

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2025
NAME OF PROVIDER OR SUPPLIER The Wesleyan Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4011 Williams Dr Georgetown, TX 78628	
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 - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44317 Based on observation, interviews, and record reviews, the facility failed to protect the residents' right to be free from abuse for one (Resident #1) of three residents reviewed for abuse. The facility failed to ensure Resident #1 was free from verbal abuse on 02/03/25 when CNA A told the resident, You shouldn't even act like this, I want to put you to bed but you're not acting right with all the yelling and screaming and yelled repeatedly at the resident. The noncompliance was identified as past noncompliance (PNC). The noncompliance began on 02/03/25 and ended on 02/07/25 . The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for abuse and psychosocial harm. Findings included: Review of Resident #1's face sheet printed on 03/03/25, reflected a [AGE] year-old female admitted to the facility on [DATE] and discharged from the facility on 02/12/25. Her diagnoses included dementia, Alzheimer's disease, anxiety disorder, unspecified glaucoma, and muscle wasting and atrophy. Review of Resident #1's quarterly MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score of 7 which indicated severe cognitive impairment. Section B (Hearing, Speech, and Vision) reflected moderately impaired vision and sometimes understands others. Section GG (Functional Abilities) reflected she required substantial to maximal assistance for transfers and standing but she was able to propel her wheelchair independently. Review of Resident #1's comprehensive care plan revised 12/03/24 reflected in part: Need - Resident requires assistance for maintaining involvement in social/cognitive/leisure activities due to cognitive impairment and disease process (dementia). Goal - Resident will maintain involvement in cognitive stimulation, social activities as desired through review date. Approaches - loud music/noises bother resident and can cause her to react negatively . (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 676280	Facility ID: 676280 If continuation sheet Page 1 of 18

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Need - Resident is at increased risk for potential ADL self-care performance deficit r/t confusion, dementia, fatigue, limited mobility . Goal Resident will have decreased risk of decline . Approaches - Transfer: Resident requires maximum assistance . Need - Resident has impaired cognitive function/dementia and Alzheimer's . Goal - Resident will maintain current level of decision-making ability . Approaches - COMMUNICATION: Use Resident's preferred name. Identify yourself at each interaction. Face Resident when speaking and make eye contact. Reduce distractions . The resident understands consistent, simple directive sentences. Provide the resident with necessary cues - stop and return if agitated. Review of the facility (PIR) provider investigation report dated 02/10/25, reflected CNA A, an agency CNA, was providing care to Resident #1 on the evening of 02/03/25. The report further reflected, Concerns were identified in the course of viewing camera footage related to the agency employee on suspension. Based on surveillance, the agency CNA's actions and verbal communication were indicative of verbal abuse. Subsequently this agency CNA is prohibited from working at this community in the future. Review of a statement from Resident #1 dated 02/04/25, signed by the DON, reflected in part, A teenager came into my room she had a mask on I asked her to remove her mask, she did not introduce herself as she was supposed to, she refused to remove her mask so I did not want her to take care of me . each time I turned the call light she will come in .then she laid me down . she keep coming in turn off the call light. The two girls came and helped me. Review of a note dated 02/05/25, signed by the SW, reflected in part, Met with Resident #1 to offer support . When asked if she feels safe, Resident #1 responded, I won't feel safe until I know the right people are taking care of me. The note also reflected Resident #1 talked about that staff person coming in several times and turning off the call light that she had put on, and that she eventually had moved herself to the doorway to ask for help. Review of a document dated 02/07/25, signed by the VP of Operations, reflected during an interview, CNA D stated he heard CNA A loudly telling the resident her name over and over. Review of a statement dated 02/04/25, signed by CNA A reflected in part, .Once I entered room (number) the resident was in her wheelchair and asked me to put her in the bed .she asked me my name which I repeated three times and she still called my name wrong but that wasn't the issue .I did not return to her room until 4:35 .She looked at me and ask my name again once again I told her and she told me to get out of her room . At 7:00 PM I ask her if she was ready for bed she ask me my name and said get out . Review of a Security Camera Review Timeline, prepared by the ADM, of two video clips recorded on 02/03/25 reflected in part: (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8:00:26pm - (Resident #1) is sitting at her door ringing a bell with call light with another staff member non visible stating room service. Another employee (CNA D) is seen down the hallways toward nursing station. 