

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676295	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/03/2024
NAME OF PROVIDER OR SUPPLIER Epic Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3210 W Hwy 22 Corsicana, TX 75110	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41654</p> <p>Based on interview and record review, the facility failed to ensure residents were free from physical and verbal abuse for 1 of 6 residents (Resident #1) reviewed for abuse.</p> <p>The facility failed to prevent LVN A, on 07/28/24, from physically abusing Resident #1 when she hit Resident #1 in the right arm.</p> <p>These failures could place resident at risk for emotional distress, fear, decreased quality of life and further abuse.</p> <p>Findings included:</p> <p>Review of the face sheet for Resident #1 reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of: Spastic hemiplegia affecting right dominant side (type of paralysis that affects one side of the body), dysphagia (difficulty swallowing), urinary tract infection (an infection that affects part of the urinary tract, and muscle wasting and atrophy (when muscles waste away).</p> <p>Review of the Quarterly MDS Assessment for Resident #1 dated 05/21/24 reflected a BIMS score of 11 which indicated Resident #1 had moderate cognitive impairment. Resident #1's physical assessment reflected she could feed herself with set up or clean up assist, she needed partial assistance for oral and personal hygiene, and she was fully dependent on staff for toileting and bathing.</p> <p>Review of the Care Plan for Resident #1 dated 01/31/20 and edited 11/06/22 reflected Resident #1 had mobility impairment due to decreased functional limitation in ROM to bilateral lower extremities and a contracture to right lower leg which interfered with daily functions. Goal of Resident #1 would not have any further decline of functional ability/mobility over next quarter. Approaches listed included to encourage Resident #1 to participate in mobility/ADL tasks to extent necessary to accomplish task and to ensure staff were aware of Resident #1's mobility/ADL impairments.</p> <p>In an interview on 08/03/24 at 9:30 AM, Resident #1 stated everything is fine here and the staff treat her well. She stated there was a staff member helping her recently and she hit her on the right arm. She stated she told the woman with the red hair and then the woman with red hair told the girl that hit her not to abuse her clients. She stated she has not seen that staff member since and no one else has mistreated her in any way. She stated she feels safe here and she has no other concerns.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/03/24 at 10:05 AM, the ADM stated she was informed on the morning of 07/29/24 that an incident of abuse had occurred on the previous night (07/28/24) in the facility. She stated she immediately began the investigation. She stated CNA A told her that Resident #1 was down at another resident's room and the other resident did not want Resident #1 to be there. She stated she was informed that CNA A and CNA B had tried to get Resident #1 away from the other residents room and Resident #1 had begun yelling and resisting and had not wanted to leave the area. She stated CNA A and CNA B was attempting to get Resident #1 out of another residents room and LVN A went to assist. She stated Resident #1 was yelling and hitting at the staff. She stated LVN A told her that Resident #1 had a grip on her arm and the LVN A had put her hand up to block resident from hitting her. She stated LVN A told her she was telling Resident #1 not to hit her because she was pregnant, but that she did not ever hit Resident #1. She stated CNA A and CNA B were present during the incident and CNA A told her that LVN A hit Resident #1. She stated CNA B told her she did not see LVN A hit Resident #1 and that CNA B only saw LVN A put her arm up to block being hit.</p> <p>In an interview on 08/03/24 at 10:45 AM, the DON stated CNA A called her on Monday (07/29/24) morning and told her that on the night before (07/28/24), Resident #1 was trying to go into another residents room and that the other resident did not want her in there. She stated CNA A, CNA B, and LVN A were trying to remove Resident #1 from the area. She stated CNA A told her that they got Resident #1 to her room and Resident #1 started swinging her arms at LVN A. She stated CNA A told her that LVN A had told resident you're not going to hit me, I am pregnant and that LVN A hit Resident #1 in the right arm. She stated she asked CNA A why she waited to tell her until the next day and CNA A told her she was afraid that LVN A may have retaliated on her. She stated she immediately informed the ADM, which is the Abuse Coordinator. She stated she interviewed CNA B and CNA B told her that LVN A had hit Resident #1 twice in the right arm/chest area.</p> <p>Attempts to interview CNA B were unsuccessful, three attempts were made to reach her by telephone on 7/03/24 at 11:46 am and 2:00 PM. No return call was received.