STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676131	A. Building B. Wing	09/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Lakeway Snf	1917 Lohmans Crossing Rd Lakeway, TX 78734

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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 - 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** 50176 Based on observation, interviews, and record review, the facility failed to ensure each resident had the right to be free from abuse and neglect for one (Resident #1) of five residents reviewed for abuse and neglect, in that: The facility failed to ensure Resident #1 was free from abuse by his SO/AP when the facility neglected the interventions of Resident #1's care plan. The facility failed to follow the interventions in Resident #1's care plan, such as, keeping the Resident's door open during visits with SO/AP to keep the resident safe. This resulted in allegations that the SO/AP physically and verbally abused Resident #1. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 08/30/2024 at 1:30 PM. While the IJ was removed on 09/01/2024 at 01:41 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with a potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of abuse, trauma, physical harm, pain, and/or psychosocial harm. Findings included: Record review of Resident #1's face sheet dated 08/10/2024, reflected an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including Glioblastoma (brain cancer), cerebral edema (swelling of the brain), muscle wasting and atrophy, seizures, hypertension (high blood pressure), and cognitive communication deficit (difficulty with speech). Resident #1 had also been diagnosed with difficulty swallowing and was a high risk for aspiration. Record review of Resident #1's MDS assessment, dated 05/21/2024, reflected a BIMS score of 12, which indicated moderate cognitive impairment. Resident was at risk of developing pressure ulcers but had no current pressure ulcers or injuries. Resident had skin tears, pressure reducing device for chair and bed. Negative for any behaviors. Resident was dependent for self-care and required maximal assistance to move from sitting to lying flat on bed. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2024
NAME OF PROVIDER OR SUPPLIER Brookdale Lakeway Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 1917 Lohmans Crossing Rd Lakeway, TX 78734	