8:00:33 - (Company name) employee (CNA A) comes to the room and ask the resident Yes, ma'am, how can I help you? (CNA A) asked the resident twice, How may I help you. (CNA A) is seen directly in front of the resident and states to the resident, Is that what you resort to? 8:00:35 (CNA A) then says again, How may I help you? (CNA A) repeats these 2 additional times, How may I help you?. The resident responds, and says I can't see what your name is. (CNA A) is asking in the normal tone of voice at this time and is standing in front of the resident at her doorway. Employee (CNA D) is witnessed walking past the room at this time with (CNA A) asking the resident How may I help you? 8:00:56 - resident remains sitting in her doorway and (CNA A) is standing in front of her. (CNA A) responds I am not the reason you fell because I haven't been here except for tonight. 8:01:09 - The resident continues to ring the bell. (CNA A) starts to push the resident backwards into the room, stating I am going to put you to bed. (CNA A) communicates in a low tone of voice. The resident at this point begins to yell and says what is your name and (CNA A) responds ma'am, ma'am, ma'am. 8:01:13 - (CNA A) is holding the arms of the wheelchair and states to the resident you shouldn't even act like this. 8:01:15 - (Resident #1) states Tell me your name. (CNA A) responds, I told you, (CNA A). 8:01:16 - (CNA A) leans into the left ear of the resident and states loudly (CNA A), (CNA A), (CNA A) (9 times) while she is holding the arms of the wheelchair. 8:01:26 - The resident responds, (name)? (CNA A) responds yes at this time. 8:02:54 - (CNA A) stands back up and states, Now do you feel better? 8:02:56 - Resident states, you came here .and does not finish her sentence. (CNA A) states to the resident you are disturbing other residents with that bell. 8:03:04 - (CNA D) is seen walking back into camera view up the hallway stating Name 8:03:09 - (CNA A) instructs the resident to roll back, we are going to shut the door because you cannot disturb the other residents. 8:03:21 - (Resident #1) states measure pain . (CNA A) states where do you come up with this stuff? (Resident #1) states you in the dark of night. 8:03:26 - (CNA A) leans forward, and states ok grabbing the resident chair and rolls her back toward the inside of the room. (Resident #1) yells out at this time. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8:03:33 - (CNA A) stands back up shaking her head and says, Are you? (Resident #1) responded that hurts . 8:03:41 - (CNA A) is clapping her hands together stating to the resident I had nothing to do, (Resident #1) states, just to be heard. 8:03:44 - (CNA A) backs out and shuts the door at this time. The resident is ringing the bell behind the closed door of her room. (CNA A) leaves the area at this time. Video clip 2 8:04:36 PM - (CNA A) standing outside resident (Resident #1) room holding door closed, resident's call light is on 8:04:47 PM - (CNA A) puts resident's hand bell on the hallway railing 8:05:09 PM - (CNA A) adds second hand to door knob, continues holding door closed; sounds of someone trying to open door can be heard 8:05:56 PM - Resident can be heard saying let me out, (CNA A) continues holding door closed from outside 8:06:18 PM - (CNA A) opens door, resident sitting right behind door, door hits resident's wheelchair Resident says I want to go to bed, (CNA A) responds that I want to put you to bed but you're not acting right with all the yelling and screaming. 8:06:27 PM - (CNA A) walks away from resident's door, call light still on 8:06:35 PM - Resident opens door all the way and moves to doorway 8:06:36 PM - end of clip [sic] During an interview on 03/03/25 at 10:01 AM, the ADM stated after watching the video of CNA A with Resident #1, she had concerns about how CNA A talked to Resident #1 and the tone used. She stated she did not want CNA A to return. She stated she reported the allegations of abuse to the staffing agency that placed CNA A at the facility. The ADM stated she did not know what the Resident #1 meant when she stated, That hurts. During a telephone interview on 03/03/25 at 10:38 AM, Resident #1's FM stated the resident did not see or hear well and she always asked for the name of anyone in the room. The FM stated the resident told her the staff would not say her name, so the resident continued to put on her call light waiting for someone different to come in the room. She stated the same person came in the room and turned off the call light every time. She stated the resident was very fearful about staying at the facility as she did not feel safe. She stated Resident #1 moved to another facility. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/03/25 at 2:23 PM, RN B stated she worked with Resident #1 on the evening of 02/03/25. She stated she was in and out of rooms on Resident #1's hallway and did not see anything unusual or out of the ordinary that evening. She stated during her interactions with Resident #1, the resident was concerned about her fall from earlier on the day shift. RN B stated she received ANE training during orientation to the facility a couple months ago and again just after the alleged abuse with Resident #1. She stated the training after the alleged abuse included type of abuse such as physical, verbal, mental, and seclusion, when to report and who to report to. The training included dealing with challenging behaviors and Resident Rights. She stated any suspected abuse was immediately reported to the ADM who was the Abuse Coordinator. She stated the notification must be a phone call not a text message. During an observation and interview on 03/03/25 at 2:40 PM, the ADM stated she was not able to send the surveillance videos but showed the videos on her