| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676290 | A. Building<br>B. Wing | 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Spjst Rest Home 1 | 1810 Old Granger Road<br>Taylor, TX 76574 |

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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<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884<br><br>Based on interview and record review, the facility failed to ensure staff did not use physical abuse or corporal punishment on a resident for one of three residents (Resident #1) reviewed for abuse.<br><br>CNA C pulled Resident #1's hands and refused to stop when Resident #1 repeatedly stated to stop and there was a bruise on Resident #1's right hand after CNA C pulled on her hand. Resident #1 stated CNA C was hurting her while attempted to transfer her from lying position in bed to sitting position on the side of bed. Resident #1 was afraid of CNA C and isolated self in room after the incident.<br><br>An Immediate Jeopardy (IJ) situation was identified on 06/03/2024 at 8:19 PM. While the IJ was removed on 06/06/2024 at 6:50 PM, the facility remained out of compliance at a severity of no actual harm that is not immediate and a scope of isolated.<br><br>This failure placed residents at risk for injury, harm, psychosocial harm, and a decreased quality of life.<br><br>Findings included:<br><br>Record review of Resident #1's face sheet, dated 06/03/2024, reflected Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of rheumatoid arthritis with rheumatoid factor, unspecified (a chronic inflammatory disorder that affects more than just your joints), polyosteoarthritis, unspecified (have arthritis in five or more joints at the same time), and scoliosis, unspecified (spine deformity).<br><br>Record review of Resident #1's BIMS assessment, dated 05/16/2024, reflected Resident #1 had a BIMS score of 15 which indicated her cognition was intact.<br><br>Record review of Resident #1's Admission Assessment, dated 05/22/2024, reflected Resident #1 had a BIMS score of 11 which indicated her cognitive status was moderately impaired. She required assistance with ADLs such as: bathing, dressing, hygiene, bed to chair transfer, sit to stand transfer, toilet transfer and shower transfer. Resident #1 was assessed to need PRN pain medication. She also had diagnosis of arthritis (joint inflammation) and medically complex conditions (usually involve multiple body systems and are often chronic in nature).<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of Resident #1's Baseline Care Plan, dated 05/17/2024, reflected Resident #1 was alert and oriented to time, place, and person. She was at risk for pain related to scoliosis and other diagnosis. Her bed mobility, dressing, transfers, and toileting required one staff person assist.<br><br>Record review of Resident #1's Comprehensive Care Plan, dated 05/22/2024, reflected Resident #1 was at risk for injury from decrease in ADLs. Intervention: Administer medication as ordered per the physician. Assess and document pain level. She had impaired physical mobility related to rheumatoid arthritis, and polyarthritis. Intervention: Encourage participation in range of motion exercises and praise accomplishments. Evaluate and treat underlying causes. PT and OT evaluations as needed. Resident is at risk for falls due to impaired mobility. Interventions: Increased staff supervision with intensity based on resident need. Monitor resident's use of side rails when repositioning and resident's ability to safely enter/exit bed. Monitor resident's use / need of side rails per protocol.<br><br>Record review of Resident #1's Nurses Notes, dated 05/15/2024 at 9:24 PM reflected Resident #1 was admitted to the facility. She had a bruise on top of her right-hand brown in color. (there was not a skin assessment completed on 05/15/2024). Signed by LVN F.<br><br>Record review of Resident #1's facility Admission Record, dated 05/16/2024, reflected Resident #1 responded to commands. She was alert and oriented to person, place, time, and situation. Resident #1's right and left-hand grasp were weak. Her left and right foot press strength was also weak.<br><br>Record review of Resident #1's facility investigation report reflected the incident occurred on 05/16/2024 at 4:00 AM Resident #1 was interviewable and had capacity to make informed decisions. She had diagnosis of rheumatoid arthritis and polyosteoarthritis. CNA C was described as the perpetrator. Description of the allegation CNA C entered Resident #1's room to change her, CNA C was telling her to sit up, he grabbed Resident #1 by her hands and was assisting her up. Resident #1 asked him (CNA C) to stop because he was hurting her. Staff member (CNA C) kept pulling her up.<br><br>Assessment of Resident #1 completed by the Director of Nurses reflected there were purple discoloration to the top of right hand between the thumb and index finger. The size of the bruise on Resident #1 right hand was 5.5 cm x 3.0 cm and was tender to touch. There was not treatment provided. The investigation reflected the investigation findings was confirmed. NP, DON, and Administrator was notified. CNA C received one-on-one counseling (date counseling was completed not indicated on the facility investigation report) and was to return to facility and reassigned to work on another hall where Resident #1 was not residing. CNA C was reeducated on resident rights, abuse, and neglect. Resident wanted to notify her family. Investigation was completed by the Administrator and Director of Nurses.<br><br>Record review on 06/03/2024 of Resident #1's nurses note dated 05/16/2024 at 4:24 AM reflected Resident #1 was in bed resting with eyes closed, unlabored breathing with no facial grimacing noted and arouses without difficulty. Resident #1 is alert and oriented. She is capable of verbalizing her needs. (has numbers for vitals but does not describe what type of vitals was completed). Unable to assess skin integrity at this time related to Resident #1 refusal. Signed by LVN D<br><br>Record review of Resident #1's MAR reflected on 5/16/2024 LVN D administered PRN pain medication a 6:43 AM. Resident #1 pain was at an eight (on 1 being the lowest pain and 10 being highest in pain).<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of Resident #1's nurses notes dated 05/16/2024 at 9:15 AM (recorded as a late entry on 05/22/2024 at 6:32 PM) reflected DON called to room for assessment. Resident voiced concerns with aide on previous shift. DON conducted assessment and found purple discoloration to top of right hand between the thumb and index finger. 5.5 cm x 3.0 cm. Tender to touch. Declined pain medication. NP notified of findings on exam. Signed by Director of Nurses.