STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676343	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Manor	9101 Panther Way Waco, TX 76712

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46708 Based on interview, and record review, the facility failed to protect one (Residents #1) of one of one reviewed, from verbal abuse, in that: The facility failed to ensure Resident #1 was not verbally abused by CNA A. This failure could place residents at risk of fear, depression, intimidation, and a diminished quality of life due to verbal abuse. Findings included: Review of the face sheet, undated, for Resident #1 reflected a [AGE] year-old female initial admitted [DATE] and readmitted [DATE] with diagnoses of hepatic encephalopathy (liver does not filter toxins as it should) cirrhosis of liver (severe scarring of the liver) end stage renal disease, and diabetes. Resident #1 discharged from the facility on [DATE] to an acute care facility and is deceased . Review of the quarterly minimum data set (MDS) for Resident #1 dated [DATE] reflected a brief interview for mental status (BIMS) was not conducted. Review of Section I Active Diagnoses revealed medically complex condition. Review of the care plan dated [DATE] reflected Resident #1 was at risk for decreased socialization and altered mood related to diagnosis of depression, disinterest in current activity, impaired cognition, signs and symptoms of depression with interventions to approach Resident #1 in calm manner, introduce self and explain procedure/care to be provided, provide positive interaction with resident, and provide validation of feelings by restating concerns and feelings and encourage Resident #1 to focus on the positive, and encourage and allow resident to verbalize needs and concerns. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an Interview with the a family member of Resident #1 on [DATE] at 2:55 pm she revealed, Resident #1 called her after the incident on [DATE] and was crying. Resident #1 told the family member she was crying because people did not want to help her. The family member had an audio and video recorder in Resident #1's room. The family member did not provide the recording . The family member revealed she could not see CNA A in the bathroom with her mother (CNA A was on the camera when her mother came out of the bathroom). The family member revealed she heard CNA A tell her mother, in an ugly tone, can you not do anything for yourself? Come on, shit. The family member said CNA A could have been more kind and CNA A upset Resident #1 enough for Resident #1 to call her crying. The family member revealed CNA A did not respect Resident #1's rights when she spoke to her in a discouraging manner. In an interview with CNA A on [DATE] at 11:00 am she revealed she did not know that Resident #1 had declined so much since the last time she assisted Resident #1. She revealed she answered Resident #1's call light on [DATE] and when Resident #1 said she needed help getting on the toilet she said to Resident #1, you are going to have to do more for yourself. She revealed she was trying to encourage Resident #1 but said she could have used different words and did not mean to upset Resident #1. She apologized to Resident #1. In an interview with the DON on [DATE] at 2:55 pm she revealed she listened to the recording that was provided to the facility by Resident #1's family member . The DON revealed CNA A said can you not do anything for yourself (use of Resident #1's first name), come on. The DON felt what CNA A said to Resident #1 was not encouraging and she should have used a more encouraging tone. The DON revealed when she spoke to Resident #1, she should have thought about how Resident #1 would have felt to hear those words. The DON revealed CNA A was suspended from work and was in-serviced on abuse and neglect and how to speak to Residents. The DON said she spoke to Resident #1 about the incident, but Resident did not recall it occurred. Review of a statement, undated, from CNA A revealed she responded to Resident #1's call light and found Resident #1 on her wheelchair asleep by the toilet. The statement revealed CNA A asked Resident #1 what she needed, and Resident #1 said she needed help getting on the toilet. The statement from CNA A revealed she said to Resident #1, are you not able to anything on your own now? CNA A revealed in her statement that she wanted Resident #1 to have the independence like she had previously. CNA A revealed in the statement that she knew she spoke in an assertive manner and realized she should have said things in a different manner. Review of CNA A's personnel file reflected a statement signed on [DATE] that reflected she had been trained in and received education on the definition of abuse and the different kinds of abuse. Review of facility abuse and neglect policy, undated, reflected the purpose of the policy was to protect the residents in the facility from abuse and neglect. Verbal abuse is defined as oral, written, or gestured language that includes disparaging and derogatory terms to the residents.