STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676226	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cypress Healthcare and Rehabilitation Center	1351 Sadler San Marcos, TX 78666

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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 - Some	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** 42949 Based on interview and record review, the facility failed to ensure the residents had the right to be free from abuse for one (Resident #1) of four residents reviewed for abuse. The facility failed to protect Resident #1 from physical and emotional abuse when CNA A forcefully dragged her to the shower room and sprayed her while still wearing her clothes while she was screaming and crying in June of 2024. The DON was notified and failed to take any action to protect Resident #1 from further abuse as CNA A continued to work at the facility and with Resident #1 and continued to emotionally abuse her. CNAs B and C did not intervene during the incident. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 07/30/24 at 3:01 PM. While the IJ was removed on 08/02/24 at 3:00 PM, the facility remained at a level of actual no actual harm at a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure placed residents at risk of abuse, trauma, and psychosocial harm. Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including major depressive disorder, anxiety disorder, and unspecified psychosis . Review of Resident #1's quarterly MDS assessment, dated 06/05/24, reflected a BIMS score of 14, indicating she was cognitively intact. Section GG (Functional Abilities and Goals) reflected she needed setup or clean-up assistance with Showering and did not require a wheelchair or walker for ambulating. Review of Resident #1's quarterly care plan, dated 06/07/24, reflected she required assistance with ADLs with an intervention of assisting with ADLs as needed. Review of a witness statement, dated 07/30/24 and documented by CNA C, reflected the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Around July or June (2024) me and my coworkers were working on 500 hall. Me and 2 other coworkers and it was [Resident #1]'s shower day. I had asked her if she wanted to shower and she said no so I left it at that. My other coworker (CNA A) comes in and says that the DON said to do whatever it takes to get her in the shower cause [sic] she hadn't had one in months. She then grabbed [Resident #1] by the arm and forced her to shower meanwhile [Resident #1] was screaming and telling her that she didn't want to shower. I left then went into the shower room to get gloves and saw [CNA A] wet her clothes to get her to sit down. A couple minutes later [Resident #1] storms out of the shower room mad then goes to her room. Me and [CNA B] were passing snacks and [Resident #1] then comes to us and throws us chunks of her hair . [Resident #1] did let therapy know and she described who it was. Review of the text message received by the OT, dated 07/02/24, reflected the following: . [CNA B] pulled me aside to tell me that [CNA A] showered [Resident #1] a couple weeks ago against her will because the DON told them to make it happen. So [CNA B] said that [CNA A] pulled [Resident #1] down the hall with her trying to fight her. Evidently [Resident #1] was put in the shower with her clothes on bc [sic] she refused to take them off and [CNA A] sprayed [Resident #1] down with the shower spray anyway. [CNA A] then took the clothes off [Resident #1] bc [sic] they were wet and changed her into dry clothes. [CNA B] stated that [CNA A] combed her hair so aggressively that it pulled a lot of her hair out. [Resident #1] has been worried about her hair falling out every time I have showered her . Review of Staffing Sheets, from 06/01/24 - 07/30/24, reflected CNA A worked the following days: 06/05/24 - Resident #1's hall 06/06/24 - Resident #1's hall 06/08/24 06/09/24 - Resident #1's hall 06/10/24 06/11/24 - Resident #1's hall 06/12/24 06/13/24 06/17/24 06/18/24 - Resident #1's hall 06/19/24 - Resident #1's hall 06/20/24 06/22/24 - Resident #1's hall (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	06/23/24 06/26/24 06/28/24 06/29/24 06/30/24 - Resident #1's hall 07/01/24 - Resident #1's hall 07/08/24 07/11/24 - Resident #1's hall 07/14/24 07/17/24 - Resident #1's hall 07/18/24 07/19/24 - Resident #1's hall During an interview on 07/30/24 at 10:21 AM, Resident #1 stated a few weeks ago CNA A dragged her to the shower room even though she was screaming and crying and did not want to shower. She stated once they got into the shower room, she sprayed her down with water until her clothes were soaked. She stated CNA A took a picture of her and was laughing and making fun of her. She stated she felt humiliated and had feared her ever since. She stated she felt so helpless as she could not fight back. She stated CNA A brushed her hair so rough she had chunks coming off her head. She stated she continued to mess with her even after that day and she had been miserable. She stated she was not sure if she worked there anymore because she had not seen her in at least a week and never wanted to see her again. During an interview on 07/30/24 at 10:38 AM, CNA B stated sometime back in June (2024) she walked into the shower room and saw CNA A spraying Resident #1 with the shower head. She stated she was so appalled she had to walk out. She stated she and CNA C had initially walked in because they heard Resident #1 screaming and crying. She stated CNA A was laughing the whole time. She stated she notified the DON and everyone knew about it. She stated the DON told everyone CNA A had been fired but she did not get fired until the week prior for something unrelated to the incident. She stated after the incident, CNA A continued to work on the same hall and would often go into Resident #1's room and taunt her. She stated she would laugh and ask her, Do you want a shower today? She stated Resident #1 had been a mess and very distraught. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 07/30/24 at 10:52 AM, CNA C stated it had been at least over a month since the incident with Resident #1 and CNA A. She stated Resident #1 refused showers a lot and CNA A told her the DON told her to do whatever it took to give her a shower. She stated she witnessed CNA A drag Resident #1 to the shower room while she was resisting and screaming. She stated she went into the shower room and saw CNA A spraying her with the shower head to get her to sit down on the shower chair while she continued to scream and cry. She stated CNA A was laughing and saying things like, You stinky! You stink! She stated eventually Resident #1 stormed out of the shower room and then threw chunks of her hair on the ground. She stated she and CNA B had spoken to the DON about it and were even interviewed separately. She stated CNA A continued to work on the same hall and taunt Resident #1 she had been irritated and scared . She stated Resident #1 had been affected by the whole thing and she believed it had been abusive. During a telephone interview on 07/30/24 at 12:25 PM, the ADM stated he was not notified by the DON of the incident involving Resident #1 and CNA A until that day (07/30/24). He stated the DON told him she had not been made aware of the incident until 07/19/24. He stated he was informed Resident #1 was refusing a shower and CNA A sprayed her with water. He stated CNA A was now suspended, he would be submitting a self-report to HHSC, and conducting a thorough investigation. During an interview on 07/30/24 at 12:32 PM, the DON stated she could not remember the date of when she was notified of the incident between Resident #1 and CNA A. She stated she believed it was in the middle of July (2024). She stated she interviewed CNAs B and C but did not have any documentation except for the witness statement she obtained that day from CNA A. She stated she was told that CNA A wet the bottom of Resident #1's pajamas in the shower room. She stated when she told CNA A to do whatever it took to give Resident #1 a shower, she stated she meant to encourage her. She stated spraying her with water would be mean. She stated she did take CNA A off the schedule and sent her home. She stated she did not tell the ADM sooner because she was still in the investigation stage. She stated the OT also notified her of the incident and he may remember the date more clearly. During an interview on 07/30/24 at 12:48 PM, the OT stated he received a text message from another therapist he worked with on 07/02/24 detailing the abusive incident between Resident #1 and CNA A. He stated because he received it in the evening, he notified the DON the next day first thing . He stated he read the text message to her and she did not seem that concerned. He stated about 2-3 days later he saw CNA A working on Resident #1's hall and noticed Resident #1 was visibly upset. He stated he went to the DON and asked her why she would have working on Resident #1's hallway as she was traumatized by the incident that had happened. He stated the DON appeared unaffected and stated, Oh, I did not know she was working on the same hall. He stated CNA A should not have bee been able to work at all at this time because all residents were being put at risk of further abuse. Review of the facility's undated Abuse Prevention and Investigation Policy reflected the following: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit abuse . 