STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676237	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Belmont at Twin Creeks	999 Raintree Circle Allen, TX 75013

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 51181 Based on observation, interviews, and record review, the facility failed to ensure the right to be free from abuse was provided for 1 (Resident #1) of 6 residents reviewed for abuse and neglect. The facility failed to protect Resident #1 from abuse when CNA A was witnessed being verbally and physically abusive to Resident #1, resulting in Resident #1 becoming fearful of CNA A. The noncompliance was identified as PNC. The noncompliance began on 12/23/24 and ended on 12/27/24. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for abuse and neglect. Findings included: Review of Resident #1's Annual Minimum Data Set (MDS), dated 01/26/2025, reflected she was an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including depression (a mood disorder that causes persistent feelings of sadness, emptiness, and loss of joy, fibromyalgia (a chronic disorder characterized by widespread musculoskeletal pain, fatigue, and trouble sleeping, it occurs in the absence of an identifiable physical or physiological cause). Resident #1 had a Brief Interview for Mental Status (BIMS) score of 10, reflecting mild cognitive impairment. The MDS also revealed Resident #1 required extensive assistance with Activities of Daily Living (ADL). During an interview and observation of Resident #1 on 01/30/2025 at 10:05 a.m., Resident #1 reported an incident in early December involving CNA A and CNA B. While CNA A was providing incontinent care, Resident #1 asked CNA A to stop rolling her over due to pain, but CNA A continued despite protest from both Resident #1 and CNA B. Resident #1 stated CNA A was verbally abusive during the interaction, though she could not recall the exact words used. The physical handling caused Resident #1 pain, and she became fearful that CNA A would harm or kill her. Resident #1 reported the incident to multiple staff members but was initially told no one matching CNA A's description or name worked at the facility. Weeks later, Resident #1 recognized CNA A during an activity and confronted her, learning that CNA A had provided a false name during the incident. Resident #1 reported this to the ADON and the DON. Resident #1 stated she had only seen CNA A one time since the initial occurrence and CNA A did not provide her care before that incident nor after. Resident #1 stated she feels safe living in the facility and receiving care. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER The Belmont at Twin Creeks		STREET ADDRESS, CITY, STATE, ZIP CODE 999 Raintree Circle Allen, TX 75013	

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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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 01/30/2025 at 1:10 PM with LVN A, she reported she worked the 6 a.m. to 2 p.m. shift on Resident #1's hall. The LVN reported Resident #1 reported that she was abused by a CNA. The LVN stated she immediately reported the alleged abuse to the Administrator and the DON. During an interview on 01/30/2025 at 2:45 with Resident #1's FM. FM stated Resident #1 told him when CNA A was rolling her over to her side to change her, Resident #1 said she did it a little aggressively. FM stated he had not heard about the incident from the facility, which is why family installed a camera in Resident #1's room, for added security. He expressed frustration that the facility initially dismissed Resident #1's claims, suggesting she might be fabricating the story, as they did not have a staff member by the name Resident #1 was saying. FM stated soon after this incident he received another call from the facility stating they were going to have his Resident #1 tested by psychology. He stated he thought this was odd because Resident #1's mind is on point. During an interview on 01/30/2025 at 2:30 PM with RN A, the Weekend Supervisor, RN A confirmed Resident #1's account and began conducting interviews of weekend staff. During his interviews, RN A learned from CNA B that she witnessed CNA A abusing Resident #1 and did not report the incident. RN A stated he educated CNA B that if she saw abuse or was unsure if it was abuse that she witnessed, CNA B should have reported the incident. RN A stated he had worked with CNA A before and never had any issues reported to him. RN A stated in speaking with Resident #1, she was unable to provide a date of when the incident occurred, she denied being in pain, and Resident #1 stated that the CNA A providing Resident #1 the wrong name upset her. RN A stated he had called the DON and the Administrator once he became aware of the allegation and that CNA B was suspended but CNA A was not on duty. RN A stated that the following Monday, (12/23/24) CNA A was suspended. RN A stated he was educated on abuse, neglect and reporting allegations of abuse to the abuse coordinator the Administrator, immediately. During an interview on 01/30/2025 at 12:50 PM, CNA B reported she was in the room with CNA A when the incident happened. CNA B said CNA A told Resident #1 to move onto her side for incontinent care and Resident #1 was refusing. She stated Resident #1 was resisting while CNA A was pushing on Resident #1's back to place her onto her side. CNA B said she told CNA A to leave the room numerous times, but she wouldn't. CNA B said CNA A also witnessed CNA B saying to Resident #1 that her FM does not love her and left her here. CNA B said she did not report this incident to management or the abuse coordinator after it happened. CNA B said she made an emotional decision on not to report the abuse. CNA B stated she knew abuse and neglect was supposed to be reported to the Abuse Coordinator, the Administrator immediately but CNA A's living conditions at the time made her hesitant to say anything as she felt bad about CNA A's situation. (continued on next page)