<br><br>Record review of Resident #1's statement to the Director of Nurses on 05/16/2024 at 9:25 AM reflected he walked in and I've (Resident #1) had never done this before. He asked what do you need? Resident #1 stated she could probably go to the bathroom. He asked me if my clothes needed to be changed. Resident #1 stated if they need to. She also stated he changed my pants and got another pair of pants out of the closet. He was going to change my pants He stated to get up. He was very rude. Resident #1 stated her right wrist was sore. Resident #1 stated the CNA told her if I don't hurt you, I will hurt myself. She asked for someone else, the CNA stated he was the only one here.<br><br>Record review of CNA C's written statement dated 05/16/2024 at 5:01 PM reflected CNA C went in Resident #1 room during normal rounds. She stated she wanted to get up for the day. She was trying to find her call light but was unable to locate the call light. He stated it was attached to her right-side rail and was within reach. He stated he asked her are you sure you want to get up and she stated yes. CNA C stated he picked out a pair of pants and a shirt. He stated her brief was wet and he changed her brief. He stated he was putting on her socks and she stated Owe. CNA C also stated he was putting her pants on her and rolled her to her side and she stated, 'Owe like something hurt. He stated this was his first time working with Resident #1 and he did not know if she was in actual pain. He stated he asked her if she still wanted to get up and she said yes. He stated he assisted her in sitting position on the side of the bed. Resident #1 stated she needed something to hold on to in order to sit up on her own. Resident #1 decided she did not want to get up and I assisted her to lay back down on the bed. CNA C stated he was in her room over 20 minutes and he ensured call light was within reach and he left the room.<br><br>Record review of Resident #1's nurses note dated 05/16/2024 at 9:05 PM reflected Resident #1 continued to follow up for new admission from the assisted living. She is very pleasant and alert and oriented x 3 (person, place, and time). She is cooperative with care. Resident #1 had a small open area to her upper back with a band aid covering the area. When the band aid was removed prior to giving her a shower and a new band aid was applied to residents back after her shower. There was very minimal drainage noted to the area on her back. Resident #1 required extensive assistance of one staff for transfers. Resident's care remains ongoing. Written by LVN E.<br><br>Record review of Resident #1's electronic medical record reflected incident/ accident report, pain assessment, skin assessment or nurses' notes was not completed on 5/16/2024 after the incident was first reported to LVN A by CNA I LVN A did document Resident #1's vital signs on 05/16/2024 at 10:03 AM.<br><br>Record review of Resident #1's nurses note on 05/17/2024 at 1:56 PM reflected Resident #1 was a new admit. Resident #1 was assisted by one staff with transfers and toileting (incontinent of bladder). She was having difficulty adjusting to new environment and the need to ask for help. Resident #1 refused to come out of her room for activities and to eat in the dining room.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of Resident #1's nurses note from 05/17/2024 through 06/04/2024 did not mention her bruise or if she was in pain, having depression, or change in her emotional status from the incident on 05/16/2024. There were no follow-up notes to the incident with bruising on her hand on 05/16/2024.<br><br>Record review of Resident #1's nurses note on 06/04/2024 at 1:24 PM reflected there was a referral for supportive care for emotional distress. Supportive services in the facility today and will visit the resident and will obtain consent for visits. Signed by LVN H.<br><br>In an interview on 06/03/2024 at 8:45 AM the Director of Nurses stated she needed to ensure CNA C gave a more descriptive interview. She stated she did not want to use leading questions. The Director of Nurses stated she needed to have asked more questions to understand in detail how he assisted her from laying position to a sitting position.<br><br>Record review of LVN A's written statement (not dated) reflected LVN A received a report from Resident #1 stated CNA C was rude and rough with her. Resident #1 stated CNA C entered her room to assist with toileting and dressing early this AM. (no date on the statement). Resident #1 stated during CNA C assisting her he was pulling on her hands and arms and telling her to get up. Resident #1 stated she expressed several times he was hurting her and CNA C stated he did not want to hurt his back. Resident #1 requested to be assisted by another staff and CNA C stated he would get someone for her and he left the room and did not get anyone else to come to my room at assist me. Resident #1 stated she had bruising on her hand and the bruise was not present last night when she fell asleep. Resident #1 requested a male aide not enter her room. LVN A stated she received a verbal report from LVN D. LVN A stated in the report LVN D stated Resident #1 voiced aide was moving too fast and was rough. LVN D stated she spoke to CNA C to be mindful of how he was providing assistance.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on 06/03/2024 at 9:15 AM Resident #1 stated she was admitted to this facility from assisted living center owned by the same company. She stated she was admitted late afternoon on 05/15/2024. She stated during the early morning on 5/16/24 between around 3:00AM- 4:00 AM a male staff came into her room and asked her if she needed to be changed. She stated she explained to him she thought she needed to be changed but she would rather be changed later. Resident #1 stated he would not stop asking her and she finally told him to go ahead and change her. She stated he was standing at an angle by her bed and grabbed her hands and began pulling her from a laying position and attempted to pull her to sit on the side of the bed. Resident #1 stated she began to tell him he was hurting her and to stop. She stated she kept explaining to him he was hurting her and to stop. Resident #1 stated he continued to pull her hands attempting to sit her up on the side of the bed. She also stated when she kept saying you are hurting me please stop the CNA stated, I rather for you to hurt than for me to get hurt. She stated later he stated again I rather for you to hurt than for me to hurt my back. Resident #1 stated she was afraid of him. She stated she thought he was going to hurt her. Resident #1 stated she believed he was going to pull her arm out of socket