STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676141	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Matlock Place Health & Rehabilitation Center	7100 Matlock Rd Arlington, TX 76002

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for 1 of 5 residents (Resident #1) reviewed for abuse. The facility failed to ensure Resident #1 had the right to be free from abuse when CNA B transferred her roughly from bed to a geri-chair and then slapped her hand when she attempted to hold onto the bed on 08/31/24. The noncompliance was identified as past noncompliance. The Immediate Jeopardy began on 08/31/24 and ended on 09/03/24. The facility had corrected the noncompliance before the investigation began. This failure placed residents at risk of abuse, trauma, and psychosocial harm. Findings included: Review of Resident #1's Admission Record, dated 10/31/24, reflected the resident was a [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident #1's Quarterly MDS Assessment, dated 07/04/24, reflected there was not a BIMS score calculated. Further review reflected a Staff Assessment for Mental Status was completed which revealed Resident #1 had a memory problem resulting in inattention and an altered level of consciousness. For the section regarding Functional Abilities and Goals reflected Resident #1 required substantial/maximal assistance with rolling left and right, lying to sitting on side of bed, and chair/bed-to-chair transfer which meant that the helper did more than half of the effort. The same section reflected Resident #1 used a manual wheelchair. Review of Resident #1's Annual MDS Assessment, dated 10/04/24, reflected for her Functional Abilities section, Resident #1 was dependent with rolling left and right and chair/bed-to-chair transfer meaning the helper did all the effort or the assistance of 2 or more helpers was required to complete the activity. Resident #1 had active diagnoses of Non-Alzheimer's Dementia (a neurodegenerative disease that starts slowly and progressively worsens), Seizure Disorder or Epilepsy (a neurological disorder that causes seizures or unusual sensations and behaviors), and Senile Degeneration of Brain (a syndrome associated with many neurodegenerative diseases, characterized by a general decline in cognitive abilities that affects a person's ability to perform everyday activities). (continued on next page)

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

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

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(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	Review of Resident #1's progress notes reflected the following: - On 09/03/24 at 5:27 AM the DON wrote: Notified by POA that patient was the recipient of physical aggression from staff. Noted that resident was handled roughly during transfer from bed to Geri-chair and subsequently was slapped on the hand when being moved in Geri chair. No injury noted to resident at time of notification. - On 09/03/24 at 2:33 PM the DON wrote: Patient needs stat x-ray of c-spine, back, left shoulder, arm, right wrist/forearm to rule out fracture. Patient is unable to sit upright for extended periods of time independently, is unable to use right arm. - On 09/04/24 at 6:13 AM RN A wrote: The X-ray in the previous shift was done during the shift, no evidence of fractures, results sent to Dr [Physician C], she denied pain at this time, no new complaint from her, will continue with the plan of care. - On 09/05/24 at 2:00 PM the DON wrote: Resident noted to be up in Geri chair. No adverse effects noted at this time related to occurrence that happened on 8/31/24. No skin issues noted/reported at this time. Resident remains at baseline. Review of Resident #1's care plan reflected the following: - Focus: Resident has an allegation of (Abuse), Date Initiated: 09/03/2024; Goal: Resident will not experience a negative outcome from alleged event through this review period; Interventions/Tasks: Any negative event will be reported to the abuse coordinator immediately. The facility will adhere to the abuse and neglect policies and protocols. - Focus: Resident requires a mechanical lift transfer(Hoyer) r/t (inability to bear weight) 2 person assist. Date Initiated: 09/03/2024; Goal: Resident will be provided a safe transfer utilizing a mechanical lift(Hoyer)throughout the review period.; Interventions/Tasks: 1. Resident has been identified as totally dependent for transfers. 2. Lifting equipment will be operated in accordance with instruction and training. 