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's initial care plan initiated on 05/15/2024 revealed no behavioral problems. Resident required assistance with ADLs due to weakness, brain cancer, cognitive deficit, and history of seizures. Resident required two -person assistance for transfer. Resident had difficulty swallowing and had a puree/thin liquid diet with 1:1 assistance for eating, monitor meal intake with each meal, and monitor weights as ordered. SO/AP was non-compliant with texture modified diet order and ordered excessive quantities of food for the resident. Resident had impairment to skin integrity and required assistance with turning and repositioning. Skin was to be evaluated on a daily and weekly basis. Geri sleeves to both arms were added on 07/22/2024 due to thin and fragile skin with discoloration and tears. Resident was on dexamethasone therapy (steroid) and at increased risk for bruising, bleeding, slow wound healing, thinning skin, red/purple spots on the skin. On 7/14/2024, potential impaired behavioral patterns were added (restlessness, agitation, movement onto the assist bar on left side of bed). Record review of Care Plan conference summary dated 08/14/2024 reflected a BIMS score of 0, which indicated severely impaired cognition. The facility reported that the internal investigation of the 07/14/2024 incident was unfounded. Surveyor requested copies of the facility's abuse/neglect investigations for Resident #1 for the past 60 days on 08/29/2024 at 11:45 AM but did not receive a copy of the 07/14/2024 internal investigation. The facility found the internal investigation of the 08/03/2024 incident to be inconclusive. Resident was alert to person, and able to answer yes or no questions. His BIMS score was 0. Resident #1 denied abuse but was unable to tell the source of the injury. SO/AP denied abuse, stated she had seen the bruise a few days ago, but was unable to recall the specific date and time. When asked why SO/AP did not report the bruise, she stated, I did not think twice about it. SO/AP admitted to covering the bruise with foundation make-up. Based on interviews and the extent of the injury no abuse or neglect was verified. Resident #1 took medications that contributed to skin fragility, and he did have spontaneous movement. Record review of Resident #1's progress note dated 08/03/2024 by RN B, revealed nursing staff noticed the resident had the appearance of a left black eye around 5:30 AM. A maroon color bruise appropriately 1 cm in diameter below the resident's left eye around upper cheek. There were also some very small faint purple marks between his eye and nose. Also noted was the appearance of foundation makeup on his skin close to the left side of his nose as evidenced on cloth after wiping face. SO/AP was questioned by CNA B, RN and Director of Social Services and SO/AP reported seeing the bruise a couple of days ago and did not report it to staff. SO/AP admitted to putting the makeup on the bruise. The resident denied being hurt by the SO/AP. A BIMS interview was attempted, and the resident was unable to participate. The resident had difficulty talking and did not answer questions. Progress notes did not reflect that a head-to-toe assessment was done. Record review of Resident #1's change of condition evaluation dated 08/03/2024 revealed bruise/purple discoloration below left eye and in the corner of left eye. Record review of Resident #1's progress note dated 08/05/2024 by Director of Social Service, revealed SO/AP came to the facility to drop off clean laundry. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's progress note dated 08/05/2024, signed by the NP, revealed Resident #1 was alert and oriented to person, insight was impaired, and he was confused and forgetful. Record review of the NP physical exam dated 08/05/2024 showed a diagnosis of contusion to left eyelid and periocular area and superficial injury to left upper arm. Notes stated that SO/AP observed bruise on 08/02/2024. Record review of Resident #1's progress note dated 08/08/2024 by Director of Social Services, revealed SO/AP was allowed back in the facility. New interventions were reviewed with SO/AP, including moving the resident closer to the nurse's station and having the resident's door always open for safety/monitoring when SO/AP was visiting the resident. Further review a Care conference took place on 08/14/2024 because SO was accused of being the AP in the 07/14/2024 and 08/03/2024 incident. Record revealed Resident #1's Care plan initiated 08/08/2024 included interventions to allow SO/AP to visit frequently, which included: move resident to room closer to nurse's station; SO/AP to notify staff immediately of any skin injury; resident's door to remain open during visits; and care plan conference with Ombudsman scheduled for 08/14/2024. Resident #1 was at risk for aspiration due to trouble swallowing and left sided weakness. Interventions included maintain appropriate, upright position during meals, remain upright for 1 hour after meals, order for puree/thin liquids diet, supervise or assist resident with oral intake as needed, 1:1 assist, monitor meal intake with each meal, encourage SO/AP compliance with diet order. SO/AP was non-compliant with texture diet orders and would order excessive quantities of food for the resident. Update on 08/13/2024, reflected that resident had delirium with changes to behavior, altered mental status, wide variation in cognition through the day, communication decline, disorientation, lethargy, restlessness and agitation, delusions, and hallucinations. Record review of Resident #1's orders dated 08/29/2024 revealed an order to keep the resident's door open when SO/AP was visiting alone with the resident. Record Review of Resident #1's skin integrity report dated 08/22/2024 revealed skin tear on left arm. Record review of Resident #1's change of condition forms indicated the following: * dated 08/29/2024, revealed skin discoloration on the left side of resident's face at jawline, and behind left ear and red area. Area was better after pressure relieved from face on call control. * dated 08/30/2024 revealed a new skin tear to the right elbow. CNA witnessed SO/AP transport resident through bedroom doorway and bump the resident's elbow. Record review of Resident #1's skin integrity report dated 08/30/2024 revealed skin not intact. Discoloration, rash, abrasion, and skin tears in multiple different healing levels. The abrasion was a new skin issue and weekly wound data collection flow sheet was selected to be created. Record review of facility sign in sheet for August 2024, revealed SO/AP was at the facility 08/03/2024, 08/09/2024 to 08/30/2024. (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 observation and attempted interview on 08/29/2024 at 12:24 PM, Resident #1 was in the dining room and SO/AP was observed trying to feed Resident #1 and said, I need your mouth open .this can be the last bite if you want .open your mouth. Resident #1 was observed in a wheelchair with pillows behind his head, back, under arms, and under his legs/feet. He was wrapped in Geri sleeves/bandages on both arms. Resident #1 wore a baseball cap that covered his head and forehead. Surveyor attempted to interview the resident in the dining room alone, but the resident did not respond to questions and closed his eyes and appeared to be asleep. During observations on 08/29/2024, revealed Resident #1's door was closed with SO/AP inside the room at the following times: 12:50 PM - 12:56 PM 1:06 PM - 1:10 PM 2:55 PM - 3:02 PM 4:36 PM - 4:45 PM During the above times of observations, six staff walked by the door and did not intervene to open the door. During an interview on 08/29/2024 at 12:11 PM, the DON stated that she had witnessed SO/AP trying to wake up Resident #1 by patting him on the cheek, shaking his chest. Staff had reported SO/AP force fed the resident. SO/AP put a lot of focus on eating and fed the resident all three meals daily. The DON stated the Medication Resident #1 took made him sleep and resident's skin got very thin and bruised a lot. The DON stated she did not think SO/AP was abusing the resident because SO/AP always said how much she loved the resident, and the SO/AP's intention was not to harm the resident. DON stated there was not any abuse to report. After the 08/03/2024 incident with the bruise on the resident's face, the facility set up a meeting with SO/AP and the Ombudsman on 08/08/2024. Facility's response was to move the resident to a room closer to the nurse's station to allow for line of sight, frequently monitoring, and the door to remain open. They have put padding on the resident's chair. The DON thought the marks on Resident #1 were due to positioning in the chair and/or bed. The DON had received in-service training on ANE this month and knew about reporting. During an interview on 08/29/2024 at 12:34 PM, RN C stated she was not aware of Resident #1's care plan about leaving the resident's door open. RN C had not been told what to do if the resident's door was closed. RN C had not told to do frequent rounds/monitoring on Resident #1. RN C did not know who the abuse coordinator was and had not received any recent training on ANE. During an interview on 08/29/2024 at 12:43 PM, CNA C stated that Resident #1 always had unexplained skin tears and bruises and SO/AP was told to visit the resident in public spaces. CNA C was not aware not aware of Resident #1's care plan about leaving the resident's door open. CNA C stated SO/AP wanted to the door closed and would close the door. CNA C had not been told what to do if the resident's door was closed. CNA C did not do anything when the door was closed. The resident only came out of his room to eat in the dining room and for therapy. They all stated they were not told to do frequent rounds/monitoring on Resident #1. CNA C observed SO/AP feed Resident #1 all meals in the dining room. (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 08/29/2024 1:10 PM, CMA stated SO/AP fed Resident #1 all meals. CMA had not been told that Resident #1's door must stay open. CMA had not been told what to do if the resident's door was closed and CMA did not do anything when the door was closed. CMA stated the resident was moved closer to the nurse's station so that staff walking pass his door would keep an eye on him. During an interview on 08/29/2024 1:25 PM, NP stated that the marks on Resident #1's face, neck, and arms were clearly a result of the high dose steroid use and not abuse. The NP stated they (the marks on Resident #1) were not bruises. The NP believed skin tears were due to transfers, brushing up against the environment (chair/bed). The NP stated that staff (speech therapy, nurse, CMA/CNAs) had expressed their concerns about how SO/AP fed the resident. NP did not think SO/AP was intentionally trying to hurt the resident. The NP had no concerns about SO/AP visiting the resident and being alone in the facility with the resident with the door closed. The NP was not aware of any order to have Resident #1's door open or to do frequent monitoring. During an interview on 08/29/2024 at 1:38 PM, the MD stated that Resident #1 was taking a high dose of steroids due to brain cancer. The MD believed the discoloration on the resident's face was related to medical condition and medications. The MD had not observed any abuse. Staff have told the MD that SO/AP was persistent with feeding the resident but did not believe that would rise to the level to be abuse. They had not discussed any concerns about abuse or aggressive feeding in the monthly or weekly QAPI meetings. Surveyor told MD about the interviews from staff in the complaint report. The MD expressed surprise and stated, that is very concerning. The MD stated that Resident #1 did not have the cognition to be interviewed about the abuse. The MD was unaware of any interventions regarding Resident #1's door kept open during visits with SO/AP. During an interview on 08/29/2024 at 2:07 PM, LVN B had observed SO/AP on 7/14/2024, grabbing both (Resident #1's) shoulders and shaking him hard; slapping him in the face; hitting him in the chest with her fist; yelling him; threatening him to say she won't come visit him anymore if he doesn't wake up. LVN B intervened