laptop. The ADM started the first video clip, time-stamped just after 8:00 PM, which revealed a resident seated in a wheelchair in the doorway of her room. The resident rang a handheld bell. The ADM identified the resident as Resident #1. The call light indicator above the doorway was illuminated which indicated the call light was on. A few seconds later, a person approached Resident #1. The ADM identified the person as CNA A. CNA A wore a blue face mask. CNA A asked twice, How may I help you? Resident #1 intermittently rang the handheld bell. Standing in front of Resident #1, CNA A stated, Is this what you resort to? Resident #1 stated, I can't see, what is your name? CNA A asked, How can I help you? CNA A stated, I'm not the reason you fell. Resident #1 continued to ring the bell. CNA A bent over and pushed the resident in the wheelchair back towards the room and said she would put her to bed. Resident #1 began asking loudly, What is your name? While she held the wheelchair in place, CNA A stated, You shouldn't act like this. Resident #1 pleaded, with desperation in her voice, Tell me your name. CNA A stated, I told you, (name). CNA A leaned over close to Resident #1's head and yelled, (name), (name), (name). She yelled her name multiple times while still holding the wheelchair in place. The resident looked confused and asked, (similar name)? CNA A stood up and asked the resident, Now do you feel better? CNA A told Resident #1 she was disturbing the other residents with the bell. CNA A told Resident #1 to roll back, We are going to shut the door because you cannot disturb the other residents. CNA A grabbed the wheelchair arms and rolled it back into the room. Resident yelled out. CNA A backed up into the hall and shut the room door. Resident #1 continued to ring the handheld bell inside the room. CNA A left the area. The video clip lasted about three minutes. The second video clip started when CNA A was observed standing outside of Resident #1's room. The door was still closed. CNA A was holding the door handle with one hand. She had Resident #1's bell and placed it on the handrail. CNA A put a second hand on the door handle and held the door closed. Noises of attempts to open the door were heard. Resident #1, sounding distressed, yelled, Let me out. CNA A opened the door and the door hit Resident #1's wheelchair. Resident #1 stated she wanted to go to bed. CNA A stated, I want to put you to bed but you aren't acting right with all that yelling and screaming. CNA A walked away from the resident. The call light was still on. Resident #1 moved her wheelchair back into the doorway. The video ended. The ADM stated the tone of voice used by CNA A concerned her. She stated she did not want CNA A back in the facility. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/03/25 at 3:44 PM with the SW, she stated she had visited with Resident #1 a few times after the alleged incident. She stated the resident did not feel safe. The SW was unable to clarify whether the resident did not feel safe because of the fall or because of something else. She stated the resident was very hard of hearing and almost blind, she had a hard time identifying people. The SW stated Resident #1 was able to move herself around once seated in the wheelchair. The SW stated she had received training after the allegation of abuse of Resident #1 on resident rights, dealing with cognitive impairment and difficult behaviors, and reporting abuse and neglect allegations. During an interview on 03/03/25 at 3:59 PM, the DON stated she had assessed Resident #1 on 02/04/25 and did not have any physical findings. The DON stated the resident told her the staff member would not say her name, so she wanted someone else to take care of her. The DON stated it was not acceptable to yell at a resident. She stated the facility provided frequent training on abuse and neglect. She stated the agency CNA would not be allowed back in the facility. During a telephone interview on 03/03/25 at 4:11 PM, the GM from the staffing agency who placed CNA A in the facility, stated she was made aware, by the facility, of the allegation of abuse against CNA A. She stated the hero, what they call CNAs, was suspended while the facility investigated. During an interview on 03/03/25 at 4:26 PM CNA C stated she worked on the evening of 02/03/25 and assisted Resident #1 from the bed to the wheelchair early in the shift. She stated Resident #1 was never a problem for me. She stated she did not see or hear anything that night unusual on Resident #1's hall, but she spent most of her time on the adjacent hall where she was assigned. She stated she had been trained on ANE and resident rights a couple days after 02/03/25. She stated if you see it or suspect it report it immediately. Report to the supervisor, the charge nurse, and the ADM. She stated the ADM was the abuse coordinator. During an interview on 03/03/25 at 4:45 PM, the ADM stated she had a conversation on 02/04/25 with CNA A about the allegations. The ADM stated CNA A told her she repeated her name three times to the resident and the CNA denied mistreating the resident and most of what she said sounded reasonable. The ADM stated it was after the conversation with CNA A that she watched the video footage from the evening of 02/03/25 that she saw a different version. The ADM stated, Based on our interactions I was not expecting to see what I saw on the video. Part of her statements were consistent with the video, but she did not tell the whole story. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 03/05/25 at 3:05 PM, CNA A confirmed that she worked with Resident #1 on the evening of 02/03/25. When asked to describe the events of the evening she stated, Resident #1 wanted to go to sleep. Something happened earlier and she kept asking if I was going to drop her. She let me put her in bed and she napped. Around 4:15 or 4:30 PM Resident #1 put the call light on and she acted like she didn't know me. She stated she wanted the other lady. After dinner I asked if she was ready to go to bed, she told me she didn't want me to put her to bed. She stated she went back to the room around 9:30 PM to ask again and when I walked into the room, she kicked me. The light was on, and I was holding the door closed until I could get someone else to come help me put her in bed. I was told there was no clear evidence that I did anything wrong. CNA A stated she was aware the facility had cameras in the building, Yes, the camera was right there. CNA A stated she had told the GM from the staffing agency that she had been kicked but did not tell anyone else. CNA A denied that she raised her voice at the resident, Never. I told her my name was (name), (name), (name). I talked to her just like we are talking right now. She stated she was not 100% sure if she had told the Resident #1 that she was disturbing other residents so she was going to close her door or that the resident should not be acting like that. CNA A stated she had been trained on ANE. She stated abuse could be neglect, verbal, or physical. Review of the undated Resident Rights policy, reflected in part, .To be treated with respect and dignity. To be free from any physical or chemical restraint imposed for convenience or discipline and not required to treat the resident's medical condition. To be free from abuse, neglect, misappropriation of resident property, and exploitation including corporal punishment, involuntary seclusion . Review of the undated Prevention and Reporting of Suspected Resident Abuse and Neglect policy, reflected in part, This facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect. This facility has implemented the following processes in an effort to provide residents and staff a comfortable and safe environment .Protection: suspend suspected employee(s) pending outcome of the investigation .definitions 1. Verbal Abuse - Oral, written or gestured language that includes disparaging and derogatory terms to the residents or their families or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability .5. Involuntary Seclusion - Separation of a resident from other resident or from his/her room against the resident's will . The facility implemented the following interventions: Review of Resident #1's medical record progress notes dated 02/04/25, reflected Resident #1 was assessed by the SW and nursing. A head-to-toe assessment dated [DATE], completed by the DON, reflected no injuries identified. The comprehensive care plan, initiated 12/03/24, was reviewed and revised on 02/11/25. Review of the facility's undated Investigation Summary reflected on 02/04/25, CNA A was interviewed by the ADM and DON. CNA A provided a written statement and was notified she was not allowed to work at the facility pending the investigation. Review of the facility's undated Investigation Summary reflected on 02/04/25, CNA A's staffing agency was notified of the allegations of abuse and indicated as Do Not Return. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's undated Investigation Summary reflected on 2/4/25, 2/5/25, and 2/7/25 the facility communicated with Resident #1's responsible party about the allegation and investigation. The facility assured her the alleged perpetrator would not work at the facility. Review of the facility's undated Investigation Summary reflected staff working the evening and night of 02/03/25 were interviewed between 02/04/25 and 02/07/25. The staff interviewed included RN B, CNA C, CNA D, CNA E, and MA F with no further adverse findings. Review of the facility's undated Investigation Summary reflected the local Police Department was contacted regarding the allegation . Review of the facility's undated Investigation Summary reflected the security camera footage of the exterior of Resident #1's room was reviewed on 02/03/25. Other concerns were identified, and CNA A was indicated as Do Not Return. The abuse allegation information was sent to the agency for their follow up. Review of the Resident Interview Questions for Abuse Allegation (Safe Surveys) dated from 02/04/25 through 02/27/25 conducted by the SW revealed no concerns of abuse identified and the residents felt safe in the facility. Review of an in-service dated 02/04/24, reflected administration and therapy staff were in-serviced on Caring for Cognitively Impaired with Challenging Behaviors. Bullet points attached. Review of an in-service dated 02/04/24, reflected all staff were in-serviced on Caring for Cognitively Impaired with Challenging Behaviors. Bullet points attached. Review of an in-service dated 02/04/24, reflected all staff were in-serviced on Abuse Prevention and Reporting - All allegations must be reported immediately to the ADM. Policy attached. Review of an in-service dated 02/04/24, reflected administration and therapy staff were in-serviced on abuse Prevention and Reporting - All allegations must be reported immediately to the ADM. Policy attached. Review of an in-service dated 02/05/25, reflected dietary staff were in-serviced on Prevention and Reporting of Abuse and Neglect. Report any suspected abuse and neglect immediately to ADM. Policy attached. Review of in-services dated 02/05/25, reflected RN B was in-serviced on Conditions to report to administration, Abuse and neglect prevention and reporting, dealing with challenging behaviors. Policies and PowerPoint attached. Review of an in-service dated 02/07/25, reflected housekeeping staff were in-serviced on Prevention and Reporting of Abuse and Neglect. Report any suspected abuse and neglect immediately to ADM. Policy attached. (continued on next page)		