he was pulling on her that hard. She also stated she was afraid he was going to break her wrist or bones in her hands or arm. Resident #1 stated she had been in hospitals and in nursing facilities but she had never experienced any type of treatment the CNA gave me. She stated she requested another aide to assist her and he explained he was the only one on duty. Resident #1 also stated he left her room and never sent anyone else in her room to assist her. She stated she described him to the Director of Nurses and another nurse worked the morning on 05/16/2024. She stated she found out CNA C was the one who hurt me. Resident #1 stated she had a bruise on her right hand and it was not there when she went to bed when she was admitted to the facility the day before. She also stated it was a new bruise and it was painful in the area where the bruise was located. Resident #1 stated a nurse came in before 7:00 AM and gave her some medication for pain. She stated the nurse who gave her the medication was the nurse that worked with CNA C. Resident #1 stated the nurse never came in her room until after the incident and wanted to see my skin. She stated she asked her why she needed to see her skin. She stated the nurse that worked the same time with CNA C stated it was something she did with everyone. Resident #1 stated she asked her about her furniture in her room. She also stated the nurse never looked at her hands. She was wanting to see her legs for something and I told her I did not have any of that on my legs. Resident #1 stated it had something to do with cells or something like that. She stated I never understood what she was wanting to look at my skin and not my hands where he had pulled on my hands. She stated she was not very clear of what she wanted to look at on her and she was afraid to let anyone touch her at that time due to being hurt by the aide. She stated she was not going to allow anyone that morning to touch her until she saw someone in charge. Resident #1 stated she was afraid to go to sleep and she did not know what the aide may do to her if he decided to move her again. She also stated she did not appreciate the tone of voice he used and making a statement he rather for me to hurt than for him to get hurt. Resident #1 stated that made me mad and she did not want to be around him. Resident #1 stated he is working on another hall and came back to work the very night this all happened to me. She stated she was afraid if she did see him in the hall and was afraid he would do something to her for reporting him. Resident #1 also stated she was so worried about the women he was taking care of on the other halls. She stated what if they cannot speak up for themselves and he hurts someone else. Resident #1 stated someone like him did not need to be taking care of anyone in a nursing home. She stated it has taken her 2 weeks or more to trust anyone in this facility. She stated when anyone comes in her room to give her care she begs them not to hurt her. She stated she asks them a lot of questions before she will agree for them to give her care. Resident #1 stated there were 2 or 3 staff that takes care of her now and she trusts them and one is a male. She said he was so gentle with her and was so good to her. She stated she did not trust not one person in the facility because she felt since they let him come back in that facility the management did not take this abuse seriously and she stated she did consider she was abused by the male aide that worked on her hall morning of 05/16/2024 and she stated his name was (she stated his name) and it was CNA C.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on 06/03/2024 at 9:57 CNA J stated she had given care to Resident #1. CNA J stated Resident #1 did not trust anyone and would ask staff to please don't hurt her or give her a bruise (Resident #1). CNA J stated Resident # 1 would talk to the staff and ask the staff questions before she would allow any staff to give her care. CNA J also stated Resident #1 trusted most staff but it was approximately 2 weeks after she was admitted to the facility before she trusted anyone. She stated Resident #1 would state the male aide hurt my hands and gave me a bruise and don't hurt me like hurt me.<br><br>In an interview on 06/03/2024 at 10:40 LVN A stated LVN D gave her verbal report at the change of shift the morning of 05/16/2024. She stated during the morning report LVN D stated Resident #1 stated CNA C was rough with her and moved too fast. LVN D stated if a staff is being rough with a resident during care that would be potential abuse. LVN D stated CNA I came to her and reported Resident #1 was making accusations of an aide hurting her hands and there were bruises on her hand. LVN A stated she went to Resident #1's room and observed a new bruise on top of her right hand between the thumb and index finger. She stated Resident #1 reported to her that the male aide worked last night and early this morning (05/16/2024) came into her room between 3:00 AM and 4:00 AM and asked her if she needed to be changed. She stated Resident #1 informed her CNA C grabbed her hands and attempted to transfer her from lying position to a sitting position by grabbing her hands and pulling on her hands. LVN A stated during interview with Resident #1 of what created the bruise on her hand, she stated CNA C would not stop when she asked him to stop pulling her hands because he was hurting her. She stated Resident #1 repeatedly stated you are hurting me and stop. LVN A also stated Resident #1 informed her CNA C stated, I rather for you to hurt than for me to get hurt. LVN A stated she did consider this physical and verbal abuse. She stated Resident #1 was afraid and stated she did not want any males in her room to give her care. LVN A also stated she was alert and oriented to person, place, time, and situation on the morning of 05/16/2024. She also stated Resident #1 did not trust staff in giving her care or come out of her room approximately 1-2 weeks after the incident with CNA C on 05/16/2024. LVN A stated Resident #1 would ask each staff who entered her room not to hurt her or give her a bruise. LVN A stated she did not trust anyone and would talk to the staff and question them before she would allow anyone to do any type of care for her.<br><br>In an interivew with Resident #1's R/P on 06/03/2024 at 11:30 AM she stated Resident #1 was afraid of CNA C and she repeated the same report of what occurred when CNA C pulled on her hands the early morning of 05/16/2024. She stated her mother (Resident #1) had been in the facility less than 24 hours. She also stated Resident #1 would not come out of her room approximately 1 week or more due to being afraid of CNA C and was afraid he may retaliate against her for reporting the incident of abuse.