'Abuse' means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting in physical harm, pain, or mental anguish, which can include staff to resident abuse . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	'Willful' means the individual must have acted deliberately, not the individual must have intended to inflict injury or harm. 'Physical Abuse' includes, but is not limited to, hitting, slapping, punching, biting, and kicking. 'Mental Abuse' includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. The DON and RADM were notified on 07/30/24 at 3:01 PM that an Immediate Jeopardy had been identified due to the above failures and an IJ template was provided. The following POR was accepted on 08/01/24 at 4:53 PM: F600 - Plan Of Removal On 7/30/2024 the surveyor provided an Immediate Jeopardy template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to the resident health and safety. The notification of Immediate Jeopardy states as follows: F600 ' The facility failed to keep the residents free from abuse. The facility failed to ensure the safety of Resident #1 during and after she was physically dragged into the shower room by CNA A, sprayed with the shower head in her full clothes to get her to sit down, all the while screaming and crying. The facility failed to ensure CNA A was suspended/terminated or removed from working with Resident #1 after the incident, causing more emotional distress. Action: *Administrator self-reported the incident on 7/30/2024 to HHSC via online portal through TULIP (reporting system), report # 521272. *Medical Director was informed of the IJ on 7/30/2024 at approx. 4:00pm and an adhoc QAPI meeting was held. In attendance were the MD, Administrator, Regional Administrator, and Regional Nurse. Discussion included what transpired leading up to the IJ, the content of the allegations and the alleged incident, personnel involved, what possibly lead to the events that caused the IJ, retraining topics, and resident care plan. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*The Regional Administrator or Administrator began re-in-servicing all staff on Abuse/Neglect/Exploitation policy and procedures, specifically who to notify (Abuse Coordinator, Administrator) or in their absence (Regional leadership, Corporate Compliance), and to take immediate action to ensure residents are not abused by staff, and actions are followed per policy and procedure once leadership is made aware for the protection of all residents in the facility. If abuse/neglect/exploitation is suspected, it is the witnesses responsibility to report directly to the Abuse Coordinator, or Corporate Compliance should there be a concern. Resident safety is paramount, and it is expected that all residents are treated with dignity and respect at all times. Should an unsatisfactory response or action be given by any person regardless of position, it is the reporters responsibility to ensure actions are taken to safeguard the resident. Additionally, education is provided by Regional Administrator or Administrator for understanding of residents rights, and their right to refuse care. Should the person receiving report provide an unsatisfactory response, this individual will receive disciplinary action. *Post test will be provided to staff covering training of ANE/Resident Rights, and employee understanding will be measured by being required to successfully answer all post test questions. Additionally, the administrator will interview 3 random staff and 3 random alert and oriented residents to ensure understanding. *Alleged Perpetrator was terminated out of the system effective 7/30/2024, and call was made by Regional Administrator to employee to inform the status change. *1:1 education was completed on 7/30/2024 by Regional Administrator and Administrator with DON regarding investigating, reporting, and addressing all allegations of ANE, including disciplinary action. While the DON has formal oversight of the nursing personnel to include agency/PRN /new staff, the Administrator will ensure education is provided to all staff regarding ANE/Resident Rights prior to their next shift. *1:1 education was completed on 7/31/2024 at 10:15am by Administrator with witness CNA#1, regarding immediate safeguarding of the residents, including but not limited to removing the resident themselves from the situation, ensuring resident safety by removing the threat, and using best judgement to ensure the resident is in a safe location before reporting to the Abuse Coordinator/Corporate Compliance. Per policy: A. Responding immediately to protect the alleged victim and integrity of the investigation; B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; C. Increased supervision of the alleged victim and residents; D. Providing emotional support and counseling to the resident during and after the investigation, as needed; E. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*1:1 education was completed on 7/31/2024 at 11:30am by Administrator with witness CNA#2, regarding immediate safeguarding of the residents, including but not limited to removing the resident themselves from the situation, ensuring resident safety by removing the threat, and using best judgement to ensure the resident is in a safe location before reporting to the Abuse Coordinator/Corporate Compliance. Per policy: A. Responding immediately to protect the alleged victim and integrity of the investigation; B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; C. Increased supervision of the alleged victim and residents; D. Providing emotional support and counseling to the resident during and after the investigation, as needed; E. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse. *Resident #1 was informed by the Administrator that the alleged perpetrator was terminated, and that the Administrator was going to ensure staff are educated on ANE/Resident Rights and held accountable by the Administrator to safeguard the residents. Resident # 1 remains on Psych Services. *All new hires will meet with Administrator before working a shift 1:1 to ensure understanding of ANE Policy and Procedures and will sign an acknowledgement attesting to the training *PRN/Agency staff will be educated on ANE/Resident Rights upon arrival by Administrator or designee, and resource binder left at the nurses station to reference for quick access for Policy and Procedures related to ANE/Resident Rights. Start Date: 07/30/2024 4:00pm Completion Date: Prior to any staff coming on shift, education will be provided and post test given and employee understanding will be measured by being required to successfully answer all post test questions. Additionally, the administrator will interview 3 random staff and 3 random alert and oriented residents to ensure understanding. Target Audience: All staff Responsible person: Regional Administrator or Administrator How do you evaluate effectiveness: Administrator will begin completing interviews beginning 8/5/2024 of at least 3 random staff, and 3 random alert and oriented residents a week regarding ANE expectations, who to report to, when, how, and expectations of safe guarding residents who are suspected to be victim of ANE. This will be tracked via spreadsheet and will remain in effect for at least 3 months, or until substantial compliance is achieved. Information will be reviewed during QAPI and findings adjusted as necessary. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Surveyor monitored the POR on 08/02/24 as followed: During an interview on 08/02/24 at 11:18 AM, the ADM stated staff were being in-serviced before working the floor. He stated after further investigation, the DON was let go from the facility. During interviews on 08/02/24 from 11:29 AM - 2:38 PM, one RN, two LVNs, three CNAs, a HSK, and the TS (from different shifts) all stated they were in-serviced and took a post-test before working their shifts. All were able to state that their ADM was the Abuse and Neglect Coordinator and give examples of different types of abuse such as physical, verbal, emotional, and psychosocial. All stated if they saw a resident being abused by a staff member, another resident, or a family member they would intervene to ensure the resident was in a safe space and would notify the ADM immediately. They all stated if the ADM or DON was not immediately available, they would call the corporate hotline that was in the breakroom to notify the RADM. They all stated it was important to notify the ADM because he needed to conduct a thorough investigation, ensure residents safety, and report to the appropriate agencies. Each staff member stated residents had the right to refuse care, such as showers, and should never be forced to do something they did not want to do. During an interview on 08/023/24 at 2:46 PM, Resident #1 stated the ADM had spoken to her about the actions taken and she was just glad the CNA (CNA A) was no longer working at the facility. She stated she felt safe and had no further concerns. Review of Safe Surveys, dated 07/30/24, reflected all residents were interviewed regarding their safety with no concerns. Review of the facility's Ad Hoc QAPI Meeting Minutes, dated 07/30/24, reflected the ADM, RADM, RegN, and MD were in attendance. Review of a Disciplinary Notice , dated 07/30/24, reflected the DON received a final warning due to the following: [The DON] failed to investigate and report an allegation of abuse and neglect. This failure resulted in 4 IJ's being declared on 07/30/24. [The DON] failed to follow the abuse and neglect policy, also did not file a self-report with HHS as required. Further investigation is on-going. Additional disciplinary actions will be determined upon completion of internal investigation. Review of an in-service, dated 07/31/24 and conducted by the RADM, reflected the ADM had a 1:1 training to review abuse, neglect and exploitation, investigation steps, and the reporting policy. Review of an in-service, dated 07/31/24 and conducted by the RADM, reflected the SW had a 1:1 training to review abuse, neglect and exploitation, the reporting policy, and SW action steps. Review of an in-service, dated 07/31/24 and conducted by the ADM, reflected CNA B had a 1:1 training to review and discuss ANE/Reporting Policy and Procedures. Review of an in-service, dated 07/31/24 and conducted by the ADM, reflected CNA C had a 1:1 training to review and discuss ANE/Reporting Policy and Procedures. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of in-services, dated 07/30/24 - 08/01/24 and conducted by the ADM, reflected staff from all shifts were in-serviced on ANE policy and procedures, the Abuse and Neglect Coordinator, reporting, resident rights (right to refuse care), and corporate compliance. Review of Abuse Post-Tests, dated 07/30/24 - 08/01/24, reflected all staff completed the test with passing scores. While the IJ was removed on 08/02/24 at 3:00 PM, the facility remained at a level of actual no actual harm at a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on interview and record review, the facility failed to implement their written policies and procedures regarding prohibiting and preventing abuse for one (Resident #1) of four residents reviewed for developing and implementing abuse and neglect policies. The facility failed to implement the facility abuse policy when they failed to protect Resident #1 from physical and emotional abuse when CNA A forcefully dragged her to the shower room and sprayed her while still wearing her clothes while she was screaming and crying in June of 2024. The DON was notified and failed to take any action to protect Resident #1 from further abuse as CNA A continued to work at the facility and with Resident #1 and continued to emotionally abuse her. CNAs B and C did not intervene during the incident. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 07/30/24 at 3:01 PM. While the IJ was removed on 08/02/24 at 3:00 PM, the facility remained at a level of actual no actual harm at a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure placed residents at risk of abuse, trauma, and psychosocial harm. Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including major depressive disorder, anxiety disorder, and unspecified psychosis. Review of Resident #1's quarterly MDS assessment, dated 06/05/24, reflected a BIMS of 14, indicating she was cognitively intact. Section GG (Functional Abilities and Goals) reflected she needed setup or clean-up assistance with Showering and did not require a wheelchair or walker for ambulating. Review of Resident #1's quarterly care plan, dated 06/07/24, reflected she required assistance with ADLs with an intervention of assisting with ADLs as needed. Review of a witness statement, dated 07/30/24 and documented by CNA C, reflected the following: (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Around July or June (2024) me and my coworkers were working on 500 hall. Me and 2 other coworkers and it was [Resident #1]'s shower day. I had asked her if she wanted to shower and she said no so I left it at that. My other coworker (CNA A) comes in and says that the DON said to do whatever it takes to get her in the shower cause [sic] she hadn't had one in months. She then grabbed [Resident #1] by the arm and forced her to shower meanwhile [Resident #1] was screaming and telling her that she didn't want to shower. I left then went into the shower room to get gloves and saw [CNA A] wet her clothes to get her to sit down. A couple minutes later [Resident #1] storms out of the shower room mad then goes to her room. Me and [CNA B] were passing snacks and [Resident #1] ten comes to us and throws us chunks of her hair . [Resident #1] did let therapy know and she described who it was. Review of the text message received by the OT, dated 07/02/24, reflected the following: . [CNA B] pulled me aside to tell me that [CNA A] showered [Resident #1] a couple weeks ago against her will because the DON told them to make it happen. So [CNA B] said that [CNA A] pulled [Resident #1] down the hall with her trying to fight her. Evidently [Resident #1] was put in the shower with her clothes on bc [sic] she refused to take them off and [CNA A] sprayed [Resident #1] down with the shower spray anyway. [CNA A] then took the clothes off [Resident #1] bc [sic] they were wet and changed her into dry clothes. [CNA B] stated that [CNA A] combed her hair so aggressively that it pulled a lot of her hair out. [Resident #1] has been worried about her hair falling out every time I have showered her . Review of Staffing Sheets, from 06/01/24 - 07/30/24, reflected CNA A worked the following days: 06/05/24 - Resident #1's hall 06/06/24 - Resident #1's hall 06/08/24 06/09/24 - Resident #1's hall 06/10/24 06/11/24 - Resident #1's hall 06/12/24 06/13/24 06/17/24 06/18/24 - Resident #1's hall 06/19/24 - Resident #1's hall 06/20/24 06/22/24 - Resident #1's hall (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676226	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cypress Healthcare and Rehabilitation Center	1351 Sadler San Marcos, TX 78666

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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 - Some	06/23/24 06/26/24 06/28/24 06/29/24 06/30/24 - Resident #1's hall 07/01/24 - Resident #1's hall 07/08/24 07/11/24 - Resident #1's hall 07/14/24 07/17/24 - Resident #1's hall 07/18/24 07/19/24 - Resident #1's hall During an interview on 07/30/24 at 10:21 AM, Resident #1 stated a few weeks ago CNA A dragged her to the shower room even though she was screaming and crying and did not want to shower. She stated once they got into the shower room, she sprayed her down with water until her clothes were soaked. She stated CNA A took a picture of her and was laughing and making fun of her. She stated she felt humiliated and had feared her ever since. She stated she felt so helpless as she could not fight back. She stated CNA A brushed her hair so rough she had chunks coming off her head. She stated she continued to mess with her even after that day and she had been miserable. She stated she was not sure if she worked there anymore because she had not seen her in at least a week and never wanted to see her again. During an interview on 07/30/24 at 10:38 AM, CNA B stated sometime back in June (2024) she walked into the shower room and saw CNA A spraying Resident #1 with the shower head. She stated she was so appalled she had to walk out. She stated she and CNA C had initially walked in because they heard Resident #1 screaming and crying. She stated CNA A was laughing the whole time. She stated she notified the DON and everyone knew about it. She stated the DON told everyone CNA A had been fired but she did not get fired until the week prior for something unrelated to the incident. She stated after the incident, CNA A continued to work on the same hall and would often go into Resident #1's room and taunt her. She stated she would laugh and ask her, Do you want a shower today? She stated Resident #1 had been a mess and very distraught. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 07/30/24 at 10:52 AM, CNA C stated it had been at least over a month since the incident with Resident #1 and CNA A. She stated Resident #1 refused showers a lot and CNA A told her the DON told her to do whatever it took to give her a shower. She stated she witnessed CNA A drag Resident #1 to the shower room while she was resisting and screaming. She stated she went into the shower room and saw CNA A spraying her with the shower head to get her to sit down on the shower chair while she continued to scream and cry. She stated CNA A was laughing and saying things like, You stinky! You stink! She stated eventually Resident #1 stormed out of the shower room and then threw chunks of her hair on the ground. She stated she and CNA B had spoken to the DON about it and were even interviewed separately. She stated CNA A continued to work on the same hall and taunt Resident #1 she had been irritated and scared. She stated Resident #1 had been affected by the whole thing and she believed it had been abusive. During a telephone interview on 07/30/24 at 12:25 PM, the ADM stated he was not notified by the DON of the incident involving Resident #1 and CNA A until that day (07/30/24). He stated the DON told him she had not been made aware of the incident until 07/19/24. He stated he was informed Resident #1 was refusing a shower and CNA A sprayed her with