and told SO/AP to stop that it was dangerous to put food in the resident's mouth when he was asleep as he could choke. LVN B reported concerns to the DON, who called ADM, who did not want to report it. LVN B reported observing further abuse by SO/AP later that month and because of this, had not returned to work for this facility. During an interview on 08/29/2024, at 3:16 PM, LVN C stated she was unaware the Resident #1's care plan and interventions. She stated the DON was responsible for educating nursing staff and CNAs about the interventions in place and changes in a resident's care plan. LVN C had received in-service training on ANE recently and was aware to report ANE to the abuse coordinator. (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 08/29/2024 at 3:28 PM, SO/AP denied hurting Resident #1. SO/AP was observed lying in bed on the right side of the resident while Resident #1 was asleep. SO/AP stated that the bruise of Resident #1's face was due to him sleeping on the call light button and reported the facility staff removed the call light at night. The AP/SO stated that was the only explanation for how the bruise occurred because SO/AP didn't do anything. Throughout the interview, SO/AP repeatedly stated she had nothing to hid and did not do anything and stated that she never noticed the bruise. It was a staff member that noticed the bruise, but SO/AP could not recall the staff member's name. When asked about the make-up, SO/AP originally denied it and then said she put make up on Resident #1's face a long time ago because SO/AP felt bad for the resident. SO/AP denied having a care plan meeting. When asked about keeping the door open, SO/AP stated she was asked to do that, but SO/AP kept the door cracked or closed because SO/AP did not want anyone looking into the room and the facility had blown that off. SO/AP wanted privacy. SO/AP denied staff coming to check on the resident or monitoring him. Surveyor attempted to interview Resident #1, but the resident remained asleep during the interview with SO/AP. During an interview and observation with LVN D on 08/29/2024 at 3:28 PM, LVN D was unaware of Resident #1's care plan interventions to keep door open. LVN D looked in Resident #1's electronic chart during the interview and could not find an order to have the resident's door open. LVN D walked off down the hallway. LVN D later returned as SO/AP was opening Resident #1's door and exiting the room with the resident. LVN D told SO/AP that the resident's door needed to stay open, and SO/AP responded, I don't care and continued to walk down the hallway pushing the resident in a wheelchair. LVN D stated she found a doctor's order in Resident #1's chart to keep the door open. LVN D told the charge nurse the care plan was not being followed and stated, I am sure the DON is aware. LVN D stated that all staff needed to be aware to keep the door open. During an interview on 08/29/2024 at 4:54 PM, Receptionist B had seen SO/AP be aggressive with Resident #1. Receptionist B observed SO/AP in the dining room grabbed his (Resident #1) jaw last month while trying to brush the resident's teeth. Receptionist B observed SO/AP grab Resident #1's arm and forced it down in a slapping motion when the resident reached out and grabbed hold of the dining room door frame. Receptionist B reported the incident to the police when they responded to the 08/03/2024 self-report and then reported it to her supervisor. Receptionist B received in-service training last month on ANE. Receptionist B had no knowledge of the resident's care plan or interventions nor if the facility had done an investigation regarding her concerns. During an interview on 08/29/2024 at 6:07 PM the ADM stated it was hard to say what the expectations were for staff not following Resident #1's care plan interventions to keep the resident safe because the facility's internal investigation revealed no abuse; the resident wanted SO/AP there and felt safe; the police had not done anything, and the Texas Health and Human Services Commission had cleared the first incident for 07/14/2024. The ADM stated that in general, when discussing other residents, the ADM's expectation was that staff follow the care plan. When surveyor asked again about expectations for Resident #1's care plan interventions and door being left open for safety and monitoring, ADM replied, that's hard to say. It is our findings that there has been no abuse. The ADM stressed there was no believe that any abuse had occurred and therefore, was not concerned about the closed door or staff not following the care plan interventions. (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 08/29/2024 at 6:07 PM the DON stated it was care planned to have Resident #1's door kept open for line of sight. DON stressed that SO/AP would hurt the resident and therefore, we don't force the door if the door was closed. SO/AP was the POA and had been in a relationship with the resident for [AGE] years and the ADM and DON must respect that. The DON had known of concerns from staff that SO/AP force fed Resident #1 and that the AP/SO shakes his (Resident #1) shoulders to wake him up, but nothing the DON would consider abuse. The DON stressed that the AP/SO was intentionally trying to feed and wake Resident #1 but did not intend to cause harm. The DON stressed there was no believe that any abuse had occurred and therefore, was not concerned about the closed door or staff not following the care plan interventions. During an interview on 08/29/2024 at 7:06 PM, the DON stated SO/AP was told to leave the building and would not be allowed in the facility again if Resident #1's door did not remain completely open during visits. SO/AP was encouraged to stay in public/common areas. The DON would start in-service training with staff about the care plan interventions. During an interview on 08/29/2024 at 7:28 PM, RN B stated that on 08/03/2024, a night CNA had reported to the night nurse that Resident #1 had a black eye around 5:30 AM. RN B did an assessment and did not think it was a bruise. RN B talked to the resident alone and the resident reported that he felt safe. RN B interviewed SO/AP and SO/AP had noticed the bruise a few days ago but had not reported it to the facility staff because she thought staff already knew. Resident #1 had fragile skin and due to medications, his skin would tear. RN B stated that the facility staff present that day had separated the resident and SO/AP and had the resident moved closer to nurse's station . RN B also called the police. RN B stated that the police officer had no concerns after interviewing the SO/AP. RN B was aware of the resident's care plan interventions to keep the door open while SO/AP visits. Staff had access to this information in the care plan. During an interview on 08/29/2024 at 7:43 PM, LVN A had observed SO/AP become impatient and frustrated with Resident #1. All staff have had to intervene because of SO/AP's behaviors. When SO/AP was not there, Resident #1 was smiley and friendly with the staff. When SO/AP was at the facility, the resident was more upset and agitated. SO/AP got loud, bossy with him. LVN A found the black eye with make-up put on Resident #1's face, which was highly suspicious. LVN A had heard that an agency nurse had seen SO/AP shake the resident in the dining room. LVN A stated Resident #1 would get skin tears on left side due to always leaning on left side. LVN A received in-service training on ANE and would report any concerns to the abuse coordinator. During an interview on 08/29/2024 at 9:25 PM, the ADM had a copy of the police report and was aware of the allegations from four staff members who reported witnessing SO/AP assault Resident #1. The report revealed on 07/13/2024, staff observed SO/AP kick Resident #1 under the table in the dining room when they attempted to video record SO/AP interaction together while in the dining room. On 07/13/2024, staff observed SO/AP yell at Resident #1, grab his arms and shake him, and shove food in Resident #1's mouth, while he was lying flat on his back laying down, sleeping. Over the past month, staff had observed SO/AP punch Resident #1 in the chest with a closed fist and slap him in the face multiple times on different days. Staff had observed a burn on Resident #1's abdomen and reported they didn't know what caused the burn and that the resident would not have been able to cause it due to his mobility limitations. Staff reported that visitors had complained that they witnessed SO/AP slap Resident #1. Staff stated that they reported these allegations and concerns to their supervisor. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation and interview on 08/30/2024 at 8:43 AM, Resident #1 was observed sitting in a wheelchair in the dining room and SO/AP was trying to feed the resident. Resident #1 appeared asleep as he had his eyes closed. Surveyor observed SLP intervene and crouch down to talk to the resident. Surveyor overhead SLP telling SO/AP, you can't feed him now .no, he's not awake enough and walked off. SLP stated he talked to SO/AP about not feeding the resident when the resident was asleep. The resident was not alert enough to eat and SO/AP needed to be educated to stop putting food in his month when the resident was asleep, which would collect in Resident #1 mouth and cause choking. SLP stated SO/AP got overzealous about feeding the resident but did not think it would be considered abuse. During an interview on 08/30/2024 at 11:37 AM, DCS stated that on 08/03/2024, Resident #1 was found to have a bruise on his face covered up by makeup. That was a big red flag. DCS reported it immediately to the previous ADM. The ADM was aware of the previous incident with SO/AP and told the DCS to call the police. Resident #1 was moved closer to the nurse's station on 08/03/2024 and then moved to another room on 08/10/2024 to keep an eye on the resident and provide frequent monitoring. ADM told DCS to remove SO/AP from the facility due to the situation. The SO/AP was still at the facility when the police arrive around 11:00 AM. Police responded to the facility on [DATE] around 11:00 AM and interviewed SO/AP and the resident. Police stated they could not do anything because there was no admission of guilt to the injury. DSC did not suspect SO/AP of any abuse. DCS had observed Resident #1's door being open but had been told that SO/AP liked to keep the door closed. DCS was in-serviced about keeping the resident's door open, the care plan interventions, and ANE about who was the abuse coordinator and about reporting when he arrived at the facility on 08/30/2024. The DCS stated the care plan was to ensure staff was providing proper care to the resident. The DCS expectation was that nursing staff follow the care plan. DCS would immediately report any allegations of ANE from staff. During an interview on 09/01/2024 at 9:50 AM, CNA A stated Resident #1 had unexplained bruises. Resident #1 was unable to communicate. An agency nurse had seen SO/AP smacking the resident and CNA A had seen SO/AP shaking the resident to wake him up a couple of month ago. We (the CNAs) had been suspicious of SO/AP for a while and could not believe no one believed it (the abuse) did not happen. During an interview on 09/01/2024 at 10:14 AM, CNA B had previously witnessed SO/AP shake (Resident #1) by the arms going back and forth. Resident #1 was sleepy, and SO/AP tried to put food in the resident's mouth. CNA B told SO/AP on 08/31/2024 not to feed Resident #1 soup with chucks of stuck in it because that could cause choking. During an interview on 09/01/2024 at 1:30 PM, LVN A had previously observed SO/AP be bossy and pushy where we as nursing staff would tell her that he has rights and we have always intervened. When asked if Resident #1 was safe at the facility, LVN A replied, I would hate to see him go home. During an interview on 09/01/2024 at 11:19 AM, RN A stated last week RN A observed SO/AP feed Resident #1 when he was not awake. Last week RN A observed SO/AP picking up Resident #1's head and holding it back. RN A intervened and explained to SO/AP that it was not appropriate to feed Resident #1 when he was asleep. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Lakeway Snf	1917 Lohmans Crossing Rd Lakeway, TX 78734

