STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676099	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Arbour at Westminster Manor	4200 Jackson Ave Austin, TX 78731

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45070 Based on observations, interviews, and record reviews, the facility failed to ensure the resident had the right to be free from abuse for one resident (Resident #44) of six residents reviewed for freedom from abuse. The facility failed to protect Resident #44 from an aggressive family member with suspected history of abuse. On 08/03/2024 at about 6:30pm, during the dinner, the family member shouted at Resident #44 and forcefully fed her against her will by putting the spoon with food in her mouth, as witnessed by staff members. On 09/24/24 at 4:36 PM an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 09/25/24, the facility remained out of compliance at a scope of isolated and a severity J level of potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure placed the residents at risk for mental and physical harm. Findings included: Review of Resident #44's face sheet dated 09/12/24 reflected, Resident #44 was admitted to the facility on [DATE]. She was an [AGE] year-old female diagnosed with aftercare following joint replacement surgery, Cognitive communication deficit, Unsteadiness on feet, Muscle weakness, Pain in right shoulder and Dementia. Record review of Resident #44's quarterly MDS assessment dated [DATE] reflected the facility was unable to complete BIMS. MDS indicated Resident #44 had some difficulty to make decisions only in new situations. She did not have any symptoms of psychosis, and no unusual behaviors were indicated. Record review of Resident #44's care plan dated 09/09/24 revealed the plan of structured visits of her FM, developed in the IDT meeting conducted on 08/06/24, was not incorporated into the care plan . Record review of facility's investigation report dated 08/06/2024 on the incident of forceful feeding and shouting involving Resident #44 and her FM on 08/02/2024 at 6:30 pm in the dining hall, confirmed the occurrence of the abuse. (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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review on 09/24/24 of the written statement of the incident by DA E dated 08/03/24 revealed Resident #44's FM insisted her to consume the food items she did not want. DA E stated she heard a scream from the dining room when only Resident #44 and FM were there, after everyone finished dinner and left. DA E stated she heard Resident #44's FM raising his voice at her. However, since DA E was far away, she could hear only Resident #44 telling him to hush. During an interview on 09/12/24 at 2:46 PM, the CADM stated Resident #44's POA reported to the facility, during the admission, that that there was abusive history with FM while Resident #44 was living with him in the community, with APS involvement. The CADM said she conducted a meeting on 08/06/24 with Resident #44's FM, Ombudsman, and the POA of Resident #44. In the meeting, it was decided to welcome Resident #44's FM to visit her during the restricted hours. As per this plan, the FM was allowed to visit daily from 2:00pm - 4:00pm or 3:00pm - 5:00pm in the common areas or participate in activities with Resident #44, to make every visit more enjoyable than stressful for Resident #44. She said Resident #44's FM could not visit her in her room due to his history of abusive behavior. The CADM stated Resident #44 had issues with dementia and might permit him to her room without remembering his abusive behaviors in the past. When the surveyor pointed out the absence of a care plan related to this arrangement for Resident #44's visits, for about a month after the decision being taken, the CADM stated she would add the plan to the care plan with immediate effect. She stated their plan for Resident #44's FM's visits were documented nowhere in the system. CADM said his visit was electronically monitored by her and explained that when the FM signed in at the facility, she would get an electronic notification on her mobile and then CADM would let the staff know about his arrival. When the surveyor asked what if CADM was away from her mobile phone when the FM arrived at the facility, she stated that there was a very rare chance for that. The CADM stated two other staff members from the administrative team had similar features on their mobile phone and they would be able to give directions to the staff Interview on 09/24/24 at 12:30 pm with the CADM and record review of Resident #44's care plan dated 09/12/24 revealed Resident #44's FM was allowed to visit daily from 2:00 pm - 4:00 pm or 3:00 pm - 5:00 pm in common areas or participate in activities with Resident #44, and he could not visit in her room. CADM stated this care plan was added on 09/12/24, after the HHSC surveyor pointed