5. Report change in conditions which may necessitate a re-evaluation of the resident and the lift. [sic] - Focus: [Resident #1] has a communication problem r/t Dementia, non-verbal .Interventions/Tasks: Ensure/provide a safe environment. Observation of the first video provided by Resident #1's POA on 10/30/24 at 8:22 AM revealed the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The video was time stamped and dated for 08/31/24 at 6:58 AM; the video did not include any sound. The video began and Resident #1 was in bed. There was a geri-chair at the foot of the bed and CNA B began pushing the geri-chair to the side of the bed. CNA B locked the left side of the geri-chair from the back and then walked in front of the geri-chair and pulled it closer to the bed. CNA B turned to Resident #1 and pulled her legs over the side of the bed and used his left arm to raise her up. CNA B used his right hand to reposition Resident #1's knees. Resident #1 had her arms crossed on her chest and CNA B uncrossed the resident's arms to put his underneath hers to lift her up and transfer her to the geri-chair. The geri-chair began to move backwards and CNA B used his left arm to hold the geri-chair while he used his right arm to hold Resident #1 up. CNA B placed Resident #1 on her back on the geri-chair seat portion, grabbed her left leg to raise it with his right hand while his left hand went under her left arm to pull her up towards him and into the chair, but the chair began to again move backwards. CNA B put Resident #1 back in the bed and rolled her over onto the bed, pulled the geri-chair closer to the side of the bed and locked the right side of the geri-chair from the back. CNA B walked to the front of the geri-chair and to the side of Resident #1's bed where she was still lying there. CNA B turned Resident #1 over and put his right arm underneath her bent legs and used his left arm to hold her by her neck to transfer her to the geri-chair. CNA B put Resident #1 in the geri-chair perpendicular where her head and legs were on the armrests of the chair. The video ended. Observation of the second video provided by Resident #1's POA on 10/30/24 at 8:22 AM revealed the following: The video was time stamped and dated for 08/31/24 at 7:09 AM; the video did not include any sound. The video began and Resident #1 was in the geri-chair, her bed was made, and she had a blanket covering her. CNA B had a trash bag in his hand, and he grabbed something (unable to determine what it was) from Resident #1's recliner in the corner and walked behind the geri-chair and set the item down out of the camera's view. CNA B then started to pull Resident #1's geri-chair backwards with his right hand while he still had the trash bag in his left hand. Resident #1's arms and hands were underneath the blanket but could be seen on the armrests. While being wheeled backwards, Resident #1 grabs the edge of the bed when CNA B forcefully takes her arm and placed it on her lap. CNA B then smacked Resident #1's arm from on top of the blanket. Resident #1 moved her arm back to the armrest and was wheeled out of the room away from the camera's view. The video ended. Observation on 10/31/24 at 9:45 AM of Resident #1 revealed she was in a common area lying in a geri-chair. The resident was dressed and groomed. Resident #1 had her eyes closed, and she did not awaken or respond when spoken to. Resident #1 was wearing a long-sleeved shirt but did not appear to have any bruises, injuries, or pain. Observation on 10/31/24 at 12:30 PM of Resident #1 revealed she was in the dining room with her POA being assisted to eat lunch. Resident #1 was still in her geri-chair and was falling asleep during the meal. Resident #1 was not able to answer any questions or acknowledge the surveyor's presence due to her cognitive condition. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Telephone interview on 10/28/24 at 12:13 PM with Resident #1's POA revealed she showed the Administrator, who was the Abuse Coordinator, a video of Resident #1 being abused by CNA B from 08/31/24. Resident #1's POA said she showed the Administrator the video on 09/03/24. Resident #1's POA said after seeing the video, the Administrator called the police and the facility terminated CNA B. Resident #1's POA said the facility took x-rays and followed up to check on Resident #1. Resident #1's POA said Resident #1 does not have the ability to show any emotion or pain and did not have any bruises or injuries from the situation. Telephone interview on on 10/31/24 at 12:48 PM with CNA B revealed he remembered caring for Resident #1, but that it was some time ago. CNA B said he was trying to transfer Resident #1 to her geri-chair one day when she was holding onto him. CNA B said he had to take Resident #1's hand off of him while still holding onto her during the transfer. CNA B said he had locked the chair but what happened during the transfer was that Resident #1 was very heavy and he could not hold her up for the transfer. CNA B said he did not use a gait belt to transfer Resident #1. CNA B said he did not slap Resident #1's hand or arm at any point and had transferred her appropriately. CNA B said he was terminated from the facility. Observation on 10/31/24 at 1:13 PM of revealed CNA F and RA Z transferred Resident #1 using a Hoyer lift from her geri-chair to her bed, and the transfer was completed safely and using proper technique. Interview on 10/31/24 at 2:37 PM with the ADON revealed he saw the video provided by Resident #1's POA which showed CNA B had transferred Resident #1 to the geri-chair. The ADON said the video then showed CNA B pulling the geri-chair backwards when Resident #1 grabbed the end of the bed and CNA B smacked her hand. The ADON said at the time of the video, Resident #1 was