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44317 Based on observation, interviews and record reviews, the facility failed to ensure the residents had the right to be free from involuntary seclusion and any physical restraint not required to treat the resident's medical symptoms for one (Resident #1) of three residents reviewed for involuntary seclusion. The facility failed to ensure Resident #1 was free from involuntary seclusion on 02/03/25 when CNA A pushed Resident #1, who was sitting in a wheelchair, into her room, closed the door, and held the door closed with two hands while Resident #1 was heard yelling let me out. The noncompliance was identified as past noncompliance (PNC). The noncompliance began on 02/03/25 and ended on 02/27/25. The facility had corrected the noncompliance before the survey began. These failures could place residents at risk for seclusion and psychosocial harm. Findings included: Review of Resident #1's face sheet printed on 03/03/25, reflected a [AGE] year-old female admitted to the facility on [DATE] and discharged from the facility on 02/12/25. Her diagnoses included dementia, Alzheimer's disease, anxiety disorder, unspecified glaucoma, and muscle wasting and atrophy. Review of Resident #1's quarterly MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score of 7 which indicated severe cognitive impairment. Section B (Hearing, Speech, and Vision) reflected moderately impaired vision and sometimes understands others. Section GG (Functional Abilities) reflected she required substantial to maximal assistance for transfers and standing but she was able to propel her wheelchair independently. Review of Resident #1's comprehensive care plan revised 12/03/24 reflected in part: Need - Resident requires assistance for maintaining involvement in social/cognitive/leisure activities due to cognitive impairment and disease process (dementia). Goal - Resident will maintain involvement in cognitive stimulation, social activities as desired through review date. Approaches - loud music/noises bother resident and can cause her to react negatively . Need - Resident is at increased risk for potential ADL self-care performance deficit r/t confusion, dementia, fatigue, limited mobility . Goal Resident will have decreased risk of decline . Approaches - Transfer: Resident requires maximum assistance . (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER The Wesleyan Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4011 Williams Dr Georgetown, TX 78628	
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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Need - Resident has impaired cognitive function/dementia and Alzheimer's . Goal - Resident will maintain current level of decision-making ability . Approaches - COMMUNICATION: Use Resident's preferred name. Identify yourself at each interaction. Face Resident when speaking and make eye contact. Reduce distractions . The resident understands consistent, simple directive sentences. Provide the resident with necessary cues - stop and return if agitated. Review of the facility (PIR) provider investigation report dated 02/10/25, reflected CNA A, an agency CNA, was providing care to Resident #1 on the evening of 02/03/25. The report further reflected, Concerns were identified in the course of viewing camera footage related to the agency employee on suspension. Subsequently this agency CNA is prohibited from working at this community in the future. The PIR did not reflect the involuntary seclusion. Review of a statement from Resident #1 dated 02/04/25, signed by the DON, reflected in part, A teenager came into my room she had a mask on I asked her to remove her mask, she did not introduce herself as she was supposed to, she refused to remove her mask so I did not want her to take care of me . each time I turned the call light she will come in .then she laid me down . she keep coming in turn off the call light. The two girls came and helped me. Review of a note dated 02/05/25, signed by the SW, reflected in part, Met with Resident #1 to offer support . When asked if she feels safe, Resident #1 responded, I won't feel safe until I know the right people are taking care of me. The note also reflected Resident #1 talked about that staff person coming in several times and turning off the call light that she had put on, and that she eventually had moved herself to the doorway to ask for help. Review of a document dated 02/07/25, signed by the VP of Operations, reflected during an interview, CNA D stated he witnessed CNA A holding a door but did not think anything of it at the time. He stated he did hear the aide loudly telling the resident her name over and over. Review of a statement dated 02/04/25, signed by CNA A reflected in part, .Once I entered room (number) the resident was in her wheelchair and asked me to put her in the bed .she asked me my name which I repeated three times and she still called my name wrong but that wasn't the issue .I did not return to her room until 4:35 .She looked at me and ask my name again once again I told her and she told me to get out of her room . At 7:00 PM I ask her if she was ready for bed she ask me my name and said get out . Review of a Security Camera Review Timeline, prepared by the ADM, of two video clips recorded on 02/03/25 reflected in part: 8:00:26pm - (Resident #1) is sitting at her door ringing a bell with call light with another staff member non visible stating room service. Another employee (CNA D) is seen down the hallways toward nursing station. 8:00:33 - (Company name) employee (CNA A) comes to the room and ask the resident Yes, ma'am, how can I help you? (CNA A) asked the resident twice, How may I help you. (CNA A) is seen directly in front of the resident and states to the resident, Is that what you resort to? (continued on next page)		