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The Belmont at Twin Creeks	999 Raintree Circle Allen, TX 75013

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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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 01/30/2025 at 3:50 PM, the DON stated she learned about the incident on between Resident #1 and CNA A from RN A. DON stated RN A called on Saturday or Sunday unsure date her to state Resident#1 had a camera put in her room, when DON asked why RN A reported that Resident #1 said she was verbally assaulted but did not state by who. DON stated she immediately called the Administrator and started an investigation. DON stated she directed RN A to talk to as many staff to find out what occurred and that was when CNA B reported she witnessed CNA A be abusive to Resident #1. DON stated prior (unknown date) Resident #1 told her a CNA was rude to her and turned her over too fast to reposition. DON stated around 12/09/24 a grievance was filed related to the information. The DON reported that Resident #1 gave her a name, but they did not have anyone by that name that worked at the facility or fit the physical description of any of their employees. The DON stated a few weeks later Resident #1 said she recognized the CNA that was abuse to her as CNA A and reported this to staff. The DON stated she completed a mental assessment and a physical assessment for injuries and non were found. DON stated that the MD referred Resident #1 to psych service. DON stated CNA A was suspended. She stated CNA B was also suspended for not reporting the abuse. DON stated she spoke to staff who all denied that anything occurred between CNA A and Resident #1. DON stated when talked to Resident #1 the first time Resident #1 said she was not abuse but the second time they spoke Resident #1 expressed she felt abused, and Resident #1 was providing conflicting information. During an interview on 01/30/2025 at 3:15 PM, the ADON reported she was made aware of the alleged abuse by Resident #1 who reported she was abused by a CNA while being provided care. The ADON stated that she and the DON went to interview Resident #1 who gave a description of a person who did not match any of the employed staff. ADON stated that Resident #1 stated the aide was being rude. ADON stated that Resident #1 had reported to RN A a week or two later that an aide had been abusive towards her. ADON stated that while RN A was interviewing, CNA B stated she had witnessed the event between Resident #1 and CNA A. ADON stated that Resident #1 did not express she was in pain during the incident. ADON stated once CNA A was identified as the perpetrator, she was suspended and later terminated from employment. ADON stated she was educated on abuse, neglect and reporting allegations of abuse to the abuse coordinator the Administrator, immediately. During an interview on 01/30/2025 at 4:00 PM, the Administrator stated she learned about the alleged abuse on 12/22/2024 when she reported it. She stated she was contacted by the DON who told her Resident #1 had reported she was abused by a CNA. The Administrator stated a couple of weeks prior to this, Resident #1 reported a CNA was rude to her and the description provided by Resident #1 did not match anyone that worked there. The Administrator stated that she did not feel like Resident #1 was abused. Administrator stated that CNA A was suspended pending the investigation and was then fired. She reported CNA B was fired for not reporting the alleged abuse. The Administrator reported she did not report the alleged abuse on 12/09/2024 because Resident #1 stated she did not feel like the abuse was intentional. Administrator stated that Resident #1 is always reporting abuse and is confused. Administrator stated as a result of the 12/22/24 incident the facility completed in-services on abuse and neglect, when and who to report allegations of abuse to with all staff. Safe surveys were completed, an assessment of Resident #1 was completed for injuries, both aides were terminated from employment. During a follow-up interview on 01/30/25 at 6:17 PM Regional Nurse Consultant, DON and Administrator stated that the facility completed safe surveys on residents, in-serviced all staff on abuse, neglect and when to report allegations of abuse and to whom, the abuse coordinator. Regional Nurse Consultant, DON and Administrator stated that they felt like CNA B stated she was there as there when CNA A abused Resident #1 as there was tension between staff. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER The Belmont at Twin Creeks		STREET ADDRESS, CITY, STATE, ZIP CODE 999 Raintree Circle Allen, TX 75013	