</p> <p>In an interview on 08/03/24 at 11:48 AM, CNA A stated she was working with CNA B and LVN A, which was on another hall from where the incident occurred. She stated Resident #1 was down at another residents room and she heard yelling. She stated she looked down the hall where Resident #1 was trying to go into another residents room, and she went down to remove Resident #1 from the area because the other resident did not want her in his room. She stated she tried re-directing Resident #1 and Resident #1 did not want to leave the area. She stated CNA B and LVN A came over to help and they got Resident #1 to hold their hands and removed Resident #1 from the area. She stated as soon they got Resident #1 to her room, Resident #1 had become more upset, and they had tried to talk to Resident #1 to calm her down. She stated Resident #1 grabbed LVN A's hand and tried to bite her and LVN A hit resident on her right arm 3 times. She stated she immediately told LVN A to get out of there. She stated she finished her round and then she got with CNA B and they both agreed the incident needed to be reported. She stated she believed they both thought the other was going to report the incident but when the DON called her to work a shift the following day, she asked if it had been reported and the DON told her no. She stated she then reported the incident to the DON, and she knew she should have reported it earlier. She stated she had been trained on abuse and neglect and reporting abuse and neglect. She stated she felt bad, but it was definitely a learning experience for her.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/03/24 at 12:55 PM, LVN B stated she had been in-serviced on abuse and neglect. She stated an example of abuse was taking away an item from a resident roughly or being rough with a resident and she had never witnessed abuse in the facility. She stated if she suspected abuse, she would immediately have reported it to the ADM which is the Abuse Coordinator. She stated if abuse occurred to a resident, it could have caused a resident to be hurt or unheard and it may have made the resident feel as though they could not have trusted or confided in any staff in the facility.</p> <p>In an interview on 08/03/24 at 1:05 PM, RN B stated she had been in-serviced regularly on abuse and neglect. She stated an example of abuse was hitting a resident and she had never witnessed abuse in this facility. She stated if she suspected abuse, she would have separated the resident from the abuse and reported it immediately to the ADM, which is the Abuse Coordinator. She stated if a resident experienced abuse it could have caused them to have experienced emotional distress or physical pain.</p> <p>In an interview on 08/03/2024 at 2:36 PM, the DON stated staff were in-serviced regularly on abuse and reporting abuse. She stated the phone number was placed all over the facility for the Abuse Coordinator in easily visible areas including all residents rooms. She stated an example of abuse would be someone yelling at a resident, and she had never witnessed abuse in this facility. She stated it was her expectation that if staff suspected abuse, they should have made sure the resident was safe and immediately reported it to Administrator which is the Abuse Coordinator. She stated if a resident experienced abuse or misappropriation it could have caused the resident to not use their call light or call for help due to them possibly not trusting anyone again.</p> <p>In an interview on 08/03/2024 at 2:40 PM, the ADM stated staff had been in-serviced regularly on abuse and reporting abuse. She stated the phone number for the Abuse Coordinator was placed all over the facility in easily visible areas, including in all residents rooms. She stated an example of abuse would be if someone had hit a resident, and she had never witnessed abuse in this facility. She stated it was her expectation that if staff suspected abuse, they should have made sure the resident was safe and immediately reported it to herself. She stated she was the Abuse Coordinator. She stated if a resident experienced abuse it could have caused emotional distress.</p> <p>In an interview on 08/03/2024 at 4:12 PM with LVN A, she stated she was aware of the allegation of abuse, and she had been made aware and suspended on July 29, 2024 pending an investigation. She stated when the incident happened, she had been trying to get Resident #1 away from another residents room. She stated Resident #1 was angry because she did not want to leave the area and Resident #1 was holding onto her arm tightly. She stated Resident #1 dug her nails into her arm and was swatting at her. She stated she put her hand up to block Resident #1 from hitting her and asked Resident #1 to please stop trying to hit her because she was pregnant. She stated she had not and would not ever hit Resident #1 or any resident. She stated Resident #1 was very sweet but had behaviors often and there were two newer aides that had helped her assist Resident #1 back to her room. She stated she had been trained on abuse and neglect and reporting abuse or neglect at the facility. She stated Resident #1 had no complaints of pain or of being hit after the incident to her knowledge.</p> <p>Review of facility's Provider Investigation Report dated 07/29/24 revealed LVN A was suspended 07/29/24 pending investigation, staff in-servicing had begun on abuse and reporting, and safe surveys had started for other residents.