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on 06/03/2024 at 11:50 AM LVN D stated she was not aware any incident occurred with Resident #1 during her shift on 05/15/2024-05/16/2024. She stated CNA C did not report anything to her. LVN D stated she went to Resident #1 during her shift sometime after midnight to check on her. LVN D stated she could not remember her nurses note documented on 05/16/2024 at 4:24 AM. She stated (after her nurses note read to her) she went in Resident #1's room to check Resident #1's skin. LVN D stated she is expected to check residents' skin before 4:00 AM if it is required to be checked. She stated Resident #1 had diagnosis of cellulitis (a common skin infection caused by bacteria), and was ordered medication for the cellulitis. LVN D stated she was required to check the area of cellulitis. She stated this is what she meant in her note when it stated to assess skin integrity. She stated she went in Resident #1's room to check the area of cellulitis. She stated Resident #1 did refuse and she did not go back to her room to check her skin. LVN D stated she did not recall why she spoke to CNA C related to being mindful of the care he was giving to Resident #1. She stated later in the morning (05/16/2024) around 6:00 AM she spoke with Resident #1 about if she had been abused. She stated she did not know the reason she asked her that question and that was something they ask new admission residents. LVN D stated Resident #1 denied being abused and they talked about her personal items in her room. LVN D stated she did not ask Resident #1 if anything happened to her earlier in the morning. She stated she did not believe there was a reason to ask Resident #1 any questions about if anything occurred with her and CNA C due to nothing had been reported to her of any type of incident. LVN D stated she did give a verbal report to LVN A at the change of shift but did not recall what she reported to LVN A. She also stated she did not know why Resident #1 was in pain around 6:45 AM on 05/16/2024. She stated she did remember giving her a pill for pain but did not recall why Resident #1 was in pain.<br><br>Record review of Resident #1's medical diagnosis in the electronic medical record revealed she does not have a diagnosis of cellulitis.<br><br>In an interview on 06/03/2024 at 12:50 PM CNA I stated she was taking care of Resident #1 the day shift on 05/16/2024. She stated on 05/16/2024 when she entered Resident #1's room, she was not smiling and had a grimace expression on her face and immediately stated don't hurt me. CNA I stated when she spoke to Resident #1 she began saying please don't give me a bruise and hurt me. CNA I also stated Resident #1 expressed to her that she did not trust anyone in the facility. CNA I stated Resident #1 explained to her a male CNA was in her room between 3:00 AM-4:00 AM early in the morning (on 5/16/2024) and asked her if she needed assistance. CNA I stated Resident #1 kept rubbing her hands and explained the male CNA pulled on her hands when he tried to pull her up from lying in the bed to sit on the side of the bed. CNA I stated Resident #1 informed her she told the male aide to stop and he was hurting her and he would not stop pulling her hands. CNA I also stated Resident #1 explained the male aide told her I rather for you to hurt than for me to get hurt. CNA I stated she observed a bruise on her right hand on top of hand near her thumb and the finger beside the thumb. She stated Resident #1 told her it was hurting but she got something for pain. CNA I stated she reassured Resident #1 she would not hurt her and would be very slow giving her care. CNA I stated she found LVN A and reported to her what Resident #1 told her and LVN A went to Resident #1 and assessed her. CNA I stated for approximately 2 weeks after the incident on 05/16/2024 with Resident #1, she would state to every staff who entered her room please don't hurt me and give me a bruise and would repeat please don't hurt me. CNA I stated Resident #1 would talk with staff before she would allow them to do anything for her. She also stated Resident #1 did not come out of her room or interact with anyone but her family approximately 1-2 weeks after the incident on 05/16/2024.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an attempted interview with CNA C on 06/03/2024 at 1:20 PM attempted to call CNA C and left voice message.<br><br>In an attempted interview with CNA C on 06/03/2024 at 3:00 PM attempted to call CNA C and left a voice message.<br><br>In an interview on 06/03/2024 at 3:10 PM the Director of Nurses stated she completed the investigation of the incident with Resident #1 and CNA C. She stated abuse was confirmed during the investigation. She stated Resident #1 had a BIMS score of 15 which indicated her cognitive status was intact. She also stated Resident #1 reported the same event that occurred with CNA C each time she had spoke to her. The Director of Nurses stated Resident #1 did have difficulty trusting staff and would talk to the staff before she agreed for any type of care given to her. She also stated LVN A reported the incident to her after LVN A assessed Resident #1. She stated she completed investigation on 05/16/2024 and it was confirmed abuse did occur when CNA C pulled on Resident #1's hands when Resident #1 asked CNA C to stop numerous times. She stated Resident #1 was afraid CNA C was going to harm her such as: break her hand or pull her shoulder out of socket. Director of Nurses stated Resident #1 did not come out of her room approximately 1-2 weeks after the incident 05/16/2024. She stated she would speak to each staff who entered her room and would not allow them to give her care until she felt safe and the staff reassured her they would not hurt her. She stated she agreed Resident #1 was reporting exactly what happened early morning of 05/16/2024 and she was physically and verbally abused by CNA C.<br><br>In an interview on 06/03/2024 at 3:45 PM The Administrator stated he did sign the investigation report and it was confirmed Resident #1 was abused by CNA C. He stated he did speak to Resident #1. The Administrator did not elaborate on the details of their conversation. He stated he was not aware of CNA C making a statement he rather for Resident #1 to hurt than for him to hurt. He stated he was not aware of this statement until 06/03/2024.