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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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the facility Provider Investigation Report dated 12/27/24, reflected the following: CNA B stated that she witnessed CNA A being unkind and rude to [Resident #1] stated this happened a few weeks ago but did not give a date Resident [#1] had no physical injuries noted, resident stated she felt okay however employee did make her upset . Treatment was not provided. Provider Response: ED notified RDO/RCS/ Executive Director reported Abuse Allegation to HHSC at 11:02 PM on 12/22/24, employee statements collected, Physician, Ombudsman and Family notified. Staff was re-in serviced on Abuse and Neglect and Injuries of Unknown Origin, Staff was re-tested for Abuse and Neglect, Resident Safe Surveys conducted. CNA were suspended. Investigation Summary: the investigation concluded that this claim was inconclusive due to inconsistencies in description and time and place from resident .Facility did terminate both CNA's due to statements by the resident and due to the CNA failing to report to administration. Please see investigation summary for detailed investigation report. (continued on next page)

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F 0600

Level of Harm - Actual harm

Residents Affected - Few

Note: The nursing home is disputing this citation.

Review of Facility External/Internal Investigation Summary dated 12/27/24 reflected the following: incident CNA B stated that she witnessed CNA A being unkind and rude to miss. She stated this happened a few weeks ago but did not give an exact date. Timeline 12/09/24 Resident #1 stated to DON that CNA by the name of [NAME] was rude to her period DON stated that we did not have an employee by that name and asked if she could describe the person. She stated she was tall black and that she had four blonde cornrows on top of her head . DON asked her if she knew what date and times occurred, Resident #1 was unsure of date or time. [DON] asked her if she felt unsafe or that it was verbally abusive Resident #1 stated she felt safe and that she felt the aid was just having a bad day, but it was not verbally abusive. [DON] informed [Resident #1] that we did not have an aide by that name or a nurse by that name and we did not have anyone who fit the description she stated she would let us know if she saw the person again. Family member was notified. [FM] stated [Resident #1] had told him something similar but also knows [Resident #1] has a history of confusion Grievance report was done, and staff interviewed no one knew of incident or employee that matched description. 12/22/24 [DON] received a phone call from the weekend supervisor [RN A] regarding Resident #1 now having a camera in her room . [Resident #1] told the supervisor it was because of aide that was rude and required. [Resident #1] stated the aids name was [the same as CNA A]. [RN A] informed [DON] that [CNA B] had just informed him that she was in the room with [CNA A] when she was being rude to [Resident #1] [CNA B] stated that [CNA A] stated that [Resident #1's] [FM] left her at the facility because they did not love her and did not want to take care of her. [CNA B] also stated that [CNA A] stated that she made a comment that she should be happy someone is there to wipe her ass these statements were never stated to [DON] prior by [Resident #1] . When administrator and [DON] inquired if she had informed anybody of the allegations prior, she stated she had not. Administrator informed her [CNA B] that she was required to inform about any type of abuse or neglect witness suspected or reported. [CNA B] has completed training on abuse neglect prior to this incident stated she did know she should have reported to us. [CNA B] was suspended while investigation was ongoing due to not reporting directly to administrator and timely manner. Facility reported to HHS allegation of verbal abuse .CNA A was informed that she was suspended by pending investigation . Resident Safe Surveys Conducted, Employee interviews conducted, ombudsman and physician notified. 12/23/24 [DON] and [ADON] spoke with [Resident #1] in the morning regarding [CNA A]. [Resident #1] stated she did see the aide she was talking about two week prior going to a Christmas Caroling evening and she had asked the aide who was taking her what her name was, and she informed her that her name was [CNA A] .All staff training and tests on abuse and neglect .12/27/24 CNA A was terminated from employment. CNA B was terminated from employment for failing to report in a timely manner, despite prior training . Actions taken by facility: ED notified RDO/RCS. [ED] reported abuse allegation to HHSC at 11:02 PM on 12/22/24, employment statements were collected, physician, ombudsman and family notified, staff was in serviced on abuse and neglect and injuries of unknown origin . retested on abuse and neglect. Safe surveys were conducted, CNA A and B were suspended.

