STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676294	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage House at Paris Rehab & Nursing	150 S.E. 47th Street Paris, TX 75462

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** 30527 Based on observation, interview and record review the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation or resident property, and exploitation for 1 of 17 residents (Resident #1) reviewed for abuse. The facility failed to keep Resident #1 free from abuse when CNA A roughly provided incontinent care to him on 06/07/2024. This failure could place residents at risk of abuse, humiliation, intimidation, fear, shame, agitation and a decreased quality of life. Findings include: Record review of a Grievance/Complaint Report dated 06/07/2024, received by ADON B reflected Resident #1's family member requested gentle movements of his legs during care. Documented facility follow-up action was to in-service staff members with 1:1 education and physical therapy in-service regarding transfer of resident out of bed. Record review of Resident #1's face sheet, dated 10/17/2024, reflected a [AGE] year old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included dementia (a group of thinking and social symptoms that interferes with daily functioning), congestive heart failure (a chronic condition where the heart does not pump blood as well as it should), Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), hypertension (high blood pressure), protein-calorie malnutrition the state of inadequate intake of food), cramp and spasm, pain in thoracic spine (the middle section of the back), muscle wasting, lack of coordination and cognitive communication deficit. Record review of Resident #1's Quarterly MDS assessment, dated 09/24/2024, reflected Resident #1 was understood and was able to understand others. Resident #1 had a BIMS score of 12, which indicated his cognition was moderately impaired. Resident #1 had no delusions or hallucinations. Resident #1 had no physical, verbal, or other behavioral symptoms directed toward others. The MDS assessment reflected functional limitation on both sides of upper and lower extremities and dependent for assistance with transfers, toileting, shower, upper and lower body dressing and personal hygiene. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's comprehensive care plan, dated 10/01/2024, reflected Resident #1 had activities of daily living self-care performance deficit and was at risk for not having his needs met in a timely manner. The care plan goal included resident to maintain a sense of dignity by being clean, dry, odor free and well-groomed through the next review date. The interventions included the following: up to dining room as tolerated or permitted by family, provide shower, shave, oral care, hair care, and nail care per schedule when needed, encourage resident to participate to fullest extent, encourage resident to use call light to call for assistance before attempting any activities of daily living. During an observation on 10/15/2024 at 12:10 PM of a video, date stamped 06/07/2024, with muffled audio and visual revealed Resident #1 lying in the middle of the bed on his back with the bed in a flat position. Resident #1 was not heard groaning or making any indications of pain. CNA A and CNA C provided incontinent care to Resident #1. In attempts to roll Resident #1 onto his right-side CNA A pushed Resident #1 with one hand on his hip and the other on his upper torso, when Resident #1 did not roll onto his right side she used more force and repeatedly and aggressively pushed on his buttocks and mid back to get him to stay on his right side. CNA C did not attempt to assist CNA A with rolling Resident #1 onto his right-side. Once Resident #1 was on his right-side CNA C held Resident #1 so he would stay on his side. CNA A snatched the soiled brief out from under Resident #1 and threw it from where she stood on his left side to the trash can across the bed on the right side of the room. CNA A stuck a clean brief under Resident #1 then hastily tugged and pulled Resident #1 to the left side towards her by his upper left shoulder and posterior upper left leg causing Resident #1's legs to come off the side of the bed swiftly . During an interview on 10/15/2024 at 12:45 PM, Resident #1 stated he had been handled roughly by two staff members at the facility. Resident #1 stated he did not know the names of the staff, but he knew one aide continued to work at the facility after the incident occurred on 06/07/2024 but not on his hall. Resident #1 said he saw the aide around the dining area on several occasions. Resident #1 said he had not seen the other aide in a good while, so he was not sure if she worked at the facility any longer. Resident #1 said it scared him when CNA A provided care because the movement was rough and fast and made him feel unsafe like he was going to fall out of bed onto the floor. Resident #1 stated the staff started to use the Hoyer lift today, but they usually did not. (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 10/15/2024 at 01:21 PM, Resident #1's family member stated she was very upset upon viewing the camera video of how rough the aide was during the incontinent care and transfer. Resident's #1's family member stated she immediately contacted ADON B and the DON regarding the unnecessary roughness used when providing care to Resident #1 on 06/07/2024. Resident #1's family member said she provided ADON B and the DON with the two videos which included incontinent care and a transfer. She said the video with the incontinent care showed all the aggressiveness and roughness by CNA A. Resident #1's family member said the second video showed the aide getting the nurse to help Resident #1 get up to hold his walker because he was having difficulty opening his hand. Resident #1's family member stated ADON B and the DON both stated they could not see the videos that the screens were just black. Resident #1's family member stated she offered to come to the facility on this date and show