a one-person transfer using a gait belt and now was a hoyer lift transfer requiring at least two people. The ADON said CNA B was not appropriate in the type of care he provided Resident #1, and it was considered abuse which should never occur. The ADON said Resident #1 was assessed and she did not have any injuries or bruises from the incident. The ADON said safe surveys were completed for other residents to make sure they had not suffered any injuries either. The ADON said the facility decided to terminate CNA B immediately based on what they saw in the video. The ADON said the facility also began in-servicing staff immediately on abuse and neglect. The ADON said the facility also began checking on Resident #1 and ensuring staff were doing what they were supposed to regarding her care to monitor the situation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 10/31/24 at 2:53 PM with the Administrator revealed he got a call from Resident #1's POA, who said she had a video she wanted to show him on 09/03/24. The Administrator said he was concerned with what he saw on the videos. The Administrator said he saw CNA B trying to transfer Resident #1 by picking her up and putting her into the chair instead of using a gait belt to transfer her. The Administrator said the video showed CNA B trying to get Resident #1 to the chair without the amount of help that was needed to complete the transfer safely. The Administrator said the video also showed that when CNA B was pulling Resident #1 out of the room, she grabbed onto things to prevent herself from moving and he grabbed her hand off the bed and swatted at her wrist. The Administrator said after reviewing the videos he immediately reported the incident and terminated CNA B. The Administrator said the facility did extensive training on abuse with staff to try and prevent this incident from happening again. The Administrator said a head-to-toe assessment was also completed on Resident #1 which revealed no bruising or marks of any kind to her body. The Administrator said multiple x-rays were completed on Resident #1 as well which all came back negative for any injuries. The Administrator said safety rounds with other residents were also completed to see if anyone else in the building had been abused by CNA B, which none were. The Administrator said abuse of residents was not tolerated in the facility and would never be. The Administrator said the techniques of CNA B's transfer were so poor which ended up meaning he provided rough care and a rough transfer. The Administrator said all staff were responsible for ensuring all residents were free from any abuse. The Administrator said each resident had the right to be free from abuse in the facility. The Administrator said if residents were abused that could cause psychological or physical harm to them. The Administrator said CNA B was not following the facility's abuse policy based on what he saw in the videos. Record review of the facility's Provider Investigation Report, dated 09/10/24, reflected the following: - Investigation Summary: Administrator approached by [Resident #1's POA] regarding a video she recorded in resident room. On video it showed [CNA B] trying to transfer resident to geri-chair. It shows CNA struggling to get her into the chair, holding resident under her arms and then back to the bed in the same way. It then shows him trying to pick her up under her knees and behind her back to get her to chair, hitting her back on the arm rests, then pulling on her arms to pull her up. Upon leaving the room, the resident holds onto the bed. The CNA removes her hand from the bed, then swats at her hand. Provider completed provider response as outlined above. All xrays and head to toe assessments came back negative. All safe surveys came back with no other abuse present. Facility completed all in-service and competencies. CNA was terminated immediately, board notified, police called. - Investigation Findings: Confirmed Record review of undated safe surveys completed with residents revealed 33 residents were interviewed and no concerns were noted regarding care provided by CNA B. Record review of CNA B's personnel file included a disciplinary action form, dated 09/03/24, which reflected he was terminated due to an allegation of abuse that was founded on a video. Record review of an in-service, dated 09/03/24, reflected staff had been trained regarding Customer Service and that all residents [were] to be treated with dignity and respect. (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 an in-service, dated 09/03/24, reflected staff had been trained regarding Safe Handling and Transfers and that Hoyer lift requires 2 people, All transfers require use of gait belt, 2 person assist equals 2 person assist .if in doubt how to transfer ask for clarification .gait belts [sic]. Record review of an in-service, dated 09/03/24, reflected staff had been trained regarding Abuse and Neglect that covered the Abuse Coordinator, Time to Report, What to Report, and Abuse versus Neglect. Interview on 10/31/24 at 11:37 AM with CNA C revealed he knew the facility's abuse policy and that hitting a resident or providing rough care to a resident would be considered abuse. CNA C said he had been trained on how to properly transfer a resident. Interview on 10/31/24 at 1:32 PM with RN D revealed she knew the facility's abuse policy and that hitting a resident or providing rough care to a resident would be considered abuse. RN D said she had been trained on how to properly transfer a resident. Record review of the facility's Abuse, Neglect and Exploitation policy, dated 01/01/23, reflected: Definitions: 'Abuse' means the willful infliction of injury .with resulting physical harm, pain or mental anguish, which can include staff to resident abuse .