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F 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Review of the Facility's Abuse, Neglect & Exploitation Policy, dated 07/2016 last revised 10/2022, reflected the facility will take necessary measures to prevent and protect residents from abuse. This policy will apply to potential abuse and injury of unknown source. Instances or allegations of abuse, neglect, mistreatment, or exploitation should be treated seriously and reported to the Administrator or the supervisor on duty for investigation and appropriate follow up. 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, and physical or chemical restraint not required to treat the resident's medical symptoms. The policy includes the definition of willful, as used in abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

Prevention

1. Abuse prevention efforts should include, but are not limited to, the following:

a. Providing residents and family information on how and to whom they may report concerns, incidents, and grievances without the fear of retribution.

b. Providing associates information on how and to whom they may report concerns, incidents and grievances without the fear or retribution.

c. Identification, correction, and intervention in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur (this should include analysis or the physical environment that might make abuse and/or, neglect more likely to occur such as secluded areas of the community, deployment of associates on each shift to meet the needs of the residents; supervision or associates to identify inappropriate behaviors; and the assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict. mistreatment or neglect).

Protection

1. Protection of Resident. Upon learning of alleged abuse, neglect, mistreatment or exploitation, the Administrator or supervisor on duty should attempt to take necessary steps to verify residents are protected from subsequent episodes of abuse, neglect, mistreatment or exploitation.

An attempted interview of Resident #1 on 08/30/2024, at 3:25 PM. Resident #1 was lying in bed in his room, awake and alert, and turned to look at surveyor when his name was called. The door was open, and a caregiver/sitter was sitting in a chair by the bed. SO/AP was lying in bed with the resident on the right side of the bed. Surveyor attempted to interview Resident #1, but SO/AP kept patting Resident #1's cheeks with her hands and turning the resident's face/head to the right and away from the surveyor when the surveyor tried to talk to the resident.

This was determined to be an Immediate Jeopardy (IJ) on 08/30/2024 at 1:03 PM. The Administrator was notified. The Administrator was provided with the IJ template on 08/30/2024 at 1:30 PM.

The following POR was accepted on 08/31/2024 at 2:23 PM and included:

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediate Jeopardy On 8/30/2024, at 1:30 PM, the facility was notified of an immediate jeopardy for F600 (Free from abuse and neglect) regarding: - The facility failed to implement interventions in Resident #1's care plan to keep Resident #1 free from abuse by his SO. F600 Abuse and Neglect 1. One resident was identified as being affected by alleged deficient practice. On 08/30/2024, the HCA and DCS reminded SO of the care plan intervention that the resident's door is to remain open during the SO's visits, except at such times staff is present providing personal care. SO was advised of risks associated with non-compliance to include limitations on or restrictions of visitation. SO verbalized her understanding and agreement. On 08/30/2024, the DCS/designee re-educated the current and on-coming staff on the following: current care plan intervention that the resident's door is to remain open during visits with SO, except at such times staff is present providing personal care; actions to take in the event the SO refuses or prevents the staff from keeping the door open or is otherwise non-compliant; and the location of care plan information to include the Kardex and care plan and how to access the same. Staff not available will be re-educated prior to the next shift by the DCS or designee. On 08/30/2024, a head-to-toe skin assessment on Resident #1 was performed by the Interim RAI Coordinator and DCS with no significant findings. On 08/3020/24, a psychosocial assessment was performed on Resident #1 by the HCA and DCS with no significant findings, and a Trauma Informed Care Screen was performed by the Interim RAI Coordinator. The resident verbalized trauma related to a diagnosis of brain cancer earlier this year but denied any recent associated emotional distress. Care plan and Kardex updated as indicated. 2. On 08/30/2024, DCS and/or designee conducted interviews with current interviewable residents regarding potential abuse and/or neglect. No additional allegations of abuse or neglect were identified. Skin assessments were conducted by DCS and/or designee on non-interviewable residents. No concerns were noted. To identify others with the potential of being affected by the alleged deficient practice, by 08/31/2024, all care plans, including tasks and interventions, were reviewed, and validated the DCS and RAI coordinator or designee for implementation. Any con [TRUNCATED]