the DON the videos and the DON declined the offer. Resident #1's family member stated she did not know the aides name that provided the care so aggressive and roughly. Resident #1's family member stated to her knowledge CNA A had not been back into Resident #1's room since she reported the incident except for one time around or about 06/10/2024 in the morning. Resident #1's family member stated she saw CNA A in the facility on a different hall on several occasions after the incident. Resident #1's family member stated a care plan meeting was held on 06/10/2024 after the incident on 06/07/2024, at her request. Resident #1's family member stated she offered again to review the videos with the Administrator, DON and ADON B wherein the offer was declined. Resident #1's family member stated during the meeting she verbally requested CNA A not be allowed in Resident #1's room any longer. Resident #1's family member stated the roughness that took place in the video, dated 06/07/2024, by CNA A was discussed and documented in the care plan notes. During an interview on 10/16/2024 at 12:30 PM, the Ombudsman stated Resident #1's family member stated during the care plan meeting Resident #1 was handled roughly while care was being provided. The Ombudsman stated Resident #1's family member offered to review the videos at that time of the incident on 06/07/2024 wherein the Administrator stated the DON and ADON B had already seen the videos. During an interview on 10/16/2024 at 07:35 AM, CNA D stated she had worked at the facility for 2 years and most of that time was on Hall 400. CNA D stated she was recently educated on abuse and neglect probably 2 maybe 3 weeks ago. CNA D was able to identify the types of abuse. CNA D stated physical abuse would include hitting or forcibly pushing or touching a resident. CNA D said any suspicion or abuse allegations should be reported immediately to the Abuse Coordinator/Administrator. CNA D stated when she provided care to a resident such as incontinent care or repositioning, she utilized the draw sheet to prevent injury to the residents. CNA D said the residents' skin was mostly fragile, so it was best to not have skin to skin friction to prevent any injuries. CNA D stated she saw CNA A swing Resident #1's legs out of the bed but not in a quick manner. CNA D stated CNA A used to work hall 400 and take care of Resident #1. CNA D said if she saw any type of abuse including being rough, she would immediately protect the resident and report the abuse. CNA D said she recalled when Resident #1 said he was scared, and CNA A was moved to another hall. CNA D said in-services were provided by the DON and ADON B. CNA D was shown the video of incontinent care provided to Resident #1, dated 06/07/2024, and gasped. CNA D identified the staff as CNA A on the left side of Resident #1 and CNA C on the right side and quickly turned away and stopped watching the video. CNA D stated the care provided by CNA A was aggressive, harsh and rough and made her sick to her stomach. CNA D stated it was abuse and should have been reported immediately. (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 10/16/2024 at 1:35 PM, CNA C stated she resigned her position with the facility on 06/25/2024 due to several health problems. CNA C stated she was a CNA since 2016. CNA C said she had never had any allegation of abuse against her. CNA C said the facility had frequent in-services regarding abuse and neglect usually monthly. CNA C stated any type of rough handling such as tugging/pulling or pushing would be considered abuse and she would immediately report to the abuse coordinator. CNA C said she utilized the draw sheet to reposition residents for care. CNA C stated she recalled a time when she asked CNA A to help her with Resident #1. CNA C stated that CNA A informed her she was not allowed in Resident #1's room or to help with his care any longer. CNA C stated she worked with Resident #1 until she departed from the facility. CNA C denied any issues involving Resident #1's care . During an interview on 10/16/2024 at 06:35 PM, CNA A stated she had worked at the facility for approximately 4 years. CNA A stated she was in-serviced on abuse and neglect within the last 30 days. CNA A stated the DON and ADONs provided in-services on abuse and neglect usually to cover themselves from the state. CNA A stated if a resident accused the facility or staff of something like abuse then the staff were in-serviced. CNA A stated she had allegations of abuse made against her but only by a resident who did not like her or a staff member saying she was rough because that was their perception. CNA A stated sometimes she could not find anyone to help her provide care, so you did what you got to do to hold up the resident . CNA A stated being rough with a resident was considered abuse. CNA A stated moving fast could be perceived as being rough handling. CNA A stated the resident could be scared or resistant to care if care was provided too roughly or quick. CNA A said that could decrease their quality of life if the resident was not getting adequate care. CNA A stated she heard CNA E and CNA F had been rough handling residents . CNA A stated she did not know the residents, nor the co-workers involved with the allegations against CNA E or CNA F. CNA A denied ever seeing or suspecting abuse or rough handling. CNA A stated she would report any allegations of abuse to the Administrator. CNA A stated all suspected abuse should immediately be reported to the Administrator, so the resident was protected. CNA A stated she worked the 6PM to 6AM shift on hall 100. CNA A stated she preferred to be on days but was moved to the night shift because the DON was picking and she was not aware of why the shifts were changed. CNA A stated she had worked with Resident #1 and provided his care. CNA A stated as she provided incontinent care or repositioned a resident, she always used the draw sheet to prevent any bruises to the resident's skin. CNA A stated she would let the resident know what care she was going to provide prior to doing the care. CNA