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse .'Willful' means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .'Physical Abuse' includes, but is not limited to hitting, slapping, punching, biting, and kicking .VI. Protection of Resident, The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. The Administrator was notified on 10/31/24 at 4:52 PM, that a past non-compliance IJ situation had been identified due to the above failures. It was determined this failure placed Resident #1 in an IJ situation on 08/31/24.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observation, interview, and record review, the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 2 of 5 residents (Residents #1 and #2) reviewed for ADL care. The facility failed to provide Residents #1 and #2 assistance with timely incontinence care on 10/31/24. This failure could place the residents at risk for decreased feelings of self-worth, skin breakdown, and infection. Findings included: 1. Record review of Resident #1's Admission Record, dated 10/31/24, reflected the resident was a [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #1's Annual MDS Assessment, dated 10/04/24, reflected there was not a BIMS score calculated. Further review reflected a Staff Assessment for Mental Status was completed which revealed Resident #1 had a memory problem resulting in inattention that was continuously present. For her Functional Abilities section, Resident #1 was dependent with rolling left and right and chair/bed-to-chair transfer meaning the helper did all the effort or the assistance of 2 or more helpers was required to complete the activity. Resident #1 had active diagnoses of Non-Alzheimer's Dementia (a neurodegenerative disease that starts slowly and progressively worsens), Seizure Disorder or Epilepsy (a neurological disorder that causes seizures or unusual sensations and behaviors), and Senile Degeneration of Brain (a syndrome associated with many neurodegenerative diseases, characterized by a general decline in cognitive abilities that affects a person's ability to perform everyday activities). Record review of Resident #1's care plan reflected the following: Focus: [Resident #1 has bowel and bladder incontinence d/t cognitive impairment r/t Dementia; Goal: [Resident #1] will remain free from skin breakdown due to incontinence and brief use through the review date.; Interventions/Tasks: BRIEF USE: [Resident #1] uses disposable briefs. Change [sic]. Observation on 10/31/24 at 9:45 AM of Resident #1 revealed she was in a common area lying in a geri-chair. The resident was dressed and groomed. Resident #1 had her eyes closed, and she did not awaken or respond when she was spoken to. Observation on 10/31/24 at 12:30 PM of Resident #1 revealed she was in the dining room with her POA being assisted to eat lunch. Resident #1 was still in her geri-chair and was falling asleep during the meal. Resident #1 was not able to answer any questions or acknowledge the surveyor's presence due to her cognitive condition. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 10/31/24 at 1:13 PM revealed CNA F had just transferred Resident #1 to bed and had planned to change her brief and provide the resident with incontinence care. After care was provided, CNA F showed the used brief to the surveyor which was extremely soaked with urine. CNA F said Resident #1 was very soaked, and the brief was heavy with urine. CNA F said the last time she changed Resident #1 was this morning before 10:00 AM. CNA F said Resident #1 drank a lot of liquids which caused her to use the bathroom more. 2. Record review of Resident #2's Admission Record, dated 10/31/24, reflected the resident was a [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #2's Admission MDS Assessment, dated 08/07/24, reflected she had a BIMS score of 15 indicating no cognitive impairment. Resident #2's Functional Abilities and Goals reflected she required partial/moderate assistance for toileting hygiene. Resident #2's Bladder and Bowel section reflected she was frequently incontinent. Resident #2's Active Diagnoses included stroke (a medical emergency that occurs when blood flow to the brain is blocked or reduced), chronic obstructive pulmonary disease (a lung condition caused by damage to the airways and alveoli, usually from smoking or other irritants), and hemiplegia or hemiparesis (weakness of one entire side of the body). Record review of Resident #2's care plan reflected the following: Focus: [Resident #2] has limited physical mobility