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled Abuse Prevention Program reflected our residents have the right to be free from abuse, neglect, exploitation, or mistreatment, including injuries of unknown sources, and misappropriation of resident property, corporal punishment and involuntary seclusion. Policy Interpretation and implementation: 1. Our facility is committed to protecting our residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual. 3. Comprehensive policies and procedures have been developed to aid our facility in preventing abuse, neglect, or mistreatment of our residents. Our abuse prevention program provides policies and procedures that govern, as a minimum: a) Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse, This may include identifying when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship; b) Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms; c) Assuring an assessment of the resources needed to provide care and services to all residents is included in the facility assessment; d) The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect; e) Ensuring the health and safety of each resident with regard to visitors such as family members or resident representatives, friends, or other individuals subject to the resident's right to deny or withdraw consent at any time and to reasonable clinical and safety restrictions; Providing residents, representatives, and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retribution; and providing feedback regarding the concerns that have been expressed; b) Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors. t) The protection of residents during abuse investigations; i) The reporting and filing of accurate documents relative to incidents of abuse .</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Facility Policy on Reporting Abuse to Facility Management dated 2001 and revised April 2012 reflected: It is the responsibility of our employees, facility consultants, Attending Physicians, family members, visitors etcetera, to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management without fear of retaliation. This facility will post a conspicuous notice of employee rights, including the right to file a complaint with the State Survey Agency if the employee believes the facility has retaliated against him/her for reporting a suspected crime and how to file such a complaint. Policy Interpretation and Implementation: 1. Our facility does not condone resident abuse by anyone, including staff members, physicians, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals. 2. To help with recognition of incidents of abuse, the following definitions of abuse are provided: b. The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. iii. Physical Abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41654</p> <p>Based on interview and record review the facility failed to ensure residents were free from misappropriation and exploitation of property for 1 of 6 residents reviewed for misappropriation of property. (Resident #2)</p> <p>The facility failed to protect Resident #2 from misappropriation/exploitation by allowing CNA C to take money from Resident #2 for CNA C's own well-being and personal expenses, exact date unknown.</p> <p>This failure could place residents who resided in this facility at risk of misappropriation of property.</p> <p>Findings included:</p> <p>Record review of a face sheet dated reflected Resident #2 was a [AGE] year-old male initially admitted to the facility on [DATE] with diagnoses which included paraplegia (a chronic condition that affects the lower half of the body, causing loss of muscle function and sensory or motor impairment), idiopathic scoliosis (a spinal condition that causes the spine to curve abnormally to the side, sometimes in the shape of an S or C) urinary tract infection (an infection that affects part of the urinary tract, and muscle wasting and atrophy (when muscles waste away).</p> <p>Record review of the Quarterly MDS assessment dated [DATE] reflected Resident #2 had a BIMS score of 7 which indicated Resident #2 had severe cognitive impairment. The MDS assessment reflected Resident #2 required set up or clean up assistance with eating and was fully dependent on staff for toileting, bathing, and personal hygiene.</p> <p>Record review of the care plan dated 03/12/24 indicated Resident #2 had a motor vehicle accident with neurological injury and was non-compliant with treatment.</p> <p>In an interview on 08/03/2024 at 9:07 AM, Resident #2 stated he had been at the facility for 6 years. He stated the staff here were all alright and they treated him well. He stated no staff had ever stolen anything from him, but he had given one lady \$300.00 pretty recently and she had not paid him back. He stated it was CNA C that he gave the money to. He stated he wrote her a check for the money. He stated he did not know where she was at now. He stated he felt safe in the facility, and he had no concerns. He state he did not care if he got his money back or not because he had plenty.