water. He stated CNA A was now suspended, he would be submitting a self-report to HHSC, and conducting a thorough investigation. During an interview on 07/30/24 at 12:32 PM, the DON stated she could not remember the date of when she was notified of the incident between Resident #1 and CNA A. She stated she believed it was in the middle of July (2024). She stated she interviewed CNAs B and C but did not have any documentation except for the witness statement she obtained that day from CNA A. She stated she was told that CNA A wet the bottom of Resident #1's pajamas in the shower room. She stated when she told CNA A to do whatever it took to give Resident #1 a shower, she stated she meant to encourage her. She stated spraying her with water would be mean. She stated she did take CNA A off the schedule and sent her home. She stated she did not tell the ADM sooner because she was still in the investigation stage. She stated the OT also notified her of the incident and he may remember the date more clearly. During an interview on 07/30/24 at 12:48 PM, the OT stated he received a text message from another therapist he worked with on 07/02/24 detailing the abusive incident between Resident #1 and CNA A. He stated because he received it in the evening, he notified the DON the next day first thing. He stated he read the text message to her and she did not seem that concerned. He stated about 2-3 days later he saw CNA A working on Resident #1's hall and noticed Resident #1 was visibly upset. He stated he went to the DON and asked her why she would have working on Resident #1's hallway as she was traumatized by the incident that had happened. He stated the DON appeared unaffected and stated, Oh, I did not know she was working on the same hall. He stated CNA A should not have bee able to work at all at this time because all residents were being put at risk of further abuse. Review of the facility's undated Abuse Prevention and Investigation Policy reflected the following: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit abuse . .V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation. . 3. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; . 6. Providing complete and thorough documentation of the investigation. VI. Protection of the 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 DON and RADM were notified on 07/30/24 at 3:01 PM that an Immediate Jeopardy had been identified due to the above failures and an IJ template was provided. The following POR was accepted on 08/01/24 at 4:53 PM: F607 - Plan Of Removal On 7/30/2024 the surveyor provided an Immediate Jeopardy template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to the resident health and safety. The notification of Immediate Jeopardy states as follows: F607 - The facility must develop and implement written policies and procedures that prohibit and prevent abuse. The facility failed to follow their policies and procedures related to abuse. The facility failed to ensure CNA A was suspended/terminated or removed from working with Resident #1 after the incident, causing more emotional distress. Action: *Administrator self-reported the incident on 7/30/2024 to HHSC via online portal through (reporting system), report # 521272. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*Medical Director was informed of the IJ on 7/30/2024 at approx. 4:00pm and an adhoc QAPI meeting was held. In attendance were the MD, Administrator, Regional Administrator, and Regional Nurse. Discussion included what transpired leading up to the IJ, the content of the allegations and the alleged incident, personnel involved, what possibly lead to the events that caused the IJ, retraining topics, and resident care plan. *The Regional Administrator or Administrator began re-in-servicing all staff on Abuse/Neglect/Exploitation policy and procedures, specifically who to notify (Abuse Coordinator, Administrator) or in their absence (Regional leadership, Corporate Compliance), and to take immediate action to ensure residents are not abused by staff, and actions are followed per policy and procedure once leadership is made aware for the protection of all residents in the facility. If abuse/neglect/exploitation is suspected, it is the witnesses responsibility to report directly to the Abuse Coordinator, or Corporate Compliance should there be a concern. Resident safety is paramount, and it is expected that all residents are treated with dignity and respect at all times. Should an unsatisfactory response or action be given by any person regardless of position, it is the reporters responsibility to ensure actions are taken to safeguard the resident. Additionally, education is provided by Regional Administrator or Administrator for understanding of residents rights, and their right to refuse care. Should the person receiving report provide an unsatisfactory response, this individual will receive disciplinary action. *Post test will be provided to staff covering training of ANE/Resident Rights, and employee understanding will be measured by being required to successfully answer all post test questions. Additionally, the administrator will interview 3 random staff and 3 random alert and oriented residents to ensure understanding. *Alleged Perpetrator was terminated out of the system effective 7/30/2024, and call was made by Regional Administrator to employee to inform the status change. *1:1 education was completed on 7/30/2024 by Regional Administrator and Administrator with DON regarding investigating, reporting, and addressing all allegations of ANE, including disciplinary action. While the DON has formal oversight of the nursing personnel to include agency/PRN/new staff, the Administrator will ensure education is provided to all staff regarding ANE/Resident Rights prior to their next shift. *1:1 education was completed on 7/31/2024 at 10:15am by Administrator with witness CNA#1, regarding immediate safeguarding of the residents, including but not limited to removing the resident themselves from the situation, ensuring resident safety by removing the threat, and using best judgement to ensure the resident is in a safe location before reporting to the Abuse Coordinator/Corporate Compliance. Per policy: F. Responding immediately to protect the alleged victim and integrity of the investigation; G. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; H. Increased supervision of the alleged victim and residents; (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	I. Providing emotional support and counseling to the resident during and after the investigation, as needed; J. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse. *1:1 education was completed on 7/31/2024 at 11:30am by Administrator with witness CNA#2, regarding immediate safeguarding of the residents, including but not limited to removing the resident themselves from the situation, ensuring resident safety by removing the threat, and using best judgement to ensure the resident is in a safe location before reporting to the Abuse Coordinator/Corporate Compliance. Per policy: F. Responding immediately to protect the alleged victim and integrity of the investigation; G. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; H. Increased supervision of the alleged victim and residents; I. Providing emotional support and counseling to the resident during and after the investigation, as needed; J. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse. *Resident #1 was informed by the Administrator that the alleged perpetrator was terminated, and that the Administrator was going to ensure staff are educated on ANE/Resident Rights and held accountable by the Administrator to safeguard the residents. Resident # 1 remains on Psych Services. *All new hires will meet with Administrator before working a shift 1:1 to ensure understanding of ANE Policy and Procedures and will sign an acknowledgement attesting to the training *PRN/Agency staff will be educated on ANE/Resident Rights upon arrival by Administrator or designee, and resource binder left at the nurses station to reference for quick access for Policy and Procedures related to ANE/Resident Rights. Start Date: 07/30/2024 4:00pm Completion Date: Prior to any staff coming on shift, education will be provided and post test given and employee understanding will be measured by being required to successfully answer all post test questions. Additionally, the administrator will interview 3 random staff and 3 random alert and oriented residents to ensure understanding. Target Audience: All staff Responsible person: Regional Administrator or Administrator (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	How do you evaluate effectiveness: Administrator will begin completing interviews beginning 8/5/2024 of at least 3 random staff, and 3 random alert and oriented residents a week regarding ANE expectations, who to report to, when, how, and expectations of safe guarding residents who are suspected to be victim of ANE. This will be tracked via spreadsheet and will remain in effect for at least 3 months, or until substantial compliance is achieved. Information will be reviewed during QAPI and findings adjusted as necessary. The Surveyor monitored the POR on 08/02/24 as followed: During an interview on 08/02/24 at 11:18 AM, the ADM stated staff