STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676123	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairfield Nursing & Rehabilitation Center	420 Moody St Fairfield, TX 75840

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on observation, interview, and record review, the facility failed to ensure residents were free from physical restraints, not required to treat the resident's symptoms, for 1 of 9 residents (Resident #1) reviewed for physical restraints. The facility failed to ensure RP #2 was educated on physical restraint policy and refrained from having tied Resident #1's right hand/wrist to her bed's assist bar with a blanket. This failure placed residents at risk of physical harm, psychosocial harm, and having their needs gone unmet. Findings included: Record review of Resident #1's AR, dated 8/14/2024, reflected an [AGE] year-old female admitted to the facility on [DATE]. She was diagnosed with Dementia (which was a disease that affected memory, thought, and interfered with daily life,) Cerebral infarction (which was a pathologic process that resulted in necrotic tissue in the brain, caused by disrupted oxygen and blood supply,) and Bullous Pemphigoid (which was a rare skin condition that caused blisters on the skin.) Record review of Resident #1's Quarterly MDS assessment, dated 7/19/2024 reflected Resident #1 had a BIMS Score of 8. A BIMS Score of 8 indicated Resident #1 had moderate cognitive impairment. Resident #1 used a wheelchair for ambulation; she was dependent upon staff for eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/talking off shoes, and personal hygiene. Dependent meant the helper did all the effort. Resident did none of the effort to complete the activity; Or the assistance of 2 or more helpers was required for the resident to complete the activity. Resident #1 had a catheter and was frequently incontinent of bowel. (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's CP reflected a focus area for potential/actual impairment to skin integrity, initiated on 5/01/2024 and revised on 8/5/2024, evidenced by self-inflicted scratches; revised focus area R/T diagnosis of Bullous Pemphigoid. The goal was to have no complications by the target date of 10/10/2024. The interventions for nursing staff were to administer treatments as ordered, initiated 5/17/2024; avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short, initiated 5/17/2024; Educate resident and responsible parties of causative factors to prevent skin injury, initiated 5/1/2024; Follow facility protocols for treatments of injury, initiated 5/1/2024; Identify potential causative factors and eliminate where possible, initiated 5/1/2024; Keep skin dry and clean/use lotion on dry skin, initiated 5/1/2024. Resident #1's CP reflected a second focus area for skin integrity, initiated on 5/30/2024, evidenced by scratching skin and skin breaks. The goal was to have fewer episodes of scratching by target date of 10/10/2024. The interventions for nursing staff were to administer medications as ordered, initiated 5/30/2024; anticipate needs of resident, initiated 5/30/2024; Apply Geri-sleeves on both upper extremities, initiated 8/12/2024. Record review of Resident #1's Order Summary Report reflected an order for hydroxyzine; (1) .25 MG tablet by mouth every 6 hours for itching. The order was written on 7/9/2024 and started on 7/9/2024.The Order Summary Report reflected an order for prednisone; (7) 10 MG tablets given via peg tube one time a day R/T Bullous Pemphigoid. The order was written 8/5/2024 and started on 8/6/2024. Record review of Resident #1's July 2024 MAR, viewed in PCC, reflected Resident #1's medication list. The July 2024 MAR indicated Resident #1 received hydroxyzine; .25 MG tablet by mouth every 6 hours. The MAR reflected medication administration started on 7/9/2024 at 11:00 PM. The July 2024 MAR indicated administration of hydroxyzine .25 MG tablet by mouth every 6 hours through 7/31/2024 (continuous.) Record review of Resident #1's August 2024 MAR, viewed in PCC, reflected Resident #1's medication list. The August 2024 MAR indicated Resident #1 received hydroxyzine; .25 MG tablet by mouth every 6 hours. The MAR reflected medication administration continued from 8/1/2024 at 5:00 AM until 8/14/2024 (continuous.) The August 2024 MAR indicated administration of prednisone; (7) 10 MG tablets given via peg tube one time a day R/T Bullous Pemphigoid. The August 2024 MAR indicated Resident #1 received prednisone; (7) 10 MG tablets given via peg tube one time a day R/T Bullous Pemphigoid 1 time daily from 8/6/2024 until 8/14/2024 (continuous.) (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Admission Contract, signed and dated 3/25/2024, reflected Section 21. Rules on Restraints, Resident's Behavior, and Health Care Center Practice. The Admission Contract indicated: It was the policy of the facility to have maintained an environment that prohibited the use of restraints for discipline or convenience. Restraint usage would have been limited to circumstances in which the resident had medical symptoms that warranted the use of restraints. The restraint assessment committee would have evaluated and established the need for restraint use or restrain reduction for residents in the health care center. The health care center was committed to nurturing the autonomy and independence of the residents by having attempted to provide a restraint free environment. A physical restraint was defined as any manual restraint method, such as physical, mechanical, material, or the use of adjacent equipment, that the individual could not remove easily, which would have restricted a resident's freedom of movement, or normal access to one's body. The Admission Contract's Notice of Rights and Services, located in Section 21, indicated: the facility must have informed the resident, or the residents next of kin/guardian, both orally and in an understandable language the rights and rules governing resident conduct and responsibilities during the resident's stay at the facility. The facility's policy related to the use of restraints and involuntary seclusion must have also been given to the resident's legally authorized representative if the resident had one. Record review of a legal document, notarized on 4/10/2024, named RP #2 as Resident #1's Medical Power of Attorney. Record review of Resident #1's incident report dated 8/3/2024 at 8:35 PM; written by the ADON, reflected an unwitnessed event in the room of Resident #1 (201-B); resident not taken to hospital; no injuries observed. Record review of Resident #1's progress notes dated 8/3/2024 at 8:35 PM; written by LVN A, reflected an entry having indicated: Resident was found with her right hand tied to the grab bar after RP #2 had left for the night, reported it to the administrator. Hand was untied and assessed resident's wrist for any marks or bruising and none where found. Record review of a written statement by LVN B, dated 8/3/2024 at 7:30 PM, reflected LVN B ad LVN A entered Resident #1's room just after RP #2 left Resident #1's room. LVN A and LVN B discovered Resident #1's right hand had been tied to the bed's assist bar. The two LVN's immediately released Resident #1's hand/wrist and assessed for trauma. No marks were noted to her wrist. Resident #1 did not appear to be in any distress. Record review of a written statement by LVN A, dated 8/5/2024, reflected LVN A entered Resident #1's room (8/3/2024) with LVN B having discovered Resident #1's right hand had been tied to the bed's assist bar with a small blanket. LVN A released Resident #1's right hand. A visual inspection of Resident #1's right hand resulted with no visible trauma. LVN A reported the incident to the ADM. Record review of Resident #1's weekly skin assessment, dated 8/5/2024, reflected Resident #1's skin color was normal, no bruises, no skin tears, no abrasions, and no lacerations. There were no areas that had not been reported to the facility medical provider. Assessment performed by LVN F. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a local police report, # 2400220, written on 8/14/2024 by Officer #3 reflected an incident, which occurred at the facility on 8/3/2024. The report indicated: On 08/05/2024 at approximately 3:30 PM, I, Officer #3 responded to a call at the Nursing and Rehab. When I arrived, I met with the ADM. The ADM stated that she was notified by a charge nurse, LVN A, that Resident #1 had her hand tied to the assist bar, by RP #2. The ADM stated LVN A reported having untied Resident #1 arms, bound by a blanket to the bed's mobility assist bar. The ADM stated LVN A reported no red marks, bruises, lacerations of any kind. The ADM stated that the facility staff had spoken with RP #2, and he explained he did not mean any harm, but was only trying to keep Resident #1 from scratching herself. Resident #1 had recently been diagnosed with an autoimmune skin condition, which caused severe itching. RP #2 did not know his actions were wrong and said he would never do it again. The ADM stated that she believed it was not a malicious intent. The ADM stated RP #2 was really good to Resident #1 and visited with her daily, and only wanted the best for