</p> <p>In an interview on 08/03/24 at 8:20 AM, the ADM stated in the case of the self-report for misappropriation of property, on 07/31/24, a CNA had informed her that Resident #2 had said he gave \$300 dollars to CNA C, and she had not paid him back. She stated she immediately began the investigation and upon interviewing Resident #2, he told her that he had given CNA C a \$300 dollar check a few weeks ago. She stated when she asked CNA C about the money, she admitted to receiving the money. She stated CNA C told her she was not going to take the money, but she did, and she knew better. She stated CNA C had been trained on misappropriation of property and had been told not to take money from residents. She stated CNA C was suspended immediately and would be terminated. She stated they performed safe surveys for other residents and there were no other related incidents . She stated she in-serviced staff on abuse and reporting.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Attempts to interview CNA C were unsuccessful, two attempts were made to reach her by telephone on 08/03/24 at 9:47 am and 12:16 PM. No return call was received.</p> <p>In an interview on 08/03/2024 at 10:45 AM, the DON stated a nurse (could not recall which nurse) had called and told her that Resident #2 had given a check to someone, and she referred them to call the Abuse Coordinator immediately. She stated she had been out of work that day but was made aware that the allegation had been reported.</p> <p>In an interview on 08/03/2024 at 2:36 PM, the DON stated staff were in-serviced regularly on abuse, neglect, and misappropriation of property. She stated an example of abuse would be someone yelling at a resident, and she had never witnessed abuse in this facility. She stated it was her expectation that if staff suspected abuse, they should have made sure the resident was safe and immediately reported it to Administrator who was the Abuse Coordinator. They stated if a resident experienced abuse or misappropriation it could have caused the resident to not use their call light or call for help due to them possibly not trusting anyone again.</p> <p>In an interview on 08/03/2024 at 2:40 PM, the ADM stated staff had been in-serviced regularly on abuse and reporting abuse. She stated an example of abuse would be if someone had hit a resident, and she had never witnessed abuse in this facility. She stated it was her expectation that if staff suspected abuse, they should have made sure the resident was safe and immediately reported it to herself. She stated she was the Abuse Coordinator. She stated if a resident experienced misappropriation of property, it could have caused the resident to experience emotional distress.</p> <p>Review of the Facility Policy on Reporting Abuse to Facility Management dated 2001 and revised April 2012 revealed: It is the responsibility of our employees, facility consultants, Attending Physicians, family members, visitors etcetera, to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management without fear of retaliation. This facility will post a conspicuous notice of employee rights, including the right to file a complaint with the State Survey Agency if the employee believes the facility has retaliated against him/her for reporting a suspected crime and how to file such a complaint. Policy Interpretation and Implementation: 1. Our facility does not condone resident abuse by anyone, including staff members, physicians, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals. 2. To help with recognition of incidents of abuse, the following definitions of abuse are provided: c. Misappropriation of Resident Property: The deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent. e. Exploitation: taking advantage of a resident for persona I gain through the use of manipulation, intimidation, threats or coercion. F. Mistreatment: inappropriate treatment or exploitation of a resident.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41654</p> <p>Based on observation, interview, and record review, the facility failed to ensure an allegation of abuse was reported immediately but not later than 24 hours after the allegation was made for 1 of 6 residents (Resident #1) reviewed for reporting.</p> <p>The facility failed to ensure staff immediately reported an allegation to the abuse coordinator when CNA reported on 07/29/24 to DON that LVN A had hit Resident #1 in the arm on 07/28/24.</p> <p>This failure could affect residents by placing them at risk of abuse if the reportable allegations are not reported timely after they are discovered.</p> <p>Findings included:</p> <p>Review of the face sheet for Resident #1 reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of: Spastic hemiplegia affecting right dominant side (type of paralysis that affects one side of the body), dysphagia (difficulty swallowing), urinary tract infection (an infection that affects part of the urinary tract, and muscle wasting and atrophy (when muscles waste away).</p> <p>Review of the Quarterly MDS Assessment for Resident #1 dated 05/21/24 reflected a BIMS score of 11 which indicated Resident #1 had moderate cognitive impairment. Resident #1's physical assessment reflected she could feed herself with set up or clean up assist, she needed partial assistance for oral and personal hygiene, and she was fully dependent on staff for toileting and bathing.