were being in-serviced before working the floor. He stated after further investigation, the DON was let go from the facility. During interviews on 08/02/24 from 11:29 AM - 2:38 PM, one RN, two LVNs, three CNAs, a HSK, and the TS (from different shifts) all stated they were in-serviced and took a post-test before working their shifts. All were able to state that their ADM was the Abuse and Neglect Coordinator and give examples of different types of abuse such as physical, verbal, emotional, and psychosocial. All stated if they saw a resident being abused by a staff member, another resident, or a family member they would intervene to ensure the resident was in a safe space and would notify the ADM immediately. They all stated if the ADM or DON was not immediately available, they would call the corporate hotline that was in the breakroom to notify the RADM. They all stated it was important to notify the ADM because he needed to conduct a thorough investigation, ensure residents safety, and report to the appropriate agencies. Each staff member stated residents had the right to refuse care, such as showers, and should never be forced to do something they did not want to do. During an interview on 08/02/24 at 2:46 PM, Resident #1 stated the ADM had spoken to her about the actions taken and she was just glad the CNA (CNA A) was no longer working at the facility. She stated she felt safe and had no further concerns. Review of Safe Surveys, dated 07/30/24, reflected all residents were interviewed regarding their safety with no concerns. Review of the facility's Ad Hoc QAPI Meeting Minutes, dated 07/30/24, reflected the ADM, RADM, RegN, and MD were in attendance. Review of a Disciplinary Notice, dated 07/30/24, reflected the DON received a final warning due to the following: [The DON] failed to investigate and report an allegation of abuse and neglect. This failure resulted in 4 IJ's being declared on 07/30/24. [The DON] failed to follow the abuse and neglect policy, also did not file a self-report with HHSC as required. Further investigation is on-going. Additional disciplinary actions will be determined upon completion of internal investigation. Review of an in-service, dated 07/31/24 and conducted by the RADM, reflected the ADM had a 1:1 training to review abuse, neglect and exploitation, investigation steps, and the reporting policy. Review of an in-service, dated 07/31/24 and conducted by the RADM, reflected the SW a 1:1 training to review abuse, neglect and exploitation, the reporting policy, and SW action steps. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of an in-service, dated 07/31/24 and conducted by the ADM, reflected CNA B had a 1:1 training to review and discuss ANE/Reporting Policy and Procedures. Review of an in-service, dated 07/31/24 and conducted by the ADM, reflected CNA C had a 1:1 training to review and discuss ANE/Reporting Policy and Procedures. Review of in-services, dated 07/30/24 - 08/01/24 and conducted by the ADM, reflected staff from all shifts were in-serviced on ANE policy and procedures, the Abuse and Neglect Coordinator, reporting, resident rights (right to refuse care), and corporate compliance. Review of Abuse Post-Tests, dated 07/30/24 - 08/01/24, reflected all staff completed the test with passing scores. While the IJ was removed on 08/02/24 at 3:00 PM, the facility remained at a level of actual no actual harm at a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on interview and record review, the facility failed to ensure all alleged violations involving abuse or neglect were reported to the facility Administrator immediately but no later than 2 hours for one (Resident #1) of four residents reviewed for abuse and neglect. The facility failed to notify their Abuse and Neglect Coordinator (The ADM) within 2 hours when CNA A forcefully dragged Resident #1 to the shower room and sprayed her while still wearing her clothes while she was screaming and crying in June of 2024. The DON was notified and failed to take any action to protect Resident #1 from further abuse as CNA A continued to work at the facility and with Resident #1 and continued to emotionally abuse her. CNAs B and C did not intervene during the incident. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 07/30/24 at 3:01 PM. While the IJ was removed on 08/02/24 at 3:00 PM, the facility remained at a level of actual no actual harm at a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure placed residents at risk of abuse, trauma, and psychosocial harm. Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including major depressive disorder, anxiety disorder, and unspecified psychosis . Review of Resident #1's quarterly MDS assessment, dated 06/05/24, reflected a BIMS score of 14, indicating she was cognitively intact. Section GG (Functional Abilities and Goals) reflected she needed setup or clean-up assistance with Showering and did not require a wheelchair or walker for ambulating. Review of Resident #1's quarterly care plan, dated 06/07/24, reflected she required assistance with ADLs with an intervention of assisting with ADLs as needed. Review of a witness statement, dated 07/30/24 and documented by CNA C, reflected the following: (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Around July or June (2024) me and my coworkers were working on 500 hall. Me and 2 other coworkers and it was [Resident #1]'s shower day. I had asked her if she wanted to shower and she said no so I left it at that. My other coworker (CNA A) comes in and says that the DON said to do whatever it takes to get her in the shower cause [sic] she hadn't had one in months. She then grabbed [Resident #1] by the arm and forced her to shower meanwhile [Resident #1] was screaming and telling her that she didn't want to shower. I left then went into the shower room to get gloves and saw [CNA A] wet her clothes to get her to sit down. A couple minutes later [Resident #1] storms out of the shower room mad then goes to her room. Me and [CNA B] were passing snacks and [Resident #1] ten comes to us and throws us chunks of her hair . [Resident #1] did let therapy know and she described who it was. Review of the text message received by the OT, dated 07/02/24, reflected the following: . [CNA B] pulled me aside to tell me that [CNA A] showered [Resident #1] a couple weeks ago against her will because the DON told them to make it happen. So [CNA B] said that [CNA A] pulled [Resident #1] down the hall with her trying to fight her. Evidently [Resident #1] was put in the shower with her clothes on bc [sic] she refused to take them off and [CNA A] sprayed [Resident #1] down with the shower spray anyway. [CNA A] then took the clothes off [Resident #1] bc [sic] they were wet and changed her into dry clothes. [CNA B] stated that [CNA A] combed her hair so aggressively that it pulled a lot of her hair out. [Resident #1] has been worried about her hair falling out every time I have showered her . Review of Staffing Sheets, from 06/01/24 - 07/30/24, reflected CNA A worked the following days: 06/05/24 - Resident #1's hall 06/06/24 - Resident #1's hall 06/08/24 06/09/24 - Resident #1's hall 06/10/24 06/11/24 - Resident #1's hall 06/12/24 06/13/24 06/17/24 06/18/24 - Resident #1's hall 06/19/24 - Resident #1's hall 06/20/24 06/22/24 - Resident #1's hall (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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	06/23/24 06/26/24 06/28/24 06/29/24 06/30/24 - Resident #1's hall 07/01/24 - Resident #1's hall 07/08/24 07/11/24 - Resident #1's hall 07/14/24 07/17/24 - Resident #1's hall 07/18/24 07/19/24 - Resident #1's hall During an interview on 07/30/24 at 10:21 AM, Resident #1 stated a few weeks ago CNA A dragged her to the shower room even though she was screaming and crying and did not want to shower. She stated once they got into the shower room, she sprayed her down with water until her clothes were soaked. She stated CNA A took a picture of her and was laughing and making fun of her. She stated she felt humiliated and had feared her ever since. She stated she felt so helpless as she could not fight back. She stated CNA A brushed her hair so rough she had chunks coming off her head. She stated she continued to mess with her even after that day and she had been miserable. She stated she was not sure if she worked there anymore because she had not seen her in at least a week and never wanted to see her again. During an interview on 07/30/24 at 10:38 AM, CNA B stated sometime back in June (2024) she walked into the shower room and saw CNA A spraying Resident #1 with the shower head. She stated she was so appalled she had to walk out. She stated she and CNA C had initially walked in because they heard Resident #1 screaming and crying. She stated CNA A was laughing the whole time. She stated she notified the DON and everyone knew about it. She stated the DON told everyone CNA A had been fired but she did not get fired until the week prior for something unrelated to the incident. She stated after the incident, CNA A continued to work on the same hall and would often go into Resident #1's room and taunt her. She stated she would laugh and ask her, Do you want a shower today? She stated Resident #1 had been a mess and very distraught. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676226	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cypress Healthcare and Rehabilitation Center	1351 Sadler San Marcos, TX 78666