<br><br>Record review of the Facility's Resident Abuse/ Neglect Policy (not dated) reflected This facility will not tolerate resident abuse and neglect. Any reported of suspected abuse or neglect will be thoroughly investigated by administrative staff. The residents in this facility have the right to be free of verbal, sexual, physical, or mental abuse, corporal punishment, involuntary seclusion, and/ or injury of unknown source. Definitions:<br><br>1. Abuse- Any act, failure to act, or incitement to act done willingly, knowingly, or recklessly through words or physical action which causes or could cause mental or physical injury or harm or death to a resident.<br><br>2. Physical Abuse- Physical action within the definition of abuse including, but not limited to, hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment.<br><br>3. Verbal Abuse- The use of any oral, written, or gesture language that includes disparaging or derogatory terms to the resident or within the resident's hearing distance, regardless of the resident's age, ability to comprehend, or disability.<br><br>The Administrator was notified on 06/03/2024 at 8:19 PM, that an Immediate Jeopardy had been identified due to the above failures and an IJ template was provided.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676290 | A. Building<br>B. Wing | 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Spjst Rest Home 1 | 1810 Old Granger Road<br>Taylor, TX 76574 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The following POR was accepted on 06/05/2024 at 06:01 PM:<br><br>On 06/03/2024, an abbreviated survey was initiated at the facility. On 06/03/2024, the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to resident health and safety.<br><br>Plan of Removal for F600<br><br>The facility failed to ensure that the resident was free from Abuse.<br><br>CNA C attempted to transfer Resident #1 from her bed by pulling her by her arms and hands causing bruising to the resident.<br><br>The facility failed to assess and document the injuries of Resident #1 after advising staff her hand was tender to touch.<br><br>The facility failed to immediately assess Resident #1 after the allegation of physical abuse was made to LVN A.<br><br>Action:<br><br>On 6/04/2024, the DON designated an LVN to make a referral to Psychological Care, and Resident #1 was evaluated by their psychologist. The psychologist reported to the DON on 06/04/2024 that resident was doing great. The psychologist will continue to visit with the resident until she discharges her from psychological services. On 06/04/2024, the DON assessed the resident's hands where injuries occurred during transfer. DON stated that the resident has no more pain and that the injuries are in the final stages of healing. No follow-up will be needed for the bruises on the resident's hands.<br><br>Starting 06/04/2024, The DON or designee will in-service and retrain nursing staff on policy and procedures of transfers. Safe transfers must be performed by all staff who work in patient care areas. All CNA's and nurses are required to follow transfer procedures. Education will include stand by, one person assists, 2 person assist, sliding board, sit to stand (Sara lift), Hoyer lift, and the stand and pivot. Return demonstration will be provided by the trainee to confirm understanding. The ADON or designee will monitor 4-5 transfers per week for 3 months to verify company policies and procedures are followed thoroughly and report findings to the DON and/or administrator weekly.<br><br>Starting 06/04/2024, The DON or designee will in-service and re-educate all nursing staff on when resident physical assessments should be completed, and appropriate documentation made. If a resident makes any type of physical abuse allegation, then a complete head-to-toe physical assessment must be completed by the charge nurse. If injuries are found on assessment, appropriate documentation in observations and progress notes should be made as well as documentation of provider informed. Progress notes should be made on each shift by the charge nurse stating a detailed update on the injury site. Staff will be educated on when families should be informed of injuries or findings in a timely manner.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The DON and administrator will be reeducated on pain and skin assessments and following proper policies & procedures by outside DON on 06/05/2024. Starting 06/04/2024, The Director of Nursing (DON) or designee will reeducate all nursing staff on triggers to notice when a resident is in pain and what steps need to be taken. If a C.N.A. observes a resident grimacing in pain, then he/she must notify the charge nurse immediately. The charge nurse should evaluate the resident for pain and take appropriate measures. If the resident has orders in place for pain management, then the charge nurse is to follow orders and follow-up an hour after treatment is provided to determine if treatment was successful. If current orders do not seem to be effective, then the charge nurse is to call the attending physician for further treatment/recommendations. If a resident makes an allegation of physical abuse, then the charge nurse is to immediately complete a head-to-toe assessment on the resident and document his/her findings on the resident's skin.<br><br>The ADON or designee will monitor all reported pain assessments, via the 24-hour reports 4-5 days per week, to ensure that policies and procedures are being followed appropriately by the nursing staff. The ADON will report her findings to the DON and/or administrator weekly unless she finds noncompliance. If noncompliance is found, she will report immediately to the DON and/or administrator.<br><br>Start Date: 06/04/2024.<br><br>Completion Date: The above will be completed by 06/07/2024.<br><br>Responsible: Administrator, DON and ADON<br><br>Monitoring:<br><br>Record review on 06/06/2024 of the in-service on abuse/neglect reflected the Administrator and the Director of Nurses was in serviced by Administrator M and DON/RN K from a facility owned by the same company. They were in serviced on the following:<br><br>1. Types of Abuse and Neglect such as verbal, physical, mental, emotional, sexual, exploitation, and neglect.<br><br>2. Procedure for suspected abuse and/or neglect.<br><br>3. Signs of abuse and /or neglect<br><br>4. Training, reporting, response, investigation [TRUNCATED] |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884<br><br>Based on interview, and record review, the facility failed to implement their written policies and procedures that prohibit and prevent the abuse of residents for one (Resident #1) of three residents reviewed for abuse.<br><br>The facility did not implement the Abuse and Neglect Policy when CNA C abused Resident #1 and CNA C was not immediately relieved of duty.<br><br>This failure could place residents at risk of abuse, neglect, physical harm, pain, mental anguish, emotional distress, and serious harm.