STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676163	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bender Terrace of Lubbock	4510 27th St Lubbock, TX 79410

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** 42515 Based on interview and record review the facility failed to ensure the resident had the right to be free from abuse for 1 of 7 residents (Resident #1) reviewed for abuse. The facility failed to ensure a safe environment free from abuse for Resident #1 when the SW witnessed CNA A slap Resident #1 on the arm. An Immediate Jeopardy (IJ) situation was determined to have existed on 07/15/24. It was determined to be past non-compliance due to the facility having implemented actions that corrected the non-compliance prior to beginning of the survey. These failures could affect all residents by placing them at risk of abuse, physical harm, pain, mental anguish, emotional distress, and serious harm. Findings include: Record review of Resident #1's face sheet, dated 08/15/24, revealed resident was a [AGE] year-old male who was admitted to the facility on [DATE] and discharged from the facility on 07/19/24. Resident #1 was admitted with the following diagnoses: autistic disorder (a condition that affects brain development), symptomatic epilepsy (uncontrollable movements), and bipolar disorder (mood disorder). Record review of Resident #1's Quarterly MDS dated [DATE], documented that Resident #1's cognitive skills for decision making were modified dependence - some difficulty in new situations only. According to the MDS, Resident #1 had physical behaviors directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) 1-3 days out of the 7 day week, Verbal behaviors directed towards others (e.g., threatening others, screaming at others, cursing at others) 1-3 days out of the 7 days week, and other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) 1-3 days out of the 7 day week. (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1s Care Plan undated, revealed Resident #1 had a focus area: I have the potential for episodes of adverse behaviors: Verbally aggressive: cursing, racial slurs, yelling/screaming and physically aggression: r/t explosive disorder. Date Initiated 12/04/23, Goal: I will remain injury free r/t adverse behaviors through next review date. Date Initiated: 12/04/23, Interventions: Anticipate behavior(s) and redirect when in close proximity to others that might invoke aggression, Monitor for early warning signs of behavior - approach in calm manner, call by name, remove from unwanted stimuli to a safe environment. Date Initiated: 12/04/23. Record review of Resident #1's Progress notes dated 07/15/24 at 3:40 pm Type: Social Services Progress note: This writer observed CNA slap resident on arm. This writer notified administrator immediately. During an interview on 08/16/24 at 9:02 AM, the SW was asked about the incident regarding Resident #1 that happened on 07/15/24. The SW stated she was standing at the nurses station, which is also near the DON office. The SW stated CNA A was also standing at the nurses station at this time. The SW stated Resident #1 then came up to the nurses station and spit at CNA A. The SW stated she then saw CNA A swing her arm and slapped Resident #1's arm. The SW stated she immediately intervened and told CNA A that she could not do that, she could not slap the residents. The SW stated the CNA A replied to her, I'm sorry, I didn't mean to. It was just a reaction. The SW stated she then removed Resident #1 from CNA A and went straight to the DON's office because the ADM and DON were both in there at that time. The SW stated she told the ADM what happened and the ADM went out to speak to CNA A at that time. The SW stated the DON started doing a head to toe assessment on Resident #1. The SW stated she did not see CNA A on the floor anymore that shift and did not see her at the facility since this incident. The SW stated the facility received abuse training every 2 weeks, on pay days. The SW was able to verbalize the different forms of abuse and stated the ADM was the abuse coordinator at the facility. The SW stated an in-service was done by the DON or ADM the same day as the incident. During a phone interview on 08/16/24 at 9:12 AM, CNA A was asked about the incident between her and Resident #1 on 07/15/24. CNA A stated she was standing at the nurses station talking to the SW about another resident on 07/15/24, when she saw Resident #1 was going up to the nurses station. CNA A stated he went to the nurses station and spit at her. CNA A stated she raised her hand and slapped at his arm. CNA A stated, I didn't mean to. It was just a knee jerk reaction. CNA A stated the SW then told her she could not hit residents and told her to sit down at the nurses station. CNA A stated the SW then took Resident #1 with her to the DON's office and told the ADM what happened. CNA A stated she was immediately suspended by the ADM and then the ADM called her a few days later to let her know she could not go back to work at the facility. CNA A stated she received abuse training every two weeks, on pay days. CNA A stated she knows she is not allowed to slap residents. CNA A stated, I'm sorry. I did wrong. During a phone interview on 08/16/24 at 9:22 AM, Family member A stated the facility notified him of an incident between Resident #1 and CNA A. Family member A stated he was told CNA A hit Resident #1 on the arm after Resident #1 spit on her. Family member A stated he was told CNA A was terminated and that the facility was going to report the incident to the Health and Human Services Commissions to be investigated. (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 08/16/24 at 9:34 AM, the DON stated he did not witness the incident between Resident #1 and CNA A on 07/15/24. The DON stated he was talking to the ADM in his office, which is near the nurses station, when the SW came in and told them she saw CNA A hit Resident #1. The DON stated the ADM suspended CNA A right away and he did an assessment on Resident #1, where no injuries were noted. The DON stated there were no other residents around the nurses station at this time. The DON stated Resident #1 was asked if he was ok, and he was calm. The DON stated he provided abuse training every two weeks on pay days, and remembers going over the in-service with CNA A on the previous pay day, 07/10/24, but was unsure if she signed the in-service document. The DON stated he expects staff to not take behaviors personally and to step away when getting frustrated with a resident. The DON stated an in-service was performed with staff regarding abuse and behaviors on 07/15/24. The DON stated CNA A was not allowed to return to work at the facility after this incident. Attempted phone interview on 08/16/24 at 12:01 PM with Resident #1 via group home House Manager phone number. This was the only phone number provided for the group home Resident #1 currently resides at. No answer. Left a voice message to call surveyor back with call back number provided. During an interview on 08/16/24 at 1:47 PM, the ADM stated she expects the facility to be abuse free and for staff to respect all residents and care for them in the best way possible, meeting every need. The ADM was asked about the incident between CNA A and Resident #1 on 07/15/24. The ADM stated she was talking with the DON in his office. The ADM stated the SW came in and advised them that Resident #1 had been removed from CNA A because CNA A slapped Resident #1. The ADM stated she immediately went out to speak with CNA A and tell her she was going to be suspended due to abuse allegations. The ADM stated she talked with the SW and called CNA A to terminate her employment at the facility. The ADM stated CNA A told her it was just a reaction. The ADM stated CNA A had worked at the facility for many years and had received many abuse trainings. The ADM stated it was her job to keep residents at the facility safe from abuse, so abuse in-services happened every pay day, which is every 2 weeks. The ADM stated safe surveys were done with other residents and a head-to-toe assessment was performed on Resident #1, which showed no injuries. The ADM stated an abuse in-service was started immediately following this incident. Record review of facility Inservice Form, dated 04/10/24, revealed: Subject: Abuse, Neglect and Use of Restraints 1. Remove resident or residents from the abuse situation immediately. 2. Report abuse allegation immediately to Administrator and or Charge Nurse if you do not report the abuse or alleged abuse, you are allowing this to happen and will be help responsible as well. 3. If you are not sure report it anyway to the ADM [phone number] CNA A's printed name and signature was observed on the in-service form. Record review of facility Inservice Form, dated 05/24/24, revealed: Subject: Abuse and Neglect You must notify the Administrator immediately if you: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	See abuse Hear abuse Suspect abuse Three types of abuse are: Physical Verbal Misappropriation CNA A's printed name and signature was observed on the in-service form. Record review of facility Inservice Attendance Record form, dated 06/25/24 revealed: Subject: .Abuse and Neglect CNA A's printed name and signature was observed on the in-service form. Record review of facility In-service Training Report form, dated 07/10/24, revealed: Topic: .Abuse/Neglect Contents or summary of training session: .Staff will not for any reason harm or treat any patient with the intent to harm. Patient will be treated with respect and dignity. Record review of facility In-Service Training Report form, dated 07/15/24, revealed: Topic: Abuse/Neglect Contents or summary of training session: No staff will use any type of physical force to cause injury or impairment, such as hitting, slapping, pinching, kicking, or force feeding. Staff shall not use nonverbal actions or words to cause distress or pain to residents, such as yelling, cursing, unwanted advances, yelling, neglect, sexual assault or emotional distress. Record review of facility Disciplinary Action Form, dated 07/15/24, revealed CNA A had suspected resident abuse. The nature of the offense was alleged physical abuse towards resident Action taken: Suspension, with suspension start date on 07/15/24. Record review of facility Separation Notice Form, dated 07/18/24, revealed CNA A received a separation notice due to Resident Abuse, signed and dated by CNA A on 07/18/24. Record review of facility policy titled, Abuse Prevention Program, with a revised date of 12/16, 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	Policy Statement: Our residents have the rights to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the residents' symptoms. Policy Interpretation and Implementation: As part of the resident abuse prevention, the administration will: 1. Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual . The ADM was notified on 08/16/24 at 1:45 PM, that a past non-compliance IJ situation had been identified due to the above failures. It was determined these failures placed Resident #1 in an IJ situation on 07/15/24. The facility implement the following interventions: CNA A was immediately removed from the residents and placed on suspension. CNA A was terminated while on suspension and not allowed to return to the facility. The facility performed a head to toe assessment on Resident #1 and MD and family were notified of the incident. The facility began in-services regarding abuse with staff on 07/15/24.