Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676341	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caprock Nursing & Rehabilitation	900 College Ave Borger, TX 79007

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 - 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** 46534 Based on observation, interview, and record review the facility failed to protect each residents right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 (Resident #1) of 5 residents reviewed for abuse and neglect. The facility failed to protect Resident #1 from emotional abuse by Resident #2 on 09/24/24 in spite of Resident #2 emotionally abusing and possibly physically abusing Resident #1 on 09/22/24. The noncompliance was found to be Past Non Compliance (PNC). The noncompliance began on 09/22/2024 and ended on 09/26/2024 The facility corrected the noncompliance before the investigation began. This failure could place residents at risk of continued and/or unrecognized abuse or neglect. Findings Included: Record review of Resident #1's admission record dated 10/04/24 revealed an [AGE] year-old female originally admitted to the facility on [DATE] with diagnoses that included, but were not limited to, dementia (a group of thinking and social symptoms that interferes with daily functioning), major depressive disorder (a mental disorder characterized by persistent low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities), and psychotic disorder with hallucinations (severe mental illness including seeing things that are not there). Record review of Resident #1's quarterly MDS completed 08/03/24 revealed the following: Section B: Resident #1 was able to understand others sometimes. Section C: Resident #1 was rarely to never understood, therefore had no BIMS. The staff assessment of her mental status revealed she had long and short-term memory problems and moderately impaired cognition. Section E: Resident #1 displayed wandering behavior daily. (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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Section GG: Resident #1 used a wheelchair. She required set up or clean up assistance with eating and upper body dressing; supervision or touching assistance with oral hygiene; partial/moderate assistance with footwear, lower body dressing, and shower/bathing; and substantial/maximal assistance with toileting and personal hygiene. Resident #1 required partial/moderate assistance across all mobility except for walking 10 feet which required supervision or touching assistance and walking 50 feet with two turns and walking 150 feet both of which were not attempted due to medical condition or safety concerns.

Section I: Resident #1's primary medical condition was non-traumatic brain dysfunction.

Section N: Resident #1 received antidepressant medication during the 7-day look back period. She did not receive anticoagulant medication.

Record review of Resident #1's care plan completed on 07/24/24 revealed she had a communication problem. Interventions included monitoring Resident #1 for physical/nonverbal indicators of discomfort or distress, focus on a word or phrase that makes sense, ensure/provide a safe environment, and be conscious of resident's position when in groups, activities, dining room to promote proper communication with others. The care plan indicated Resident #1 had a history of physical aggression received. The corresponding intervention was to keep resident away from any situation that will put resident at risk for situations of physical aggression. Resident #1 was residing in the secure unit related to her diagnosis of dementia and her risk for elopement.

Record review of Resident #1's Order Summary Report dated 10/04/24 revealed she had an active order for antidepressant medication Duloxetine HCI 60 mg delayed release capsule once a day with a start date of 08/29/24.

Record review of Resident #1's progress notes from 09/04/24 to 10/04/24 revealed no notes from 09/22/24. The progress notes did reveal the following notes:

A note written by DON on 09/24/24 at 2:26 PM entered as LATE ENTRY This nurse notified of another resident kissing this resident on forehead. This nurse assessed this resident. No new or worsening injury note at this time. Res (Resident) unable to recall events and states 'No, I'm fine.' Provider notified of incident at this time, no new orders.

A note written by DON on 09/24/24 at 4:00 PM This nurse notified [name of psychiatric doctor] office of resident receiving kiss on forehead from another resident. Message left with nurse who stated will notify provider and awaiting call back.