her. Officer #3 went to Resident #1's room and looked at her arm. There were no signs of any bruising or any other marks. Resident #1's hand was in a sock when having arrived at her room. Record review of Resident #1's progress notes dated 8/5/2024 at 7:58 PM; written by the ADM, reflected an entry having indicated: The Administrator had a care plan with RP #2. The ADM discussed using restraints and explained that this was not allowed in the facility and was considered to be a form of abuse. RP #2 became very upset as he did not know and was very sorry, having explained all he tried to do was to keep Resident #1 from having scratched herself. RP #2 explained all he wanted was to take good care of Resident #1 and that he had devoted the last several years of his life doing that. Resident #1 had a new diagnosis of Bullous Pemphigoid, 7/23/2024, and it did cause her to scratch. The facility's MD had prescribed hydroxyzine. RP #2 was glad to hear this and promised he would never restrain Resident #1 again. Record review of Resident #1's progress notes dated 8/8/2024 at 4:57 PM; written by the SW, reflected an entry having indicated: The SW followed up with Resident #1 for the incident having regarded to RP #2 securing Resident #1's wrist to the bed rails to prevent Resident #1 from scratching herself. Resident #1 stated she was not in any distress from the incident or upset with RP #2. Resident #1 stated RP #2 had good intentions and tried his best to help her from scratching, which had caused her skin to bleed. Resident #1 stated RP #2 understood why he should not have tied her right hand/wrist to the bed side rail and that it was a mistake, an error. Resident #1 was calm, alert, and oriented to self, place, and time. Record review of a facility self-reported intake reflected an email, dated 8/5/2024. The email indicated [To Whom it May Concern, please find attached a late-self report on abuse that occurred on the evening of 8/3/2024. Attached were the following: Initial self-report, resident face sheet, witness statements, heat to toe assessment completed 8/5/2024. If you have any questions, please feel free to contact the ADM. Observation on 8/13/2024 at 10:15 AM of Resident #1 reflected the resident seated /reclined in her Geri-chair (a large wheelchair with a padded back/seat and leg stirrups) in the television area near the facility's nurse's station. Resident #1 was covered up to her torso with a white sheet, her head was supported with a horseshoe shaped pillow around her neck, and she did not appear to be in any distress. Resident #1 had her eyes closed and was non-responsive to verbal prompts. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 8/14/2024 at 8:43 AM with RP #2 revealed he was at the facility the night of 8/3/2024 to see Resident #1. To keep Resident #1 from having scratched her skin, he stated he used the material from the softest material he could find, which was a blanket, and tied Resident #1's right hand/wrist to the support bar on the side of the bed. He stated he did not try to hide what he had done, and left the knotted blanket exposed for anyone who had entered the room to see. He did not know, at the time, that having tied Resident #1's hand/wrist to the support bar was a form of abuse through restraint. He stated he was seen by the ADM, a couple of days later, and learned that physical restraints were not allowed at the facility. He was only trying to help Resident #1 and promised he would never do it again. Observation and interview on 8/14/2024 at 9:55 AM of Resident #1 revealed the resident seated /reclined in her Geri-chair in the television area near the facility's nurse's station. Through verbal responses and facial features, Resident #1 affirmed that she was feeling ok and denied any pain. She recalled RP #2 tying her right arm to the bedside assist bar on 8/3/2024 but denied that it caused her any pain. The itching was just about the same. Resident was observed wearing Geri-gloves (which were mesh gloves worn to protect skin without having sacrificed comfort or mobility.) Phone interview on 8/14/2024 at 10:22 AM with Officer #3 revealed she was called out to the facility on [DATE] for an allegation described as RP #2 having allegedly tied Resident #1's right arm/wrist to the bed side support bar on 8/3/2024. When she arrived at the facility, the RP #2 was in the room. Officer #3 reported RP #2 told her he did not know he could not tie Resident #1's hand/wrist to the bed's support bar. RP #2 was only trying to have helped Resident #1. Officer #3 performed a visual inspection of Resident #1's right hand/wrist