2017) indicated Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. 4. Implementing interventions to reduce accident risks and hazards shall include the following: a. Communicating specific interventions to all relevant staff; b. Assigning responsibility for carrying out interventions; c. Providing training as necessary; d. Ensuring all interventions are implemented; and e. documenting interventions. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of facility's Managing Falls and Fall Risk policy dated 2001 (revised March 2018) indicated: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try and minimize complications from falling. 6. If underlying causes cannot be readily identified or corrected, staff will try various interventions, . 7. In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try and minimize serious consequences of falling.