A note written by SW on 09/24/24 at 04:16 PM SW met with resident in the unit. She was sitting in her wheelchair in the dining room. She had her head down as she appeared to be sleeping. SW completed PRN Trauma Screen with resident. She denied any trauma at this time. She shook her head yes/no when answering questions. She appeared to be sleepy and did not want to be disturb at this time. No trauma noted.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A note written by GVN D on 09/25/24 at 06:18 PM CNA reported major bruise to nurse and ADON immediately [sic]. Nurse and ADON went to assess resident immediately. Purple bruise to right posterior forearm noted, measuring [sic] approximately 14X9.5 cm. Other findings documented in skin assessment. When this nurse asked res what happeneded [sic] res confused and unable to respond due to impaired [sic] mental status. Resident denies any pain or distress at this time. Res taken back to dinning [sic] room, ready to eat dinner. RN compliance nurse and [name of ADM] notified immediately [sic] by nurse and ADON. [Name of physician] and NP notified. [name of Resident #1's family member] emergency contact notified of injury. [name of Resident #1's family member] stated ' the slightest bump makes her bruise very badly, I'm not worried. Just keep me updated.' This nurse notified oncoming shift of injury. Record review of Resident #1's Event Nurses' Note - Bruise completed by DON on 09/25/24 at 05:31 PM revealed the bruise on Resident #1's right posterior forearm was of unknown origin and measured 14 X 9.5 cm. It was blue/purple in color. Resident #1 was unable to recall how she obtained the bruise. Physician and family were notified, and padding was applied to the arm rest of Resident #1's w/c. Record review of Resident #1's Trauma Informed PRN Assessment completed by SW on 09/24/24 at 04:04 PM revealed the following questions with answers in the negative: . 4. Have you (or has the resident) been in a situation that was extremely frightening? 5. Have you (or has the resident witnessed any extremely frightening situations? . Record review of Resident #1's Order Summary Report dated 10/04/24 revealed she was admitted to the secure unit on 08/28/23 due to a high elopement risk. Resident #1 had no order for anticoagulant medication. Record review of Resident #2's admission record dated 10/04/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, dementia (a group of thinking and social symptoms that interferes with daily functioning), generalized anxiety disorder (inability to control constant worrying), and prostate cancer. He was discharged from the facility on 09/26/24 to a psychiatric hospital. Record review of Resident #2's admission MDS completed on 09/13/24 revealed the following: Section B: Resident #2 was able to understand others and make himself understood. Section C: Resident #2 had a BIMS of 3 which indicated severely impaired cognition. Section D: Resident #2 sometimes felt lonely or isolated from those around him. Section E: Resident #2 had no behaviors during the look back period. Section GG: Resident #2 did not use any mobility devices. He needed set up or clean up assistance for eating, oral hygiene, toileting hygiene, dressing, and personal hygiene. Resident #2 was independent across all mobility ADLs except for shower/bath transfer, walking over uneven surfaces, and picking up an object where he needed supervision or touching assistance. Section I: Resident #2's primary medical condition was non-traumatic brain dysfunction. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Section K: Resident #2 was 5 feet seven inches tall and weighed 146 pounds. Section N: Resident #2 received antianxiety and antidepressant medications during the 7-day look back period. Record review of Resident #2's care plan completed on 09/16/24 revealed he was taking antianxiety medications and one of the interventions listed was to monitor and record occurrence of target behavior symptoms including violence/aggression towards staff/others and document per facility protocol. Resident #2 was noted to be at risk for wandering. He resided in the secure unit related to his diagnosis of dementia and his risk for elopement. Resident #2 was noted to have potential to demonstrate physical behaviors. He kissed another resident on forehead 09/24/24. [name of behavioral hospital] admission on 09/26/24. Two of the interventions listed was, If the resident has physical behaviors toward another resident, immediately intervene to protect the residents involved and call for assistance. If intervening would be unsafe, call out for staff assistance immediately and Notify the charge nurse of any physically abusive behaviors. The care plan noted Resident #2 was placed on 1 on 1 monitoring following his kiss on Resident #1's forehead on 09/24/24. No mention made of incident between Resident #2 and Resident #1 on 09/22/24 in the care plan. Record review of Resident #2's orders after the incident with Resident #1 and prior to his discharge to the behavioral hospital revealed the following: An order with start date of 09/23/24 and end date of 09/23/24 for antipsychotic medication Haloperidol Oral Tablet 0.5 MG Give 1 tablet by mouth four times a day related to GENERALIZED ANXIETY DISORDER An order with start date of 09/23/24 and end date of 09/23/24 for antianxiety medication LORazepam Oral Tablet 0.5 MG Give 1 tablet by mouth every 4 hours related to GENERALIZED ANXIETY DISORDER An order with start date of 09/24/24 and end date of 09/27/24 for anticonvulsant medication Divalproex Sodium Oral Tablet Delayed Release 250 MG Give 1 tablet by mouth one time a day related to GENERALIZED ANXIETY DISORDER An order with start date of 09/23/24 and end date of 09/27/24 for anticonvulsant medication Divalproex Sodium Oral Tablet Delayed Release 500 MG Give 1 tablet by mouth one time a day related to GENERALIZED ANXIETY DISORDER An order with start date of 09/23/24 and end date of 09/24/24 for antipsychotic medication Haloperidol Oral Tablet 0.5 MG Give 1 tablet by mouth every 2 hours as needed for Anxiety related to GENERALIZED ANXIETY DISORDER An order with start date of 09/24/24 and end date of 09/24/24 for antipsychotic medication Haloperidol Oral Tablet 0.5 MG Give 1 tablet by mouth three times a day for Anxiety related to GENERALIZED ANXIETY DISORDER An order with start date of 09/24/24 and end date of 09/27/24 for antipsychotic medication Haloperidol Oral Tablet 0.5 MG Give 2 tablet by mouth every 2 hours as needed for Anxiety related to GENERALIZED ANXIETY DISORDER (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An order with start date of 09/24/24 and end date of 09/27/24 for antipsychotic medication Haloperidol Oral Tablet 0.5 MG Give 2 tablet by mouth every 6 hours for Anxiety related to GENERALIZED ANXIETY DISORDER Record review of Resident #2's progress notes from 09/04/24 to 10/04/24 revealed the following notes: A note written by LVN A on 09/22/24 at 07:59 PM Pt was seen going into womans [sic] room and waking her up out of bed and touching her innappropriatly [sic]. Woman pt started to panic and get away from him. Staff transferred [sic] woman pt out of bed and into wc to monitor. This pt began grabbing womans [wic] wc handles and dragging her back. This staff intervened d/t pt woman crying and tryhing [sic] to get away. Pt began hitting staff and chasing after woman pt. At this time, woman has been taken out of secure unit and placed with one staff member for safety. [Hospice] on call called,no response at this time. On call [name of ADON] notifed [sic], stated I am trying to get a hold of SW but she won't answer me. Awaiting a call back at this time from management [sic] and [Hospice]. Pt is currently standing at secure unit doors trying to pry them open. A note written by LVN A on 09/22/24 at 10:51 PM Pt is now hovering over aide down secure unit touching her cheek and stating You like this, come on. Aide sternly educated pt to go back to bed. Pt walked in room and is sitting on bed staring out into the hall. A note written by LVN B on 09/23/24 at 12:02 AM Hospice returned call at this time and this nurse explained situation and noting new behavior for resident. Hospice nurse to call her on call provider for orders. Notified ADON. Hospice returned call at approx 2002 (02:02 AM) with new orders for [antipsychotic medication] 0. 5mg Q6hrs and to schedule the [antianxiety medication] 0.5mg q4hrs and morphine(20mg/5ml)0.2ml q4hrs. [Antipsychotic medication] will be delivered to facility via hospice pharmacy tomorrow. DON notified of new orders. A note written by LVN F on 09/23/24 at 10:59 PM While this nurse was doing med pass, the aid informed this nurse that the resident would not let her use the restroom. The resident would push the door open and would not allow the aid any privacy. This nurse gave the resident PRN [antianxiety medication] and [antipsychotic medication]. Immediately [sic] after administering [sic] the residents medication, the resident went into another residents room and was messing with her and her bedding. This nurse and a aid had to remove the resident from the other residents room. As per the residents daughter request this nurse notified the residents' daughter about the situation. A note written by LVN G on 09/24/24 at 02: 22 PM This nurse found resident kissing other resident on the forehead in dining area. This nurse removed other resident from the area. Resident is now in room making bed. No distress noted. A note written by DON on 09/24/24 at 02:23 PM This DON notified of incident. Administrator notified. Self report protocol initiated. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A note written by DON on 09/24/24 at 02:50 PM This nurse spoke with resident daughter and educated on situation that occurred and facility policy. This nurse also educated resident daughter on interventions put in place such as one on one and referral to inpatient psych. Res daughter verbalizes understanding and appreciative of interventions facility has provided. Res daughter also appreciative on this nurse explaining situation and protocol. Res daughter inquires as to if res will readmit after psych stay, res education on clinical will be reviewed to ensure facility can meet res needs and res or other res will not be at risk of safety if readmitted and facility/inpatient psych assisting with placement if unable to readmit - res daughter verbalizes understanding. A note written by SW on 09/26/24 at 01:36 PM SW has worked with [behavioral hospital] for admission for today. Res was transported to [behavioral hospital]. SW sent ED paperwork to the Judge to be completed. Paperwork was completed and sent to [behavioral hospital]. SW also spoke to resident daughter about him receiving a 30 day notice. Res / daughter also given copy of 30 day notice. Res daughter was appreciative about his care at facility. She reported that they would come Monday and pick up his stuff. Record review of Event Nurses' Note - Behavior written by DON on 09/24/24 at 02:24 PM revealed Resident #2 exhibited physical, resident to resident behavior in the hallway. The behavior was kissing another resident on the forehead, and it was witnessed by LVN on duty. Resident was redirected and provided with 1 on 1 supervision. During an interview on 10/04/24 at 05:30 PM ADM stated he was not sure who the female resident mentioned in Resident #2's progress note written by LVN A on 09/22/24 at 07:59 PM. He stated DON would know. During an interview on 10/04/24 at 05:32 PM DON stated the female resident from Resident #2's progress note written by LVN A on 09/22/24 at 07:59 PM was Resident #1. She stated she had concerns about the wording of the progress note and she called LVN A and got a statement from LVN A stating she put the words touching her inappropriately in the progress note based on what the CNA told her. DON stated the CNA was CNA E. DON stated English is CNA E's second language and confusion had led to the wrong thing being documented. DON stated she would bring me a written copy of CNA E's statement regarding the incident on 09/22/24 between Resident #1 and Resident #2. DON stated after she spoke to CNA E and LVN A she felt Resident #2 only wanted to help/protect the women. DON stated, He was their (female residents') protector and didn't really want us (facility staff) to help. She said this was made very clear after Resident #2 was placed on 1 to 1 supervision following his kiss to Resident #1's forehead when every time a staff member would enter a resident's room he would ask, Who is that? Record review of CNA E's statement revealed it was dated 09/24/24. In the statement CNA E revealed Resident #2 was calling Resident #1 his girl and his girlfriend and patting her on the shoulder. Record review of LVN A's statement regarding why she documented Resident #2 was touching Resident #1 inappropriately on 09/22/24s revealed a photo of a text message which read, I documented the 'inappropriate touching' due to CNA statement.'