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Video clip 2 8:04:36 PM - (CNA A) standing outside resident (Resident #1) room holding door closed, resident's call light is on 8:04:47 PM - (CNA A) puts resident's hand bell on the hallway railing 8:05:09 PM - (CNA A) adds second hand to door knob, continues holding door closed; sounds of someone trying to open door can be heard 8:05:56 PM - Resident can be heard saying let me out, (CNA A) continues holding door closed from outside 8:06:18 PM - (CNA A) opens door, resident sitting right behind door, door hits resident's wheelchair Resident says I want to go to bed, (CNA A) responds that I want to put you to bed but you're not acting right with all the yelling and screaming. 8:06:27 PM - (CNA A) walks away from resident's door, call light still on 8:06:35 PM - Resident opens door all the way and moves to doorway 8:06:36 PM - end of clip [sic] During an interview on 03/03/25 at 10:01 AM, the ADM stated after watching the video of CNA A with Resident #1, she had concerns about how CNA A talked to Resident #1 and the tone used. She stated CNA A should not have isolated the resident in the room. She stated she did not want CNA A to return. She stated she reported the allegations of abuse to the staffing agency that placed CNA A at the facility. The ADM stated she did not know what the Resident #1 meant when she stated, That hurts. During a telephone interview on 03/03/25 at 10:38 AM, Resident #1's FM stated the resident did not see or hear well and she always asked for the name of anyone in the room. The FM stated the resident told her the staff would not say her name, so the resident continued to put on her call light waiting for someone different to come in the room. She stated the same person came in the room and turned off the call light every time. She stated the resident was very fearful about staying at the facility as she did not feel safe. She stated Resident #1 moved to another facility. (continued on next page)		

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/03/25 at 2:23 PM, RN B stated she worked with Resident #1 on the evening of 02/03/25. She stated she was in and out of rooms on Resident #1's hallway and did not see anything unusual or out of the ordinary that evening. She stated during her interactions with Resident #1, the resident was concerned about her fall from earlier on the day shift. RN B stated she received ANE training during orientation to the facility a couple months ago and again just after the alleged abuse with Resident #1. She stated the training after the alleged abuse included type of abuse such as physical, verbal, mental, and seclusion, when to report and who to report to. The training included dealing with challenging behaviors and Resident Rights. She stated any suspected abuse was immediately reported to the ADM who was the Abuse Coordinator. She stated the notification must be a phone call not a text message. During an observation and interview on 03/03/25 at 2:40 PM, the ADM stated she was not able to send the surveillance videos but showed the videos on her laptop. The ADM started the first video clip, time-stamped just after 8:00 PM, which revealed a resident seated in a wheelchair in the doorway of her room. The resident rang a handheld bell. The ADM identified the resident as Resident #1. The call light indicator above the doorway was illuminated which indicated the call light was on. A few seconds later, a person approached Resident #1. The ADM identified the person as CNA A. CNA A wore a blue face mask. CNA A asked twice, How may I help you? Resident #1 intermittently rang the handheld bell. Standing in front of Resident #1, CNA A stated, Is this what you resort to? Resident #1 stated, I can't see, what is your name? CNA A asked, How can I help you? CNA A stated, I'm not the reason you fell. Resident #1 continued to ring the bell. CNA A bent over and pushed the resident in the wheelchair back towards the room and said she would put her to bed. Resident #1 began asking loudly, What is your name? While she held the wheelchair in place, CNA A stated, You shouldn't act like this. Resident #1 pleaded, with desperation in her voice, Tell me your name. CNA A stated, I told you, (name). CNA A leaned over close to Resident #1's head and yelled, (name), (name), (name). She yelled her name multiple times while still holding the wheelchair in place. The resident looked confused and asked, (similar name)? CNA A stood up and asked the resident, Now do you feel better? CNA A told Resident #1 she was disturbing the other residents with the bell. CNA A told Resident #1 to roll back, We are going to shut the door because you cannot disturb the other residents. CNA A grabbed the wheelchair arms and rolled it back into the room. Resident yelled out. CNA A backed up into the hall and shut the room door. Resident #1 continued to ring the handheld bell inside the room. CNA A left the area. The video clip lasted about three minutes. The second video clip started when CNA A was observed standing outside of Resident #1's room. The door was still closed. CNA A was holding the door handle with one hand. She