out the absence of a careplan related to the restricted visit of Resident #44's FM. During an interview on 08/11/24 at 10:00 am, Resident #44 stated she was married for [AGE] years and like to see FM every day. When asked about the incident that occurred in the dining room, she stated that was a month ago, and currently the visits occurred outside her room. She stated they spent time together with playing board games and chatting. She said there was no issues after the incident occurred in the dining hall and happy with the current arrangement. During a telephone interview on 08/12/24 at 11:30 am, the FM stated he wanted to see Resident #44 and have dinner with her every day. He stated the facility was unfair to him by putting restriction on his visits. He stated he was trying to make her eat the whole meal severed so that she would get well faster. The FM stated he did that many times in the past when she refused to eat. He said he was not abusive and did nothing wrong, however the facility was interpreting the incident differently. FM stated his intention was to improve her health. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 09/24/24/ at 11:30 am, the DM stated on 08/03/24 at about 6:30 pm she was at home after her shift and got a phone call from DA D stating Resident #44's FM was shouting at Resident #44 and forcefully feeding her by putting the spoon in her mouth. The DM stated Resident #44 was screaming as if she was in pain. The DM stated she managed to get the security with the help of the receptionist. She said Resident #44's FM was escorted out of the facility by the security without any further incidents. During a telephone interview on 09/24/24 at 1:00 pm, DA D stated she witnessed the incident that happened between Resident #44 and her FM on 08/03/24 at about 6:30 pm. She stated ,after the dinner time while cleaning the dining area and the kitchen in the back with DA E, she heard Resident #44 yelling that sounded as if she was hurt or was in pain. She stated she went up front and observed Resident #44 telling her FM to shut up and kept saying stop feeding. She said, at that time, FM kept telling Resident #44 she had to eat and then forced her to eat. She stated she saw him putting the fork into her mouth and she pushed it away. DA D stated Resident #44 asked for dessert, however FM told DA D not give the desert. DA D stated when she provided the dessert, the FM told Resident #44 that she could not have the desert before finishing all the meal left in the plate. DA D stated they kept arguing, and at one point, she saw Resident #44 drying her eyes with a paper towel. DA D added that wasn't the first time she had seen him trying to force feed her. When asked why she did not report it that time, she stated she thought things would get better. However, she now realized it was going bad. On 09/24/24 at 1:30 pm, an attempt to have a telephone interview with DA E was unsuccessful. During an interview on 09/13/24 at 11:30 am, Resident #44's POA stated she had a meeting with the CADM, Resident #44's FM, and the ombudsman at the facility on 08/06/24, and they decided to have a plan for restricted and supervised visits for Resident #44's FM. She stated she agreed with this arrangement as she was aware of the long history of physical and mental abuse by him while Resident #44 was living with him in the community. The POA stated there was APS involvement in the past due to domestic violence and abusive behavior of the FM. She stated she wanted to protect Resident #44 from incidents of abuse at the facility. The POA added , at the same time, she did not want to totally cut her off from FM and found the idea of supervised visits as a useful solution to the situation. During an interview on 09/12/24 at 2:46 PM, the MDSC stated it was his responsibility to make changes in the care plan based on the information passed on by SW worker, DON, CADM, or other responsible parties. He stated he heard about the incident that occurred in the dining hall and the meeting thereafter. However, no one reported to him about the outcome of the meeting for care planning. During interview on 09/12/24 at 4:00 pm, CNA A stated she worked on Resident #44's hall. She said she was not aware of any care plan related to Resident #44's FM's visit. She stated she knew him and would allow him to meet Resident #44 in her room if he wanted, as it was part of the resident's rights policy. During an interview on 09/12/24 at 4:10 PM, CNA B stated Resident #44's family member was a regular visitor and would encourage him to visit her anytime if they wanted to. She said she was not aware of any specific plan for his visit. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 09/12/24 at 4:45 pm, the RA stated she had seen Resident #44 and her family member almost every day in the recreational area, engaged in board games. RA said she did not know why they were there instead of her room. The RA stated she would guide him to her room if he requested, or would encourage them to have meals together. During an observation and interview on 09/24/24 at 10:55 am, MA C was administering medications to residents. She stated she generally worked on the 1st floor and occasionally works at 2nd floor where Resident #44 resides. She stated she heard from other staff members that there were restrictions on Resident #44's FM to visit her. She stated she did not know what the restricted hours and the exact plan was. During an interview on 09/24/24 at 11:10 am, CNA D stated she worked at the facility as PRN and was aware of some restrictions on Resident #44's FM to visit her. She stated she did not know the details about it. However, when he asked to see Resident #44 , she would redirect him to the nurse in charge. During an interview on 09/24/24 at 3:30 pm, DA F stated she worked at the facility part time since April 2024. She stated she knew Resident #44 and her FM, and saw them, many times, arguing . She stated she had an impression that FM was trying control Resident #44 . She stated she had seen Resident #44 trying to get away from FM during dinner times as FM took control on her and insisted her to eat the way he decided. She stated she never had seen any physical abuse from him so she thought they were not reportable. DA F stated she knew there were some restrictions on his visits, however, she did not know the visitation time or the plan for his restricted visits. During an interview on 09/24/24 at 3:45 pm, DA G stated she worked at the facility for about a year and knew the dynamics between Resident #44 and the FM. She stated serving food to them was always difficult as the FM demanded attention as if there were no other residents to attend to. She stated Resident #44's FM gave priority to him over Resident #44. DA G stated she had seen Resident #44 and the FM arguing while having dinner , mostly when the FM shouted at her. When the investigator asked DA G if there were any restrictions in place for Resident #44's FM's visits , she stated she was not aware of any and would serve them dinner if they wanted to eat together. She stated she had not seen the FM at dinner for while, however, she had seen them spending time together in the activity room. During an interview on 09/24/24 at 4:00 pm, the CADM stated Resident #44's FM visited her as per the plan without any deviation. She stated they remained in the open area so that staff could supervise. When the surveyor asked, since it was a supervised visit who was responsible for supervision during his visit, CADM stated there were no specific persons responsible as they sat in the open area and were visible to everybody. Record review of the in-services revealed on 08/11/24 in-services were conducted on Definition of caregiver, provider, and sitter to include staff responsibilities. Limitations of visit for [Resident #44's FM] and on 09/13/24 Visitation for [Resident #44] and [FM]. The attendance sheet reflected 8 staff members were in serviced and CNA A, CNA B , RA, MA C, DM, DA E, DA F and DA G were not participant in these in-services. Review of the facility's policy Reporting abuse to facility management revised February 2024 reflected: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1.Our facility does not condone resident abuse to anyone, including staff members, physicians, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals. 2. To help with recognition of incidents of abuse, the following definitions of abuse are provided: a. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. b. Verbal abuse is defined as any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents; regardless of their age, ability to comprehend, or disability. This was determined to be an Immediate Jeopardy (IJ) on 09/24/24 at 3:00 PM. The ADM was notified and provided with the IJ template on 09/24/24 at 4:36pm. The following Plan of Removal submitted by the facility was accepted on 09/25/24 at 12:40 PM and reflected the following: Immediate Jeopardy On 09/10/2024 an abbreviated survey was initiated at [facility]. On 09/24/2024 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to resident health and safety. The notification of Immediate Jeopardy states as follows: The facility failed to protect Resident #44 from an aggressive family member with behaviors. Action: Referral made to, for Resident #44. Will be completed on 09/25/2024. Start Date: 9/25/24, Completion Date: 9/25/24, Responsible: Administrator. Action: Social Worker to interview Resident #44 for psychosocial well-being. Start Date: 9/25/24, Completion Date: 9/25/24, Responsible: Administrator Action: Executive Director in serviced Administrator and Director of Nursing on any allegation of resident abuse/neglect with findings, will have interventions care planned and will ensure