A stated it was important to let the resident know so they would not be scared. CNA A was shown the video, dated 06/07/2024. CNA A identified CNA C in the video immediately. CNA A stated the care being provided was rough and was considered abuse. CNA A was hesitant to answer on the identity of the second CNA in the video. CNA A stared at the video and finally responded that it looked like her but asked what did the State Surveyor think. CNA A stated quietly the more I look at it, damn - I think it is me, but I don't have that kind of hair - it might be CNA G. CNA A continued to stare at the video on replay . Attempted telephone call to CNA G on 10/16/2024 at 07:52 PM was unable to leave a voice message (currently, CNA G was on medical leave). During an interview on 10/16/2024 at 08:00 PM, the Staffing Coordinator identified the two CNAs in the video, dated 06/07/2024, as CNA A and CNA C. The Staffing Coordinator stated the actions by CNA A in the video were aggressive and uncalled for and could have resulted in harm to Resident #1. The Staffing Coordinator stated there was no reason to be using that much force and Resident #1's lower extremities should not have flew off the bed. (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 10/16/2024 at 8:07 PM, ADON B stated she was educated and trained on abuse and neglect. ADON B stated she had also provided training on abuse and neglect for the facility to the staff. ADON B was able to identify the types of abuse. ADON B stated rough handling could be considered abuse depending on the situation such as some residents were stiff and required more strength to move them. ADON B stated abuse should be reported to the Abuse Coordinator/Administrator immediately to allow a proper investigation to be conducted to protect the residents. ADON B denied any allegation of abuse or rough handling being reported to her on any resident specifically Resident #1. ADON B stated Resident #1's family member attempted to send the videos for viewing but she was never able to see the videos due to the screen was black and the video did not play. ADON B stated Resident #1's family member did not ever use the words handled roughly when she received the grievance, dated 06/07/2024. ADON B stated she never viewed either video sent to her because she could not get them to play. ADON B viewed the video dated 06/07/2024 with the State Surveyor and became tearful and identified the aides in the video as CNA A and CNA C. ADON B stated CNA A was being too rough with Resident #1 during the incontinent care and the draw sheet should have been used to prevent the excessive pushing. During an interview on 10/16/2024 at 8:20 PM, the DON said the Administrator was the abuse coordinator. The DON stated she was educated and trained on abuse and neglect. The DON stated she had also provided training on abuse and neglect for the facility to the staff. The DON was able to identify the types of abuse. The DON stated abuse should be reported to the Abuse Coordinator/Administrator immediately to allow a proper investigation to be conducted to protect the residents from any further or potential abuse. The DON stated she had not viewed the videos because they would not show on her phone that the screen was black and blank. The State Surveyor requested to see the videos on the phone received from Resident #1's family member. Upon opening the video and pushing play, the video started playing of the transfer until the end of the video stopped. The DON stated she had watched the transfer video but could not hear any audio. The DON said the transfer of Resident #1 was the only video she received. The DON said she told Resident #1's family member that she had only received one video. The DON stated Resident #1's family member said she would resend the other video, but the DON said she never received it. The DON stated she asked for the second video again, but she had not received it. The DON stated she never declined Resident #1's family member's offer to show her the videos. The DON stated it was important to follow up on these allegations to protect the residents. The DON stated Resident #1 never used the term rough, rough handling, snatched, pulled, pushed to give any indication of abuse to be suspected. The DON said even suspected allegations of abuse should be reported and acted upon. The DON said during the care plan meeting with Resident #1's family member, she asked Resident #1's family member, are you saying this is abuse? The DON stated Resident #1's family member said, don't put words in my mouth. Therefore, the DON stated she did not feel this needed to be reported or investigated in an abuse form because she had not see the video to suspect allegations of abuse. The DON stated the care provided by CNA A to Resident #1 during the video was aggressive and rough. The DON stated if CNA A stated she was not allowed in Resident #1's room that was at her own preference. The DON stated she did not remove CNA A from the 6AM to 6PM schedule to 6PM to 6AM and from hall 400 to hall 100 related to the Resident #1's family members grievance. The DON stated that schedule and hall change was related to CNA A's inability to get along with a co-worker. The DON stated CNA A had been educated on abuse and neglect but often refused to sign the sign-in sheet because she was not allowed to write a statement on the sign in sheet. (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 10/16/2024 at 08:41 PM, the Administrator stated he was the abuse coordinator for the facility and responsible to investigate and report any and all abuse allegations. The Administrator stated the importance of reporting and investigation timely was to prevent any further harm or harm to residents. The Administrator stated he had not seen any of the videos nor had the ADON B or the DON to his knowledge. The Administrator stated he did not tell the Ombudsman they had seen the videos prior to the care plan meeting. The Administrator stated he was not aware Resident #1's family member had videos during the meeting to be viewed. The