for injuries and did not observe any. Officer #3 stated that the local police department did not receive the call about the allegation, which occurred on 8/3/2024, until 8/5/2024. Interview on 8/14/2024 at 2:25 PM with the facility SW revealed the facility addressed the incident (allegation of abuse,) which occurred on 8/3/2024, with both Resident #1 and RP #2. The SW stated she had reviewed Resident #1's assessments and CP. The SW stated any future risk of abuse from RP #2 towards Resident #1 had been removed. Interview on 8/14/2024 at 2:35 PM with the ADON revealed staff was trained to report allegations, or suspicions, of abuse immediately to the abuse coordinator, who was the ADM. Some examples of abuse were described as physical, such as hitting residents and being too rough. Some examples of abuse were described as verbal/emotional such calling resident names or cursing them. Staff was trained the facility had a no restraint policy. Some examples of restraint were described as chemical, such as medications. Some examples of restraint were described as physical, such as blocking a resident in bed or a chair, tying one up, or holding one down. Family members, responsible parties, or authorized representatives were held to the same standard of restraints and abuse, and any observations, or suspicions, were to be reported to the abuse coordinator immediately. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 8/14/2024 at 2:45 with NA C revealed she had been trained on restraints and abuse. Any observations, or suspicions, were supposed to be reported to the abuse coordinator, who was the ADM, immediately. Some examples of abuse were described as physical, such as slapping, pulling, holding down, or being rough with a resident. Some examples of abuse were described as emotional/verbal, such as telling a resident to shut up or calling them names. Restraints were not allowed at the facility. Some examples of restraints were described as belting a client in a chair or tying one up in their bed. Staff had been trained that resident's significant others could be abusive towards residents and instances of suspected abuse, or the use of restraints, was supposed to be reported to the abuse coordinator immediately. Interview on 8/14/2024 at 3:04 PM with LVN D revealed she had been trained on abuse, neglect, exploitation, and the use of restraints. Some examples of abuse were described as physical, such as hitting, pushing, and pinching a resident. Some examples of abuse were described as emotional/verbal, such as name calling, putting down, or being made to feel bad. The facility was a no restraint facility. It was not ok for staff, or guests, to restrain residents. Some restraints were described as physical, such as tying a resident to a bed, or inhibiting their natural body movements; Some examples of restraints were described as chemical, such as overmedication for a resident to make a staff's job easier. Allegations of abuse and restraints, or suspicions of, were supposed to be reported to the abuse coordinator, who was the ADM, immediately. Interview on 8/14/2024 at 3:10 with CNA E revealed she had recently received training on abuse, restraints, and resident's rights recently. She stated she was trained to report allegations, or suspicions, or abuse to the abuse coordinator, who was the ADM. Some examples of abuse were described as physical, such as jerking a resident during a transfer or being rough while having provided care. Some examples of abuse were described as emotional/verbal, such as name calling, yelling, venting frustrations, or having dismissed a resident's feelings. The facility was restraint free. Some examples of restraints were described as forcing a resident to wear gloves, raising full bed rails, and locking chair belts. Family members, and guests, were not allowed to be abusive, or to restrain residents, so allegations or suspicions of family member abuse or restraints were supposed to be reported to the ADM immediately. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 8/14/2024 at 3:30 PM with the DON revealed staff was trained to identify and report instances, allegations, or suspicions of abuse to the abuse coordinator, who was the ADM, immediately. Some examples of abuse were described as physical, such as gripping resident's too hard, dropping residents during a transfer, hitting, or slapping, a resident. Some examples of abuse were described as emotional/verbal, such as lashing out at a resident, making a resident cry, having called them names, or having used derogatory remarks. The facility was a restraint free facility. Some examples of restraints were physical, such as having tightly tucked residents in their sheets, having tied them to a bed rail, or having had restricted their body movements. Some examples of restraints were described as chemical, such as having purposefully medicated a resident to make staff's jobs easier. Any allegations or suspicions, such as abuse or the use of a restraints, were supposed to be reported to the ADM immediately. The DON stated she had reviewed Resident #1's CP, and assessments, and the risk of abuse by RP #2 towards Resident #1 had been removed. RP #2 had been educated that restraints were not allowed. Resident #1 had received new medications for her itching, has had her fingernails continually trimmed short, and had been provided Geri-gloves for her upper extremities to help protect her exposed skin. The DON stated a measure in place to inform residents, and family members, about the use of restraints was in the admissions packet. Residents who were placed in the situation to have been restrained against their will risked psychosocial harm, physical injuries, or the development of distrust and fearfulness of staff. Interview on 8/14/2024 at 3:39 PM with the ADM revealed her staff was trained to recognize instances of abuse and expected her staff to report allegations, or suspicions, of abuse, to her immediately. As well, the ADM stated her staff was trained on the facility's policy on restraints and expected her staff to report allegations of resident restraint, or suspicions, to her immediately. The facility's Admission Contract, which discussed the facility's no restraint policy, was signed by Resident #1 on 3/25/2024. The Admission Contract was a failsafe in place for residents, and significant others, to learn that restraints were not allowed at the facility; however, Resident #1 had was her own responsible party at the time of admittance but had chosen a significant other, RP #2, to become their Medical Power of Attorney on 4/10/2024. The ADM was not aware, and could not state with certainty, if the facility forwarded RP #2 a copy of Resident #1's Admission Agreement, which discussed the facility's no restraint policy. Residents who were abused in the form of having been restrained, were placed at risk of physical harm, such as injuries, and psychosocial harm, such as trauma related emotions. The reporting time for allegations of abuse, per the facility's Abuse and Neglect policy, indicated the allegation of abuse was supposed to have been reported to Health and Human Services within 2 hours of the report; however, the ADM did not report the allegation of abuse, which was initially reported to her by staff on 8/3/2024 at 8:35 PM, through the reporting website until 8/5/2024 at 3:11 PM. The ADM did not try to rationalize why the report was made late and acknowledged she was not in compliance and had no excuse. Record review of the ADM's one-on-one in-service, dated 8/5/2024, addressed the Long-Term Care Regulatory Provider Letter, PL 19-17, titled: Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Other incident that a Nursing Facility Must Report to the Health and Human Services Commission; Provider types: Nursing Facilities; Date Issued: 7/10/2019. The provider letter indicated abuse, with or without serious bodily injury, was supposed to be reported immediately, but not less than two hours after the incident occurred or was suspected. The instructor was RRN. (continued on next page)

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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** 47772 Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, for 1 of 9 residents (Resident #1) reviewed for reporting abuse allegations. The facility failed to report an incident involving the use of a restraint on Resident #1 by RP #2, that occurred on 8/3/2024 at 8:35 PM, until 8/5/2024 to Health and Human Service. This failure placed residents at risk of physical harm, psychosocial harm, lack of regulatory oversite, and having their needs gone unmet. Findings included: Record review of Resident #1's AR, dated 8/14/2024, reflected an [AGE] year-old female admitted to the facility on [DATE]. She was diagnosed with Dementia (which was a disease that affected memory, thought, and interfered with daily life,) Cerebral infarction (which was a pathologic process that resulted in necrotic tissue in the brain, caused by disrupted oxygen and blood supply,) and Bullous Pemphigoid (which was a rare skin condition that caused blisters on the skin.) Record review of Resident #1's Quarterly MDS assessment, dated 7/19/2024 reflected