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50176 Based on observations, interviews, and record review, the facility failed to implement their written policies and procedures to report, prohibit, and prevent abuse for one (Resident #1) of five residents reviewed for developing and implementing abuse and neglect policies, in that: The facility failed to implement abuse policies and procedures when they failed to protect Resident #1 from being abused by his SO/AP. The facility failed to report and investigate all suspected abuse and/or aggressive behaviors when staff reported observing SO/AP slap, hit, punch, grab, kick, yell, and shake Resident #1 and reported suspicious bruises, skin tears, and a burn on Resident #1's body and abdomen. By failing to implement these policies, the facility failed to identify and assess all possible incidents of abuse and investigate and report all allegations of abuse within timeframes required by federal requirements. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 08/30/2024 at 1:30 PM. While the IJ was removed on 09/01/2024 at 01:41 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with a potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of undetected abuse, trauma, and/or decline in feelings of safety and well-being or psychosocial harm. Findings included: Record review of Resident #1's face sheet dated 08/10/2024, reflected an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including Glioblastoma (brain cancer), cerebral edema (swelling of the brain), muscle wasting and atrophy, seizures, hypertension (high blood pressure), and cognitive communication deficit (difficulty with speech). Resident #1 had also been diagnosed with difficulty swallowing and was a high risk for aspiration. Record review of Resident #1's MDS assessment, dated 05/21/2024, reflected a BIMS score of 12, which indicated moderate cognitive impairment. Resident was at risk of developing pressure ulcers but had no current pressure ulcers or injuries. Resident had skin tears, pressure reducing device for chair and bed. Negative for any behaviors. Resident was dependent for self-care and required maximal assistance to move from sitting to lying flat on bed. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's initial care plan initiated on 05/15/2024 revealed no behavioral problems. Resident required assistance with ADLs due to weakness, brain cancer, cognitive deficit, and history of seizures. Resident required two -person assistance for transfer. Resident had difficulty swallowing and had a puree/thin liquid diet with 1:1 assistance for eating, monitor meal intake with each meal, and monitor weights as ordered. SO/AP was non-compliant with texture modified diet order and ordered excessive quantities of food for the resident. Resident had impairment to skin integrity and required assistance with turning and repositioning. Skin was to be evaluated on a daily and weekly basis. Geri sleeves to both arms were added on 07/22/2024 due to thin and fragile skin with discoloration and tears. Resident was on dexamethasone therapy (steroid) and at increased risk for bruising, bleeding, slow wound healing, thinning skin, red/purple spots on the skin. On 7/14/2024, potential impaired behavioral patterns were added (restlessness, agitation, movement onto the assist bar on left side of bed). Record review of Care Plan conference summary dated 08/14/2024 reflected a BIMS score of 0, which indicated severely impaired cognition. The facility reported that the internal investigation of the 07/14/2024 incident was unfounded. Surveyor requested copies of the facility's abuse/neglect investigations for Resident #1 for the past 60 days on 08/29/2024 at 11:45 AM but did not receive a copy of the 07/14/2024 internal investigation. The facility found the internal investigation of the 08/03/2024 incident to be inconclusive. Resident was alert to person, and able to answer yes or no questions. His BIMS score was 0. Resident #1 denied abuse but was unable to tell the source of the injury. SO/AP denied abuse, stated she had seen the bruise a few days ago, but was unable to recall the specific date and time. When asked why SO/AP did not report the bruise, SO/AP stated, I did not think twice about it. SO/AP admitted to covering the bruise with foundation make-up. Based on interviews and the extent of the injury no abuse or neglect was verified. Resident #1 took medications that contributed to skin fragility, and he did have spontaneous movement. During an interview on 08/29/2024 at 9:25 PM, the ADM had a copy of the police report and was aware of the allegations from four staff members who reported witnessing SO/AP assault Resident #1. The report revealed on 07/13/2024, staff observed SO/AP kick Resident #1 under the table in the dining room when they attempted to video record SO/AP interaction together while in the dining room. On 07/13/2024, staff observed SO/AP yell at Resident #1, grab his arms and shake him, and shove food in Resident #1's mouth, while he was lying flat on his back laying down, sleeping. Over the past month, staff had observed SO/AP punch Resident #1 in the chest with a closed fist and slap him in the face multiple times on different days. Staff had observed a burn on Resident #1's abdomen and reported they didn't know what caused the burn and that the resident would not have been able to cause it due to his mobility limitations. Staff reported that visitors had complained that they witnessed SO/AP slap Resident #1. Staff stated that they reported these allegations and concerns to their supervisor. Review on 08/30/2024 of Facility records in TULIP did not reveal a self-report that matched the allegations of physical abuse of Resident #1 on 07/13/2024 or other assault that occurred in June/July 2024. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's progress note dated 08/03/2024 by RN B, revealed nursing staff noticed the resident had the appearance of a left black eye around 5:30 AM. A maroon color bruise appropriately 1 cm in diameter below the resident's left eye around upper cheek. There were also some very small faint purple marks between his eye and nose. Also noted was the appearance of foundation makeup on his skin close to the left side of his nose as evidenced on cloth after wiping face. SO/AP was questioned by CNA B, RN and Director of Social Services and SO/AP reported seeing the bruise a couple of days ago and did not report it to staff. SO/AP admitted to putting the makeup on the bruise. The resident denied being hurt by the SO/AP. A BIMS interview was attempted, and the resident was unable to participate. The resident had difficulty talking and did not answer questions. Progress notes did not reflect that a head-to-toe assessment was done. Record review of Resident #1's change of condition evaluation dated 08/03/2024 revealed bruise/purple discoloration below left eye and in the corner of left eye. Record review of Resident #1's progress note dated 08/05/2024 by Director of Social Service, revealed SO/AP came to the facility to drop off clean laundry. Record review of Resident #1's progress note dated 08/05/2024, signed by the NP, revealed Resident #1 was alert and oriented to person, insight was impaired, and he was confused and forgetful. Record review of NP physical exam dated 08/05/2024 showed a diagnosis of contusion to left eyelid and periocular area and superficial injury to left upper arm. Notes stated that SO/AP observed bruise on 08/02/2024. Record review of Resident #1's progress note dated 08/08/2024 by Director of Social Services, revealed SO/AP was allowed back in the facility. New interventions were reviewed with SO/AP, including moving the resident closer to the nurse's station and having the resident's door always open for safety/monitoring when SO/AP was visiting the resident. Further review a Care conference took place on 08/14/2024 because SO was accused of being the AP in the 07/14/2024 and 08/03/2024 incident. Record revealed Resident #1's Care plan initiated 08/08/2024 included interventions to allow SO/AP to visit frequently, which included: move resident to room closer to nurse's station; SO/AP to notify staff immediately of any skin injury; resident's door to remain open during visits; and care plan conference with Ombudsman scheduled for 08/14/2024. Resident #1 was at risk for aspiration due to trouble swallowing and left sided weakness. Interventions included maintain appropriate, upright position during meals, remain upright for 1 hour after meals, order for puree/thin liquids diet, supervise or assist resident with oral intake as needed, 1:1 assist, monitor meal intake with each meal, encourage SO/AP compliance with diet order. SO/AP was non-compliant with texture diet orders and would order excessive quantities of food for the resident. Update on 08/13/2024, reflected that resident had delirium with changes to behavior, altered mental status, wide variation in cognition through the day, communication decline, disorientation, lethargy, restlessness and agitation, delusions, and hallucinations. Record review of Resident #1's orders dated 08/29/2024 revealed an order to keep the resident's door open when SO/AP was visiting alone with the resident. Record review of Resident #1's change of condition forms indicated the following: (continued on next page)