all staff are educated on the interventions. Start Date: 9/24/2024, Completion Date: 9/24/2024, Responsible: Executive Director Action: All staff in-serviced on Resident #44's visiting instructions with Resident #44's husband. In-service includes visiting hours, husband's meal restriction while visiting, and if there are any concerns during visitation to immediately inform charge nurse, ADON, DON, or Administrator. Start Date: 9/24/2024. Completion Date: on-going until all staff (nursing department, dietary department, housekeeping department, activity department, front desk) who are employed by the facility are in serviced. Responsible: Administrator (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action: All staff not present and new staff will be in-serviced on Resident #44's visiting instructions with Resident #44's husband prior to the start of their shift. Start Date: 9/24/2024,Completion Date: on-going, Responsible: Administrator Action: New staff, PRN and agency nursing staff will be in serviced prior to the start of their shift. Start Date: 9/24/2024,Completion Date: on-going, Responsible: Director of Nursing. Action: Resident #44's FM is allowed to have observed visits by staff during an agreeable time frame by Resident #44, her POA, and her husband. Start Date: 9/24/2024,Completion Date: 9/24/24,Responsible: Administrator. Action: Resident #44's POA agreed with the Resident #44's FM's visitation instructions. Start Date: 9/24/2024,Completion Date: 9/24/24,Responsible: Administrator. Action: Resident #44 agreed with her FM's visitation instructions. Start Date: 9/24/2024, Completion Date: 9/24/24,Responsible: Administrator. Action: Resident #44's FM visitation instructions have been care planned by the Director of Nursing ensuring Resident's rights are being met. Start Date: 9/24/2024,Completion Date: 9/24/24,Responsible: Administrator. Action: Resident #44's FM had agreed to the visitation instructions. Start Date: 9/24/2024,Completion Date: 9/24/24,Responsible: Administrator Monitoring of the Plan of Removal on 09/25/24 included the following: POA approved for a Referral for psychiatric assessment of Resident #44. During an interview on 09/25/24 at 12:00pm CADM reported that the team visited and assessed of Resident #44 was in progress on 09/25/24 at 12:45pm. During an interview on 09/25/24 at 12:00pm CADM stated the psychosocial wellbeing interview was completed by the social worker to asses her mood, on 09/25/24. CADM and the DON on any allegation of resident abuse/neglect with findings, will have interventions care planned and will ensure all staff are educated on the interventions. Record review of the employee list revealed that the facility employed about 100 staff members including PRN staff members. Review of in-service record revealed about 80 staff members were in serviced and the program was still going on. During an interview on 09/25/24 at 12:00pm CADM stated she texted all the PRN employees and instructed about the in service. She stated they would be able to complete the in-service sooner than later. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 09/25/24 at 2:00pm CADM explained the structure and plan of the visits. She stated on Monday - Friday, the activities director or assistant, would either observe or designate observation of visitation in the activity room. She stated Saturday - Sunday, the weekend ADON will either observe or designate observation of visitation in the activity room. During an interview on 09/24/24 at 4:50 pm, the POA stated she was happy with the current arrangement of the restricted visit. During an interview on 09/25/24, at 10:30am Resident#44 stated she wanted her FM to visit her every day and was okay with the plan. Review of Resident #44's updated careplan dated 09/12/24 revealed Resident #44's FM was allowed to visit daily from 2:00 pm - 4:00 pm or 3:00 pm - 5:00 pm in common areas or participate in activities with Resident #44, and he could not visit in her room. CADM stated this care plan was added on 09/12/24, after the HHSC surveyor pointed out the absence of a careplan related to the restricted visit of Resident #44's FM. Record review of the in-service record on 9/25/24 revealed Executive Director in serviced on 09/24/24 the CADM and DON on any allegation of resident abuse/neglect with findings, will have interventions care planned and will ensure all staff are educated on the interventions. The staff from morning and afternoon shift who were interviewed on 09/25/24 stated, they had attended the in-service on the restricted visit of Resident #44's FM and were able to explain the plan in place for the restricted visit. The CADM was informed the Immediate Jeopardy (IJ) was removed on 09/25/24 at 3:10pm. The facility remained out of compliance at a scope of isolated and a severity J level of potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.