Resident #1 had a BIMS Score of 8. A BIMS Score of 8 indicated Resident #1 had moderate cognitive impairment. Resident #1 used a wheelchair for ambulation; she was dependent upon staff for eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/talking off shoes, and personal hygiene. Dependent meant the helper did all the effort. Resident did none of the effort to complete the activity; Or the assistance of 2 or more helpers was required for the resident to complete the activity. Resident #1 had a catheter and was frequently incontinent of bowel. Record review of Resident #1's CP reflected a focus area for potential/actual impairment to skin integrity, initiated on 5/01/2024 and revised on 8/5/2024, evidenced by self-inflicted scratches; revised focus area R/T diagnosis of Bullous Pemphigoid. The goal was to have no complications by the target date of 10/10/2024. The interventions for nursing staff were to administer treatments as ordered, initiated 5/17/2024; avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short, initiated 5/17/2024; Educate resident and responsible parties of causative factors to prevent skin injury, initiated 5/1/2024; Follow facility protocols for treatments of injury, initiated 5/1/2024; Identify potential causative factors and eliminate where possible, initiated 5/1/2024; Keep skin dry and clean/use lotion on dry skin, initiated 5/1/2024. Resident #1's CP reflected a second focus area for skin integrity, initiated on 5/30/2024, evidenced by scratching skin and skin breaks. The goal was to have fewer episodes of scratching by target date of 10/10/2024. The interventions for nursing staff were to administer medications as ordered, initiated 5/30/2024; anticipate needs of resident, initiated 5/30/2024; Apply Geri-sleeves on both upper extremities, initiated 8/12/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676123	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairfield Nursing & Rehabilitation Center	420 Moody St Fairfield, TX 75840

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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	Record review of Resident #1's Order Summary Report reflected an order for hydroxyzine; (1) .25 MG tablet by mouth every 6 hours for itching. The order was written on 7/9/2024 and started on 7/9/2024.The Order Summary Report reflected an order for prednisone; (7) 10 MG tablets given via peg tube one time a day R/T Bullous Pemphigoid. The order was written 8/5/2024 and started on 8/6/2024. Record review of Resident #1's July 2024 MAR, viewed in PCC, reflected Resident #1's medication list. The July 2024 MAR indicated Resident #1 received hydroxyzine; .25 MG tablet by mouth every 6 hours. The MAR reflected medication administration started on 7/9/2024 at 11:00 PM. The July 2024 MAR indicated administration of hydroxyzine .25 MG tablet by mouth every 6 hours through 7/31/2024 (continuous.) Record review of Resident #1's August 2024 MAR, viewed in PCC, reflected Resident #1's medication list. The August 2024 MAR indicated Resident #1 received hydroxyzine; .25 MG tablet by mouth every 6 hours. The MAR reflected medication administration continued from 8/1/2024 at 5:00 AM until 8/14/2024 (continuous.) The August 2024 MAR indicated administration of prednisone; (7) 10 MG tablets given via peg tube one time a day R/T Bullous Pemphigoid. The August 2024 MAR indicated Resident #1 received prednisone; (7) 10 MG tablets given via peg tube one time a day R/T Bullous Pemphigoid 1 time daily from 8/6/2024 until 8/14/2024 (continuous.) Record review of Resident #1 Admission Contract, signed and dated 3/25/2024, reflected Section 21. Rules on Restraints, Resident's Behavior, and Health Care Center Practice. The Admission Contract indicated: It was the policy of the facility to have maintained an environment that prohibited the use of restraints for discipline or convenience. Restraint usage would have been limited to circumstances in which the resident had medical symptoms that warranted the use of restraints. The restraint assessment committee would have evaluated and established the need for restraint use or restrain reduction for residents in the health care center. The health care center was committed to nurturing the autonomy and independence of the residents by having attempted to provide a restraint free environment. A physical restraint was defined as any manual restraint method, such as physical, mechanical, material, or the use of adjacent equipment, that the individual could not remove easily, which would have restricted a resident's freedom of movement, or normal access to