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 07/30/24 at 10:52 AM, CNA C stated it had been at least over a month since the incident with Resident #1 and CNA A. She stated Resident #1 refused showers a lot and CNA A told her the DON told her to do whatever it took to give her a shower. She stated she witnessed CNA A drag Resident #1 to the shower room while she was resisting and screaming. She stated she went into the shower room and saw CNA A spraying her with the shower head to get her to sit down on the shower chair while she continued to scream and cry. She stated CNA A was laughing and saying things like, You stinky! You stink! She stated eventually Resident #1 stormed out of the shower room and then threw chunks of her hair on the ground. She stated she and CNA B had spoken to the DON about it and were even interviewed separately. She stated CNA A continued to work on the same hall and taunt Resident #1 she had been irritated and scared . She stated Resident #1 had been affected by the whole thing and she believed it had been abusive. During a telephone interview on 07/30/24 at 12:25 PM, the ADM stated he was not notified by the DON of the incident involving Resident #1 and CNA A until that day (07/30/24). He stated the DON told him she had not been made aware of the incident until 07/19/24. He stated he was informed Resident #1 was refusing a shower and CNA A sprayed her with water. He stated CNA A was now suspended, he would be submitting a self-report to HHSC, and conducting a thorough investigation. During an interview on 07/30/24 at 12:32 PM, the DON stated she could not remember the date of when she was notified of the incident between Resident #1 and CNA A. She stated she believed it was in the middle of July (2024). She stated she interviewed CNAs B and C but did not have any documentation except for the witness statement she obtained that day from CNA A. She stated she was told that CNA A wet the bottom of Resident #1's pajamas in the shower room. She stated when she told CNA A to do whatever it took to give Resident #1 a shower, she stated she meant to encourage her. She stated spraying her with water would be mean. She stated she did take CNA A off the schedule and sent her home. She stated she did not tell the ADM sooner because she was still in the investigation stage. She stated the OT also notified her of the incident and he may remember the date more clearly. During an interview on 07/30/24 at 12:48 PM, the OT stated he received a text message from another therapist he worked with on 07/02/24 detailing the abusive incident between Resident #1 and CNA A. He stated because he received it in the evening, he notified the DON the next day first thing . He stated he read the text message to her and she did not seem that concerned. He stated about 2-3 days later he saw CNA A working on Resident #1's hall and noticed Resident #1 was visibly upset. He stated he went to the DON and asked her why she would have working on Resident #1's hallway as she was traumatized by the incident that had happened. He stated the DON appeared unaffected and stated, Oh, I did not know she was working on the same hall. He stated CNA A should not have bee able to work at all at this time because all residents were being put at risk of further abuse. Review of the facility's undated Abuse Prevention and Investigation Policy reflected the following: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit abuse . . 2. The facility has designated the Administrator as the Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law . (continued on next page)

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	676226	A. Building B. Wing	08/02/2024

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The DON and RADM were notified on 07/30/24 at 3:01 PM that an Immediate Jeopardy had been identified due to the above failures and an IJ template was provided. The following POR was accepted on 08/01/24 at 4:53 PM: F609 - Plan Of Removal On 7/30/2024 the surveyor provided an Immediate Jeopardy template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to the resident health and safety. The notification of Immediate Jeopardy states as follows: F609 ' The facility must ensure all allegations of abuse are reported immediately but no more than two hours after the allegation is made. The facility failed to ensure the safety of Resident #1 during and after she was physically dragged into the shower room by CNA A, sprayed with the shower head in her full clothes to get her to sit down, all the while screaming and crying. The facility did not self-report this allegation the Administrator. Action: *Administrator self-reported the incident on 7/30/2024 to HHSC via online portal through TULIP , report # 521272. *Medical Director was informed of the IJ on 7/30/2024 at approx. 4:00pm and an adhoc QAPI meeting was held. In attendance were the MD, Administrator, Regional Administrator, and Regional Nurse. Discussion included what transpired leading up to the IJ, the content of the allegations and the alleged incident, personnel involved, what possibly lead to the events that caused the IJ, retraining topics, and resident care plan. *The Regional Administrator or Administrator began re-in-servicing all staff on Abuse/Neglect/Exploitation policy and procedures, specifically who to notify (Abuse Coordinator, Administrator) or in their absence (Regional leadership, Corporate Compliance), and to take immediate action to ensure residents are not abused by staff, and actions are followed per policy and procedure once leadership is made aware for the protection of all residents in the facility. If abuse/neglect/exploitation is suspected, it is the witnesses responsibility to report directly to the Abuse Coordinator, or Corporate Compliance should there be a concern. Resident safety is paramount, and it is expected that all residents are treated with dignity and respect at all times. Should an unsatisfactory response or action be given by any person regardless of position, it is the reporters responsibility to ensure actions are taken to safeguard the resident. Additionally, education is provided by Regional Administrator or Administrator for understanding of residents rights, and their right to refuse care. Should the person receiving report provide an unsatisfactory response, this individual will receive disciplinary action. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*Post test will be provided to staff covering training of ANE/Resident Rights, and employee understanding will be measured by being required to successfully answer all post test questions. Additionally, the administrator will interview 3 random staff and 3 random alert and oriented residents to ensure understanding. *Alleged Perpetrator was terminated out of the system effective 7/30/2024, and call was made by Regional Administrator to employee to inform the status change. *1:1 education was completed on 7/30/2024 by Regional Administrator and Administrator with DON regarding investigating, reporting, and addressing all allegations of ANE, including disciplinary action. While the DON has formal oversight of the nursing personnel to include agency/PRN /new staff, the Administrator will ensure education is provided to all staff regarding ANE/Resident Rights prior to their next shift. *1:1 education was completed on 7/31/2024 at 10:15am by Administrator with witness CNA#1, regarding immediate safeguarding of the residents, including but not limited to removing the resident themselves from the situation, ensuring resident safety by removing the threat, and using best judgement to ensure the resident is in a safe location before reporting to the Abuse Coordinator/Corporate Compliance. Per policy: K. Responding immediately to protect the alleged victim and integrity of the investigation; L. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; M. Increased supervision of the alleged victim and residents; N. Providing emotional support and counseling to the resident during and after the investigation, as needed; O. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse. *1:1 education was completed on 7/31/2024 at 11:30am by Administrator with witness CNA#2, regarding immediate safeguarding of the residents, including but not limited to removing the resident themselves from the situation, ensuring resident safety by removing the threat, and using best judgement to ensure the resident is in a safe location before reporting to the Abuse Coordinator/Corporate Compliance. Per policy: K. Responding immediately to protect the alleged victim and integrity of the investigation; L. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; M. Increased supervision of the alleged victim and residents; N. Providing emotional support and counseling to the resident during and after the investigation, as needed; (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	O. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse. *Resident #1 was informed by the Administrator that the alleged perpetrator was terminated, and that the Administrator was going to ensure staff are educated on ANE/Resident Rights and held accountable by the Administrator to safeguard the residents. Resident # 1 remains on Psych Services. *All new hires will meet with Administrator before working a shift 1:1 to ensure understanding of ANE Policy and Procedures and will sign an acknowledgement attesting to the training *PRN/Agency staff will be educated on ANE/Resident Rights upon arrival by Administrator or designee, and resource binder left at the nurses station to reference for quick access for Policy and Procedures related to ANE/Resident Rights. Start Date: 07/30/2024 4:00pm Completion Date: Prior to any staff coming on shift, education will be provided and post test given and employee understanding will be measured by being required to successfully answer all post test questions. Additionally, the administrator will interview 3 random staff and 3 random alert and oriented residents to ensure understanding. Target Audience: All staff Responsible person: Regional Administrator or Administrator How do you evaluate effectiveness: Administrator will begin completing interviews beginning 8/5/2024 of at least 3 random staff, and 3 random alert and oriented residents a week regarding ANE expectations, who to report to, when, how, and expectations of safe guarding residents who are suspected to be victim of ANE. This will be tracked via spreadsheet and will remain in effect for at least 3 months, or until substantial compliance is achieved. Information will be reviewed during QAPI and findings adjusted as necessary. The Surveyor monitored the POR on 08/02/24 as followed: During an interview on 08/02/24 at 11:18 AM, the ADM stated staff were being in-serviced before working the floor. He stated after further investigation, the DON was let go from the facility. During interviews on 08/02/24 from 11:29 AM - 2:38 PM, one RN, two LVNs, three CNAs, a HSK, and the TS (from different shifts) all stated they were in-serviced and took a post-test before working their shifts. All were able to state that their ADM was the Abuse and Neglect Coordinator and give examples of different types of abuse such as physical, verbal, emotional, and psychosocial. All stated if they saw a resident being abused by a staff member, another resident, or a family member they would intervene to ensure the resident was in a safe space and would notify the ADM immediately. They all stated if the ADM or DON was not immediately available, they would call the corporate hotline that was in the breakroom to notify the RADM. They all stated it was important to notify the ADM because he needed to conduct a thorough investigation, ensure residents safety, and report to the appropriate agencies. Each staff member stated residents had the right to refuse care, such as showers, and should never be forced to do something they did not want to do. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 08/02/24 at 2:46 PM, Resident #1 stated the ADM had spoken to her about the actions taken and she was just glad the CNA (CNA A) was no longer working at the facility. She stated she felt safe and had no further concerns. Review of Safe Surveys, dated 07/30/24, reflected all residents were interviewed regarding their safety with no concerns. Review of the facility's Ad Hoc QAPI Meeting Minutes, dated 07/30/24, reflected the ADM, RADM, RegN, and MD were in attendance. Review of a Disciplinary Notice, dated 07/30/24, reflected the DON received a final warning due to the following: [The DON] failed to investigate and report an allegation of abuse and neglect. This failure resulted in 4 IJ's being declared on 07/30/24. [The DON] failed to follow the abuse and neglect policy, also did not file a self-report with HHS as required. Further investigation is on-going. Additional disciplinary actions will be determined upon completion of internal investigation. Review of an in-service, dated 07/31/24 and conducted by the RADM, reflected the ADM had a 1:1 training to review abuse, neglect and exploitation, investigation steps, and the reporting policy. Review of an in-service, dated 07/31/24 and conducted by the RADM, reflected the SW had a 1:1 training to review abuse, neglect and exploitation, the reporting policy, and SW action steps. Review of an in-service, dated 07/31/24 and conducted by the ADM, reflected CNA B had a 1:1 training to review and discuss ANE/Reporting Policy and Procedures. Review of an in-service, dated 07/31/24 and conducted by the ADM, reflected CNA C had a 1:1 training to review and discuss ANE/Reporting Policy and Procedures. Review of in-services, dated 07/30/24 - 08/01/24 and conducted by the ADM, reflected staff from all shifts were in-serviced on ANE policy and procedures, the Abuse and Neglect Coordinator, reporting, resident rights (right to refuse care), and corporate compliance. Review of Abuse Post-Tests, dated 07/30/24 - 08/01/24, reflected all staff completed the test with passing scores. While the IJ was removed on 08/02/24 at 3:00 PM, the facility remained at a level of actual no actual harm at a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on interview and record review, the facility failed to, in response to allegations of abuse, neglect or mistreatment, have evidence that all alleged violations were thoroughly investigated for one (Resident #1) of four residents reviewed for abuse and neglect. The facility failed to investigate an allegation of abuse when CNA A forcefully dragged Resident #1 to the shower room and sprayed her while still wearing her clothes while she was screaming and crying in June of 2024. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 07/30/24 at 3:01 PM. While the IJ was removed on 08/02/24 at 3:00 PM, the facility remained at a level of actual no actual harm at a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure placed residents at risk of abuse, trauma, and psychosocial harm. Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including major depressive disorder, anxiety disorder, and unspecified psychosis . Review of Resident #1's quarterly MDS assessment, dated 06/05/24, reflected a BIMS score of 14, indicating she was cognitively intact. Section GG (Functional Abilities and Goals) reflected she needed setup or clean-up assistance with Showering and did not require a wheelchair or walker for ambulating. Review of Resident #1's quarterly care plan, dated 06/07/24, reflected she required assistance with ADLs with an intervention of assisting with ADLs as needed. Review of a witness statement, dated 07/30/24 and documented by CNA C, reflected the following: Around July or June (2024) me and my coworkers were working on 500 hall. Me and 2 other coworkers and it was [Resident #1]'s shower day. I had asked her if she wanted to shower and she said no so I left it at that. My other coworker (CNA A) comes in and says that the DON said to do whatever it takes to get her in the shower cause [sic] she hadn't had one in months. She then grabbed [Resident #1] by the arm and forced her to shower meanwhile [Resident #1] was screaming and telling her that she didn't want to shower. I left then went into the shower room to get gloves and saw [CNA A] wet her clothes to get her to sit down. A couple minutes later [Resident #1] storms out of the shower room mad then goes to her room. Me and [CNA B] were passing snacks and [Resident #1] ten comes to us and throws us chunks of her hair . [Resident #1] did let therapy know and she described who it was. Review of the text message received by the OT, dated 07/02/24, reflected the following: (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	. [CNA B] pulled me aside to tell me that [CNA A] showered [Resident #1] a couple weeks ago against her will because the DON told them to make it happen. So [CNA B] said that [CNA A] pulled [Resident #1] down the hall with her trying to fight her. Evidently [Resident #1] was put in the shower with her clothes on bc [sic] she refused to take them off and [CNA A] sprayed [Resident #1] down with the shower spray anyway. [CNA A] then took the clothes off [Resident #1] bc [sic] they were wet and changed her into dry clothes. [CNA B] stated that [CNA A] combed her hair so aggressively that it pulled a lot of her hair out. [Resident #1] has been worried about her hair falling out every time I have showered her . Review of Staffing Sheets, from 06/01/24 - 07/30/24, reflected CNA A worked the following days: 06/05/24 - Resident #1's hall 06/06/24 - Resident #1's hall 06/08/24 06/09/24 - Resident #1's hall 06/10/24 06/11/24 - Resident #1's hall 06/12/24 06/13/24 06/17/24 06/18/24 - Resident #1's hall 06/19/24 - Resident #1's hall 06/20/24 06/22/24 - Resident #1's hall 06/23/24 06/26/24 06/28/24 06/29/24 06/30/24 - Resident #1's hall 07/01/24 - Resident #1's hall (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	07/08/24 07/11/24 - Resident #1's hall 07/14/24 07/17/24 - Resident #1's hall 07/18/24 07/19/24 - Resident #1's hall During an interview on 07/30/24 at 10:21 AM, Resident #1 stated a few weeks ago CNA A dragged her to the shower room even though she was screaming and crying and did not want to shower. She stated once they got into the shower room, she sprayed her down with water until her clothes were soaked. She stated CNA A took a picture of her and was laughing and making fun of her. She stated she felt humiliated and had