[sic] (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/04/24 at 05:51 PM LVN A stated she wrote Resident #2's progress note on 09/22/24 at 07:59 PM based on what CNA E told her over the phone. (staff in the locked unit often communicate with staff outside the locked unit via phone call) LVN A stated what she saw with her own eyes was Resident #2 grabbing at her (Resident #1's) arms and pulling on her and she was verbally crying and screaming. LVN A said earlier in the night when she assisted Resident #1 to bed Resident #1 said, This is not my room, this is his room. This is his room. He is going to come in here and be fraudulent. LVN A said she did not think anything of it at the time due to Resident #1 having dementia. She said she assured Resident #1 that she would keep her safe. LVN A stated Resident #1 then said, They are going to come in here before you are gone. LVN A stated, Looking back on it, I feel bad because I wonder if she was afraid that night. You know people with dementia say some wild things but in light of what happened, I wonder. LVN A stated that after the incident the nurses took Resident #1 out of the locked unit and had her seated in her w/c at the nurses' station. LVN A said of Resident #1, She stayed up the whole night, I felt so bad for her. LVN A stated the nurses tried putting Resident #1 to bed in an empty room on hall 400 but she would not stay in bed. I think she recognized it was not her room. LVN A stated she knew the staff in the locked unit needed her help when LVN B called her and asked her to open the door of the locked unit so LVN B could push Resident #1 out of the unit without letting Resident #2 out of the unit as well. LVN A stated she opened the door and saw LVN B pushing Resident #1 in her w/c at a slow walk and behind her she saw Resident #2 get away from LVN C and CNA E who were trying to keep him from following and he began to sprint down the hall after Resident #1 and LVN B. LVN A said she told LVN B, Okay, [first name of LVN B] I'm gonna need you to pick it up. LVN A stated LVN B began to walk faster while pushing Resident #1 in her w/c and they got LVN B and Resident #1 out of the locked unit just in time to shut the door and keep Resident #2 in the locked unit. During an observation and interview on 10/04/24 at 06:22 PM Resident #1 was wheeling herself down the hall of the locked unit. When asked if she was [name of Resident #1] she shook her head and continued wheeling herself down the hall. During an interview on 10/04/24 at 06:26 PM SW stated she did interview Resident #1 about trauma following Resident #2 kissing Resident #1 on the forehead. SW stated Resident #1 was alert but not sure what was going on during the interview. When asked if she thought Resident #1 was traumatized by Resident #2 pulling on her and chasing her on the locked unit on 09/22/24 SW said it was hard to tell as the change of venue from the locked unit to the nurses' station for the night might have also been traumatizing. When asked if she thought a reasonable person would have been traumatized by the events that took place between Resident #1 and Resident #2 on 09/22/24, SW stated, It absolutely could be traumatizing. During an interview on 10/04/24 at 06:29 PM LVN A stated she thought Resident #1 was traumatized by the interaction on 09/22/24 with Resident #2 because, she was in bed initially and when I went back, she was out of bed, crying, and trying not to let him (Resident #2) touch her. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/04/24 at 06:31 PM LVN B stated LVN C texted her to please come help in the locked unit as Resident #2 would not let go of Resident #1's w/c. LVN B stated when she got to the locked unit she observed Resident #2 holding onto the handles of Resident #1's w/c and Resident #1 was in the w/c and kept saying, No, you don't want me, I'm too old, I don't want to go with you. LVN B stated she tried to distract Resident #2 and get him to go outside with her to pick weeds as that was one of his favorite pastimes, but he would not let go and kept trying to push Resident #1 in her w/c. LVN B said Resident #2 kept saying Resident #1 was his girl and he was going to go wherever she went. LVN B said she got Resident #1 away from Resident #2 at one point and called LVN A to open the door of the locked unit for her because LVN C and CNA E were holding Resident #2's hands to keep him from following them out. LVN B said during the entire situation she could tell Resident #1 was scared. LVN B stated, We had [name of Resident #1] out here for the night. She was upset. I tried to distract her by giving her a banana but she was scared. LVN B said after she and Resident #1 exited the locked unit Resident #2 stood on the other side of the locked doors hitting the doors and yelling. LVN B said of Resident #1, We (nursing staff) tried putting her to bed on hall 400 but she kept getting up and she kept saying, 'That guy is going to come get me.' LVN B stated she reported the entire incident to ADON and hospice nurse. LVN B said in her opinion not reporting possible abuse of a resident is just bad. During an interview on 10/04/24 at 06:37 PM LVN C stated that during report at the beginning of her shift on 09/22/24 she found out Resident #2 had been having behaviors all day. She stated she heard CNA E needed help on the locked hall with Resident #2. LVN C said when she got to the locked unit Resident #2 was trying to direct [name of Resident #1] to his room and I could tell she (Resident #1) was afraid. She was saying, 'I'm too old, no you don't want me.' LVN C said Resident #2 was grabbing Resident #1's hands and grabbing the handle of Resident #1's w/c. LVN C stated Resident #1 was crying during part of the interaction. LVN C said Resident #2 became so agitated he was hitting at staff and hitting near Resident #1 but did not hit Resident #1. She said she and CNA E attempted to hold Resident #2's hands to keep him from chasing Resident #1 and LVN B out of the locked unit and because at this point, he was just hitting us. She said Resident #2 got out of their grasp and ran after Resident #1 and LVN B but they made it out the door before he got to them. LVN C said, I figured if we weren't there, there was going to be abuse going on. During an interview on 10/04/24 at 06:46 PM CNA E stated on 09/22/24 Resident #2 was confused and after [Resident #1]. She said Resident #2 started saying Resident #1 was his girlfriend and his wife and he wouldn't let her go. CNA E said Resident #1 started saying, 'Listen, I don't like you, you're not mine.' CNA E said she had to call the nurses because Resident #2 would not let go of Resident #1's w/c and he got mad. She said Resident #1 kept saying, You don't want to be with me. I don't like you. CNA E did not exhibit any issues with speaking English clearly during this interview. During an interview on 10/04/24 at 07:11 PM DON stated staff are responsible to report to ADM or charge nurse when they notice anything that could constitute resident abuse. When asked what a possible negative outcome of not reporting resident abuse immediately DON said, If a resident did receive abuse possible negative outcome is they wouldn't receive treatment that was necessary. When asked why Resident #2's treatment of Resident #1 on 09/22/24 was not reported as possible abuse she said, I think her case would be different because she does have dementia. When asked what would happen if a reasonable person had endured the same treatment as Resident #1, DON said, If it was somebody else, I'd look at it differently because they were not a dementia patient. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/04/24 at 07:15 PM ADM stated that if the same thing that happened to Resident #1 at the hands of Resident #2 happened to a reasonable person it could be considered abuse. ADM stated it was a no brainer that there could be a negative outcome to residents if possible abuse of residents was not reported timely. During an interview on 10/04/24 at 07:30 PM ADM stated he was not informed of the incident between Resident #1 and Resident #2 on 09/22/24 and that if he had been informed, he would have reported it as possible abuse. During an interview on 10/18/24 at 10:28 AM ADM stated he expected his staff to let him know right away if anything that might constitute resident abuse or neglect took place on the weekend. He stated he was not sure why ADON and DON did not inform him of the incident between Resident #1 and Resident #2 on 09/22/24. He stated, We would have started the process of getting him (Resident #2) out (of the facility). ADM stated the facility started that process on 09/24/24 when Resident #2 was seen kissing Resident #1 on the forehead. He stated to address his staff not informing him of the incident on 09/22/24 all staff were in-serviced on Abuse/Neglect and ADON was in-serviced on what is expected from weekend on-call staff regarding contacting him with concerns. During an interview on 10/18/24 at 10:32 AM DON stated she felt staff kept Resident #1 safe from Resident #2 following the incident on 09/22/24 by removing Resident #1 for the night from the locked unit and calling Hospice to have Resident #2's medications changed to address his behavior. DON stated staff did not report any distress on the part of Resident #1 when reporting the incident to ADON. She stated the next day when Resident #1 was returned to the locked unit she was kept safe by having two staff members in the locked unit with the 8-10 residents. DON stated no other incidents occurred until 09/24/24 when Resident #2 was witnessed kissing Resident #1 on the forehead. During an interview on 10/18/24 at 11:05 AM ADON stated nurses did not indicate any distress on the part of Resident #1 following the incident on 09/22/24. She stated, They (nurses) said he (Resident #2) was going up and down the hallways and walking everywhere and trying to take female residents to their rooms and nurses and CNAs would not let him. They did not report distress to me at all (for Resident #1). I told them to get ahold of Hospice. I called DON and SW. Could not get hold of SW. DON told me we did need to get hold of [name of hospice for Resident #2] They got ahold of hospice and they were able to take care of him and keep her safe. During an interview on 10/18/24 at 01:19 PM DON stated she called CNA E to ask about the date on her statement regarding the incident between Resident #1 and Resident #2 on 09/22/24. CNA E told DON she dated it incorrectly. DON provided a copy of CNA E's working schedule. Record Review of CNA E's work schedule for 09/24/24 revealed she did not work that date but she did work on 09/22/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER: Caprock Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 900 College Ave Borger, TX 79007	