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F 0607

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

* dated 08/29/2024, revealed skin discoloration on the left side of resident's face at jawline, and behind left ear and red area. Area was better after pressure relieved from face on call control.

* dated 08/30/2024 revealed a new skin tear to the right elbow. CNA witnessed SO/AP transport resident through bedroom doorway and bump the resident's elbow.

Record review of Resident #1's skin integrity report dated 08/30/2024 revealed skin not intact. Discoloration, rash, abrasion, and skin tears in multiple different healing levels. The abrasion was a new skin issue and weekly wound data collection flow sheet was selected to be created.

Record Review of facility sign in sheet for the month of August 2024, revealed SO/AP was at the facility 08/03/2024, 08/09/2024 to 08/30/24. SO/AP would arrive between 7:45 AM and would often not sign out.

During an observation and attempted interview on 08/29/2024 at 12:24 PM, Resident #1 was in the dining room and SO/AP was observed trying to feed Resident #1 and said, I need your mouth open .this can be the last bite if you want .open your mouth. Resident #1 was observed in a wheelchair with pillows behind his head, back, under arms, and under his legs/feet. He was wrapped in Geri sleeves/bandages on both arms. Resident #1 wore a baseball cap that covered his head and forehead. Surveyor attempted to interview the resident in the dining room alone, but the resident did not respond to questions and closed his eyes and appeared to be asleep.

During observations on 08/29/2024, revealed Resident #1's door was closed with SO/AP inside the room at the following times:

12:50 PM - 12:56 PM

1:06 PM - 1:10 PM

2:55 PM - 3:02 PM

4:36 PM - 4:45 PM

During the above times of observations, six staff walked by the door and did not intervene to open the door.

During an interview on 08/29/2024 at 12:11 PM, the DON stated that she had witnessed SO/AP trying to wake up Resident #1 by patting him on the cheek, shaking his chest. Staff had reported SO/AP force fed the resident. SO/AP put a lot of focus on eating and fed the resident all three meals daily. The DON stated the Medication Resident #1 took made him sleep and resident's skin got very thin and bruised a lot. The DON stated she did not think SO/AP was abusing the resident because SO/AP always said how much she loved the resident, and the SO/AP's intention was not to harm the resident. DON stated there was not any abuse to report. After the 08/03/2024 incident with the bruise on the resident's face, the facility set up a meeting with SO/AP and the Ombudsman on 08/08/2024. Facility's response was to move the resident to a room closer to the nurse's station to allow for line of sight, frequently monitoring, and the door to remain open. They have put padding on the resident's chair. The DON thought the marks on Resident #1 were due to positioning in the chair and/or bed. The DON had received in-service training on ANE this month and knew about reporting.