Review of facility in-service titled Abuse and Neglect dated 12/23/24 was presented by the DON, the contents included abuse in reporting guidelines; If you witness or suspect any type of abuse, you must report it immediately. Failure to report abuse is grounds for corrective action and or termination. Revealed 59 staff members (RN, LVN, ADON, PTA, Cook, DOR, Nutritional Aide, PT, DOR, MA, Concierge, HR, DOM, SW, Hskping Supervisor, Laundry Aide) had taken the in-service.

Review of facility Review Discussion Form with a creation date of 12/22/24 initiated by DON reflected that CNA A was suspended pending investigation.

(continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of facility Personnel Action Form with an effective date of 12/27/24, for CNA B reflected: Employee status TERMINATED. Date last worked: 12/21/24. Review of facility Personnel Action Form with an effective date of 12/27/24, for CNA A reflected: Manager Comments: Misconduct/Violation of rules and policies. Failure to report allegations Employee status TERMINATED . Date last worked: 12/21/24. Review of facility Resident Safe Surveys dated 12/22/24 reflected all residents felt safe in the facility and had no concerns. Review of facility [Facility Name] Abuse Protocol Test reflected 89 staff had taken the tests between 12/23/24 through 12/27/24. Interview on 01/30/24 from 9:30 AM to 4:00 PM revealed that 5 LVN (1 PRN), 1 RN, ADON, 3 CNAs had been educated by the DON on abuse neglect exploitation, including when and who to report abuse to. All staff confirmed that they had taken a post test on the abuse policy. An Abuse Prevention and Reporting Policy dated April 2029 indicated .our facility will not condone patient abuse, neglect, mistreatment, or misappropriation of patient property and exploitation (collectively Patient Abuse) by anyone, including staff members, other patient, consultants, volunteers, staff of other agencies serving the patient, family members, legal guardians, sponsors, friends, or other individuals.Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.Verbal abuse is defined as any use of oral, written or gestured language that includes disparaging and derogatory terms to patient or their families, or within their hearing distance, or describe patient, regardless of their age, ability to comprehend, or disability.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 51181 Based on interviews and record review, the facility failed to ensure all alleged violations involving abuse and neglect were immediately reported, including injuries of unknown origin, but not later than 2 hours after the allegation was made if the events that caused the allegation involved abuse or resulted in serious bodily injury 24 hours after the allegations were made, to the State Survey Agency for one (Resident #1) of six residents reviewed for abuse. 1. Facility staff (CNA B) failed to notify the Abuse Coordinator/ADM of witnessed abuse of Resident #1 by CNA A. 2. The Abuse Coordinator failed to report to the State Survey Agency alleged abuse when Resident #1 reported abuse to facility staff on 12/09/2024. This failure could place residents at risk of injuries, abuse, and/or neglect. Findings Include: Review of Resident #1's Annual Minimum Data Set (MDS), dated 01/26/2025, reflected she was an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including depression (a mood disorder that causes persistent feelings of sadness, emptiness, and loss of joy, fibromyalgia (a chronic disorder characterized by widespread musculoskeletal pain, fatigue, and trouble sleeping, it occurs in the absence of an identifiable physical or physiological cause). Resident #1 had a Brief Interview for Mental Status (BIMS) score of 10, reflecting mild cognitive impairment. The MDS also revealed Resident #1 required extensive assistance with Activities of Daily Living (ADL). During an interview and observation of Resident #1 on 01/30/2025 at 10:05 a.m., Resident #1 reported an incident in early December involving CNA A and CNA B. While CNA A was providing incontinent care, Resident #1 asked CNA A to stop rolling her over due to pain, but CNA A continued despite protest from both Resident #1 and CNA