STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676248	A. Building B. Wing	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Founders Plaza Nursing & Rehab	721 S Hwy 78 Wylie, TX 75098

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 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** 45268 Based on interview and record review, the facility failed to ensure all alleged violations involving abuse, neglect and exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but no later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials, which included the State Survey Agency, in accordance with State law through established procedures for one of three residents (Resident #1) reviewed for abuse and neglect. The facility did not report to the State Survey Agency when Resident #1 reported allegations of abuse within 2 hours. These failures could place residents at risk for injuries, abuse, and/or neglect. Findings include: 1. Record review of Resident #1's electronic face sheet, dated 02/09/24, reflected an [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1's diagnosis included cerebral infarction (stroke), Alzheimer's disease (most common type of dementia), anxiety, and cognitive communication deficit. Record review of Resident #1's Quarterly MDS assessment, dated 11/25/23, reflected a BIMS score of 01, which indicated severe cognitive impairment. Record review of Resident #1's Care Plan, revised 11/28/23, reflected Resident #1 required hospice services and assistance with his ADLs. Review of the Hospice occurrence form dated 01/24/24 reflected: ADON at facility communicated with [staff] that [Resident #1] had made an accusation that the aid that morning was rough with her and caused her bruising. It was determined that [hospice 2] had never transferred the patient off their service, despite having being notified of the transfer on 1/18/24. The [staff] that saw [Resident #1] that morning was from [hospice 2]. [Hospice 1] sent out an RN that evening to assess the patient regarding the complaint. Please see her attached clinical note, confirming bruising and patient statement (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Hospice complaint form-reporting page dated 01/15/24 revealed 1720- SN arrived to facility to find pt ambulating halls going in and out of different rooms having to be redirected multiple times. Pt able to show SN to her room. Alert to self. Denies any pain or discomfort. When arrived asked pt how was her day. Pt begin to explain that she been working with other residents as if she is part of the staff. Asked if she had a bath today and she states, No, I don't want no one cleaning my behind. I can clean my own behind. Then pt states, Do you know the lady that came to shower me today? You are not her. SN informed pt that it was not her but asked how did that go. Pt states, Well, she beat me up. I have all the bruises from her trying to force me to let her bathe me and I don't even know why she was doing that because, she was no where near the soap or water when she was grabbing on me. Asked if any of the bruises on her arms hurt, and pt states, Yes, my arms (upper arms pointed) were she grabbed me trying to make me do what she wanted me to do, I guess. This one on my bone is sore too but nothing too bad I can handle it. Pt has multiple bruises to to bilateral upper extremities: Right out upper arm has bruise: 1.7x0.9cm light red Right medial forearm: 1.7x1.4cm light red color Right posterior wrist: 1.6x 1cm deep purple color Top of right hand: 1x0.7cm and 0.5x1.5cm 1.7x1.1 cm multiple small purple in color Left upper arm outer upper arm:0.5x1cm light red Posterior left lower arm: 2x1.2cm deep purple Scattered light red discoloration to posterior left forearm Left anterior wrist: 5.8x3.7 large green and purple discoloration with noted knot. Top of Left hand: 1.1x1cm light purple discoloration Pt pleasantly confused but continues to recall the events from the morning of someone trying to make her shower. She ask, You not going to try and make me shower are you because I can do my own shower. SN discussed finding with FN who states she was aware of event from early. No other needs or concerns voiced or noted at this time. Review of the nursing notes dated 01/24/24 authored by LVN A revealed hospice aid in facility to give resident shower. Resident refused, after a few tries resident started to be upset. Interview on 02/09/24 at 10:41 AM with Resident #1 revealed she was confused about her location and was not able to answer questions directly due to thinking she was in a church and the surveyor was a church worker. The resident was observed well groomed, no bruises were observed. Interview on 02/9/24 at 12:45 PM with the ADON revealed she had not received any complaints from residents regarding hospice staff being rough toward any resident nor had she received allegation of any resident having bruises caused by hospice staff. The ADON stated she did not recall if she had contacted hospice on 01/24/24 however if there were concerns of abuse, she would have notified the administrator. (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	In an interview on 02/09/24 at 1:00 PM with the Hospice field staff and Director of Quality revealed the Hospice field staff received a call from the ADON stating Resident #1 had informed her that the hospice aide was rough with her and had caused bruising to her. The Hospice Field staff stated she did send a nurse to assess the resident following the incident. The Hospice Field staff stated she found out that the hospice worker was not from her agency and no longer had contact with Resident #1. In a follow up interview on 02/09/24 at 1:15 PM with the ADON revealed she = recalled calling the hospice agency to inform them that Resident #1 wanted a new hospice aide because her current aide was getting her up too late. The ADON stated she did not remember stating anything about bruises or the aide being rough. The ADON stated if there were allegation of the hospice aide being rough, she would have had to report it to her administrator who in turn would have completed a self-report. The ADON stated she did not document her conversation with the hospice field staff. Interview on 02/09/23 at 1:30 PM with the Administrator and DON revealed they were not aware of the ADON being made aware by Resident #1 of abuse by hospice aide nor were they aware that hospice was contacted. The Administrator stated he spoke with the ADON, and she stated she contacted hospice but did not mention any abuse. The Administrator stated the resident had bruises. However, they were not sure if they were new or not. The Administrator stated an investigation was not complete regarding the incident and a self-report was not complete because he nor the DON were made aware of any allegations of abuse. The Administrator revealed he was the abuse coordinator and would have been responsible for completing the self report Review of the facility's undated policy LEADERSHIP POLICIES AND PROCEDURES ORGANIZATIONAL ETHICS, abuse, neglect, exploitation or mistreatment reflected: .2.The Facility shall report immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not result in serious bodily injury to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. See Also Reporting Reasonable Suspicion of a Crime Policy.The facility's Leadership will conduct a prompt investigation of any allegation received of suspected abuse, neglect or exploitation or mistreatment and will implement immediate action to safeguard resident