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 08/29/2024 at 12:34 PM, RN C stated she was not aware of Resident #1's care plan about leaving the resident's door open. RN C had not been told what to do if the resident's door was closed. RN C had not told to do frequent rounds/monitoring on Resident #1. RN C did not know who the abuse coordinator was and had not received any recent training on ANE. During an interview on 08/29/2024 at 12:43 PM, CNA C stated that Resident #1 always had unexplained skin tears and bruises and SO/AP was told to visit the resident in public spaces. CNA C was not aware not aware of Resident #1's care plan about leaving the resident's door open. CNA C stated SO/AP wanted to the door closed and would close the door. CNA C had not been told what to do if the resident's door was closed. CNA C did not do anything when the door was closed. The resident only came out of his room to eat in the dining room and for therapy. They all stated they were not told to do frequent rounds/monitoring on Resident #1. CNA C observed SO/AP feed Resident #1 all meals in the dining room. During an interview on 08/29/2024 1:10 PM, CMA stated SO/AP fed Resident #1 all meals. CMA had not been told that Resident #1's door must stay open. CMA had not been told what to do if the resident's door was closed and CMA did not do anything when the door was closed. CMA stated the resident was moved closer to the nurse's station so that staff walking pass his door would keep an eye on him. During an interview on 08/29/2024 1:25 PM, NP stated that the marks on Resident #1's face, neck, and arms were clearly a result of the high dose steroid use and not abuse. The NP stated they (the marks on Resident #1) were not bruises. The NP believed skin tears were due to transfers, brushing up against the environment (chair/bed). The NP stated that staff (speech therapy, nurse, CMA/CNAs) had expressed their concerns about how SO/AP fed the resident. NP did not think SO/AP was intentionally trying to hurt the resident. The NP had no concerns about SO/AP visiting the resident and being alone in the facility with the resident with the door closed. The NP was not aware of any order to have Resident #1's door open or to do frequent monitoring. During an interview on 08/29/2024 at 1:38 PM, the MD stated that Resident #1 was taking a high dose of steroids due to brain cancer. The MD believed the discoloration on the resident's face was related to medical condition and medications. The MD had not observed any abuse. Staff have told the MD that SO/AP was persistent with feeding the resident but did not believe that would rise to the level to be abuse. They had not discussed any concerns about abuse or aggressive feeding in the monthly or weekly QAPI meetings. Surveyor told MD about the interviews from staff in the complaint report. The MD expressed surprise and stated, that is very concerning. The MD stated that Resident #1 did not have the cognition to be interviewed about the abuse. The MD was unaware of any interventions regarding Resident #1's door kept open during visits with SO/AP. During an interview on 08/29/2024 at 2:07 PM, LVN B had observed SO/AP on 7/14/2024, grabbing both (Resident #1's) shoulders and shaking him hard; slapping him in the face; hitting him in the chest with her fist; yelling him; threatening him to say she won't come visit him anymore if he doesn't wake up. LVN B intervened and told SO/AP to stop that it was dangerous to put food in the resident's mouth when he was asleep as he could choke. LVN B reported concerns to the DON, who called ADM, who did not want to report it. LVN B reported observing further abuse by SO/AP later that month and because of this, had not returned to work for this facility. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 08/29/2024, at 3:16 PM, LVN C stated she was unaware the Resident #1's care plan and interventions. She stated the DON was responsible for educating nursing staff and CNAs about the interventions in place and changes in a resident's care plan. LVN C had received in-service training on ANE recently and was aware to report ANE to the abuse coordinator. During an interview on 08/29/2024 at 3:28 PM, SO/AP denied hurting Resident #1. SO/AP was observed lying in bed on the right side of the resident while Resident #1 was asleep. SO/AP stated that the bruise of Resident #1's face was due to him sleeping on the call light button and reported the facility staff removed the call light at night. The AP/SO stated that was the only explanation for how the bruise occurred because SO/AP didn't do anything. Throughout the interview, SO/AP repeatedly stated she had nothing to hid and did not do anything and stated that she never noticed the bruise. It was a staff member that noticed the bruise, but SO/AP could not recall the staff member's name. When asked about the make-up, SO/AP originally denied it and then said she put make up on Resident #1's face a long time ago because SO/AP felt bad for the resident. SO/AP denied having a care plan meeting. When asked about keeping the door open, SO/AP confirmed she was asked to do that, but SO/AP kept the door cracked or closed because SO/AP did not want anyone looking into the room and the facility had blown that off. SO/AP wanted privacy. SO/AP denied staff coming to check on the resident or monitoring him. Surveyor attempted to interview Resident #1, but the resident remained asleep during the interview with SO/AP. During an interview and observation with LVN D on 08/29/2024 at 3:28 PM, LVN D was unaware of Resident #1's care plan interventions to keep door open. LVN D looked in Resident #1's electronic chart during the interview and could not find an order to have the resident's door open. LVN D walked off down the hallway. LVN D later returned as SO/AP was opening Resident #1's door and exiting the room with the resident. LVN D told SO/AP that the resident's door needed to stay open, and SO/AP responded, I don't care and continued to walk down the hallway pushing the resident in a wheelchair. LVN D stated she found a doctor's order in Resident #1's chart to keep the door open. LVN D told the charge nurse the care plan was not being followed and stated, I am sure the DON is aware. LVN D stated that all staff needed to be aware to keep the door open. During an interview on 08/29/2024 at 4:54 PM, Receptionist B had seen SO/AP be aggressive with Resident #1. Receptionist B observed SO/AP in the dining room grabbed his (Resident #1) jaw last month while trying to brush the resident's teeth. Receptionist B observed SO/AP grab Resident #1's arm and forced it down in a slapping motion when the resident reached out and grabbed hold of the dining room door frame. Receptionist B reported the incident to the police when they responded to the 08/03/2024 self-report and then reported it to her supervisor. Receptionist B received in-service training last month on ANE. Receptionist B had no knowledge of the resident's care plan or interventions nor if the facility had done an investigation regarding her concerns. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/01/2024
NAME OF PROVIDER OR SUPPLIER: Brookdale Lakeway Snf		STREET ADDRESS, CITY, STATE, ZIP CODE: 1917 Lohmans Crossing Rd Lakeway, TX 78734	