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of facility policy titled Abuse/Neglect and dated March 11, 2013 revealed the following: . Abuse is the willful infliction of . intimidation . with resulting . mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Any person having reasonable cause to believe an elderly or incapacitated adults is suffering from abuse, neglect or exploitation must report this to the DON, administrator, state and/or adult protective services. Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 2024-14 dated 08/29/24. a. If the allegations involve abuse or result in serious bodily injury, the report must be made within 24 hours of the allegation. b. If the allegation does not involved abuse or serious bodily injury, the report must be made within 24 hours of the allegation. Record review of abuse/neglect in-services for the past three months revealed in-services on the following dates: 07/02/24, 07/07/24, 07/08/24, 07/10/24, 07/11/24, 07/16/24, 07/30/24, 08/14/24, 08/13/24, 08/08/24, 08/27/24, 09/24/24, 09/25/24, 09/26/24, 09/29/24, 10/01/24. Each of the in-services included, Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents . If abuse and/or neglect witnessed or suspected, intervene immediately and report to abuse preventionist-the administrator [name of ADM] or immediate supervisor. Record Review of the abuse/neglect in-services for the past three months revealed the following dates: 07/02/24, 07/07/24, 07/08/24, 07/10/24, 07/11/24, 07/16/24, 07/30/24, 08/14/24, 08/13/24, 08/08/24, 08/27/24, 09/24/24, 09/25/24, 09/26/24, 09/29/24, 10/01/24, the ADON and DON participated in said in-service training covering what is abuse and when and to whom it should be reported.

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F 0607

Level of Harm - Actual harm

Residents Affected - Few

Develop and implement policies and procedures to prevent abuse, neglect, and theft.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46534

Based on observation, interview, and record review the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, for 1 (Resident #1) of 5 residents reviewed for abuse and neglect.

The facility failed to report the emotional and possible physical abuse of Resident #1 by Resident #2 as per the facility's Abuse/Neglect policy.

The noncompliance was found to be Past Noncompliance (PNC). The noncompliance began on 09/22/24 and ended on 09/26/24. The facility corrected the noncompliance before the investigation began.

This failure could place residents at risk of continued and/or unrecognized abuse or neglect.