had Resident #1's bell and placed it on the handrail. CNA A put a second hand on the door handle and held the door closed. Noises of attempts to open the door were heard. Resident #1, sounding distressed yelled, Let me out. CNA A opened the door and the door hit Resident #1's wheelchair. Resident #1 stated she wanted to go to bed. CNA A stated, I want to put you to bed but you aren't acting right with all that yelling and screaming. CNA A walked away from the resident. The call light was still on. Resident #1 moved her wheelchair back into the doorway. The video ended. The ADM stated the tone of voice used by CNA A concerned her. The ADM stated the first time she watched the video, she did not realize CNA A held the room door closed. She stated CNA A should not have closed the door to Resident #1's room, nor held it closed. She stated she did not want CNA A back in the facility. (continued on next page)		

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/03/25 at 3:44 PM with the SW, she stated she had visited with Resident #1 a few times after the alleged incident. She stated the resident did not feel safe. The SW was unable to clarify whether the resident did not feel safe because of the fall or because of something else. She stated the resident was very hard of hearing and almost blind, she had a hard time identifying people. The SW stated Resident #1 was able to move herself around once seated in the wheelchair. The SW stated she had received training after the allegation of abuse of Resident #1 on resident rights, dealing with cognitive impairment and difficult behaviors, and reporting abuse and neglect allegations. During an interview on 03/03/25 at 3:59 PM, the DON stated she had assessed Resident #1 on 02/04/25 and did not have any physical findings. The DON stated the resident told her the staff member would not say her name, so she wanted someone else to take care of her. She stated it was not okay to close a resident's door if they want it open. She stated it was not acceptable to hold a room door closed to prevent the resident from leaving the room. She stated the facility provided frequent training on abuse and neglect. She stated the agency CNA would not be allowed back in the facility. During a telephone interview on 03/03/25 at 4:11 PM, the GM from the staffing agency who placed CNA A in the facility, stated she was made aware, by the facility, of the allegation of abuse against CNA A. She stated the hero, what they call CNAs, was suspended while the facility investigated. During an interview on 03/03/25 at 4:26 PM CNA C stated she worked on the evening of 02/03/25 and assisted Resident #1 from the bed to the wheelchair early in the shift. She stated Resident #1 was never a problem for me. She stated she did not see anything that night unusual on Resident #1's hall. She stated she had been trained on ANE . She stated if you see it or suspect it report it immediately. Report to the supervisor, the charge nurse, and the ADM. She stated the ADM was the abuse coordinator. During an interview on 03/03/25 at 4:26 PM CNA C stated she worked on the evening of 02/03/25 and assisted Resident #1 from the bed to the wheelchair early in the shift. She stated Resident #1 was never a problem for me. She stated she did not see or hear anything that night unusual on Resident #1's hall, but she spent most of her time on the adjacent hall where she was assigned. She stated she had been trained on ANE and resident rights a couple days after 02/03/25. She stated if you see it or suspect it report it immediately. Report to the supervisor, the charge nurse, and the ADM. She stated the ADM was the abuse coordinator. (continued on next page)		

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 03/05/25 at 3:05 PM, CNA A confirmed that she worked with Resident #1 on the evening of 02/03/25. When asked to describe the events of the evening she stated, Resident #1 wanted to go to sleep. Something happened earlier and she kept asking if I was going to drop her. She let me put her in bed and she napped. Around 4:15 or 4:30 PM Resident #1 put the call light on and she acted like she didn't know me. She stated she wanted the other lady. After dinner I asked if she was ready to go to bed, she told me she didn't want me to put her to bed. She stated she went back to the room around 9:30 PM to ask again and when I walked into the room, she kicked me. The light was on, and I was holding the door closed until I could get someone else to come help me put her in bed. I was told there was no clear evidence that I did anything wrong. CNA A stated she was aware the facility had cameras in the building, Yes, the camera was right there. CNA A stated she had told the GM from the staffing agency that she had been kicked but did not tell anyone else. CNA A stated she was not 100% sure if she had told the Resident #1 that she was disturbing other residents, so she was going to close her door. CNA A stated she had closed Resident #1's door between 7:30 PM to 8:30 PM but was not sure of the specific time. CNA A stated she held the door closed because Resident #1 was yanking on it trying to get out, I did not want her to hurt her arm. She stated she cracked the door open, and they talked through the opening then, opened the door all the way. CNA A stated she had been trained on ANE . She stated abuse could be neglect, verbal, or physical. Review of the undated Resident Rights policy, reflected in part, .To be treated with respect and dignity. To be free from any physical or chemical restraint imposed for convenience or discipline and not required to treat the resident's medical condition. To