Administrator stated he could recall from the care plan meeting Resident #1's family member stated, do not put words in my mouth when the DON asked are you alleging abuse. The Administrator stated the care provided to Resident #1 by CNA A was aggressive. The Administrator stated he should report and suspicion of abuse and then implement an investigation per the abuse policy. Record review of an in-service, dated 07/07/2024, provided by ADON B and the DON regarding the following topics: Resident #1's care - Respect resident's personal belongings and personal space, do not talk over resident or exclude resident while in conversations, attend physical therapy in-service regarding lifts/transfers, contact family with medication changes, continue to encourage resident to feed self, always use two employees for resident care, with all changes, notify the charge nurse and charge nurse to notify Resident #1's family member. The in-service indicated 14 staff members signed the in-service. CNA A was not included on the sign in sheet . Record review of an in-service, dated 06/10/2024, provided by the DON, regarding Sit-to-Stand Lift Usage Training and CNA skills review for transfers reflected 21 staff members signed the in-service. CNA A was included on the sign in sheet. Record review of an in-service, dated 06/11/2024, provided by the DON, regarding Hoyer Lift Usage and check offs training reflected 16 staff members signed the in-service. CNA A was included on the sign in sheet. Record review of an in-service, dated 06/11/2024, provided by DON, regarding Incontinence care for all residents training reflected 14 staff members signed the in-service. CNA A was included on the sign in sheet. Record review of the personnel chart of CNA A reflected completion of Abuse and Neglect training upon hire date of 09/15/2020 and yearly thereafter. The following Associate Disciplinary Memorandums for CNA A: 10/16/2024 regarding throwing soiled briefs on the floor of resident's room, 08/09/2024 regarding leaving shift without prior approval, 04/05/2024 regarding leaving shift without prior approval, 04/04/2024 regarding leaving shift without prior approval, 09/15/2022 regarding tardiness for shifts. 08/22/2022 regarding incompletion of timely monthly Relias training. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the schedule, dated 06/07/2024, reflected CNA was scheduled to work hall 400 from 6AM to 6PM. Record review of CNA A's Employee Timecard report, dated 06/07/2024, time reporting period was created on 10/22/2024 by the BOM. The report indicated CNA A worked: 06/07/2024 05:29 AM to 12:44 PM 06/07/2024 02:33 PM to 17:00 PM Record review of Resident #1's care plan meeting, dated 06/11/2024 at 11:00AM, and signed by the Social Worker and approved by ADON B. The participants of Resident #1's care plan meeting included the Administrator, DON, ADON B, Dietary Manager, Social Worker, Activity Director, Director of Rehabilitation, Resident #1's family member and the Ombudsman. Social Services Summary (7a) reflected Resident #1's family member voiced concerns with care and sit to stand procedures. Family is updated on recent in-services and re-education with staff regarding problems and concerns. 9. Resident/Family concerns expressed during care plan concerns reflected: Staff rough when getting out of bed, can't hold bar on sit to stand at times, can't always open hands .CNA A not be back in Resident #1's room. Record review of the facility's policy, titled Abuse, Neglect and Exploitation, last revised on 10/24/2022, reflected, .It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property .' Protection of Resident The facility makes efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation. B. Physical exam of the alleged victim for any sign of injury such as a. physical harm, b. pain, c. mental anguish, or d. emotional distress including a psychosocial assessment if needed .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527 Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 17 residents (Resident #1) reviewed for abuse and neglect. The facility failed to report to Health and Human Services Commission Resident #1's family member's allegation that CNA A roughly provided incontinent care to the resident on 06/07/2024. This failure could place residents at risk for abuse, humiliation, intimidation, fear, shame, agitation, and a decreased quality of life. Findings include: Record review of a Grievance/Complaint Report dated 06/07/2024 received by ADON B indicated Resident #1's family member requested gentle movements of his legs during care. Documented facility follow-up action was to in-service staff members with 1:1 education and physical therapy in-service regarding transfer of resident out of bed. Record review of Resident #1's face sheet dated 10/17/2024, indicated Resident #1 was a [AGE] year old male admitted to the facility on [DATE], with diagnoses which include dementia (a group of thinking and social symptoms that interferes with daily functioning), congestive heart failure (a chronic condition where the heart does not pump blood as well as it should), Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), hypertension (high blood pressure), protein-calorie malnutrition the state of inadequate intake of food), cramp and spasm, pain in thoracic spine (the middle section of the back), muscle wasting, lack of coordination, cognitive communication deficit. Record review of Resident #1's Quarterly MDS assessment dated [DATE], indicated Resident #1 was understood and was able to understand others. The MDS assessment indicated Resident #1 had a BIMS score of 12, which indicated his cognition was moderately impaired. The MDS assessment indicated Resident #1 had no delusions or hallucinations. The MDS assessment indicated Resident #1 had no physical, verbal, or other behavioral symptoms directed toward others. The MDS assessment indicated functional limitation on both sides of upper and lower extremities and dependent for assistance with transfers, toileting, shower, upper and lower body dressing, and personal hygiene. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's comprehensive care plan dated 10/01/2024, indicated Resident #1 had activities of daily living self-care performance deficit and was at risk for not having his needs met in a timely manner. The care plan goal included resident to maintain a sense of dignity by being clean, dry, odor free and well-groomed through the next review date. The interventions included the following: up to dining room as tolerated or permitted by family, provide shower, shave, oral care, hair care, and nail care per schedule when needed, encourage resident to participate to fullest extent, encourage resident to use call light to call for assistance before attempting any activities of daily living. During an observation on 10/15/2024 at 12:10 PM of a ring video date stamped 06/07/2024. with muffled audio and visual revealed Resident #1 lying in the middle of the bed on his back with the bed in a flat position. CNA A and CNA C provided incontinent care to Resident #1. In attempts to roll Resident #1 onto his right-side CNA A pushed Resident #1 with one hand on his hip and the other on his upper torso, when Resident #1 did not roll onto his right side she used more force and repeatedly and aggressively pushed on his buttocks and mid back to get him to stay on his right side. CNA C did not attempt to assist CNA A with rolling Resident #1 onto his right-side. Once Resident #1 was on his right-side CNA C held Resident #1 so he would stay on his side. CNA A snatched the soiled brief out from under Resident #1 and threw it from where she stood on his left side to the trash can across the bed on the right side of the room. CNA A stuck a clean brief under Resident #1 then hastily tugged and pulled Resident #1 to the left side towards her by his upper left shoulder and posterior upper left leg causing Resident #1 's legs to come off the side of the bed swiftly. During an interview on 10/15/2024 at 12:45 PM, Resident #1 stated he had been handled roughly by two staff members at the facility. Resident #1 stated he did not know the names of the staff, but he knew that one aide continued to work at the facility after the incident that occurred on 06/07/2024 but not on his hall. Resident #1 said he had seen the aide around the dining area on several occasions. Resident #1 said he had not seen the other aide in a good while, so he was not sure if she worked at the facility any longer. Resident #1 said it scared him when CNA A provided care because the movement was rough and fast and made him feel unsafe like he was going to fall out of bed onto the floor. Resident #1 stated the staff started to use the Hoyer lift today, but they usually did not. (continued on next page)

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	676294	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage House at Paris Rehab & Nursing	150 S.E. 47th Street Paris, TX 75462

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/15/2024 at 01:21 PM, Resident #1's family member stated she was very upset upon viewing the camera video of how rough the aide was during the incontinent care and transfer. Resident's #1's family member stated she immediately contacted ADON B and the DON regarding the unnecessary roughness used when providing care to Resident #1 on 06/07/2024. Resident #1's family member said she provided ADON B and the DON with the two videos which included incontinent care and a transfer. She said the video with the incontinent care showed all the aggressiveness and roughness by CNA A. Resident #1's family member said the second video showed the aide getting the nurse to help Resident #1 get up to hold his walker because he was having difficulty opening his hand. Resident #1's family member stated ADON B and the DON both stated they could not see the videos that the screens were just black. Resident #1's family member stated she offered to come to the facility on this date and show the DON the videos and the DON declined the offer. Resident #1's family member stated she did not know the aides name that provided the care so aggressive and roughly. Resident #1's family member stated to her knowledge CNA A had not been back into Resident #1's room since she reported the incident except for one time the around or about 06/10/2024 in the AM. Resident #1's family member stated she had seen CNA A in the facility on a different hall on several occasions after the incident. Resident #1's family member stated a care plan meeting was held on 06/10/2024 after the incident on 06/07/2024, at her request. Resident #1's family member stated she offered again to review the videos with the Administrator, DON, and ADON B wherein the offer was declined. Resident #1's family member stated during the meeting she verbally requested CNA A not be allowed in Resident #1"s room any longer. Resident #1's family member stated the roughness that took place in the video dated 06/07/2024 by CNA A was discussed and documented in the care plan notes. During an interview on 10/16/2024 at 12:15 PM, the Administrator stated the Grievance by Resident #1's family member was not reported to HHSC and there was not a Provider's Investigation Report. The Administrator stated he was the abuse coordinator for the facility. During an interview on 10/16/2024 at 12:30 PM, the Ombudsman stated Resident #1's family member stated during the care plan meeting that Resident #1 was handled roughly while care was being provided. The Ombudsman stated Resident #1's family member offered to review the videos at that time of the incident on 06/07/2024 wherein the Administrator stated that the DON and ADON B had already seen the videos. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/2024 at 07:35 AM, CNA D stated she had worked at the facility for 2 years and most of that time was on Hall 400. CNA D stated she was recently educated on abuse and neglect probably 2 maybe 3 weeks ago. CNA D was able to identify the types of abuse. CNA D stated physical abuse would include hitting or forcibly pushing or touching a resident. CNA D said any suspicion or abuse allegations should be reported immediately to the Abuse Coordinator/Administrator. CNA D stated when she provides care to a resident such as incontinent care or repositioning, she utilized the draw sheet to prevent injury to the residents. CNA D said the residents' skin is mostly fragile, so it is best to not have skin to skin friction to prevent any injuries. CNA D stated she had seen CNA A swing Resident #1"s legs out of the bed but not in a quick manner. CNA D stated CNA A used to work hall 400 and take care of Resident #1. CNA D stated Resident #1 told her he did not want to stand anymore because he was scared because CNA A was rough with him. CNA D said if she saw any type of abuse including being rough, she would immediately protect the resident and report the abuse. CNA D said she recalled when Resident #1 said he was scared, and CNA A was moved to another hall. CNA D said in-services were provided by the DON and ADON B. CNA D was shown the video of incontinent care provided to Resident #1 dated 06/07/2024 and gasped. CNA D identified the staff as CNA A on the left side of Resident #1 and CNA C on the right side and quickly turned away and stopped watching the video. CNA D stated the care provided by CNA A was aggressive, harsh and rough and made her sick to her stomach. CNA D stated it was abuse and should have been reported immediately. During a telephone interview on 10/16/2024 at 1:35 PM, CNA C stated she resigned her position with the facility 06/25/2024 due to several health problems. CNA C stated she had been a CNA since 2016. CNA C said she had never had any allegation of abuse against her. CNA C said the facility had frequent in-services regarding abuse and neglect usually monthly. CNA C stated any type of rough handling such as tugging/pulling or pushing would be considered abuse and she would immediately report to the abuse coordinator. CNA C said she utilized the draw sheet to reposition residents for care. CNA C stated she recalled a time when she asked CNA A to help her with Resident #1. However, CNA A stated she was not allowed in Resident #1's room or to help with his care any longer. CNA C stated she worked with Resident #1 until she departed from the facility. CNA C denied any issues involving Resident #1's care. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/2024 at 06:35 PM, CNA A stated she had worked at the facility for approximately 4 years. CNA A stated she had been in-serviced on abuse and neglect within the last 30 days. CNA A stated the DON and ADONs provided in-services on abuse and neglect usually to cover themselves from the state. CNA A stated if a resident accused the facility or staff of something like abuse then the staff got in-serviced. CNA A stated she had allegations of abuse made against her but only by a resident that did not like her or a staff member saying she was rough because that was their perception. CNA A stated sometimes nobody can help you, so you do what you got to do to hold up the resident. CNA A stated that being rough with a resident is considered abuse. CNA A stated moving fast can be perceived as being rough handling. CNA A stated the resident could be scared or resistant to care if care was provided too roughly or quick. CNA A said that could decrease their quality of life if the resident was not getting adequate care. CNA A stated she had heard that CNA E and CNA F had been rough handling residents. CNA A stated she did not know the residents, nor the co-workers involved with the allegations against CNA E or CNA F. CNA A denied ever seeing or suspecting abuse or rough handling. CNA A stated she would report any allegations of abuse to the Administrator. CNA A stated all suspected abuse should immediately be reported to the Administrator, so the resident was protected. CNA A stated she worked the 6PM to 6AM shift on hall 100. CNA A stated she preferred to be on days but got moved to the night shift because the DON is picking and she was not aware of why the shifts got changed. CNA A stated as she provided incontinent care or repositioned a resident, she always used the draw sheet to prevent any bruises to the resident's skin. CNA A stated she would let the resident know what care she was going to provide prior to doing the care. CNA A stated it was important to let the resident know so they would not be scared. CNA A was shown the video dated 06/07/2024. CNA A identified CNA C in the video immediately. CNA A stated the care being provided was rough and was considered abuse. CNA A was hesitant to answer the surveyor on the identity of the second CNA in the video. CNA A stared at the video and finally responded that it looked like her but what did the surveyor think. CNA A stated quietly the more I look at it, damn - I think it is me, but I don't have that kind of hair - it might be CNA G. CNA A continued to stare at the video on replay. Attempted telephone call to CNA G on 10/16/2024 at 07:52PM was unable to leave a voice message (currently, CNA G was on medical leave). During an interview on 10/16/2024 at 08:00 PM, the staffing coordinator identified the two CNAs in the video dated 06/07/2024 as CNA A and CNA C. The staffing coordinator stated the actions by CNA A in the video were aggressive and uncalled for and could have resulted in harm to Resident #1. The staffing coordinator stated there was no reason to be using that much force and Resident #1's lower extremities should not have flew off the bed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/2024 at 8:07 PM, ADON B stated she had been educated and trained on abuse and neglect. ADON B stated she had also provided training on abuse and neglect for the facility to the staff. ADON B was able to identify the types of abuse. ADON B stated rough handling could be considered abuse depending on situation such as some residents are stiff and required more strength to move them. ADON B stated abuse should be reported to the Abuse Coordinator/Administrator immediately to allow a proper investigation to be conducted to protect the residents. ADON B denied any