one's body. The Admission Contract's Notice of Rights and Services, located in Section 21, indicated: the facility must have informed the resident, or the residents next of kin/guardian, both orally and in an understandable language the rights and rules governing resident conduct and responsibilities during the resident's stay at the facility. The facility's policy related to the use of restraints and involuntary seclusion must have also been given to the resident's legally authorized representative if the resident had one. Record review of a legal document, notarized on 4/10/2024, named RP #2 as Resident #1's Medical Power of Attorney. Record review of Resident #1's incident report dated 8/3/2024 at 8:35 PM; written by the ADON, reflected an unwitnessed event in the room of Resident #1 (201-B); resident not taken to hospital; no injuries observed. Record review of Resident #1's progress notes dated 8/3/2024 at 8:35 PM; written by LVN A, reflected an entry having indicated: Resident was found with her right hand tied to the grab bar after RP #2 had left for the night, reported it to the administrator. Hand was untied and assessed resident's wrist for any marks or bruising and none where found. (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 a written statement by LVN B, dated 8/3/2024 at 7:30 PM, reflected LVN B ad LVN A entered Resident #1's room just after RP #2 left Resident #1's room. LVN A and LVN B discovered Resident #1's right hand had been tied to the bed's assist bar. The two LVN's immediately released Resident #1's hand/wrist and assessed for trauma. No marks were noted to her wrist. Resident #1 did not appear to be in any distress. Record review of a written statement by LVN A, dated 8/5/2024, reflected LVN A entered Resident #1's room (8/3/2024) with LVN B having discovered Resident #1's right hand had been tied to the bed's assist bar with a small blanket. LVN A released Resident #1's right hand. A visual inspection of Resident #1's right hand resulted with no visible trauma. LVN A reported the incident to the ADM. Record review of Resident #1's weekly skin assessment, dated 8/5/2024, reflected Resident #1's skin color was normal, no bruises, no skin tears, no abrasions, and no lacerations. There were no areas that had not been reported to the facility medical provider. Assessment performed by LVN F. Record review of a local police report, # 2400220, written on 8/14/2024 by Officer #3 reflected an incident, which occurred at the facility on 8/3/2024. The report indicated: On 08/05/2024 at approximately 3:30 PM, I, Officer #3 responded to a call at the Nursing and Rehab. When I arrived, I met with the ADM. The ADM stated that she was notified by a charge nurse, LVN A, that Resident #1 had her hand tied to the assist bar, by RP #2. The ADM stated LVN A reported having untied Resident #1 arms, bound by a blanket to the bed's mobility assist bar. The ADM stated LVN A reported no red marks, bruises, lacerations of any kind. The ADM stated that the facility staff had spoken with RP #2, and he explained he did not mean any harm, but was only trying to keep Resident #1 from scratching herself. Resident #1 had recently been diagnosed with an autoimmune skin condition, which caused severe itching. RP #2 did not know his actions were wrong and said he would never do it again. The ADM stated that she believed it was not a malicious intent. The ADM stated RP #2 was really good to Resident #1 and visited with her daily, and only wanted the best for her. Officer #3 went to Resident #1's room and looked at her arm. There were no signs of any bruising or any other marks. Resident #1's hand was in a sock when having arrived at her room. Record review of Resident #1's progress notes dated 8/5/2024 at 7:58 PM; written by the ADM, reflected an entry having indicated: The Administrator had a care plan with RP #2. The ADM discussed using restraints and explained that this was not allowed in the facility and was considered to be a form of abuse. RP #2 became very upset as he did not know and was very sorry, having explained all he tried to do was to keep Resident #1 from having scratched herself. RP #2 explained all he wanted was to take good care of Resident #1 and that he had devoted the last several years of his life doing that. Resident #1 had a new diagnosis of Bullous Pemphigoid, 7/23/2024, and it did cause her to scratch. The facility's MD had prescribed hydroxyzine. RP #2 was glad to hear this and promised he would never restrain Resident #1 again. Record review of Resident #1s progress notes, dated 8/8/2024 at 4:57 PM; written by the