B. Resident #1 stated CNA A was verbally abusive during the interaction, though she could not recall the exact words used. The physical handling caused Resident #1 pain, and she became fearful that CNA A would harm or kill her. Resident #1 reported the incident to multiple staff members but was initially told no one matching CNA A's description or name worked at the facility. Weeks later, Resident #1 recognized CNA A during an activity and confronted her, learning that CNA A had provided a false name during the incident. Resident #1 reported this to the ADON and the DON. Resident #1 stated she had only seen CNA A one time since the initial occurrence and CNA A did not provide her care before that incident nor after. Resident #1 stated she feels safe living in the facility and receiving care. During an interview on 01/30/2025 at 1:10 PM with LVN A, she reported she worked the 6 a.m. to 2 p.m. shift on Resident #1's hall. The LVN reported Resident #1 reported that she was abused by a CNA. The LVN stated she immediately reported the alleged abuse to the Administrator and the DON. (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 - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/30/2025 at 2:45 with Resident #1's FM. FM stated Resident #1 told him when CNA A was rolling her over to her side to change her, Resident #1 said she did it a little aggressively. FM stated he had not heard about the incident from the facility, which is why family installed a camera in Resident #1's room, for added security. He expressed frustration that the facility initially dismissed Resident #1's claims, suggesting she might be fabricating the story, as they did not have a staff member by the name Resident #1 was saying. FM stated soon after this incident he received another call from the facility stating they were going to have his Resident #1 tested by psychology. He stated he thought this was odd because Resident #1's mind is on point. During an interview on 01/30/2025 at 2:30 PM with RN A, the Weekend Supervisor, RN A confirmed Resident #1's account and began conducting interviews of weekend staff. During his interviews, RN A learned from CNA B that she witnessed CNA A abusing Resident #1 and did not report the incident. RN A stated he educated CNA B that if she saw abuse or was unsure if it was abuse that she witnessed, CNA B should have reported the incident. RN A stated he had worked with CNA A before and never had any issues reported to him. RN A stated in speaking with Resident #1, she was unable to provide a date of when the incident occurred, she denied being in pain, and Resident #1 stated that the CNA A providing Resident #1 the wrong name upset her. RN A stated he had called the DON and the Administrator once he became aware of the allegation and that CNA B was suspended but CNA A was not on duty. RN A stated that the following Monday, (12/23/24) CNA A was suspended. RN A stated he was educated on abuse, neglect and reporting allegations of abuse to the abuse coordinator the Administrator, immediately. During an interview on 01/30/2025 at 12:50 PM, CNA B reported she was in the room with CNA A when the incident happened. CNA B said CNA A told Resident #1 to move onto her side for incontinent care and Resident #1 was refusing. She stated Resident #1 was resisting while CNA A was pushing on Resident #1's back to place her onto her side. CNA B said she told CNA A to leave the room numerous times, but she wouldn't. CNA B said CNA A also witnessed CNA B saying to Resident #1 that her FM does not love her and left her here. CNA B said she did not report this incident to management or the abuse coordinator after it happened. CNA B said she made an emotional decision on not to report the abuse. CNA B stated she knew abuse and neglect was supposed to be reported to the Abuse Coordinator, the Administrator immediately but CNA A's living conditions at the time made her hesitant to say anything as she felt bad about CNA A's situation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/30/2025 at 3:50 PM, the DON stated she learned about the incident on between Resident #1 and CNA A from RN A. DON stated RN A called on Saturday or Sunday unsure date her