be free from abuse, neglect, misappropriation of resident property, and exploitation including corporal punishment, involuntary seclusion . Review of the undated Prevention and Reporting of Suspected Resident Abuse and Neglect policy, reflected in part, This facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect. This facility has implemented the following processes in an effort to provide residents and staff a comfortable and safe environment .Protection: suspend suspected employee(s) pending outcome of the investigation .definitions 1. Verbal Abuse - Oral, written or gestured language that includes disparaging and derogatory terms to the residents or their families or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability .5. Involuntary Seclusion - Separation of a resident from other resident or from his/her room against the resident's will . The facility implemented the following interventions : Review of Resident #1's medical record progress notes dated 02/04/25, reflected Resident #1 was assessed by the SW and nursing. A head-to-toe assessment dated [DATE], completed by the DON, reflected no injuries identified. The comprehensive care plan, initiated 12/03/24, was reviewed and revised on 02/11/25. Review of the facility's undated Investigation Summary reflected on 02/04/25, CNA A was interviewed by the ADM and DON. CNA A provided a written statement and was notified she was not allowed to work at the facility pending the investigation. Review of the facility's undated Investigation Summary reflected on 02/04/25, CNA A's staffing agency was notified of the allegations of abuse and indicated as Do Not Return. (continued on next page)		

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's undated Investigation Summary reflected on 2/4/25, 2/5/25, and 2/7/25 the facility communicated with Resident #1's responsible party about the allegation and investigation. The facility assured her the alleged perpetrator would not work at the facility. Review of the facility's undated Investigation Summary reflected staff working the evening and night of 02/03/25 were interviewed between 02/04/25 and 02/07/25. The staff interviewed included RN B, CNA C, CNA D, CNA E, and MA F with no further adverse findings. Review of the facility's undated Investigation Summary reflected the local Police Department was contacted regarding the allegation. Review of the facility's undated Investigation Summary reflected the security camera footage of the exterior of Resident #1's room was reviewed on 02/03/25. Other concerns were identified, and CNA A was indicated as Do Not Return. The abuse allegation information was sent to the agency for their follow up. Review of the Resident Interview Questions for Abuse Allegation (Safe Surveys) dated from 02/04/25 through 02/27/25 conducted by the SW revealed no concerns of abuse identified and the residents felt safe in the facility. Review of an in-service dated 02/04/24, reflected administration and therapy staff were in-serviced on Caring for Cognitively Impaired with Challenging Behaviors. Bullet points attached. Review of an in-service dated 02/04/24, reflected all staff were in-serviced on Caring for Cognitively Impaired with Challenging Behaviors. Bullet points attached. Review of an in-service dated 02/04/24, reflected all staff were in-serviced on Abuse Prevention and Reporting - All allegations must be reported immediately to the ADM. Policy attached. Review of an in-service dated 02/04/24, reflected administration and therapy staff were in-serviced on abuse Prevention and Reporting - All allegations must be reported immediately to the ADM. Policy attached. Review of an in-service dated 02/05/25, reflected dietary staff were in-serviced on Prevention and Reporting of Abuse and Neglect. Report any suspected abuse and neglect immediately to ADM. Policy attached. Review of in-services dated 02/05/25, reflected RN B was in-serviced on Conditions to report to administration, Abuse and neglect prevention and reporting, dealing with challenging behaviors. Policies and PowerPoint attached. Review of an in-service dated 02/07/25, reflected housekeeping staff were in-serviced on Prevention and Reporting of Abuse and Neglect. Report any suspected abuse and neglect immediately to ADM. Policy attached. (continued on next page)		

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an in-service dated 02/07/25, reflected administration and therapy staff were in-serviced on Resident Rights. Please see list of Resident Rights, including the right to a dignified existence, self-determination, and communication . to be treated with respect and dignity, and to be free from abuse and neglect. Policy attached. Review of an in-service dated 02/07/25, reflected the receptionists were in-serviced on Resident Rights. Please see list of Resident Rights, including the right to a dignified existence, self-determination, and communication . to be treated with respect and dignity, and to be free from abuse and neglect. Policy attached. Review of an in-service dated 02/07/25, reflected all staff were in-serviced on Resident Rights. Please see list of Resident Rights, including the right to a dignified existence, self-determination, and communication . to be treated with respect and dignity, and to be free from abuse and neglect. Policy attached. Review of an in-service dated 02/07/25, reflected dietary staff were in-serviced on Resident Rights. Please see list of Resident Rights, including the right to a dignified existence, self-determination, and communication . to be treated with respect and dignity, and to be free from abuse and neglect. Policy attached.		