allegation of abuse or rough handling being reported to her on any resident specifically Resident #1. ADON B stated Resident #1's family member attempted to send the videos for viewing but she was never able to see the videos due to the screen was black and the video did not play. ADON B stated Resident #1's family member did not ever use the words handled roughly when she received the grievance dated 06/07/2024. ADON B stated she never viewed either video sent to her because she could not get them to play. ADON B viewed the video dated 06/07/2024 with the surveyor and became tearful and identified the aides in the video as CNA A and CNA C. ADON B stated CNA A was being too rough with Resident #1 during the incontinent care and the draw sheet should have been used to prevent the excessive pushing. During an interview on 10/16/2024 at 8:20 PM, the DON said the Administrator was the abuse coordinator. The DON stated she had been educated and trained on abuse and neglect. The DON stated she had also provided training on abuse and neglect for the facility to the staff. The DON was able to identify the types of abuse. The DON stated abuse should be reported to the Abuse Coordinator/Administrator immediately to allow a proper investigation to be conducted to protect the residents from any further or potential abuse. The DON stated she had not viewed the videos because they would not show on her phone that the screen was black and blank. The surveyor requested to see the videos on the phone received from Resident #1's family member. Upon opening the video and pushing play, the video started playing of the transfer until the end of the video stopped. The DON stated she had watched the transfer video but could not hear any audio. The DON said the transfer of Resident #1 was the only video she received. The DON said she told Resident #1's family member that she had only received one video. The DON stated that Resident #1's family member said she would resend the other video, but the DON said she never received it. The DON stated she asked for the second video again, but she had not received it. The DON stated she never declined Resident #1's family member's offer to show her the videos. The DON stated it was important to follow up on these allegations to protect the residents. The DON stated that Resident #1 never used the term rough, rough handling, snatched, pulled, pushed to give any indication of abuse to be suspected. The DON said even suspected allegations of abuse should be reported and acted upon. The DON said during the care plan meeting with Resident #1's family member, she asked Resident #1's family member, are you saying this is abuse? The DON stated Resident #1's family member said, don't put words in my mouth. Therefore, the DON stated she did not feel this needed to be reported or investigated in an abuse form because she had not seen the video to suspect allegation of abuse. The DON stated the care provided by CNA A to Resident #1 during the video was aggressive and rough. The DON stated if CNA A stated she was not allowed in Resident #1's room that was at her own preference. The DON stated she did not remove CNA A from the 6AM to 6PM schedule to 6PM to 6AM and from hall 400 to hall 100 related to the Resident #1's family members grievance. The DON stated that schedule and hall change was related to CNA A's inability to get along with a co-worker. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/2024 at 08:41 PM, the Administrator stated he was the abuse coordinator for the facility and responsible to investigate and report any and all abuse allegations. The Administrator stated the importance of reporting and investigation timely is to prevent any further harm or harm to residents. The Administrator stated he had not seen any of the videos nor had the ADON B or the DON to his knowledge. The Administrator stated he did not tell the Ombudsman that they had seen the videos prior to the care plan meeting. The Administrator stated he was not aware that Resident #1's family member had videos during the meeting to be viewed. The Administrator stated he can recall from the care plan meeting Resident #1's family member stating, do not put words in my mouth when the DON asked are you alleging abuse. The Administrator stated the care provided to Resident #1 by CNA A was aggressive. The Administrator stated he should report and suspicion of abuse and then implement an investigation per the abuse policy. Record review of the facility's policy, titled, Abuse, Neglect and Exploitation, last revised on 10/24/2022, reflected, . 1. Reporting allegations involving staff to-resident abuse, resident-to resident altercations, injuries of unknown source, misappropriation of resident property/exploitation, and mistreatment. 2. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. 3. Assuring that reporters are free from retaliation or reprisal. . B. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies Administrator .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527 Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for 1 of 2 residents (Resident #1) reviewed for infection control practices. 1. CNA A failed to change her gloves and perform hand hygiene after removing Resident #1's soiled brief on 06/07/2024. 