feared her ever since. She stated she felt so helpless as she could not fight back. She stated CNA A brushed her hair so rough she had chunks coming off her head. She stated she continued to mess with her even after that day and she had been miserable. She stated she was not sure if she worked there anymore because she had not seen her in at least a week and never wanted to see her again. During an interview on 07/30/24 at 10:38 AM, CNA B stated sometime back in June (2024) she walked into the shower room and saw CNA A spraying Resident #1 with the shower head. She stated she was so appalled she had to walk out. She stated she and CNA C had initially walked in because they heard Resident #1 screaming and crying. She stated CNA A was laughing the whole time. She stated she notified the DON and everyone knew about it. She stated the DON told everyone CNA A had been fired but she did not get fired until the week prior for something unrelated to the incident. She stated after the incident, CNA A continued to work on the same hall and would often go into Resident #1's room and taunt her. She stated she would laugh and ask her, Do you want a shower today? She stated Resident #1 had been a mess and very distraught. During an interview on 07/30/24 at 10:52 AM, CNA C stated it had been at least over a month since the incident with Resident #1 and CNA A. She stated Resident #1 refused showers a lot and CNA A told her the DON told her to do whatever it took to give her a shower. She stated she witnessed CNA A drag Resident #1 to the shower room while she was resisting and screaming. She stated she went into the shower room and saw CNA A spraying her with the shower head to get her to sit down on the shower chair while she continued to scream and cry. She stated CNA A was laughing and saying things like, You stinky! You stink! She stated eventually Resident #1 stormed out of the shower room and then threw chunks of her hair on the ground. She stated she and CNA B had spoken to the DON about it and were even interviewed separately. She stated CNA A continued to work on the same hall and taunt Resident #1 she had been irritated and scared . She stated Resident #1 had been affected by the whole thing and she believed it had been abusive. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 07/30/24 at 12:25 PM, the ADM stated he was not notified by the DON of the incident involving Resident #1 and CNA A until that day (07/30/24). He stated the DON told him she had not been made aware of the incident until 07/19/24. He stated he was informed Resident #1 was refusing a shower and CNA A sprayed her with water. He stated CNA A was now suspended, he would be submitting a self-report to HHSC, and conducting a thorough investigation. During an interview on 07/30/24 at 12:32 PM, the DON stated she could not remember the date of when she was notified of the incident between Resident #1 and CNA A. She stated she believed it was in the middle of July (2024). She stated she interviewed CNAs B and C but did not have any documentation except for the witness statement she obtained that day from CNA A. She stated she was told that CNA A wet the bottom of Resident #1's pajamas in the shower room. She stated when she told CNA A to do whatever it took to give Resident #1 a shower, she stated she meant to encourage her. She stated spraying her with water would be mean. She stated she did take CNA A off the schedule and sent her home. She stated she did not tell the ADM sooner because she was still in the investigation stage . She stated the OT also notified her of the incident and he may remember the date more clearly. During an interview on 07/30/24 at 12:48 PM, the OT stated he received a text message from another therapist he worked with on 07/02/24 detailing the abusive incident between Resident #1 and CNA A. He stated because he received it in the evening, he notified the DON the next day first thing. He stated he read the text message to her and she did not seem that concerned. He stated about 2-3 days later he saw CNA A working on Resident #1's hall and noticed Resident #1 was visibly upset. He stated he went to the DON and asked her why she would have working on Resident #1's hallway as she was traumatized by the incident that had happened . He stated the DON appeared unaffected and stated, Oh, I did not know she was working on the same hall. He stated CNA A should not have been able to work at all at this time because all residents were being put at risk of further abuse. Review of the facility's undated Abuse Prevention and Investigation Policy reflected the following: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit abuse . .V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation. . 3. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; . 6. Providing complete and thorough documentation of the investigation. (continued on next page)

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	676226	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cypress Healthcare and Rehabilitation Center	1351 Sadler San Marcos, TX 78666

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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	VI. Protection of the 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 DON and RADM were notified on 07/30/24 at 3:01 PM that an Immediate Jeopardy had been identified due to the above failures and an IJ template was provided. The following POR was accepted on 08/01/24 at 4:53 PM: F610 - Plan Of Removal On 7/30/2024 the surveyor provided an Immediate Jeopardy template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to the resident health and safety. The notification of Immediate Jeopardy states as follows: F610 - In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must have evidence that all alleged violations are thoroughly investigated. The facility failed to thoroughly investigate an allegation of abuse after the DON was notified of an incident with CNA A and Resident #1 when she was physically dragged into the shower room by CNA A, sprayed with the shower head in her full clothes to get her to sit down, all the while screaming and crying. Action: *Administrator self-reported the incident on 7/30/2024 to HHSC via online portal through TULIP , report # 521272. *Medical Director was informed of the IJ on 7/30/2024 at approx. 4:00pm and an adhoc QAPI meeting was held. In attendance were the MD, Administrator, Regional Administrator, and Regional Nurse. Discussion included what transpired leading up to the IJ, the content of the allegations and the alleged incident, personnel involved, what possibly lead to the events that caused the IJ, retraining topics, and resident care plan. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*1:1 education was completed on 7/31/2024 at 11:30am by Administrator with witness CNA#2, regarding immediate safeguarding of the residents, including but not limited to removing the resident themselves from the situation, ensuring resident safety by removing the threat, and using best judgement to ensure the resident is in a safe location before reporting to the Abuse Coordinator/Corporate Compliance. Per policy: P. Responding immediately to protect the alleged victim and integrity of the investigation; Q. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; R. Increased supervision of the alleged victim and residents; S. Providing emotional support and counseling to the resident during and after the investigation, as needed; T. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse. *Resident #1 was informed by the Administrator that the alleged perpetrator was terminated, and that the Administrator was going to ensure staff are educated on ANE/Resident Rights and held accountable by the Administrator to safeguard the residents. Resident # 1 remains on Psych Services. *All new hires will meet with Administrator before working a shift 1:1 to ensure understanding of ANE Policy and Procedures and will sign an acknowledgement attesting to the training *PRN/Agency staff will be educated on ANE/Resident Rights upon arrival by Administrator or designee, and resource binder left at the nurses station to reference for quick access for Policy and Procedures related to ANE/Resident Rights. Start Date: 07/30/2024 4:00pm Completion Date: Prior to any staff coming on shift, education will be provided and post test given and employee understanding will be measured by being required to successfully answer all post test questions. Additionally, the administrator will interview 3 random staff and 3 random alert and oriented residents to ensure understanding. Target Audience: All staff Responsible person: Regional Administrator or Administrator How do you evaluate effectiveness: Administrator will begin completing interviews beginning 8/5/2024 of at least 3 random staff, and 3 random alert and oriented residents a week regarding ANE expectations, who to report to, when, how, and expectations of safe guarding residents who are suspected to be victim of ANE. This will be tracked via spreadsheet and will remain in effect for at least 3 months, or until substantial compliance is achieved. Information will be reviewed during QAPI and findings adjusted as necessary. (continued on next page)

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