<br><br>An Immediate Jeopardy (IJ) situation was identified on 06/03/2024 at 8:19 PM. While the IJ was removed on 06/06/2024 at 6:50 PM, the facility remained out of compliance at a scope of isolated with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.<br><br>Findings included:<br><br>Record review of the Facility Policy of Resident Abuse/ Neglect, (not dated), reflected This facility will not tolerate resident abuse and neglect. Any reported of suspected abuse or neglect will be thoroughly investigated by administrative staff. The residents in this facility have the right to be free of verbal, sexual, physical, or mental abuse, corporal punishment, involuntary seclusion, and/ or injury of unknown source. Definitions:<br><br>1. Allegations of Abuse/Neglect (Employees): After investigation is completed, and there is reason to believe that abuse, neglect, or mistreatment of a resident has occurred, the administrator or his/her designee will notify the family, attending physician, medical director, ombudsman, and the licensing agency. The administrator will relieve the employee of duty immediately.<br><br>2.Abuse- Any act, failure to act, or incitement to act done willingly, knowingly, or recklessly through words or physical action which causes or could cause mental or physical injury or harm or death to a resident.<br><br>3. Physical Abuse- Physical action within the definition of abuse including, but not limited to, hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment.<br><br>3. Verbal Abuse- The use of any oral, written, or gesture language that includes disparaging or derogatory terms to the resident or within the resident's hearing distance, regardless of the resident's age, ability to comprehend, or disability.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of Resident #1's face sheet, dated 06/03/2024, reflected Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of rheumatoid arthritis with rheumatoid factor, unspecified (a chronic inflammatory disorder that affect more than just your joints), polyosteoarthritis, unspecified (have arthritis in five or more joints at the same time), and scoliosis, unspecified (spine deformity).<br><br>Record review of Resident #1's BIMS assessment, dated 05/16/2024, reflected Resident #1 had a BIMS score of 15 which indicated her cognition was intact.<br><br>Record review of Resident #1's Admission MDS Assessment, dated 05/22/2024, reflected Resident #1 had a BIMS score of 11 which indicated her cognitive status was moderately impaired. She required assistance with ADLs such as: bathing, dressing, hygiene, bed to chair transfer, sit to stand transfer, toilet transfer and shower transfer. Resident #1 was assessed to need PRN pain medication. She also had diagnosis of arthritis (joint inflammation) and medically complex conditions (usually involve multiple body systems and are often chronic in nature).<br><br>Record review of Resident #1's Baseline Care Plan, dated 05/17/2024, reflected Resident #1 was alert and oriented to time, place, and person. She was risk for pain related to scoliosis and other diagnosis. Her bed mobility, dressing, transfers, and toileting required one staff person assist.<br><br>Record review of Resident #1's Comprehensive Care Plan, dated 05/22/2024, reflected Resident #1 was at risk for injury from decrease in ADLs. Intervention: Administer medication as ordered per the physician. Assess and document pain level. She had impaired physical mobility related to rheumatoid arthritis, and polyarthritis. Intervention: Encourage participation in range of motion exercises and praise accomplishments. Evaluate and treat underlying causes. PT and OT evaluations as needed. Resident is at risk for falls due to impaired mobility. Interventions: Increased staff supervision with intensity based on resident need. Monitor resident's use of side rails when repositioning and resident's ability to safely enter/exit bed. Monitor resident's use / need of side rails per protocol.<br><br>Record review of Resident #1's facility investigation report reflected the incident occurred on 05/16/2024 at 4:00 AM Resident #1 was interviewable and had capacity to make informed decisions. She had diagnosis of rheumatoid arthritis and polyosteoarthritis. CNA C was described as the perpetrator. Description of the allegation CNA C entered Resident #1's room to change her, CNA C was telling her to sit up, he grabbed Resident #1 by her hands and was assisting her up. Resident #1 asked him (CNA C) to stop because he was hurting her. Staff member (CNA C) kept pulling her up.<br><br>Assessment of Resident #1 completed by the Director of Nurses reflected there were purple discoloration to the top of right hand between the thumb and index finger. The size of the bruise on Resident #1 right hand was 5.5 cm x 3.0 cm and was tender to touch. There was not treatment provided. The investigation reflected the investigation findings was confirmed. NP, DON, and Administrator was notified. CNA C received one-on-one counseling (date counseling was completed not indicated on the facility investigation report) and was to return to facility and reassigned to work on another hall where Resident #1 was not residing. CNA C was reeducated on resident rights, abuse, and neglect. Resident wanted to notify her family. Investigation was completed by the Administrator and Director of Nurses.<br><br>Record review of CNA C's time sheet reflected he was allowed to return to work the night of 05/16/2024.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of CNA C's disciplinary action dated 05/22/2024 reflected CNA C had a final written warning for performance and policy violation. Details of the incident: see self-report (gave the intake number of this investigation). Methods by which the employee can correct the unsatisfactory behavior: No further C/O abuse by residents. Consequences: Termination. Time frame for improvement: Remaining Employment. Employee Signature: Via Phone date: -5/22/2024. Preparer's signature: Director of Nurses date: 05/22/2024.