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268 Based on interviews and record review, the facility failed to ensure in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must have evidence that all alleged violations are thoroughly investigated and prevent further abuse, neglect, exploitation, or mistreatment while the investigation is in process for one of three (Resident #1) residents reviewed for abuse and neglect. The facility did investigate the allegation of abuse made by Resident #1. These failures could place residents at risk for injuries, abuse, and/or neglect. Findings include: 1. Record review of Resident #1's electronic face sheet, dated 02/09/24, reflected an [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1's diagnosis included cerebral infarction (stroke), Alzheimer's disease (most common type of dementia), anxiety, and cognitive communication deficit. Record review of Resident #1's Quarterly MDS assessment, dated 11/25/23, reflected a BIMS score of 01, which indicated severe cognitive impairment. Record review of Resident #1's Care Plan, revised 11/28/23, reflected Resident #1 required hospice services and assistance with his ADLs Review of the Hospice occurrence form dated 01/24/24 reflected: ADON at facility communicated with [staff] that [Resident #1] had made an accusation that the aid that morning was rough with her and caused her bruising. It was determined that [hospice 2] had never transferred the patient off their service, despite having being notified of the transfer on 1/18/24. The [staff] that saw [Resident #1] that morning was from [hospice 2]. [Hospice 1] sent out an RN that evening to assess the patient regarding the complaint. Please see her attached clinical note, confirming bruising and patient statement. Review of the Hospice complaint form-reporting page dated 1/15/24 reflected: 1720- SN arrived to facility to find pt ambulating halls going in and out of different rooms having to be redirected multiple times. Pt able to show SN to her room. Alert to self. Denies any pain or discomfort. When arrived asked pt how was her day. Pt begin to explain that she been working with other residents as if she is part of the staff. Asked if she had a bath today and she states, No, I don't want no one cleaning my behind. I can clean my own behind. Then pt states, Do you know the lady that came to shower me today? You are not her. SN informed pt that it was not her but asked how did that go. Pt states, Well, she beat me up. I have all the bruises from her trying to force me to let her bathe me and I don't even know why she was doing that because, she was no where near the soap or water when she was grabbing on me. Asked if any of the bruises on her arms hurt, and pt states, Yes, my arms (upper arms pointed) were she grabbed me trying to make me do what she wanted me to do, I guess. This one on my bone is sore too but nothing too bad I can handle it. Pt has multiple bruises to to bilateral upper extremities: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Right out upper arm has bruise: 1.7x0.9cm light red Right medial forearm: 1.7x1.4cm light red color Right posterior wrist: 1.6x 1cm deep purple color Top of right hand: 1x0.7cm and 0.5x1.5cm 1.7x1.1 cm multiple small purple in color Left upper arm outer upper arm:0.5x1cm light red Posterior left lower arm: 2x1.2cm deep purple Scattered light red discoloration to posterior left forearm Left anterior wrist: 5.8x3.7 large green and purple discoloration with noted knot. Top of Left hand: 1.1x1cm light purple discoloration Pt pleasantly confused but continues to recall the events from the morning of someone trying to make her shower. She ask, You not going to try and make me shower are you because I can do my own shower. SN discussed finding with FN who states she was aware of event from early. No other needs or concerns voiced or noted at this time. Review of the nursing notes dated 01/24/24 authored by LVN A revealed hospice aid in facility to give resident shower. Resident refused, after a few tries resident started to be upset. Interview on 02/09/24 at 10:41 AM with Resident #1 revealed she was confused about her location and was not able to answer questions directly due to thinking she was in a church and the surveyor was a church worker. The resident was observed well groomed, no bruises were observed. Interview on 02/9/24 at 12:45 PM with the ADON revealed she had not received any complaints from residents regarding hospice staff being rough toward any resident nor had she received allegation of any resident having bruises caused by hospice staff. The ADON stated she did not recall if she had contacted hospice on 01/24/24 however if there were concerns of abuse, she would have notified the administrator. In an interview on 02/09/24 at 1:00 PM with the Hospice field staff and Director of Quality revealed the Hospice field staff received a call from the ADON stating Resident #1 had informed her that the hospice aide was rough with her and had caused bruising to her. The Hospice Field staff stated she did send a nurse to assess the resident following the incident. The Hospice Field staff stated she found out that the hospice worker was not from her agency and no longer had contact with Resident #1. In a follow-up interview on 02/09/24 at 1:15 PM with the ADON revealed she recalled calling the hospice agency to inform them that Resident #1 wanted a new hospice aide because her current aide was getting her up too late. The ADON stated she did not remember stating anything about bruises or the aide being rough. The ADON stated if there were allegation of the hospice aide being rough, she would have had to report it to her administrator who in turn would have completed a self-report. The ADON stated she did not document her conversation with the hospice field staff. (continued on next page)

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