</p> <p>Review of the Care Plan for Resident #1 dated 01/31/20 and edited 11/06/22 reflected Resident #1 had mobility impairment due to decreased functional limitation in ROM to bilateral lower extremities and a contracture to right lower leg which interfered with daily functions. Goal of Resident #1 would not have any further decline of functional ability/mobility over next quarter. Approaches listed included to encourage Resident #1 to participate in mobility/ADL tasks to extent necessary to accomplish task and to ensure staff were aware of Resident #1's mobility/ADL impairments.</p> <p>In an interview on 08/03/24 at 9:30 AM, Resident #1 stated everything is fine here and the staff treat her well. She stated there was a staff member helping her recently and she hit her on the right arm. She stated she told the woman with the red hair and then the woman with red hair told the girl that hit her not to abuse her clients. She stated she has not seen that staff member since and no one else has mistreated her in any way. She stated she feels safe here and she has no other concerns.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Epic Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3210 W Hwy 22 Corsicana, TX 75110	
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/03/24 at 10:05 AM, the ADM stated she was informed on the morning of 07/29/24 that an incident of abuse had occurred on the previous night (07/28/24) in the facility. She stated she immediately began the investigation. She stated CNA A told her that Resident #1 was down at another resident's room and the other resident did not want Resident #1 to be there. She stated she was informed that CNA A and CNA B had tried to get Resident #1 away from the other residents room and Resident #1 had begun yelling and resisting and had not wanted to leave the area. She stated CNA A and CNA B was attempting to get Resident #1 out of another residents room and LVN A went to assist. She stated Resident #1 was yelling and hitting at the staff. She stated LVN A told her that Resident #1 had a grip on her arm and the LVN A had put her hand up to block resident from hitting her. She stated LVN A told her she was telling Resident #1 not to hit her because she was pregnant, but that she did not ever hit Resident #1. She stated CNA A and CNA B were present during the incident and CNA A told her that LVN A hit Resident #1. She stated CNA B told her she did not see LVN A hit Resident #1 and that CNA B only saw LVN A put her arm up to block being hit.</p> <p>In an interview on 08/03/24 at 10:45 AM, the DON stated CNA A called her on Monday (07/29/24) morning and told her that on the night before (07/28/24), Resident #1 was trying to go into another residents room and that the other resident did not want her in there. She stated CNA A, CNA B, and LVN A were trying to remove Resident #1 from the area. She stated CNA A told her that they got Resident #1 to her room and Resident #1 started swinging her arms at LVN A. She stated CNA A told her that LVN A had told resident you're not going to hit me, I am pregnant and that LVN A hit Resident #1 in the right arm. She stated she asked CNA A why she waited to tell her until the next day and CNA A told her she was afraid that LVN A may have retaliated on her. She stated she immediately informed the ADM, which is the Abuse Coordinator. She stated she interviewed CNA B and CNA B told her that LVN A had hit Resident #1 twice in the right arm/chest area.</p> <p>Attempts to interview CNA B were unsuccessful, three attempts were made to reach her by telephone on 7/03/24 at 11:46 am and 2:00 PM. No return call was received.</p> <p>In an interview on 08/03/24 at 11:48 AM, CNA A stated she was working with CNA B and LVN A, which was on another hall from where the incident occurred. She stated Resident #1 was down at another residents room and she heard yelling. She stated she looked down the hall where Resident #1 was trying to go into another residents room, and she went down to remove Resident #1 from the area because the other resident did not want her in his room. She stated she tried re-directing Resident #1 and Resident #1 did not want to leave the area. She stated CNA B and LVN A came over to help and they got Resident #1 to hold their hands and removed Resident #1 from the area. She stated as soon they got Resident #1 to her room, Resident #1 had become more upset, and they had tried to talk to Resident #1 to calm her down. She stated Resident #1 grabbed LVN A's hand and tried to bite her and LVN A hit resident on her right arm 3 times. She stated she immediately told LVN A to get out of there. She stated she finished her round and then she got with CNA B and they both agreed the incident needed to be reported. She stated she believed they both thought the other was going to report the incident but when the DON called her to work a shift the following day, she asked if it had been reported and the DON told her no. She stated she then reported the incident to the DON, and she knew she should have reported it earlier. She stated she had been trained on abuse and neglect and reporting abuse and neglect. She stated she felt bad, but it was definitely a learning experience for her.