<br><br>In an interview on 06/03/2024 at 2:00 PM Resident #1 stated she was happy someone was here to investigate what happened to her when she was admitted to this facility. She stated she had not seen CNA C and she hoped she never saw him for the rest of her life. Resident #1 stated if she saw him she did not know what she would do but try to get away from him. She also stated she was afraid that morning when he was pulling her hands and she kept asking him to stop. She stated her hand did hurt and she asked for a pain pill for her hand. She stated the nurse worked the same time as CNA C did not ask her anything what happened. She stated she wanted to look at her skin and did not understand what she was wanting to look at. She did not ask to look at her hands. Resident #1 stated if the nurse (LVN D) asked her to look at her hands she would have let her. Resident #1 stated she did not understand why the CNA C did not stop when she told him to stop he was hurting her hands. She stated she interviewed staff and asked them questions before she allows anyone to touch her. Resident #1 stated she was lying in bed asleep when CNA C came in the room and kept on wanting her to sit up on the bed and be changed. She stated she did not trust him by the way he talked to her in a loud tone and was not treating her like a human. Resident #1 stated he kept pulling on her hands and then told me he rather for me to hurt than from him to get hurt. She stated no one had ever treated me so bad like he did early that morning. She stated she had only been in the facility less than 24 hours. Resident #1 also stated when CNA C said to her he rather for her to hurt than for him to get hurt, she stated she felt he was the meanest person to say something like that to an elderly lady who could not care for herself. She stated it made her mad and she became more afraid of CNA C after he said he did not care if she hurt as long as he did not hurt. Resident #1 stated she did not see him again after that night he pulled on her hands.<br><br>In an interview on 06/03/2024 at 3:10 PM the Director of Nurses stated she completed the investigation of the incident with Resident #1 and CNA G. She stated abuse was confirmed during the investigation. The Director of Nurses stated Resident #1 did have difficulty trusting staff and would talk to the staff before she agreed for any type of care given to her. She also stated LVN A reported the incident to her after LVN A assessed Resident #1. She stated she completed investigation on 05/16/2024 and determined abuse did occur with Resident #1 from CNA C. She stated Resident #1 was afraid CNA C was going to harm her such as: break her hand or pull her shoulder out of socket. Director of Nurses stated Resident #1 did not come out of her room approximately 1-2 weeks after the incident 05/16/2024. She stated she would speak to each staff who entered her room and would not allow them to give her care until she felt safe and the staff reassured her they would not hurt her. The Director of Nurses stated CNA C was counseled via phone on 05/22/2024. She stated the investigation was completed on 05/16/2024 and she did not counsel with him and give him a written disciplinary action until 05/22/2024 via phone. She stated she should have spoken to him face to face when she gave him the disciplinary action. The Director of Nurses stated she did not recall the reason the disciplinary action was not completed on 05/16/2024 after the investigation. She stated according to the facility policy he should have been terminated immediately and the abuse was violation of their abuse and neglect policy.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on 06/03/2024 at 3:45 PM The Administrator stated he did sign the investigation report and it was confirmed Resident #1 was abused by CNA C. He stated CNA C had not been accused of abusing anyone in the facility until now. The Administrator also stated he believed CNA C had only been confirmed abuse one time and the Administrator did not agree with terminating him at that particular time. He stated according to the policy the facility was required to terminate CNA C immediately.<br><br>The Administrator was notified on 06/03/2024 at 8:19 PM, that an Immediate Jeopardy had been identified due to the above failures and an IJ template was provided.<br><br>The following POR was accepted on 06/05/2024 at 06:01 PM:<br><br>On 06/03/2024, an abbreviated survey was initiated at the facility. On 06/03/2024, the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to resident health and safety.<br><br>The notification of Immediate Jeopardy states as follows:<br><br>F607 The facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect and exploitation of residents.<br><br>CNA A- attempted to transfer Resident #1 from her bed by pulling her by her arms and hands causing bruising to the resident.<br><br>The facility failed to follow their policy when physical abuse was confirmed.<br><br>Action:<br><br>On 6/04/2024, the DON designated an LVN to make a referral to Psychological Care, and Resident #1 was evaluated by their psychologist. The psychologist reported to the DON on 6/04/2024 that resident was doing great. The psychologist will continue to visit with resident until she discharges her from psychological services. On 6/04/2024, the DON assessed the resident's hands where injuries occurred during transfer. DON stated that the resident has no more pain and that the injuries are in the final stages of healing. No follow-up will be needed for the bruises on the resident's hands.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The DON and administrator will be reeducated on pain and skin assessments and following proper policies & procedures by outside DON on 6/05/2024. Starting 6/04/2024, The Director of Nursing (DON) or designee will reeducate all nursing staff on triggers to notice when a resident is in pain and what steps need to be taken. C.N.A.'s will be trained by the DON or designee on how to observe a resident that is grimacing in pain. The C.N.A. must notify the charge nurse immediately. The charge nurse should evaluate the resident for pain and take appropriate measures including documenting under pain assessment. If the resident has orders in place for pain management, then the charge nurse is to follow orders and follow-up an hour after treatment is provided to determine if treatment was successful. If current orders do not seem to be effective, then the charge nurse is to call the attending physician for further treatment/recommendations. All of this will be documented in the resident's progress notes and chart reports. The ADON or designee will monitor all reported pain assessments, via the 24-hour reports 4-5 days per week, to ensure that policies and procedures are being followed appropriately by the nursing staff. The ADON will report her findings to the DON and/or administrator weekly unless she finds noncompliance. If noncompliance is found, she will report immediately to the DON and/or administrator.