to state Resident#1 had a camera put in her room, when DON asked why RN A reported that Resident #1 said she was verbally assaulted but did not state by who. DON stated she immediately called the Administrator and started an investigation. DON stated she directed RN A to talk to as many staff to find out what occurred and that was when CNA B reported she witnessed CNA A be abusive to Resident #1. DON stated prior (unknown date) Resident #1 told her a CNA was rude to her and turned her over too fast to reposition. DON stated around 12/09/24 a grievance was filed related to the information. The DON reported that Resident #1 gave her a name, but they did not have anyone by that name that worked at the facility or fit the physical description of any of their employees. The DON stated a few weeks later Resident #1 said she recognized the CNA that was abuse to her as CNA A and reported this to staff. The DON stated she completed a mental assessment and a physical assessment for injuries and non were found. DON stated that the MD referred Resident #1 to psych service. DON stated CNA A was suspended. She stated CNA B was also suspended for not reporting the abuse. DON stated she spoke to staff who all denied that anything occurred between CNA A and Resident #1. DON stated when talked to Resident #1 the first time Resident #1 said she was not abuse but the second time they spoke Resident #1 expressed she felt abused, and Resident #1 was providing conflicting information. During an interview on 01/30/2025 at 3:15 PM, the ADON reported she was made aware of the alleged abuse by Resident #1 who reported she was abused by a CNA while being provided care. The ADON stated that she and the DON went to interview Resident #1 who gave a description of a person who did not match any of the employed staff. ADON stated that Resident #1 stated the aide was being rude. ADON stated that Resident #1 had reported to RN A a week or two later that an aide had been abusive towards her. ADON stated that while RN A was interviewing, CNA B stated she had witnessed the event between Resident #1 and CNA A. ADON stated that Resident #1 did not express she was in pain during the incident. ADON stated once CNA A was identified as the perpetrator, she was suspended and later terminated from employment. ADON stated she was educated on abuse, neglect and reporting allegations of abuse to the abuse coordinator the Administrator, immediately. During an interview on 01/30/2025 at 4:00 PM, the Administrator stated she learned about the alleged abuse on 12/22/2024 when she reported it. She stated she was contacted by the DON who told her Resident #1 had reported she was abused by a CNA. The Administrator stated a couple of weeks prior to this, Resident #1 reported a CNA was rude to her and the description provided by Resident #1 did not match anyone that worked there. The Administrator stated that she did not feel like Resident #1 was abused. Administrator stated that CNA A was suspended pending the investigation and was then fired. She reported CNA B was fired for not reporting the alleged abuse. The Administrator reported she did not report the alleged abuse on 12/09/2024 because Resident #1 stated she did not feel like the abuse was intentional. Administrator stated that Resident #1 is always reporting abuse and is confused. Administrator stated as a result of the 12/22/24 incident the facility completed in-services on abuse and neglect, when and who to report allegations of abuse to with all staff. Safe surveys were completed, an assessment of Resident #1 was completed for injuries, both aides were terminated from employment. During a follow-up interview on 01/30/25 at 6:17 PM Regional Nurse Consultant, DON and Administrator stated that the facility completed safe surveys on residents, in-serviced all staff on abuse, neglect and when to report allegations of abuse and to whom, the abuse coordinator. Regional Nurse Consultant, DON and Administrator stated that they felt like CNA B stated she was there as there when CNA A abused Resident #1 as there was tension between staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Belmont at Twin Creeks	999 Raintree Circle Allen, TX 75013