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/03/24 at 12:55 PM, LVN B stated she had been in-serviced on abuse and neglect. She stated an example of abuse was taking away an item from a resident roughly or being rough with a resident and she had never witnessed abuse in the facility. She stated if she suspected abuse, she would immediately have reported it to the ADM which is the Abuse Coordinator. She stated if an abuse incident was not reported immediately it could have caused a misrepresentation of when and what actually occurred or delayed response in care for the resident.</p> <p>In an interview on 08/03/24 at 1:05 PM, RN B stated she had been in-serviced regularly on abuse and neglect. She stated an example of abuse was hitting a resident and she had never witnessed abuse in this facility. She stated if she suspected abuse, she would have separated the resident from the abuse and reported it immediately to the ADM, which is the Abuse Coordinator. She stated if an incident of abuse was not reported immediately, it could have caused the potential of future abuse happening or caused more harm to the resident.</p> <p>In an interview on 08/03/2024 at 2:36 PM, the DON stated staff were in-serviced regularly on abuse and reporting abuse. She stated the phone number was placed all over the facility for the Abuse Coordinator in easily visible areas including all residents rooms. She stated an example of abuse would be someone yelling at a resident, and she had never witnessed abuse in this facility. She stated it was her expectation that if staff suspected abuse, they should have made sure the resident was safe and immediately reported it to Administrator which is the Abuse Coordinator. She stated if an incident of abuse was not reported immediately, it could have caused the abuse to continue to happen.</p> <p>In an interview on 08/03/2024 at 2:40 PM, the ADM stated staff had been in-serviced regularly on abuse and reporting abuse. She stated the phone number for the Abuse Coordinator was placed all over the facility in easily visible areas, including in all residents rooms. She stated an example of abuse would be if someone had hit a resident, and she had never witnessed abuse in this facility. She stated it was her expectation that if staff suspected abuse, they should have made sure the resident was safe and immediately reported it to herself. She stated she was the Abuse Coordinator. She stated if an incident of abuse was not reported immediately, it could have caused the abuse to continue to go on.</p> <p>In an interview on 08/03/2024 at 4:12 PM with LVN A, she stated she was aware of the allegation of abuse, and she had been made aware and suspended on Monday pending an investigation. She stated when the incident happened, she had been trying to get Resident #1 away from another residents room. She stated Resident #1 was angry because she did not want to leave the area and Resident #1 was holding onto her arm tightly. She stated Resident #1 dug her nails into her arm and was swatting at her. She stated she put her hand up to block Resident #1 from hitting her and asked Resident #1 to please stop trying to hit her because she was pregnant. She stated she had not and would not ever hit Resident #1 or any resident. She stated Resident #1 was very sweet but had behaviors often and there were two newer aides that had helped her assist Resident #1 back to her room. She stated she had been trained on abuse and neglect and reporting abuse or neglect at the facility. She stated Resident #1 had no complaints of pain or of being hit after the incident to her knowledge.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Facility Policy on Reporting Abuse to Facility Management dated 2001 and revised April 2012 revealed: It is the responsibility of our employees, facility consultants, Attending Physicians, family members, visitors etcetera, to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management without fear of retaliation. 3. All personnel, residents, family members, visitors, etcetera, are encouraged to report incidents of resident abuse or suspected incidents of abuse. Such reports may be made without fear of retaliation from the facility or its staff. 4. Employees, facility consultants and/or Attending Physicians must immediately report any suspected abuse or incidents of abuse to -the Director of Nursing Services. In the absence of the Director of Nursing Services such reports may be made to the Nurse Supervisor on duty. 5. Any individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the Administrator or Director of Nursing Services. a. The name(s) of the resident(s) to which the abuse or suspected abuse occurred; b. The date and time that the incident occurred; c. Where the incident took place; d. The name(s) of the person(s) allegedly committing the incident, if known; e. The name(s) of any witnesses to the incident; f. The type of abuse that was committed (i.e., verbal, physical, sexual, neglect, etcetera.); and g. Any other information that may be requested by management. 6. Any staff member or person affiliated with this facility who has witnessed or who believes that a resident has been a victim of mistreatment, abuse, neglect, or any other criminal offense shall immediately report, or cause a report to be made of, the mistreatment or offense .</p>		