r/t Stroke with right side weakness . [sic]. Resident #2's care plan did not address her need for incontinent care. Observation and interview on 10/31/24 at 9:38 AM with Resident #2 revealed she was sitting in her wheelchair next to her bed. Resident #2 said she was upset because she needed to be changed and had been waiting since breakfast. Resident #2 said she had soaked through the towel in her wheelchair now because it had been so long since she had received care. Resident #2 said it was around 8:00 AM that she had asked someone earlier to change her, but they told her they had to finish passing out the breakfast trays before helping her, but no one had come back. Observation on 10/31/24 at 9:52 AM revealed CNA G went into Resident #2's room. At 10:02 AM CNA G came out of Resident #2's room and brought out two trash bags, one had a soaked brief with other supplies in it and the other had a soaked towel in it. Interview on 10/31/24 at 10:15 AM with CNA G revealed she was Resident #2's aide for the day. CNA G said she changed Resident #2 earlier around 7:40 AM and had planned to change Resident #2 again after 2 hours. CNA G said Resident #2 did have a wet brief and had soaked through the towel that was underneath her on the wheelchair. CNA G said she was not told that Resident #2 needed to be changed during the breakfast service this morning but had to help assist residents to eat breakfast in the dining room this morning, so she was not on the hall earlier. Interview on 10/31/24 at 2:37 PM with the ADON revealed incontinent care should be provided to residents every 2 hours. The ADON said CNA's were responsible for providing timely incontinent care. The ADON said if residents were not changed timely, they could have skin breakdowns or get a UTI. The ADON said he was not aware that residents were being left for more than 2 hours without being changed. Interview on 10/31/24 at 2:53 PM with the Administrator revealed staff should be checking on residents and doing daily rounds, providing incontinent care when they needed it. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Activities of Daily Living (ADLs) policy, dated 01/01/23, reflected: Policy: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: .3. Toileting; .Policy Explanation and Compliance Guidelines: .2. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 4 residents (Resident #1) reviewed for accidents and supervision. CNA B failed to use a gait-belt to transfer Resident #1 from the bed to a geri-chair on 08/31/24 resulting in rough care during the transfer. The noncompliance was identified as past noncompliance. The Immediate Jeopardy began on 08/31/24 and ended on 09/03/24. The facility had corrected the noncompliance before the investigation began. This failure could place residents at risk for neglect, harm, pain, and injuries. Findings included: Record review of Resident #1's Admission Record, dated 10/31/24, reflected the resident was a [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #1's Quarterly MDS Assessment, dated 07/04/24, reflected there was not a BIMS score calculated. Further review reflected a Staff Assessment for Mental Status was completed which revealed Resident #1 had a memory problem resulting in inattention and an altered level of consciousness. For the section regarding Functional Abilities and Goals reflected Resident #1 required substantial/maximal assistance with rolling left and right, lying to sitting on side of bed, and chair/bed-to-chair transfer which meant that the helper did more than half of the effort. The same section reflected Resident #1 used a manual wheelchair. Record review of Resident #1's Annual MDS Assessment, dated 10/04/24, reflected for her Functional Abilities section, Resident #1 was dependent with rolling left and right and chair/bed-to-chair transfer meaning the helper did all the effort or the assistance of 2 or more helpers was required to complete the activity. Resident #1 had active diagnoses of Non-Alzheimer's Dementia (a neurodegenerative disease that starts slowly and progressively worsens), Seizure Disorder or Epilepsy (a neurological disorder that causes seizures or unusual sensations and behaviors), and Senile Degeneration of Brain (a syndrome associated with many neurodegenerative diseases, characterized by a general decline in cognitive abilities that affects a person's ability to perform everyday activities). Record review of Resident #1's progress notes reflected the following: -On 09/03/24 at 05:27 (5:27 AM) the DON wrote: Notified by POA that patient was the recipient of physical aggression from staff. Noted that resident was handled roughly during transfer from bed to Geri-chair and subsequently was slapped on the hand when being moved in Geri chair. No injury noted to resident at time of notification. Record review of Resident #1's care plan reflected the following: (continued on next page)

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	676141	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Matlock Place Health & Rehabilitation Center	7100 Matlock Rd Arlington, TX 76002