Findings Included:

Record review of Resident #1's admission record dated 10/04/24 revealed an [AGE] year-old female originally admitted to the facility on [DATE] with diagnoses that included, but were not limited to, dementia (a group of thinking and social symptoms that interferes with daily functioning), major depressive disorder (a mental disorder characterized by persistent low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities), and psychotic disorder with hallucinations (severe mental illness including seeing things that are not there).

Record review of Resident #1's quarterly MDS completed 08/03/24 revealed the following:

Section C: Resident #1 was rarely to never understood, therefore had no BIMS. The staff assessment of her mental status revealed she had long and short-term memory problems and moderately impaired cognition.

Section GG: Resident #1 used a wheelchair. She required set up or clean up assistance with eating and upper body dressing; supervision or touching assistance with oral hygiene; partial/moderate assistance with footwear, lower body dressing, and shower/bathing; and substantial/maximal assistance with toileting and personal hygiene. Resident #1 required partial/moderate assistance across all mobility except for walking 10 feet which required supervision or touching assistance and walking 50 feet with two turns and walking 150 feet both of which were not attempted due to medical condition or safety concerns.

Section I: Resident #1's primary medical condition was non-traumatic brain dysfunction.

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F 0607 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's care plan completed on 07/24/24 revealed she had a communication problem. Interventions included monitoring Resident #1 for physical/nonverbal indicators of discomfort or distress, focus on a word or phrase that makes sense, ensure/provide a safe environment, and be conscious of resident's position when in groups, activities, dining room to promote proper communication with others. The care plan indicated Resident #1 had a history of physical aggression received. The corresponding intervention was to keep resident away from any situation that will put resident at risk for situations of physical aggression. Resident #1 was residing in the secure unit related to her diagnosis of dementia and her risk for elopement. Record review of Resident #1's progress notes from 09/04/24 to 10/04/24 revealed no notes from 09/22/24. The progress notes did reveal the following notes: A note written by DON on 09/24/24 at 2:26 PM entered as LATE ENTRY This nurse notified of another resident kissing this resident on forehead. This nurse assessed this resident. No new or worsening injury note at this time. Res (Resident) unable to recall events and states 'No, I'm fine.' Provider notified of incident at this time, no new orders. A note written by DON on 09/24/24 at 4:00 PM This nurse notified [name of psychiatric doctor] office of resident receiving kiss on forehead from another resident. Message left with nurse who stated will notify provider and awaiting call back. A note written by GVN D on 09/25/24 at 06:18 PM CNA reported major bruise to nurse and ADON immediately [sic]. Nurse and ADON went to assess resident immediately. Purple bruise to right posterior forearm noted, measuring [sic] approximately 14X9.5 cm. Other findings documented in skin assessment. When this nurse asked res what happeneded [sic] res confused and unable to respond due to impaired [sic] mental status. Resident denies any pain or distress at this time. Res taken back to dinning [sic] room, ready to eat dinner. RN compliance nurse and [name of ADM] notified immediately [sic] by nurse and ADON. [Name of physician] and NP notified. [name of Resident #1's family member] emergency contact notified of injury. [name of Resident #1's family member] stated ' the slightest bump makes her bruise very badly, I'm not worried. Just keep me updated.' This nurse notified oncoming shift of injury. Record review of Resident #1's Event Nurses' Note - Bruise completed by DON on 09/25/24 at 05:31 PM revealed the bruise on Resident #1's right posterior forearm was of unknown origin and measured 14 X 9.5 cm. It was blue/purple in color. Resident #1 was unable to recall how she obtained the bruise. Physician and family were notified, and padding was applied to the arm rest of Resident #1's w/c. Record review of Resident #1's Trauma Informed PRN Assessment completed by SW on 09/24/24 at 04:04 PM revealed the following questions with answers in the negative: . 4. Have you (or has the resident) been in a situation that was extremely frightening? 5. Have you (or has the resident witnessed any extremely frightening situations? . Record review of Resident #1's Order Summary Report dated 10/04/24 revealed she was admitted to the secure unit on 08/28/23 due to a high elopement risk. Resident #1 had no order for anticoagulant medication. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #2's admission record dated 10/04/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, dementia (a group of thinking and social symptoms that interferes with daily functioning), generalized anxiety disorder (inability to control constant worrying), and prostate cancer. He was discharged from the facility on 09/26/24 to a behavioral health hospital. Record review of Resident #2's admission MDS completed on 09/13/24 revealed the following: Section B: Resident #2 was able to understand others and make himself understood. Section C: Resident #2 had a BIMS of 3 which indicated severely impaired cognition. Section D: Resident #2 sometimes felt lonely or isolated from those around him. Section E: Resident #2 had no behaviors during the look back period. Section GG: Resident #2 did not use any mobility devices. He needed set up or clean up assistance for eating, oral hygiene, toileting hygiene, dressing, and personal hygiene. Resident #2 was independent across all mobility ADLs except for shower/bath transfer, walking over uneven surfaces, and picking up an object where he needed supervision or touching assistance. Section I: Resident #2's primary medical condition was non-traumatic brain dysfunction. Section K: Resident #2 was 5 feet seven inches tall and weighed 146 pounds. Section N: Resident #2 received antianxiety and antidepressant medications during the 7-day look back period. Record review of Resident #2's care plan completed on 09/16/24 revealed he was taking antianxiety medications and one of the interventions listed was to monitor and record occurrence of target behavior symptoms including violence/aggression towards staff/others and document per facility protocol. Resident #2 was noted to be at risk for wandering. He resided in the secure unit related to his diagnosis of dementia and his risk for elopement. Resident #2 was noted to have potential to demonstrate physical behaviors. He kissed another resident on forehead 09/24/24. [name of behavioral hospital] admission on 09/26/24. Two of the interventions listed was, If the resident has physical behaviors toward another resident, immediately intervene to protect the residents involved and call for assistance. If intervening would be unsafe, call out for staff assistance immediately and Notify the charge nurse of any physically abusive behaviors. The care plan noted Resident #2 was placed on 1 on 1 monitoring following his kiss on Resident #1's forehead on 09/24/24. No mention made of incident between Resident #2 and Resident #1 on 09/22/24 in the care plan. Record review of Resident #2's orders prior to his discharge to the behavioral hospital revealed he was started on an antipsychotic medication on 09/23/24 and was receiving antianxiety and antidepressant medications with start dates of 09/04/24. Record review of Resident #2's progress notes from 09/04/24 to 10/04/24 revealed the following notes: (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few	A note written by LVN A on 09/22/24 at 07:59 PM Pt was seen going into womans [sic] room and waking her up out of bed and touching her innappropriatly [sic]. Woman pt started to panic and get away from him. Staff transferred [sic] woman pt out of bed and into wc to monitor. This pt began grabbing womans [wic] wc handles and dragging her back. This staff intervened d/t pt woman crying and tryhing [sic] to get away. Pt began hitting staff and chasing after woman pt. At this time, woman has been taken out of secure unit and placed with one staff member for safety. [Hospice] on call called,no response at this time. On call [name of ADON] notifed [sic], stated I am trying to get a hold of SW but she won't answer me. Awaiting a call back at this time from management [sic] and [Hospice]. Pt is currently standing at secure unit doors trying to pry them open. A note written by LVN F on 09/23/24 at 10:59 PM While this nurse was doing med pass, the aid informed this nurse that the resident would not let her use the restroom. The resident would push the door open and would not allow the aid any privacy. This nurse gave the resident PRN [antianxiety medication] and [antipsychotic medication]. Immediately [sic] after administering [sic] the residents medication, the resident went into another residents room and was messing with her and her bedding. This nurse and a aid had to remove the resident from the other residents room. As per the residents daughter request this nurse notified the residents' daughter about the situation. A note written by LVN G on 09/24/24 at 02: 22 PM This nurse found resident kissing other resident on the forehead in dining area. This nurse removed other resident from the area. Resident is now in room making bed. No distress noted. A note written by DON on 09/24/24 at 02:23 PM This DON notified of incident. Administrator notified. Self report protocol initiated. Record review of Event Nurses' Note - Behavior written by DON on 09/24/24 at 02:24 PM revealed Resident #2 exhibited physical, resident to resident behavior in the hallway. The behavior was kissing another resident on the forehead, and it was witnessed by LVN on duty. Resident was redirected and provided with 1 on 1 supervision. Record review of CNA E's statement revealed it was dated 09/24/24. In the statement CNA E revealed Resident #2 was calling Resident #1 his girl and his girlfriend and patting her on the shoulder. Record review of LVN A's statement regarding why she documented Resident #2 was touching Resident #1 inappropriately on 09/22/24s revealed a photo of a text message which read, I documented the 'inappropriate touching' due to CNA statement.'[sic] During interviews on 10/04/24 beginning at 10:04 AM HSK H, HSK K, HSK I, [NAME] J, [NAME] M, COTA L, and CNA N stated they had been trained to recognize abuse, neglect, exploitation, and misappropriation of resident property and to report any suspicion of such to ADM. During an interview on 10/04/24 at 05:30 PM ADM stated he was not sure who the female resident mentioned in Resident #2's progress note written by LVN A on 09/22/24 at 07:59 PM was. He stated DON would know. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/04/24 at 05:32 PM DON stated the female resident from Resident #2's progress note written by LVN A on 09/22/24 at 07:59 PM was Resident #1. She stated she had concerns about the wording of the progress note and she called LVN A and got a statement from LVN A stating she put the words touching her inappropriately in the progress note based on what the CNA told her. DON stated the CNA was CNA E. DON stated English is CNA E's second language and confusion had led to the wrong thing being documented. DON stated she would bring me a written copy of CNA E's statement regarding the incident on 09/22/24 between Resident #1 and Resident #2. DON stated after she spoke to CNA E and LVN A she felt Resident #2 only wanted to help/protect the women. DON stated, He was their (female residents') protector and didn't really want us (facility staff) to help. She said this was made very clear after Resident #2 was placed on 1 to 1 supervision following his kiss to Resident #1's forehead when every time a staff member would enter a resident's room he would ask, Who is that? During an interview on 10/04/24 at 05:51 PM LVN A stated she wrote Resident #2's progress note on 09/22/24 at 07:59 PM based on what CNA E told her over the phone. (staff in the locked unit often communicate with staff outside the locked unit via phone call) LVN A stated what she saw with her own eyes was Resident #2 grabbing at her (Resident #1's) arms and pulling on her and she was verbally crying and screaming. LVN A said earlier in the night when she assisted Resident #1 to bed Resident #1 said, This is not my room, this is his room. This is his room. He is going to come in here and be fraudulent. LVN A said she did not think anything of it at the time due to Resident #1 having dementia. She said she assured Resident #1 that she would keep her safe. LVN A stated Resident #1 then said, They are going to come in here before you are gone. LVN A stated, Looking back on it, I feel bad because I wonder if she was afraid that night. You know people with dementia say some wild things but in light of what happened, I wonder. LVN A stated that after the incident the nurses took Resident #1 out of the locked unit and had her seated in her w/c at the nurses' station. LVN A said of Resident #1, She stayed up the whole night, I felt so bad for her. LVN A stated the nurses tried putting Resident #1 to bed in an empty room on hall 400 but she would not stay in bed. I think she recognized it was not her room. LVN A stated she knew the staff in the locked unit needed her help when LVN B called her and asked her to open the door of the locked unit so LVN B could push Resident #1 out of the unit without letting Resident #2 out of the unit as well. LVN A stated she opened the door and saw LVN B pushing Resident #1 in her w/c at a slow walk and behind her she saw Resident #2 get away from LVN C and CNA E who were trying to keep him from following and he began to sprint down the hall after Resident #1 and LVN B. LVN A said she told LVN B, Okay, [first name of LVN B] I'm gonna need you to pick it up. LVN A stated LVN B began to walk faster while pushing Resident #1 in her w/c and they got LVN B and Resident #1 out of the locked unit just in time to shut the door and keep Resident #2 in the locked unit. During an observation and interview on 10/04/24 at 06:22 PM Resident #1 was wheeling herself down the hall of the locked unit. When asked if she was [name of Resident #1] she shook her head and continued wheeling herself down the hall. During an interview on 10/04/24 at 06:23 PM CNA O stated he had been trained to recognize abuse, neglect, exploitation, and misappropriation of resident property and to report any suspicion of such to the ADM. He stated staff are trained on the above all the time. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/04/24 at 06:26 PM SW stated she did interview Resident #1 about trauma following Resident #2 kissing Resident #1 on the forehead. SW stated Resident #1 was alert but not sure what was going on during the interview. When asked if she thought Resident #1 was traumatized by Resident #2 pulling on her and chasing her on the locked unit on 09/22/24 SW said it was hard to tell as the change of venue from the locked unit to the nurses' station for the night might have also been traumatizing. When asked if she thought a reasonable person would have been traumatized by the events that took place between Resident #1 and Resident #2 on 09/22/24, SW stated, It absolutely could be traumatizing. During an interview on 10/04/24 at 06:29 PM LVN A stated she thought Resident #1 was traumatized by the interaction on 09/22/24 with Resident #2 because, she was in bed initially and when I went back, she was out of bed, crying, and trying not to let him (Resident #2) touch her. LVN A stated she had been trained to recognize abuse, neglect, exploitation, and misappropriation of resident property and to report any suspicion of such to the ADM. During an interview on 10/04/24 at 06:31 PM LVN B stated LVN C texted her to please come help in the locked unit as Resident #2 would not let go of Resident #1's w/c. LVN B stated when she got to the locked unit she observed Resident #2 holding onto the handles of Resident #1's w/c and Resident #1 was in the w/c and kept saying, No, you don't want me, I'm too old, I don't want to go with you. LVN B stated she tried to distract Resident #2 and get him to go outside with her to pick weeds as that was one of his favorite pastimes, but he would not let go and kept trying to push Resident #1 in her w/c. LVN B said Resident #2 kept saying Resident #1 was his girl and he was going to go wherever she went. LVN B said she got Resident #1 away from Resident #2 at one point and called LVN A to open the door of the locked unit for her because LVN C and CNA E were holding Resident #2's hands to keep him from following them out. LVN B said during the entire situation she could tell Resident #1 was scared. LVN B stated, We had [name of Resident #1] out here for the night. She was upset. I tried to distract her by giving her a banana but she was scared. LVN B said after she and Resident #1 exited the locked unit Resident #2 stood on the other side of the locked doors hitting the doors and yelling. LVN B said of Resident #1, We (nursing staff) tried putting her to bed on hall 400 but she kept getting up and she kept saying, 'That guy is going to come get me.' LVN B stated she reported the entire incident to ADON and hospice nurse. LVN B said in her opinion not reporting possible abuse of a resident is just bad. LVN B stated she had been trained to recognize abuse, neglect, exploitation, and misappropriation of resident property and to report any suspicion of such to ADM but she felt that if she told ADON the information would reach ADM and it was a weekend. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/04/24 at 06:37 PM LVN C stated that during report at the beginning of her shift on 09/22/24 she found out Resident #2 had been having behaviors all day. She stated she heard CNA E needed help on the locked hall with Resident #2. LVN C said when she got to the locked unit Resident #2 was trying to direct [name of Resident #1] to his room and I could tell she (Resident #1) was afraid. She was saying, 'I'm too old, no you don't want me.' LVN C said Resident #2 was grabbing Resident #1's hands and grabbing the handle of Resident #1's w/c. LVN C stated Resident #1 was crying during part of the interaction. LVN C said Resident #2 became so agitated he was hitting at staff and hitting near Resident #1 but did not hit Resident #1. She said she and CNA E attempted to hold Resident #2's hands to keep him from chasing Resident #1 and LVN B out of the locked unit and because at this point, he was just hitting us. She said Resident #2 got out of their grasp and ran after Resident #1 and LVN B but they made it out the door before he got to them. LVN C said, I figured if we weren't there, there was going to be abuse going on. LVN C stated she had been trained to recognize abuse, neglect, exploitation, and misappropriation of resident property and to report any suspicion of such to ADM. During an interview on 10/04/24 at 06:46 PM CNA E stated on 09/22/24 Resident #2 was confused and after [Resident #1]. She said Resident #2 started saying Resident #1 was his girlfriend and his wife and he wouldn't let her go. CNA E said Resident #1 started saying, 'Listen, I don't like you, you're not mine.' CNA E said she had to call the nurses because Resident #2 would not let go of Resident #1's w/c and he got mad. She said Resident #1 kept saying, You don't want to be with me. I don't like you. CNA E stated she had been trained to recognize abuse, neglect, exploitation, and misappropriation of resident property and to report any suspicion of such to the ADM. She said staff are trained on recognizing and reporting abuse and neglect almost every day. CNA E did not exhibit any issues with speaking English clearly during this interview. During an interview on 10/04/24 at 07:11 PM DON stated staff are responsible to report to ADM or charge nurse when they notice anything that could constitute resident abuse. When asked what a possible negative outcome of not reporting resident abuse immediately DON said, If a resident did receive abuse possible negative outcome is they wouldn't receive treatment that was necessary. When asked why Resident #2's treatment of Resident #1 on 09/22/24 was not reported as possible abuse she said, I think her case would be different because she does have dementia. When asked what would happen if a reasonable person had endured the same treatment as Resident #1, DON said, If it was somebody else, I'd look at it differently because they were not a dementia patient. During an interview on 10/04/24 at 07:15 PM ADM stated that if the same thing that happened to Resident #1 at the hands of Resident #2 happened to a reasonable person it could be considered abuse. ADM stated it was a no brainer that there could be a negative outcome to residents if possible abuse of residents was not reported timely. During an interview on 10/04/24 at 07:30 PM ADM stated he was not informed of the incident between Resident #1 and Resident #2 on 09/22/24 and that if he had been informed, he would have reported it as possible abuse. (continued on next page)

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676341	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caprock Nursing & Rehabilitation	900 College Ave Borger, TX 79007

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F 0607 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/18/24 at 10:28 AM ADM stated he expected his staff to let him know right away if anything that might constitute resident abuse or neglect took place on the weekend. He stated he was not sure why ADON and DON did not inform him of the incident between Resident #1 and Resident #2 on 09/22/24. He stated to address his staff not informing him of the incident on 09/22/24 all staff were in-serviced on Abuse/Neglect and ADON was in-serviced on what is expected from weekend on-call staff regarding contacting him with concerns that might constitute abuse or neglect. During an interview on 10/18/24 at 10:32 AM DON stated staff did not report any distress on the part of Resident #1 when reporting the incident from 09/22/24 to ADON. During an interview on 10/18/24 at 11:05 AM ADON stated nurses did not indicate any distress on the part of Resident #1 following the incident on 09/22/24. She stated, They (nurses) said he (Resident #2) was going up and down the hallways and walking everywhere and trying to take female residents to their rooms and nurses and CNAs would not let him. They did not report distress to me at all (for Resident #1). I told them to get ahold of Hospice. I called DON and SW. Could not get hold of SW. DON told me we did need to get hold of [name of hospice for Resident #2] They got ahold of hospice and they were able to take care of him and keep her safe. Record review of facility policy titled Abuse/Neglect and dated March 11, 2013 revealed the following: . Any person having reasonable cause to believe an elderly or incapacitated adults is suffering from abuse, neglect or exploitation must report this to the DON, administrator, state and/or adult protective services. Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 2024-14 dated 08/29/24. a. If the allegations involve abuse or result in serious bodily injury, the report must be made within 24 hours of the allegation. b. If the allegation does not involved abuse or serious bodily injury, the report must be made within 24 hours of the allegation. Record review of abuse/neglect in-services for the past three months revealed in-services on the following dates: 07/02/24, 07/07/24, 07/08/24, 07/10/24, 07/11/24, 07/16/24, 07/30/24, 08/14/24, 08/13/24, 08/08/24, 08/27/24, 09/24/24, 09/25/24, 09/26/24, 09/29/24, 10/01/24. Each of the in-services included, Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents . If abuse and/or neglect witnessed or suspected, intervene immediately and report to abuse preventionist-the administrator [name of ADM] or immediate supervisor. Record Review of the abuse/neglect in-services for the past three months revealed the following dates: 07/02/24, 07/07/24, 07/08/24, 07/10/24, 07/11/24, 07/16/24, 07/30/24, 08/14/24, 08/13/24, 08/08/24, 08/27/24, 09/24/24, 09/25/24, 09/26/24, 09/29/24, 10/01/24, the ADON and DON participated in said in-service training covering what is abuse and when and to whom it should be reported.

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NAME OF PROVIDER OR SUPPLIER: Caprock Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 900 College Ave Borger, TX 79007	

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F 0609

Level of Harm - 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 46534

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, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 (Resident #1) of 5 residents reviewed for abuse and neglect.

The facility failed to report the emotional and possible physical abuse of Resident #1 by Resident #2 which occurred on 09/22/24 to administrator and the state survey agency.

The noncompliance was found to be Past Non Compliance (PNC). The noncompliance began on 09/22/2024 and ended on 09/26/2024 The facility corrected the noncompliance before the investigation began.

This failure could place residents at risk of continued and/or unrecognized abuse or neglect.

Findings Included:

Record review of Resident #1's admission record dated 10/04/24 revealed an [AGE] year-old female originally admitted to the facility on [DATE] with diagnoses that included, but were not limited to, dementia (a group of thinking and social symptoms that interferes with daily functioning), major depressive disorder (a mental disorder characterized by persistent low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities), and psychotic disorder with hallucinations (severe mental illness including seeing things that are not there).

Record review of Resident #1's quarterly MDS completed 08/03/24 revealed the following:

Section B: Resident #1 was able to understand others sometimes.

Section C: Resident #1 was rarely to never understood, therefore had no BIMS. The staff assessment of her mental status revealed she had long and short-term memory problems and moderately impaired cognition.

Section E: Resident #1 displayed wandering behavior daily.

(continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	Section GG: Resident #1 used a wheelchair. She required set up or clean up assistance with eating and upper body dressing; supervision or touching assistance with oral hygiene; partial/moderate assistance with footwear, lower body dressing, and shower/bathing; and substantial/maximal assistance with toileting and personal hygiene. Resident #1 required partial/moderate assistance across all mobility except for walking 10 feet which required supervision or touching assistance and walking 50 feet with two turns and walking 150 feet both of which were not attempted due to medical condition or safety concerns. Section I: Resident #1's primary medical condition was non-traumatic brain dysfunction. Section N: Resident #1 received antidepressant medication during the 7-day look back period. She did not receive anticoagulant medication. Record review of Resident #1's care plan completed on 07/24/24 revealed she had a communication problem. Interventions included monitoring Resident #1 for physical/nonverbal indicators of discomfort or distress, focus on a word or phrase that makes sense, ensure/provide a safe environment, and be conscious of resident's position when in groups, activities, dining room to promote proper communication with others. The care plan indicated Resident #1 had a history of physical aggression received. The corresponding intervention was to keep resident away from any situation that will put resident at risk for situations of physical aggression. Resident #1 was residing in the secure unit related to her diagnosis of dementia and her risk for elopement. Record review of Resident #1's Order Summary Report dated 10/04/24 revealed she had an active order for antidepressant medication Duloxetine HCl 60 mg delayed release capsule once a day with a start date of 08/29/24. Record review of Resident #1's progress notes from 09/04/24 to 10/04/24 revealed no notes from 09/22/24. The progress notes did reveal the following notes: A note written by DON on 09/24/24 at 2:26 PM entered as LATE ENTRY This nurse notified of another resident kissing this resident on forehead. This nurse assessed this resident. No new or worsening injury note at this time. Res (Resident) unable to recall events and states 'No, I'm fine.' Provider notified of incident at this time, no new orders. A note written by DON on 09/24/24 at 4:00 PM This nurse notified [name of psychiatric doctor] office of resident receiving kiss on forehead from another resident. Message left with nurse who stated will notify provider and awaiting call back. A note written by SW on 09/24/24 at 04:16 PM SW met with resident in the unit. She was sitting in her wheelchair in the dining room. She had her head down as she appeared to be sleeping. SW completed PRN Trauma Screen with resident. She denied any trauma at this time. She shook her head yes/no when answering questions. She appeared to be sleepy and did not want to be disturb at this time. No trauma noted. (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	A note written by GVN D on 09/25/24 at 06:18 PM CNA reported major bruise to nurse and ADON immediately [sic]. Nurse and ADON went to assess resident immediately. Purple bruise to right posterior forearm noted, measuring [sic] approximately 14X9.5 cm. Other findings documented in skin assessment. When this nurse asked res what happeneded [sic] res confused and unable to respond due to impaired [sic] mental status. Resident denies any pain or distress at this time. Res taken back to dinning [sic] room, ready to eat dinner. RN compliance nurse and [name of ADM] notified immediately [sic] by nurse and ADON. [Name of physician] and NP notified. [name of Resident #1's family member] emergency contact notified of injury. [name of Resident #1's family member] stated 'the slightest bump makes her bruise very badly, I'm not worried. Just keep me updated.' This nurse notified oncoming shift of injury. Record review of Resident #1's Event Nurses' Note - Bruise completed by DON on 09/25/24 at 05:31 PM revealed the bruise on Resident #1's right posterior forearm was of unknown origin and measured 14 X 9.5 cm. It was blue/purple in color. Resident #1 was unable to recall how she obtained the bruise. Physician and family were notified, and padding was applied to the arm rest of Resident #1's w/c. Record review of Resident #1's Trauma Informed PRN Assessment completed by SW on 09/24/24 at 04:04 PM revealed the following questions with answers in the negative: . 4. Have you (or has the resident) been in a situation that was extremely frightening? 5. Have you (or has the resident witnessed any extremely frightening situations? . Record review of Resident #1's Order Summary Report dated 10/04/24 revealed she was admitted to the secure unit on 08/28/23 due to a high elopement risk. Resident #1 had no order for anticoagulant medication. Record review of Resident #2's admission record dated 10/04/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, dementia (a group of thinking and social symptoms that interferes with daily functioning), generalized anxiety disorder (inability to control constant worrying), and prostate cancer. He was discharged from the facility on 09/26/24 to a behavioral health hospital. Record review of Resident #2's admission MDS completed on 09/13/24 revealed the following: Section B: Resident #2 was able to understand others and make himself understood. Section C: Resident #2 had a BIMS of 3 which indicated severely impaired cognition. Section D: Resident #2 sometimes felt lonely or isolated from those around him. Section E: Resident #2 had no behaviors during the look back period. Section GG: Resident #2 did not use any mobility devices. He needed set up or clean up assistance for eating, oral hygiene, toileting hygiene, dressing, and personal hygiene. Resident #2 was independent across all mobility ADLs except for shower/bath transfer, walking over uneven surfaces, and picking up an object where he needed supervision or touching assistance. Section I: Resident #2's primary medical condition was non-traumatic brain dysfunction. (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	Section K: Resident #2 was 5 feet seven inches tall and weighed 146 pounds. Section N: Resident #2 received antianxiety and antidepressant medications during the 7-day look back period. Record review of Resident #2's care plan completed on 09/16/24 revealed he was taking antianxiety medications and one of the interventions listed was to monitor and record occurrence of target behavior symptoms including violence/aggression towards staff/others and document per facility protocol. Resident #2 was noted to be at risk for wandering. He resided in the secure unit related to his diagnosis of dementia and his risk for elopement. Resident #2 was noted to have potential to demonstrate physical behaviors. He kissed another resident on forehead 09/24/24. [name of behavioral hospital] admission on 09/26/24. Two of the interventions listed was, If the resident has physical behaviors toward another resident, immediately intervene to protect the residents involved and call for assistance. If intervening would be unsafe, call out for staff assistance immediately and Notify the charge nurse of any physically abusive behaviors. The care plan noted Resident #2 was placed on 1 on 1 monitoring following his kiss on Resident #1's forehead on 09/24/24. No mention made of incident between Resident #2 and Resident #1 on 09/22/24 in the care plan. Record review of Resident #2's orders prior to his discharge to the behavioral hospital revealed he was started on an antipsychotic medication on 09/23/24 and was receiving antianxiety and antidepressant medications with start dates of 09/04/24. Record review of Resident #2's progress notes from 09/04/24 to 10/04/24 revealed the following notes: A note written by LVN A on 09/22/24 at 07:59 PM Pt was seen going into womans [sic] room and waking her up out of bed and touching her innappropriatly [sic]. Woman pt started to panic and get away from him. Staff transferred [sic] woman pt out of bed and into wc to monitor. This pt began grabbing womans [wic] wc handles and dragging her back. This staff intervened d/t pt woman crying and tryhing [sic] to get away. Pt began hitting staff and chasing after woman pt. At this time, woman has been taken out of secure unit and placed with one staff member for safety. [Hospice] on call called, no response at this time. On call [name of ADON] notifed [sic], stated I am trying to get a hold of SW, but she won't answer me. Awaiting a call back at this time from management [sic] and [Hospice]. Pt is currently standing at secure unit doors trying to pry them open. A note written by LVN A on 09/22/24 at 10:51 PM Pt is now hovering over aide down secure unit touching her cheek and stating, You like this, come on. Aide sternly educated pt to go back to bed. Pt walked in room and is sitting on bed staring out into the hall. A note written by LVN B on 09/23/24 at 12:02 AM Hospice returned call at this time and this nurse explained situation and noting new behavior for resident. Hospice nurse to call her on call provider for orders. Notified ADON. Hospice returned call at approx 2002 (02:02 AM) with new orders for [antipsychotic medication] 0.5mg Q6hrs and to schedule the [antianxiety medication] 0.5mg q4hrs and morphine(20mg/5ml)0.2ml q4hrs. [Antipsychotic medication] will be delivered to facility via hospice pharmacy tomorrow. DON notified of new orders. (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	A note written by LVN F on 09/23/24 at 10:59 PM While this nurse was doing med pass, the aid informed this nurse that the resident would not let her use the restroom. The resident would push the door open and would not allow the aid any privacy. This nurse gave the resident PRN [antianxiety medication] and [antipsychotic medication]. Immediately [sic] after administering [sic] the residents medication, the resident went into another residents room and was messing with her and her bedding. This nurse and a aid had to remove the resident from the other residents room. As per the residents daughter request this nurse notified the residents' daughter about the situation. A note written by LVN G on 09/24/24 at 02: 22 PM This nurse found resident kissing other resident on the forehead in dining area. This nurse removed other resident from the area. Resident is now in room making bed. No distress noted. A note written by DON on 09/24/24 at 02:23 PM This DON notified of incident. Administrator notified. Self report protocol initiated. A note written by DON on 09/24/24 at 02:50 PM This nurse spoke with resident daughter and educated on situation that occurred and facility policy. This nurse also educated resident daughter on interventions put in place such as one on one and referral to inpatient psych. Res daughter verbalizes understanding and appreciative of interventions facility has provided. Res daughter also appreciative on this nurse explaining situation and protocol. Res daughter inquires as to if res will readmit after psych stay, res education on clinical will be reviewed to ensure facility can meet res needs and res or other res will not be at risk of safety if readmitted and facility/inpatient psych assisting with placement if unable to readmit - res daughter verbalizes understanding. A note written by SW on 09/26/24 at 01:36 PM SW has worked with [behavioral hospital] for admission for today. Res was transported to [behavioral hospital]. SW sent ED paperwork to the Judge to be completed. Paperwork was completed and sent to [behavioral hospital]. SW also spoke to resident daughter about him receiving a 30 day notice. Res / daughter also given copy of 30 day notice. Res daughter was appreciative about his care at facility. She reported that they would come Monday and pick up his stuff. Record review of Event Nurses' Note - Behavior written by DON on 09/24/24 at 02:24 PM revealed Resident #2 exhibited physical, resident to resident behavior in the hallway. The behavior was kissing another resident on the forehead, and it was witnessed by LVN on duty. Resident was redirected and provided with 1 on 1 supervision. During an interview on 10/04/24 at 05:30 PM ADM stated he was not sure who the female resident mentioned in Resident #2's progress note written by LVN A on 09/22/24 at 07:59 PM. He stated DON would know. (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/04/24 at 05:32 PM DON stated the female resident from Resident #2's progress note written by LVN A on 09/22/24 at 07:59 PM was Resident #1. She stated she had concerns about the wording of the progress note and she called LVN A and got a statement from LVN A stating she put the words touching her inappropriately in the progress note based on what the CNA told her. DON stated the CNA was CNA E. DON stated English is CNA E's second language and confusion had led to the wrong thing being documented. DON stated she would bring me a written copy of CNA E's statement regarding the incident on 09/22/24 between Resident #1 and Resident #2. DON stated after she spoke to CNA E and LVN A she felt Resident #2 only wanted to help/protect the women. DON stated, He was their (female residents') protector and didn't really want us (facility staff) to help. She said this was made very clear after Resident #2 was placed on 1 to 1 supervision following his kiss to Resident #1's forehead when every time a staff member would enter a resident's room he would ask, Who is that? Record review of CNA E's statement revealed it was dated 09/24/24. In the statement CNA E revealed Resident #2 was calling Resident #1 his girl and his girlfriend and patting her on the shoulder. Record review of LVN A's statement regarding why she documented Resident #2 was touching Resident #1 inappropriately on 09/22/24 revealed a photo of a text message which read, I documented the 'inappropriate touching' due to CNA statement.'[sic] During an interview on 10/04/24 at 05:51 PM LVN A stated she wrote Resident #2's progress note on 09/22/24 at 07:59 PM based on what CNA E told her over the phone. (staff in the locked unit often communicate with staff outside the locked unit via phone call) LVN A stated what she saw with her own eyes was Resident #2 grabbing at her (Resident #1's) arms and pulling on her and she was verbally crying and screaming. LVN A said earlier in the night when she assisted Resident #1 to bed Resident #1 said, This is not my room, this is his room. This is his room. He is going to come in here and be fraudulent. LVN A said she did not think anything of it at the time due to Resident #1 having dementia. She said she assured Resident #1 that she would keep her safe. LVN A stated Resident #1 then said, They are going to come in here before you are gone. LVN A stated, Looking back on it, I feel bad because I wonder if she was afraid that night. You know people with dementia say some wild things but in light of what happened, I wonder. LVN A stated that after the incident the nurses took Resident #1 out of the locked unit and had her seated in her w/c at the nurses' station. LVN A said of Resident #1, She stayed up the whole night, I felt so bad for her. LVN A stated the nurses tried putting Resident #1 to bed in an empty room on hall 400 but she would not stay in bed. I think she recognized it was not her room. LVN A stated she knew the staff in the locked unit needed her help when LVN B called her and asked her to open the door of the locked unit so LVN B could push Resident #1 out of the unit without letting Resident #2 out of the unit as well. LVN A stated she opened the door and saw LVN B pushing Resident #1 in her w/c at a slow walk and behind her she saw Resident #2 get away from LVN C and CNA E who were trying to keep him from following and he began to sprint down the hall after Resident #1 and LVN B. LVN A said she told LVN B, Okay, [first name of LVN B] I'm gonna need you to pick it up. LVN A stated LVN B began to walk faster while pushing Resident #1 in her w/c and they got LVN B and Resident #1 out of the locked unit just in time to shut the door and keep Resident #2 in the locked unit. During an observation and interview on 10/04/24 at 06:22 PM Resident #1 was wheeling herself down the hall of the locked unit. When asked if she was [name of Resident #1] she shook her head and continued wheeling herself down the hall. (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/04/24 at 06:26 PM SW stated she did interview Resident #1 about trauma following Resident #2 kissing Resident #1 on the forehead. SW stated Resident #1 was alert but not sure what was going on during the interview. When asked if she thought Resident #1 was traumatized by Resident #2 pulling on her and chasing her on the locked unit on 09/22/24 SW said it was hard to tell as the change of venue from the locked unit to the nurses' station for the night might have also been traumatizing. When asked if she thought a reasonable person would have been traumatized by the events that took place between Resident #1 and Resident #2 on 09/22/24, SW stated, It absolutely could be traumatizing. During an interview on 10/04/24 at 06:29 PM LVN A stated she thought Resident #1 was traumatized by the interaction on 09/22/24 with Resident #2 because, she was in bed initially and when I went back, she was out of bed, crying, and trying not to let him (Resident #2) touch her. During an interview on 10/04/24 at 06:31 PM LVN B stated LVN C texted her to please come help in the locked unit as Resident #2 would not let go of Resident #1's w/c. LVN B stated when she got to the locked unit she observed Resident #2 holding onto the handles of Resident #1's w/c and Resident #1 was in the w/c and kept saying, No, you don't want me, I'm too old, I don't want to go with you. LVN B stated she tried to distract Resident #2 and get him to go outside with her to pick weeds as that was one of his favorite pastimes, but he would not let go and kept trying to push Resident #1 in her w/c. LVN B said Resident #2 kept saying Resident #1 was his girl and he was going to go wherever she went. LVN B said she got Resident #1 away from Resident #2 at one point and called LVN A to open the door of the locked unit for her because LVN C and CNA E were holding Resident #2's hands to keep him from following them out. LVN B said during the entire situation she could tell Resident #1 was scared. LVN B stated, We had [name of Resident #1] out here for the night. She was upset. I tried to distract her by giving her a banana, but she was scared. LVN B said after she and Resident #1 exited the locked unit Resident #2 stood on the other side of the locked doors hitting the doors and yelling. LVN B said of Resident #1, We (nursing staff) tried putting her to bed on hall 400 but she kept getting up and she kept saying, 'That guy is going to come get me.' LVN B stated she reported the entire incident to ADON and hospice nurse. LVN B said in her opinion not reporting possible abuse of a resident is just bad. During an interview on 10/04/24 at 06:37 PM LVN C stated that during report at the beginning of her shift on 09/22/24 she found out Resident #2 had been having behaviors all day. She stated she heard CNA E needed help on the locked hall with Resident #2. LVN C said when she got to the locked unit Resident #2 was trying to direct [name of Resident #1] to his room and I could tell she (Resident #1) was afraid. She was saying, 'I'm too old, no you don't want me.' LVN C said Resident #2 was grabbing Resident #1's hands and grabbing the handle of Resident #1's w/c. LVN C stated Resident #1 was crying during part of the interaction. LVN C said Resident #2 became so agitated he was hitting at staff and hitting near Resident #1 but did not hit Resident #1. She said she and CNA E attempted to hold Resident #2's hands to keep him from chasing Resident #1 and LVN B out of the locked unit and because at this point, he was just hitting us. She said Resident #2 got out of their grasp and ran after Resident #1 and LVN B, but they made it out the door before he got to them. LVN C said, I figured if we weren't there, there was going to be abuse going on. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Caprock Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 900 College Ave Borger, TX 79007	