2. CNA A failed to dispose of Resident #1's soiled brief properly after removing it during incontinent care on 06/07/2024. These failures could place residents at risk of exposure to communicable diseases, cross-contamination, and infections. Findings include: Record review of Resident #1's face sheet dated 10/17/2024, indicated Resident #1 was a [AGE] year old male admitted to the facility on [DATE], with diagnoses which include dementia (a group of thinking and social symptoms that interferes with daily functioning), congestive heart failure (a chronic condition where the heart does not pump blood as well as it should), Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), hypertension (high blood pressure), protein-calorie malnutrition the state of inadequate intake of food), cramp and spasm, pain in thoracic spine (the middle section of the back), muscle wasting, lack of coordination, cognitive communication deficit. Record review of Resident #1's Quarterly MDS assessment dated [DATE], indicated Resident #1 was understood and was able to understand others. The MDS assessment indicated Resident #1 had a BIMS score of 12, which indicated his cognition was moderately impaired. The MDS assessment indicated Resident #1 had no delusions or hallucinations. The MDS assessment indicated Resident #1 had no physical, verbal, or other behavioral symptoms directed toward others. The MDS assessment indicated functional limitation on both sides of upper and lower extremities and dependent for assistance with transfers, toileting, shower, upper and lower body dressing, and personal hygiene. Record review of Resident #1's comprehensive care plan dated 10/01/2024, indicated Resident #1 had activities of daily living self-care performance deficit and was at risk for not having his needs met in a timely manner. The care plan goal included resident to maintain a sense of dignity by being clean, dry, odor free and well-groomed through the next review date. The interventions included the following: up to dining room as tolerated or permitted by family, provide shower, shave, oral care, hair care, and nail care per schedule when needed, encourage resident to participate to fullest extent, encourage resident to use call light to call for assistance before attempting any activities of daily living. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/15/2024 at 12:10 PM of a video, date stamped 06/07/2024, revealed CNA A and CNA C provided incontinent care to Resident #1. Once Resident #1 was on his right-side CNA C held Resident #1 so he would stay on his side. CNA A snatched the soiled brief out from under Resident #1 and threw it from where she stood on his left side to the trash can across the bed on the right side of the room. CNA A used a wipe across Resident #1 peri area and threw the dirty wipe behind her onto the floor. CNA A stuck a clean brief under Resident #1 then hastily tugged and pulled Resident #1 to the left side towards her by his upper left shoulder and posterior upper left leg causing Resident #1 's legs to come off the side of the bed swiftly. CNA A did not change her gloves and perform hand hygiene after removing Resident #1's soiled brief and continued to touch the resident and other surfaces with the contaminated gloves . During an interview on 10/16/2024 at 06:35 PM, CNA A stated she had worked at the facility for approximately 4 years. CNA A stated she was in-serviced on incontinent care on several occasions probably in the last few weeks. CNA A stated the DON and ADONs provided in-services on incontinent care usually to cover themselves from the state. CNA A stated she had residents accuse her of not doing incontinent care the right way because she was fast. CNA A stated she would let the resident know what care she was going to provide prior to doing the care. CNA A stated it was important to let the resident know so they would not be scared. CNA A stated she always took extra supplies into the resident's room for incontinent care such as trash bags, gloves and wipes. CNA A stated she placed the extra trash bag inside the trash can. CNA A stated she would put the trash can beside her on the floor next to the bed to prevent spreading any germs and infections while getting rid of the soiled diaper. CNA A stated she changed her gloves after cleansing her hands with hand sanitizer between dirty and clean diapers before touching any other surfaces or the resident. CNA A stated once she changed her gloves or took them off and put it in the trash, she would reposition the resident in the bed. CNA A said, she would gather the trash bag with the dirty diaper and remove it from the resident's room. CNA A stated the purpose of preventing cross contamination was to keep the residents healthy. CNA A was shown the video, dated 06/07/2024, CNA A identified CNA C in the video immediately. CNA A stated the incontinent care being provided to Resident #1 was done incorrectly and throwing a soiled brief over the resident across the room was cross contamination and an infection control issue. CNA A stated peri care was not performed in the correct manner and the resident was at a risk of infection such as a UTI from not properly cleaning the private area. CNA A stated the gloves should have been changed between dirty and clean diaper changes and hand hygiene should have been performed to prevent cross contamination. Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 17 residents (Resident #1) reviewed for abuse and neglect. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/2024 at 8:20 PM, the DON said she was the Infection Control Preventionist and ultimately responsible for infection control procedures. The DON said she, the charge nurses, the ADONs were responsible for ensuring the CNAs were performing adequate hand hygiene and infection control measures during incontinent care. The DON said she completed 1:1 skill checks off during in-servicing on incontinent care recently. After viewing the video, dated 06/07/2024, the DON stated CNA A had not followed the infection control policy for incontinent care, The DON said it was important to perform hand hygiene, practice proper infection control measures while performing incontinent care because the residents could get a urinary tract infection and sepsis (infection in the bloodstream) and spread other infections. During an interview on 10/16/2024 at 08:41 PM, the Administrator said he expected all the staff to follow the policy on hand washing, changing gloves, and proper incontinent care to prevent any infection risk to the residents. After viewing the video, dated 06/07/2024, the Administrator stated CNA A had not followed the infection control policy for incontinent care. Record review of the facility's policy titled infection Prevention and Control Program, updated on 3/26/2024, reflected Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures.