STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676349	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Willow Bend	2620 Communications Parkway Plano, TX 75093

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0600

Level of Harm - Actual harm

Residents Affected - Some

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 48560

Based on interviews and record review, the facility failed to protect the resident's right to be free from abuse for one (Resident #1) of 10 residents reviewed for abuse.

CNA A, who was assigned to Resident #1 for the night shift from 12/31/23 to 1/1/24 failed to provide care or check on Resident #1 during the entire shift from 10:00 PM 12/31/2023 - 6 AM 1/1/2024 and CNA B who failed to provide care on her shift from 6 AM 1/1/2024 to 10:22 AM 1/1/24. As a result, Resident #1 was not provided incontinent care or repositioned for over 13 hours on 12/31/23 9:05 PM to 01/01/24 at 10:22 AM.

These failures could affect the residents by placing them at deprivation of goods abuse, risk for a delay in ADL care including incontinent care and life-saving treatments, which could result in psychosocial harm.

Findings included:

Review of Resident #1's Admission MDS assessment dated [DATE] revealed he was [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Critical illness myopathy (significant slowing of the muscle fiber) , hypertension, pneumonia, Diabetes mellitus, aphasia (loss of ability to understand or express speech, caused by brain damage) , Cerebrovascular Attack , Respiratory Failure, Dysphagia (difficult swallowing) , G-tube feeding dependent (G-tube is a tube inserted through the belly that brings nutrition directly to the stomach). Resident #1 required extensive assistance of at least two people with Activities of Daily Living. He was totally dependent with transfers and bathing. It revealed that Resident#1 was always incontinent of urine and bowel. MDS assessment revealed BIMS of 99 indicating resident had severe cognitive impairment.

Review of Resident #1's physician order dated 12/20/23 revealed Resident #1 was on Furosemide 20 mg tablet 1 tablet by mouth per day which was prescribed for DX of primary hypertension (high blood pressure). (Furosemide is a diuretic will make a resident urinate more often to remove the body of excess fluid/fluid retention).

Review of Resident #1's physician order dated 12/23023 revealed Resident #1 was on Nystatin 100,000 unit/gram topical cream 2 times per day for rash on the peri area.

(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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F 0600 Level of Harm - Actual harm Residents Affected - Some	Review of Resident # 1 ADL Documentation on EHR for 12/31/23- 1/1/24 revealed incontinent care documented at 9 PM on 12/31/23 and 10 am on 1/1/24. There was no documentation of incontinent care on the ADL in the electronic health record or paper documentation. Review of Resident #1 Admission Care Plan dated 12/9/2023 revealed Resident #1 was on Diuretic therapy , Furosemide 20 mg tablet 1 tablet 1 time per day; Resident will have decrease in edema during drug therapy. Review of Resident #1 Nurses note on the EHR revealed that there was no documentation for 12/31/23. Record Review of LVN D Nurse's progress noted dated 1/1/24 charted on 12:32 PM on 1/1/24 revealed Resident #1 Family Member A came to nurse station upset and yelling that Resident #1 was not changed overnight. This nurse informed Family Member A that his shift started at 0600 and was unsure who worked last night. Family Member A stated that nobody was on camera and wanted to talk to manager. Told resident to go to front and speak to secretary. Resident also stated she saw this nurse give meds and asked for Resident #1 to be pulled up. Resident is a TWO PERSON ASSIST with everything per family request. This LVN C could not find CNA at the time and continued with my med pass and blood glucose checks. Resident is clean and dry. Resting comfortably in bed with call light within reach. Observation on 1/3/24 at 2:18 PM of Resident #1 room revealed resident had Blink camera in the room that detects any motion close to the resident in the room. Observed Resident #1 was lying in the bed and covered with sheets. Resident #1 looked groomed, and no odors noted. Also observed tube feeding pump next to the bed and infusing tube feed formula. Observed call light within reach. Interview with Resident #1 attempted on 1/3/24 at 2:20 PM revealed resident is not verbal and cannot respond as stated by the resident's #1 Family Member A that was present in the room. Interview with Resident#1's Family Member A and Family Member B on 1/3/24 at 2:18 PM revealed that she was very concerned that Resident#1 was not changed during the night shift of 12/31/23. Resident# 1 admitted to the facility on [DATE]. She stated when she came to the facility around 11 am on 1/1/24, she noted that Resident#1's side support pillow and other pillow was placed on the chair in the room and was soaking wet and smelled of urine. She picked up the pillow from the chair and saw the chair was wet from the pillow. She then called Resident#1 Family Member B to check if she could review the camera to see when Resident#1 was last changed. Family Member A also stated that per camera placed in the room revealed Resident#1 was not changed or repositioned from 12/31/23 at 9:05 PM until 1/4/24 at 10:20 AM. She also stated that she had requested LVN D to reposition resident#1 around 7 am on 1/1/24 through the camera. She then stated that she went to LVN D who told her he started his shift at 6 AM on 1/1/24 and did not know which nursing staff was assigned for Resident #1 that worked on night shift of 10 am -6 AM on 12/31/23. Family Member A asked LVN D if he received shift report in the morning for Resident# 1's care and which nursing staff provided the report. Per Family Member A , LVN D refused to talk to the Family Member A and directed her to the front office. She stated that she was not able to find any Administrator nursing staff and was told ADON B had left for the day. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Family Member A also revealed that she had complained to the DON regarding her concerns with Resident# 1 ADL care earlier on 12/18/23 and approached the DON that Resident#1 needed two people assist on all ADL's, including incontinent care. She also stated that on the night shift on 12/17-12/18/23 CNA A was changing and repositioning the resident by herself incorrectly when resident's Family Member B intervened from the camera and had to come to the facility at midnight to make sure that Resident #1 was okay. She stated that resident's Family Member B spoke with Charge Nurse LVN I on 12/18/23, who stated that she will have another CNA care for the resident for that night. She also stated that Resident#1's Family Member B spoke with the DON on 12/21/23 regarding needing two people assist on all ADL care including incontinent care and repositioning. Family Member B also stated that she had told the Nurse that Resident #1 had a diaper rash and they started ointment on it couple of days back. She stated the DON reported it was not the facility policy to turn the resident every 2 hours, but the DON and Family Member A agreed on checking on the resident every four hours. Family Member A reported that Resident #1's room was fitted with a Blink Mini indoor plug-In HD Smart security motor detection camera and will detect any motion that will take place around the resident. It will not show any activity on the camera if there is no motion around the resident. Review of Resident #1's electronic monitoring video along with Family Member A date and time stamped on 12/31/23/20 at 9:05 PM revealed 2 staff members providing incontinent care and repositioning Resident # 1. Review of Resident #1's electronic monitoring video along with Family Member A date and time stamped on 12/31/23/20 at 10:43-10:45 PM revealed LVN C changed the tube