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F 0609 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/04/24 at 06:46 PM CNA E stated on 09/22/24 Resident #2 was confused and after [Resident #1]. She said Resident #2 started saying Resident #1 was his girlfriend and his wife and he wouldn't let her go. CNA E said Resident #1 started saying, 'Listen, I don't like you, you're not mine.' CNA E said she had to call the nurses because Resident #2 would not let go of Resident #1's w/c and he got mad. She said Resident #1 kept saying, You don't want to be with me. I don't like you. CNA E did not exhibit any issues with speaking English clearly during this interview. During an interview on 10/04/24 at 07:11 PM DON stated staff are responsible to report to ADM or charge nurse when they notice anything that could constitute resident abuse. When asked what a possible negative outcome of not reporting resident abuse immediately DON said, If a resident did receive abuse possible negative outcome is they wouldn't receive treatment that was necessary. When asked why Resident #2's treatment of Resident #1 on 09/22/24 was not reported as possible abuse she said, I think her case would be different because she does have dementia. When asked what would happen if a reasonable person had endured the same treatment as Resident #1, DON said, If it was somebody else, I'd look at it differently because they were not a dementia patient. During an interview on 10/04/24 at 07:15 PM ADM stated that if the same thing that happened to Resident #1 at the hands of Resident #2 happened to a reasonable person it could be considered abuse. ADM stated it was a no brainer that there could be a negative outcome to residents if possible abuse of residents was not reported timely. During an interview on 10/04/24 at 07:30 PM ADM stated he was not informed of the incident between Resident #1 and Resident #2 on 09/22/24 and that if he had been informed, he would have reported it as possible abuse. During an interview on 10/18/24 at 10:28 AM ADM stated he expected his staff to let him know right away if anything that might constitute resident abuse or neglect took place on the weekend because he is the one who reports such incidents to the state. He stated he was not sure why ADON and DON did not inform him of the incident between Resident #1 and Resident #2 on 09/22/24. He stated, We would have started the process of getting him (Resident #2) out (of the facility). ADM stated the facility started that process on 09/24/24 when Resident #2 was seen kissing Resident #1 on the forehead. He stated to address his staff not informing him of the incident on 09/22/24 all staff were in-serviced on Abuse/Neglect and ADON was in-serviced on what is expected from weekend on-call staff regarding contacting him with concerns. During an interview on 10/18/24 at 10:32 AM DON stated staff did not report any distress on the part of Resident #1 when reporting the incident from 09/22/24 to ADON. During an interview on 10/18/24 at 11:05 AM ADON stated nurses did not indicate any distress on the part of Resident #1 following the incident on 09/22/24. She stated, They (nurses) said he (Resident #2) was going up and down the hallways and walking everywhere and trying to take female residents to their rooms and nurses and CNAs would not let him. They did not report distress to me at all (for Resident #1). I told them to get ahold of Hospice. I called DON and SW. Could not get hold of SW. DON told me we did need to get hold of [name of hospice for Resident #2] They got ahold of hospice, and they were able to take care of him and keep her safe. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Caprock Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 900 College Ave Borger, TX 79007	

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F 0609 Level of Harm - Actual harm Residents Affected - Few	Record review of facility policy titled Abuse/Neglect and dated March 11, 2013 revealed the following: . Abuse is the willful infliction of . intimidation . with resulting . mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Any person having reasonable cause to believe an elderly or incapacitated adults is suffering from abuse, neglect or exploitation must report this to the DON, administrator, state and/or adult protective services. Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 2024-14 dated 08/29/24. a. If the allegations involve abuse or result in serious bodily injury, the report must be made within 24 hours of the allegation. b. If the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation. Record review of abuse/neglect in-services for the past three months revealed in-services on the following dates: 07/02/24, 07/07/24, 07/08/24, 07/10/24, 07/11/24, 07/16/24, 07/30/24, 08/14/24, 08/13/24, 08/08/24, 08/27/24, 09/24/24, 09/25/24, 09/26/24, 09/29/24, 10/01/24. Each of the in-services included, Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents . If abuse and/or neglect witnessed or suspected, intervene immediately and report to abuse preventionist-the administrator [name of ADM] or immediate supervisor. Record Review of the abuse/neglect in-services for the past three months revealed the following dates: 07/02/24, 07/07/24, 07/08/24, 07/10/24, 07/11/24, 07/16/24, 07/30/24, 08/14/24, 08/13/24, 08/08/24, 08/27/24, 09/24/24, 09/25/24, 09/26/24, 09/29/24, 10/01/24, the ADON and DON participated in said in-service training covering what is abuse and when and to whom it should be reported.