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 08/29/2024 at 6:07 PM the ADM stated it was hard to say what the expectations were for staff not following Resident #1's care plan interventions to keep the resident safe because the facility's internal investigation revealed no abuse; the resident wanted SO/AP there and felt safe; the police had not done anything, and the Texas Health and Human Services Commission had cleared the first incident for 07/14/2024. The ADM stated that in general, when discussing other residents, the ADM's expectation was that staff follow the care plan. When surveyor asked again about expectations for Resident #1's care plan interventions and door being left open for safety and monitoring, ADM replied, that's hard to say. It is our findings that there has been no abuse. The ADM stressed there was no believe that any abuse had occurred and therefore, was not concerned about the closed door or staff not following the care plan interventions. During an interview on 08/29/2024 at 6:07 PM the DON stated it was care planned to have Resident #1's door kept open for line of sight. DON stressed that SO/AP would hurt the resident and therefore, we don't force the door if the door was closed. SO/AP was the POA and had been in a relationship with the resident for [AGE] years and the ADM and DON must respect that. The DON had known of concerns from staff that SO/AP force fed Resident #1 and that the AP/SO shakes his (Resident #1) shoulders to wake him up, but nothing the DON would consider abuse. The DON stressed that the AP/SO was intentionally trying to feed and wake Resident #1 but did not intend to cause harm. The DON stressed there was no believe that any abuse had occurred and therefore, was not concerned about the closed door or staff not following the care plan interventions. During an interview on 08/29/2024 at 7:28 PM, RN B stated that on 08/03/2024, a night CNA had reported to the night nurse that Resident #1 had a black eye around 5:30 AM. RN B did an assessment around 6:00 AM and did not think it was a bruise. RN B talked to the resident alone and the resident reported that he felt safe. RN B interviewed SO/AP and SO/AP had noticed the bruise a few days ago but had not reported it to the facility staff because she thought staff already knew. Resident #1 had fragile skin and due to medications, his skin would tear. RN B stated that the facility staff present that day had separated the resident and SO/AP and had the resident moved closer to nurse's station . RN B also called the police. RN B stated that the police officer had no concerns after interviewing the SO/AP. RN B was aware of the resident's care plan interventions to keep the door open while SO/AP visits. Staff had access to this information in the care plan. During an interview on 08/29/2024 at 7:43 PM, LVN A had observed SO/AP become impatient and frustrated with Resident #1. All staff have had to intervene because of SO/AP's behaviors. When SO/AP was not at the facility, Resident #1 was smiley and friendly with the staff. When SO/AP was at the facility, the resident was more upset and agitated. SO/AP got loud, bossy with him. On 8/3/2024, LVN A found the black eye with make-up put on Resident #1's face, which was highly suspicious. LVN A had heard that an agency nurse had seen SO/AP shake the resident in the dining room. LVN A stated Resident #1 would get skin tears on left side due to always leaning on left side. LVN A received in-service training on ANE and would report any concerns to the abuse coordinator. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation and interview on 08/30/2024 at 8:43 AM, Resident #1 was observed sitting in a wheelchair in the dining room and SO/AP was trying to feed the resident. Resident #1 appeared asleep as he had his eyes closed. Surveyor observed SLP intervene and crouch down to talk to the resident. Surveyor overhead SLP telling SO/AP, you can't feed him now .no, he's not awake enough and walked off. SLP stated he talked to SO/AP about not feeding the resident when the resident was asleep. The resident was not alert enough to eat and SO/AP needed to be educated to stop putting food in his month when the resident was asleep, which would collect in Resident #1 mouth and cause choking. SLP stated SO/AP got overzealous about feeding the resident but did not think it would be considered abuse. During an interview on 08/30/2024 at 11:37 AM, DCS stated that on 08/03/2024, Resident #1 was found to have a bruise on his face covered up by makeup. That was a big red flag. DCS reported it immediately to the previous ADM. The ADM was aware of the previous incident with SO/AP and told the DCS to call the police. Resident #1 was moved closer to the nurse's station on 08/03/2024 and then moved to another room on 08/10/2024 to keep an eye on the resident and provide frequent monitoring. ADM told DCS to remove SO/AP from the facility due to the situation. The SO/AP was still at the facility when the police arrive around 11:00 AM. Police responded to the facility on [DATE] around 11:00 AM and interviewed SO/AP and the resident. Police stated they could not do anything because there was no admission of guilt to the injury. DSC did not suspect SO/AP of any abuse. DCS had observed Resident #1's door being open but had been told that SO/AP liked to keep the door closed. DCS was in-serviced about keeping the resident's door open, the care plan interventions, and ANE about who was the abuse coordinator and about reporting when he arrived at the facility on 08/30/2024. The DCS stated the care plan was to ensure staff was providing proper care to the resident. The DCS expectation was that nursing staff follow the care plan. DCS would immediately report any allegations of ANE from staff. During an interview on 09/01/2024 at 9:50 AM, CNA A stated Resident #1 had unexplained bruises. Resident #1 was unable to communicate. An agency nurse had seen SO/AP smacking the resident and CNA A had seen SO/AP shaking the resident to wake him up a couple of month ago. We (the CNAs) had been suspicious of SO/AP for a while and could not believe no one believed it (the abuse) did not happen. During an interview on 09/01/2024 at 10:14 AM, CNA B had previously witnessed SO/AP shake (Resident #1) by the arms going back and forth. Resident #1 was sleepy, and SO/AP tried to put food in the resident's mouth. CNA B told SO/AP on 08/31/2024 not to feed Resident #1 soup with chucks of stuck in it because that could cause choking. During an interview on 09/01/2024 at 1:30 PM, LVN A had previously observed SO/AP be bossy and pushy where we as nursing staff would tell her that he has rights and we have always intervened. When asked if Resident #1 was safe at the facility, LVN A replied, I would hate to see him go home. During an interview on 09/01/2024 at 11:19 AM, RN A stated last week RN A observed SO/AP feed Resident #1 when he was not awake. Last week RN A observed SO/AP picking up Resident #1's head and holding it back. RN A intervened and explained to SO/AP that it was not appropriate to feed Resident #1 when he was asleep. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Facility's Abuse, Neglect & Exploitation Policy, dated 07/2016 last revised 10/2022, reflected the facility will take necessary measures to prevent and protect residents from abuse. This policy will apply to potential abuse and injury of unknown source. Instances or allegations of abuse, neglect, mistreatment, or exploitation should be treated seriously and reported to the Administrator or the supervisor on duty for investigation and appropriate follow up. 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, and physical or chemical restraint not required to treat the resident's medical symptoms. The policy includes the definition of willful, as used in abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Prevention 1. Abuse prevention efforts should include, but are not limited to, the following: a. Providing residents and family information on how and to whom they may report concerns, incidents, and grievances without the fear of retribution. b. Providing associates information on how and to whom they may report concerns, incidents and grievances without the fear or retribution. c. Identification, correction, and intervention in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur (this should include analysis or the physical environment that might make abuse and/or, neglect more likely to occur such as secluded areas of the community, deployment of associates on each shift to meet the needs of the residents; supervision or associates to identify inappropriate behaviors; and the assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict. mistreatment or neglect). Protection 1. Protection of Resident. Upon learning of alleged abuse, neglect, mistreatment or exploitation, the Administrator or supervisor on duty should attempt to take necessary steps to verify residents are protected from subsequent episodes of abuse, neglect, mistreatment or exploitation. Investigation of Potential Abuse, Neglect, and Exploitation Internal Investigation. Upon receipt of an allegation of resident abuse, neglect, mistreatment, or exploitation, the Administrator or designee should conduct a confidential internal investigation of the incident. Timing of Investigation. The investigation should be initiated as soon as practicable upon becoming aware of the incident. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	As required, the Administrator should provide a written report of the results of abuse investigations and appropriate action taken to the state survey and certification agency, the local police department, the ombudsman, and others as may be required by state or local laws, within five (5) working days of the reported incident. External Reporting Alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property should be reported. As soon as practical, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Such alleged violations shall be reported to: I. The State Survey Agency; and II. Adult Protective Services. Internal Reporting Individuals observing an incident of resident abuse or suspecting resident abuse should immediately report such incident to the Administrator or Director of Clinical Services. The facility's policy on reporting abuse and neglect was requested on 08/29/2024 at 11:45 AM and 5:46 PM. It was not provided before exit. Attempted interview of Resident #1 on 08/30/2024, at 3:25 PM. Resident #1 was lying in bed in his room, awake and alert, and turned to look at surveyor when his name was called. The door was open, and a caregiver/sitter was sitting in a chair by the bed. SO/AP was lying in bed with the resident on the right side of the bed and surveyor was standing on the left side of the bed. Surveyor attempted to interview Resident #1, but SO/AP kept patting Resident #1's cheeks with her hands and turning the resident's face/head to the right and away from the surveyor when the surveyor tried to talk to the resident. This was determined to be an Immediate Jeopardy (IJ) on 08/30/2024 at 1:03 PM. The Administrator was notified. The Administrator was provided with the IJ template on 08/30/2024 at 1:30 PM. The following POR was accepted on 08/31/2024 at 2:23 PM: Plan of Removal Immediate Jeopardy (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/30/2024, at 1:30PM, the facility was notified of an immediate jeopardy for F607 (implement their written policies and procedures to prohibit and prevent abuse) regarding: - The facility staff had failed to prevent Resident #1 from being abused. F607 Implement Policies to Prevent Abuse and Neglect One resident was identified as being affected by alleged deficient practice. On 08/30/2024, the HCA and DCS reminded SO of the care plan intervention