SW, reflected an entry having indicated: The SW followed up with Resident #1 for the incident having regarded to RP #2 securing Resident #1's wrist to the bed rails to prevent Resident #1 from scratching herself. Resident #1 stated she was not in any distress from the incident or upset with RP #2. Resident #1 stated RP #2 had good intentions and tried his best to help her from scratching, which had caused her skin to bleed. Resident #1 stated RP #2 understood why he should not have tied her right hand/wrist to the bed side rail and that it was a mistake, an error. Resident #1 was calm, alert, and oriented to self, place, and time. (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 a facility self-reported intake reflected an email, dated 8/5/2024. The email indicated [To Whom it May Concern, please find attached a late-self report on abuse that occurred on the evening of 8/3/2024. Attached are the following: Initial self-report, resident face sheet, witness statements, heat to toe assessment completed 8/5/2024. If you have any questions, please feel free to contact the ADM. Observation on 8/13/2024 at 10:15 AM of Resident #1 reflected the resident seated /reclined in her Geri-chair (a large wheelchair with a padded back/seat and leg stirrups) in the television area near the facility's nurse's station. Resident #1 was covered up to her torso with a white sheet, her head was supported with a horseshoe shaped pillow around her neck, and she did not appear to be in any distress. Resident #1 had her eyes closed and was non-responsive to verbal prompts. Interview on 8/14/2024 at 8:43 AM with RP #2 revealed he was at the facility the night of 8/3/2024 to see Resident #1. To keep Resident #1 from having scratched her skin, he stated he used the material from the softest material he could find, which was a blanket, and tied Resident #1's right hand/wrist to the support bar on the side of the bed. He stated he did not try to hide what he had done, and left the knotted blanket exposed for anyone who had entered the room to see. He did not know, at the time, that having tied Resident #1's hand/wrist to the support bar was a form of abuse through restraint. He stated he was seen by the ADM, a couple of days later, and learned that physical restraints were not allowed at the facility. He was only trying to help Resident #1 and promised he would never do it again. Observation and interview on 8/14/2024 at 9:55 AM of Resident #1 revealed the resident seated /reclined in her Geri-chair in the television area near the facility's nurse's station. Through verbal responses and facial features, Resident #1 affirmed that she was feeling ok and denied any pain. She recalled RP #2 tying her right arm to the bedside assist bar on 8/3/2024 but denied that it caused her any pain. The itching was just about the same. Resident was observed wearing Geri-gloves (which were mesh gloves worn to protect skin without having sacrificed comfort or mobility.) Interview on 8/14/2024 at 3:39 PM with the ADM revealed her staff was trained to recognize instances of abuse and expected her staff to report allegations, or suspicions, of abuse, to her immediately. As well, the ADM stated her staff was trained on the facility's policy on restraints and expected her staff to report allegations of resident restraint, or suspicions, to her immediately. Residents who were abused in the form of having been restrained, were placed at risk of physical harm, such as injuries, and psychosocial harm, such as trauma related emotions. The reporting time for allegations of abuse, per the facility's Abuse and Neglect policy, indicated the allegation of abuse was supposed to have been reported to Health and Human Services within 2 hours of the report; however, the ADM did not report the allegation of abuse, which was initially reported to her by staff on 8/3/2024 at 8:35 PM, through the reporting website until 8/5/2024 at 3:11 PM. The ADM did not try to rationalize why the report was made late and acknowledged she was not in compliance and had no excuse. Record review of the ADM's one-on-one in-service, dated 8/5/2024, addressed the Long-Term Care Regulatory Provider Letter, PL 19-17, titled: Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Other incident that a Nursing Facility Must Report to the Health and Human Services Commission; Provider types: Nursing Facilities; Date Issued: 7/10/2019. The provider letter indicated abuse, with or without serious bodily injury, was supposed to be reported immediately, but not less than two hours after the incident occurred or was suspected. The instructor was RRN.