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Provider Investigation Report dated 12/27/24, reflected the following: CNA B stated that she witnessed CNA A being unkind and rude to [Resident #1] stated this happened a few weeks ago but did not give a date Resident [#1] had no physical injuries noted, resident stated she felt okay however employee did make her upset . Treatment was not provided. Provider Response: ED notified RDO/RCS/ Executive Director reported Abuse Allegation to HHSC at 11:02 PM on 12/22/24, employee statements collected, Physician, Ombudsman and Family notified. Staff was re-in serviced on Abuse and Neglect and Injuries of Unknown Origin, Staff was re-tested for Abuse and Neglect, Resident Safe Surveys conducted. CNA were suspended. Investigation Summary: the investigation concluded that this claim was inconclusive due to inconsistencies in description and time and place from resident .Facility did terminate both CNA's due to statements by the resident and due to the CNA failing to report to administration. Please see investigation summary for detailed investigation report. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Facility External/Internal Investigation Summary dated 12/27/24 reflected the following: incident CNA B stated that she witnessed CNA A being unkind and rude to miss. She stated this happened a few weeks ago but did not give an exact date. Timeline 12/09/24 Resident #1 stated to DON that CNA by the name of [NAME] was rude to her period DON stated that we did not have an employee by that name and asked if she could describe the person. She stated she was tall black and that she had four blonde cornrows on top of her head . DON asked her if she knew what date and times occurred, Resident #1 was unsure of date or time. [DON] asked her if she felt unsafe or that it was verbally abusive Resident #1 stated she felt safe and that she felt the aid was just having a bad day, but it was not verbally abusive. [DON] informed [Resident #1] that we did not have an aide by that name or a nurse by that name and we did not have anyone who fit the description she stated she would let us know if she saw the person again. Family member was notified. [FM] stated [Resident #1] had told him something similar but also knows [Resident #1] has a history of confusion Grievance report was done, and staff interviewed no one knew of incident or employee that matched description. 12/22/24 [DON] received a phone call from the weekend supervisor [RN A] regarding Resident #1 now having a camera in her room . [Resident #1] told the supervisor it was because of aide that was rude and required. [Resident #1] stated the aids name was [the same as CNA A]. [RN A] informed [DON] that [CNA B] had just informed him that she was in the room with [CNA A] when she was being rude to [Resident #1] [CNA B] stated that [CNA A] stated that [Resident #1's] [FM] left her at the facility because they did not love her and did not want to take care of her. [CNA B] also stated that [CNA A] stated that she made a comment that she should be happy someone is there to wipe her ass these statements were never stated to [DON] prior by [Resident #1] . When administrator and [DON] inquired if she had informed anybody of the allegations prior, she stated she had not. Administrator informed her [CNA B] that she was required to inform about any type of abuse or neglect witness suspected or reported. [CNA B] has completed training on abuse neglect prior to this incident stated she did know she should have reported to us. [CNA B] was suspended while investigation was ongoing due to not reporting directly to administrator and timely manner. Facility reported to HHS allegation of verbal abuse .CNA A was informed that she was suspended by pending investigation . Resident Safe Surveys Conducted, Employee interviews conducted, ombudsman and physician notified. 12/23/24 [DON] and [ADON] spoke with [Resident #1] in the morning regarding [CNA A]. [Resident #1] stated she did see the aide she was talking about two week prior going to a Christmas Caroling evening and she had asked the aide who was taking her what her name was, and she informed her that her name was [CNA A] .All staff training and tests on abuse and neglect .12/27/24 CNA A was terminated from employment. CNA B was terminated from employment for failing to report in a timely manner, despite prior training . Actions taken by facility: ED notified RDO/RCS. [ED] reported abuse allegation to HHSC at 11:02 PM on 12/22/24, employment statements were collected, physician, ombudsman and family notified, staff was in serviced on abuse and neglect and injuries of unknown origin . retested on abuse and neglect. Safe surveys were conducted, CNA A and B were suspended. Review of facility in-service titled Abuse and Neglect dated 12/23/24 was presented by the DON, the contents included abuse in reporting guidelines; If you witness or suspect any type of abuse, you must report it immediately. Failure to report abuse is grounds for corrective action and or termination. Revealed 59 staff members (RN, LVN, ADON, PTA, Cook, DOR, Nutritional Aide, PT, DOR, MA, Concierge, HR, DOM, SW, Hskping Supervisor, Laundry Aide) had taken the in-service. Review of facility Review Discussion Form with a creation date of 12/22/24 initiated by DON reflected that CNA A was suspended pending investigation. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: The Belmont at Twin Creeks		STREET ADDRESS, CITY, STATE, ZIP CODE: 999 Raintree Circle Allen, TX 75013	