<br><br>Starting 6/04/2024, The DON or designee will in-service all nursing staff on when providing a thorough skin assessment is necessary and expected, such as upon admission, if a bruise or skin tear is noticed for the first time on a resident, if resident complains of roughness or states they were abused. The charge nurse will be responsible for completing and documenting a thorough skin assessment, incident report and calling the physician for orders, if necessary. Along with a skin assessment, a pain assessment must always be performed to determine the pain level of the resident. If it is determined that the resident is in pain, then the procedures for pain treatment must be followed by the charge nurse. The ADON or designee will monitor all reported bruises / skin tears to ensure company policies and procedures are followed thoroughly. Findings will be reported weekly to the DON and/or administrator unless she discovers violation of policy. If violation of company policy is found, then she will report immediately to the DON and/or administrator.<br><br>Starting 06/04/2024, The DON or designee will in-service and retrain staff on policy and procedures of transfers. Safe transfers must be performed by all staff who work in patient care areas. All CNA's and nurses are required to follow transfer procedures. Education will include stand by, one person assists, 2 person assist, sliding board, sit to stand (Sara lift), Hoyer lift, and the stand and pivot. Return demonstration will be provided by the trainee to confirm understanding.<br><br>The ADON or designee will monitor 4-5 transfers per week for 3 months to verify company policies and procedures are followed thoroughly. Findings will be reported to the DON and/or administrator weekly unless noncompliance is observed. If noncompliance is observed, then she will report immediately to the DON and/or administrator.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The facility administrator and DON will be reeducated by outside administrator on company policies and procedures regarding resident abuse. The administrator, who is the abuse coordinator, or designee will in-service all facility staff on company policies and procedures regarding resident abuse/neglect. Administrator and DON will thoroughly review company policy and procedures regarding resident abuse and neglect for retraining purposes. If an employee witnesses an abuse allegation or if an employee is told that a resident is abused/neglected by a resident/family member or visitor, the employee will be trained by the administrator or designee to report the allegation, immediately to the administrator. If the administrator is unavailable, then the employee is to report the allegation to their immediate supervisor. It is then the supervisor's responsibility to notify the administrator. It is then the administrator's responsibility to ensure that all of the proper steps are completed, and a thorough investigation is completed, after reporting the allegation(s) to HHSC. The administrator or designee are responsible for completing the investigation and sending in the final report to HHSC in accordance with state regulatory requirements.<br><br>If any of the staff are unavailable for training sessions by 6/7/2024, then each employee, including agency staff will not be able to work on the floor until they have gone through the appropriate training.<br><br>C.N.A. A has been terminated from employment by the administrator, effective 6/04/2024.<br><br>Start Date: 06/04/2024.<br><br>Completion Date: The above will be completed by 6/7/2024.<br><br>Responsible: Administrator, DON and ADON<br><br>Record review on 06/06/2024 of the inservice on Resident Abuse/Neglect Policy, dated 06/04/2024, reflected 67 staff was inserviced on the abuse and neglect policy by the Administrator and DON.<br><br>Record review on 06/06/2024 of CNA C personnel record reflected he was terminated on 06/04/2024.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676290 | A. Building<br>B. Wing | 06/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Spjst Rest Home 1 | 1810 Old Granger Road<br>Taylor, TX 76574 |

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 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on 06/06/2024 at 11:03 am the DON stated she was reeducated on pain and skin assessments and the proper policies and procedures by DON K from a sister facility. She stated she was inserviced when pain and skin assessments were to be completed after an incident with a resident. The DON stated a pain and or skin assessment should be reported when any new skin findings or abnormalities are discovered, or resident has new complaints of pain or if resident falls. The DON stated if this occurred, a skin and pain assessment should be completed, and resident should be evaluated head to toe including any report of abuse or neglect. She also stated nurses were to evaluate pain, look at non-verbal grimacing, verbal screaming, the nurses had a scale of 0 - 10 to use on residents who are verbal. She also stated reporting should be completed when there was bruises from an unexplained injury within 2 hours of discovery. The DON also stated the nurses was expected to document in the chart any administration of pain medication as ordered or needed and to notify the physician. She also stated the CNAs was expected to immediately report any abuse/neglect, change of condition or pain to the charge nurse. She stated she was in-serviced on abuse and neglect and read over the policy. She stated she learned the facility had five days to complete investigation and send in the report to HHSC. She stated if anyone reported abuse or neglect to her or the Administrator they had 2 hours to resport it to HHSC. She sated the Administrator was the abuse and neglect coordinator. The DON also stated the staff was expected and had been in serviced to report any signs of abuse or neglect to the Abuse Coordinator, the Administrator.<br><br>On 6/6/2024 at 1:57 am the Administrator revealed he was reeducated on pain and skin assessments and the proper policies and procedures by RN K DON and Administer M at a sister facility. He learned pain and skin assessment should be complete anytime anything is noticed on a resident that has not been seen before. If it is noticed by the CNA, it should be report to the nurse immediately. If the CNA sees something that is red on the resident's body, and it is new it needs to be reported to the charge nurse. The charge nurse should then do a head-to-toe assessment and a pain assessment. He was also in-serviced in abuse and neglect. If someone is dismissed for abuse or neglect, the facility needs to report it to the licensing authority within 5 days. He will report abuse and neglect to HHSC as soon as possible as soon as he can get his computer up and running.<br><br>On 06/06/2024 at 6:50 PM, the Administrator was notified the IJ was removed on 06/06/2024 at 6:50 PM, the facility remained at a level of with potential for more than minimal harm that is not immediate jeopardy at a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. |