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Focus: Resident has an allegation of (Abuse), Date Initiated: 09/03/2024; Goal: Resident will not experience a negative outcome from alleged event through this review period; Interventions/Tasks: Any negative event will be reported to the abuse coordinator immediately. The facility will adhere to the abuse and neglect policies and protocols. -Focus: Resident requires a mechanical lift transfer(Hoyer) r/t (inability to bear weight) 2 person assist. Date Initiated: 09/03/2024; Goal: Resident will be provided a safe transfer utilizing a mechanical lift(Hoyer)throughout the review period.; Interventions/Tasks: 1. Resident has been identified as totally dependent for transfers. 2. Lifting equipment will be operated in accordance with instruction and training. 5. Report change in conditions which may necessitate a re-evaluation of the resident and the lift. [sic] -Focus: [Resident #1] has a communication problem r/t Dementia, non-verbal .Interventions/Tasks: Ensure/provide a safe environment. Telephone interview on 10/28/24 at 12:13 PM with Resident #1's POA revealed she showed the Administrator, who was the Abuse Coordinator, a video of Resident #1 being abused by CNA B from 08/31/24. Resident #1's POA said after seeing the video, the Administrator called the police and the facility terminated CNA B. Resident #1's POA said the facility took x-rays and followed up to check on Resident #1. Resident #1's POA said Resident #1 does not have the ability to show any emotion or pain and did not have any bruises or injuries from the situation. Observation of the first video provided by Resident #1's POA on 10/30/24 at 8:22 AM revealed the following: The video was time stamped and dated for 08/31/24 at 6:58 AM; the video did not include any sound. The video began and Resident #1 was in bed. There was a geri-chair at the foot of the bed and CNA B began pushing the geri-chair to the side of the bed. CNA B locked the left side of the geri-chair from the back and then walked in front of the geri-chair and pulled it closer to the bed. CNA B turned to Resident #1 and pulled her legs over the side of the bed and used his left arm to raise her up. CNA B used his right hand to reposition Resident #1's knees. Resident #1 had her arms crossed on her chest and CNA B uncrossed the resident's arms to put his underneath hers to lift her up and transfer her to the geri-chair. The geri-chair began to move backwards and CNA B used his left arm to hold the geri-chair while he used his right arm to hold Resident #1 up. CNA B placed Resident #1 on her back on the geri-chair seat portion, grabbed her left leg to raise it with his right hand while his left hand went under her left arm to pull her up towards him and into the chair but the chair began to again move backwards. CNA B put Resident #1 back in the bed and rolled her over onto the bed, pulled the geri-chair closer to the side of the bed and locked the right side of the geri-chair from the back. CNA B walked to the front of the geri-chair and to the side of Resident #1's bed where she was still lying there. CNA B turned Resident #1 over and put his right arm underneath her bent legs and used his left arm to hold her by her neck to transfer her to the geri-chair. CNA B put Resident #1 in the geri-chair perpendicular where her head and legs were on the armrests of the chair. The video ended. Observation on 10/31/24 at 9:45 AM of Resident #1 revealed she was in a common area lying in a geri-chair; she appeared dressed and groomed. Resident #1 had her eyes closed and she did not wake while being talked to by the surveyor. Resident #1 was wearing a long-sleeved shirt but did not appear to have any bruises, injuries, or pain. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 10/31/24 at 12:30 PM of Resident #1 revealed she was in the dining room with her POA being assisted to eat lunch. Resident #1 was still in her geri-chair and was falling asleep during the meal. Resident #1 was not able to answer any questions or acknowledge the surveyor's presence due to her cognitive condition. Telephone interview on 10/31/24 at 12:48 PM with CNA B revealed he remembered caring for Resident #1, but that it was some time ago. CNA B said he was trying to transfer Resident #1 to her geri-chair one day when she was holding onto him. CNA B said he had to take Resident #1's hand off of him while still holding onto her during the transfer. CNA B said he had locked the chair but what happened during the transfer was that Resident #1 was very heavy and he could not hold her up for the transfer. CNA B said he did not use a gait belt to transfer Resident #1. CNA B said he was terminated from the facility. Observation on 10/31/24 at 1:13 PM revealed CNA F and RA Z transferring Resident #1 by Hoyer lift from her geri-chair to her bed, and the transfer was completed was completed safely and using proper technique. Interview on 10/31/24 at 2:37 PM with the ADON revealed he saw the video provided by Resident #1's POA which showed CNA B had transferred Resident #1 to the geri-chair. The ADON said at the time of the video, Resident #1 was a one person transfer using a gait belt and now was a hoyer lift transfer requiring at