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility Personnel Action Form with an effective date of 12/27/24, for CNA B reflected: Employee status TERMINATED. Date last worked: 12/21/24. Review of facility Personnel Action Form with an effective date of 12/27/24, for CNA A reflected: Manager Comments: Misconduct/Violation of rules and policies. Failure to report allegations Employee status TERMINATED . Date last worked: 12/21/24. Review of facility Resident Safe Surveys dated 12/22/24 reflected all residents felt safe in the facility and had no concerns. Review of facility [Facility Name] Abuse Protocol Test reflected 89 staff had taken the tests between 12/23/24 through 12/27/24. Interview on 01/30/24 from 9:30 AM to 4:00 PM revealed that 5 LVN (1 PRN), 1 RN, ADON, 3 CNAs had been educated by the DON on abuse neglect exploitation, including when and who to report abuse to. All staff confirmed that they had taken a post test on the abuse policy. An Abuse Prevention and Reporting Policy dated April 2029 indicated .our facility will not condone patient abuse, neglect, mistreatment, or misappropriation of patient property and exploitation (collectively Patient Abuse) by anyone, including staff members, other patient, consultants, volunteers, staff of other agencies serving the patient, family members, legal guardians, sponsors, friends, or other individuals.Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.Verbal abuse is defined as any use of oral, written or gestured language that includes disparaging and derogatory terms to patient or their families, or within their hearing distance, or describe patient, regardless of their age, ability to comprehend, or disability.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42283 Based on observation, interview and record review, the facility failed to ensure that residents received routine and 24-hour emergency dental services for one of (Residents #2) of three residents reviewed for the provision of routine/emergency dental services. The facility failed to ensure Resident #2 received routine dental care. This failure could affect residents by placing them at risk of pain, weight loss, infection, difficulty eating and a decline in their quality of life due to unmet dental needs. Findings included: Review of Resident #2's annual MDS Resident assessment dated [DATE] revealed she was a [AGE] year old female who admitted to the facility on [DATE]. Her diagnoses included heart failure, hypertension, gastroesophageal reflux disease, hyperkalemia, hyperlipidemia, Alzheimer's disease, multiple sclerosis, and seizure disorder. Her functional abilities section reflected she was dependent on staff regarding personal hygiene. Interview with RP on 01/30/25 at 11:24 am revealed she had requested dental services for Resident #2 multiple times. She stated Resident #2 had not been seen by the dentist. She stated Resident #2 needed to be seen by the dentist because her top denture kept falling out. Observation and interview with Resident #2 on 01/30/25 at 12:35 PM revealed her top denture was not secured to her gum. Her top denture kept sliding down. Resident #2's entire top denture was visible while she talked. She stated she did not remember receiving dental services. She appeared to be confused. Review of Resident #2's progress notes on 01/30/25 dated 05/13/24 and 05/22/24 reflected the RP had requested dental services for Resident #2 and a referral was sent to the dental company. There was no documentation reflecting Resident #2 was seen by the dentist. Review of the dental company visit summary dated 11/06/24 reflected Resident #2 was not seen by the dentist. Interview with the social worker on 01/30/25 at 4:49 pm revealed she was responsible for ensuring Resident #2 received dental services. She stated the previous social worker had submitted Resident #2 dental referral to the dental company. She stated she did not know if Resident #2 received dental services. She stated Resident #2 was not her dental list. She stated there was no reason Resident #2 should not have received dental services. She stated the dentist or dental hygienist saw residents monthly at the facility. The purpose of Resident #2 receiving dental services was maintain good hygiene and dental care. Record review of the facility policy titled Dental Services, dated December 2016, revealed Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care.