least two people. The ADON said CNA B was not appropriate in the type of care he provided Resident #1, and it was considered abuse which should never occur. The ADON said Resident #1 was assessed and she did not have any injuries or bruises from the incident. The ADON said safe surveys were completed for other residents to make sure they had not suffered any injuries either. The ADON said the facility decided to terminate CNA B immediately based on what they saw in the video. The ADON said the facility also began in-servicing staff immediately on abuse and neglect. The ADON said the facility also began checking on Resident #1 and ensuring staff were doing what they were supposed to regarding her care to monitor the situation. Interview on 10/31/24 at 2:53 PM with the Administrator revealed he got a call from Resident #1's POA who said she had a video she wanted to show him. The Administrator said he was concerned with what he saw on the videos. The Administrator said he saw CNA B trying to transfer Resident #1 by picking her up and putting her into the chair instead of using a gait belt to transfer her. The Administrator said the video showed CNA B trying to get Resident #1 to the chair without the amount of help that was needed to complete the transfer safely. The Administrator said after reviewing the videos he immediately reported the incident and terminated CNA B. The Administrator said a head-to-toe assessment was also completed on Resident #1 which revealed no bruising or marks of any kind to her body. The Administrator said multiple x-rays were completed on Resident #1 as well which all came back negative for any injuries. The Administrator said the techniques of CNA B's transfer were so poor which ended up meaning he provided rough care and a rough transfer. Follow-up interview on 10/31/24 at 4:52 PM with the Administrator revealed staff should seek help if they could not complete a transfer safely. The Administrator said the purpose of a safe transfer was to prevent injury or any negative outcome to the resident. The Administrator said staff were in-serviced regarding safe transfers and all staff were responsible for providing safe transfers to residents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's Provider Investigation Report, dated 09/10/24, reflected the following: - Investigation Summary: Administrator approached by [Resident #1's POA] regarding a video she recorded in resident room. On video it showed [CNA B] trying to transfer resident to geri-chair. It shows CNA struggling to get her into the chair, holding resident under her arms and then back to the bed in the same way. It then shows him trying to pick her up under her knees and behind her back to get her to chair, hitting her back on the arm rests, then pulling on her arms to pull her up. Upon leaving the room, the resident holds onto the bed. The CNA removes her hand from the bed, then swats at her hand. Provider completed provider response as outlined above. All xrays and head to toe assessments came back negative. All safe surveys came back with no other abuse present. Facility completed all in-service and competencies. CNA was terminated immediately, board notified, police called. - Investigation Findings: Confirmed Record review of undated safe surveys completed with residents revealed 33 residents were interviewed and no concerns were noted. Record review of CNA B's personnel file included a disciplinary action form, dated 09/03/24, which reflected he was terminated due to an allegation of abuse that was founded on a video. Record review of an in-service, dated 09/03/24, reflected staff had been trained regarding Customer Service and that all residents [were] to be treated with dignity and respect. Record review of an in-service, dated 09/03/24, reflected staff had been trained regarding Safe Handling and Transfers and that Hoyer lift requires 2 people, All transfers require use of gait belt, 2 person assist equals 2 person assist .if in doubt how to transfer ask for clarification .gait belts [sic]. Interview on 10/31/24 at 11:37 AM with CNA C revealed he had been trained on how to properly transfer a resident. Interview on 10/31/24 at 1:15 PM with CNA F revealed she had been trained on how properly transfer a resident. CNA F said Resident #1 was now transferred using a hoyer lift whereas she was previously transferred using a gait belt. Interview on 10/31/24 at 1:32 PM with RN D revealed she had been trained on how to properly transfer a resident. RN D said Resident #1 was now transferred using a hoyer lift whereas she was previously transferred using a gait belt. Record review of the facility's Safe Resident Handling/Transfers policy, dated 09/03/24, reflected: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Policy: It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. Policy Explanation: All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them .13. Staff members are expected to maintain compliance with safe handling/transfer practices. The Administrator was notified on 11/13/24 that a past non-compliance IJ situation had been identified following administrative review due to the above failure.