feeding bag and worked on the tube feed pump setting. Review of Resident #1's electronic monitoring video along with Family Member A revealed no motion detection from 12/31/23 at 10:45 PM to 1/1/24 6:47 AM. Review of Resident #1's electronic monitoring video along with Family Member A date and time stamped on 1/1/24 at 6:47 AM revealed LVN D walking into the Resident #1 room and briefly lifted Resident #1 sheets to check for possible incontinence. Review of Resident #1's electronic monitoring video along with Family Member A date and time stamped on 1/1/24 at 7:01 AM to 7:03 AM revealed that LVN D providing G-tube medications and checking blood sugar levels. LVN D did not reposition or provide incontinent care to Resident #1 between 7:01 am - 7:03 am. Review of Resident #1's electronic monitoring video along with Family Member A date and time stamped on 1/1/24 at 8:30 AM revealed LVN D resetting the tube feeding pump. LVN D did not reposition or provide incontinent care to Resident #1 at 8:30 am Review of Resident #1's electronic monitoring video along with Family Member A date and time stamped on 1/1/24 at 10:22 AM revealed that CNA B and Staffing Coordinator changed the resident. Resident# 1's Family Member A was unable to provide actual video recording as a continuous stream of events from 9:05 PM 12/31/23 -10:20 AM on 1/1/24 due to technical difficulties. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Interview with LVN D on 1/4/24 at 2:36 PM revealed that he had started working in the facility around November 2023, he reported he was the LVN who was taking care of Resident #1 on 1/1/24 morning shift from 6 AM-2 PM. He reported that he checked on Resident #1 around 7am on 1/1/24 and administered his G-tube (medications and checked Resident#1's blood glucose). He also reported that he briefly lifted Resident#1 sheets and it appeared that Resident #1 brief was dry. He stated that he did not physically check on Resident#1 for incontinence. He also stated that Family Member A talked to him from the camera around 7 am on 1/1/24 when he was providing G-tube care to the resident and asked him to reposition Resident#1. He reported that since Resident#1 was 2-person assist, LVN D went to look for CNA and could not find the CNA, so he continued with his med pass and blood glucose checks to other residents in the hall. LVN D reported he did not reposition Resident #1. LVN D also stated that the Staffing Coordinator and CNA B provided incontinent care and repositioning around 10 am on 1/1/24. He also reported that Resident#1's Family Member A came to him at the nurse's station around 11am on 1/1/24 stating that Resident #1 was not changed on the night shift of 12/31/23 and asked for nursing staff that took care of the resident the previous night. LVN D redirected Family Member A to the front office. He reported that Family Member A came to him again after some time (around noon) asking to put Nystatin ointment on resident's peri-area by herself. LVN D informed Family Member A that since the ointment is a prescribed medication, it will need to be applied by a nursing staff. LVN D stated he did not feel comfortable entering the resident's room by himself and hence he, along with Staffing Coordinator entered the Resident's room and applied Nystatin ointment for Resident#1. LVN D reported that Nystatin was applied to resident's peri care area between 12:15 PM - 12:30 PM on 1/1/24. LVN D reported that Nystatin was started on Resident #1 on 12/30/23 for diaper rash and it was usually used for fungal infection or skin irritation that can be caused if area was wet for a long time. LVN D stated that he did not report the allegation from the Family Member A that the resident was not changed over several hours of night shift to anyone. LVN D reported when he started at the facility about a month ago, he was provided with several in services that included abuse and neglect as well. He defined neglect as resident not being provided the needed care and services by the facility. He stated he knew to report any allegation of abuse and neglect to the Abuse Coordinator immediately. He stated that if the allegation from the Family Member A was true that the resident indeed did not receive incontinent or ADL care during the night shift, it looked like neglect to him, and he should have reported it then. Interview with CNA E on 1/3/24 at 2:42 PM revealed that she worked in the facility for last 8-9 months. She stated that she did not work on the night shift from 10PM to 6 AM on 12/31/23 in the facility and She usually worked the 2PM -10 PM shift. She had taken care of Resident #1 in the past and was aware with Resident #1 care needs. She reported that Resident #1 needed two-person assist with all ADL care and she always took help from the Nurse or CNA from other halls for changing or repositioning the resident. She reported that she was not aware of rounding policy for the facility, but she rounded on her residents at least every two hours. She also reported that resident#1 has Nystatin cream for diaper rash that was always applied by Nursing staff when they change the resident. CNA E also reported that he was provided abuse and neglect in services in the past and defined neglect as resident not getting the needed goods or services. She also stated that if a resident had not been provided ADL care may result in neglect and should be reported to the administration team immediately. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Interview with LVN C on 1/3/24 at 2:50 PM revealed that he worked at the facility for about 2 years. He reported that he worked the night shift 10PM - 6AM on 12/31/23. He reported that he hung a new tube feeding bag and reprogrammed the feeding pump around 10:30-11 PM on 12/31/23, but he did not check resident for incontinent care at that time nor did he repositioned Resident #1 at that time. LVN C also stated that he did not repositioned or provided incontinent care to Resident #1 at all during his shift because he thought the CNA would have provided that care. He also reported that he was the Charge Nurse for the unit on the night of 12/31/23. He reported as a Charge Nurse, he assigned residents to CNA's that they need to take care of during their shift. He reported that Resident #1 was assigned to CNA A along with all other residents on 500, 600, 700 Hall. He reported he became aware of the incident that family alleged that resident was not provided ADL care including incontinent care on the night shift of 12/31/23 when Resident #1's Family Member A approached him during his afternoon shift 2PM- 10 PM on 1/1/24. LVN C also stated that CNA A did not tell him that she will not be caring for Resident#1 anytime during the night shift of 12/31/23 when they worked the halls together. He stated that when he spoke with CNA A around 10 PM on 1/1/24 she told him she assumed he knew that she will not take care of Resident#1 because of some prior concerns that CNA A had with Resident#1's family. He further added that he asked CNA A if she communicated this with him beforehand OR ask for swapping residents so other CNA could take care of the resident OR made nursing administration aware of her dispute or displeasure to work with Resident #1, CNA A replied NO to all his questions. He also stated that since CNA's usually took care of all ADL's, he did not check whether Resident #1 was provided ADL care, including incontinent care. He also stated that Resident #1 was two persons assist and that most CNA's will ask for help from Nurses on the floor or CNAs from other halls. LVN C reported that he had received in-services on abuse and neglect and defined neglect as not providing good and services to the resident. He also said that CNA A not providing care was an example of neglect. He also stated that he was going to report the alleged Neglect to the Abuse Coordinator soon but waited to speak with CNA A about the incident. Interview with ADON B on 1/3/24 at 3:05 PM revealed that she was familiar with Resident#1's care. She stated she spoke with Resident#1's Family Member B during the admission care conference. She had not spoken with the Family Member regarding family's concern for two persons assist for ADL's; however, she was aware of family requesting two-person assist with ADL care from the DON. She stated that she was not aware if DON had filed any grievance report regarding family concern of resident care. She also reported that family approached her about 30 minutes before this interview regarding their allegation of Resident#1 not being provided ADL care included incontinent care during the night shift of 12/31/23. She also stated that no other staff member including Charge nurses, CNA or floor Nurses reported the allegation to her before the Family Member . She reported she will file a grievance report and investigate the incident soon. She also reported that she was the on-call Nurse Manager for night shifts of 12/30/23, 12/31/23 and 1/1/24. She also stated that she had not reported the allegation of potential neglect for not providing care to the resident at the time of this interview and was preparing to send the email to the Abuse Coordinator . ADON B stated that if Family Member A 's allegation of not providing resident with ADL care throughout the night shift was true, that would be an example of neglect since the resident was not provided with service he needed. She also reported that any resident can have rash in peri area if the area was wet for long time. She also stated that Resident#1 cannot reposition himself and her expectation was staff checked on resident every two hours for ADL care. She stated that if ADL care including incontinent care was not provided in a timely manner it can lead to rash, skin breakdown and Resident's dignity and comfort can be compromised. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Attempted phone interview with CNA A on 1/3/24 3:16 PM, left voicemail to call back. In a phone interview with CNA A on 1/4/24 9:03 AM she revealed she was aware of Resident#1's care. She stated she worked the night shift 10pm-6am on 12/31/23 and was assigned to the resident#1's care per assignments provided to her by the Charge Nurse, LVN C. She also stated that she did not provide any ADL care including incontinent care or repositioning to Resident #1 on the night shift from 10pm-6am on 12/31/23. She does not know if any other CNA or LVN provided care to the resident that night. She reported that she had a situation with the Family Member s of Resident#1 roughly 2 weeks ago, she does not remember the exact date - but thought it was around 18/19th of December. CNA A stated that the family was rude to her and was not happy with the ADL care she provided to the resident the night of December 18th. She stated the incident was reported to LVN I who was charge Nurse that shift since the family came to the facility at midnight. She reported she failed to communicate with LVN C about her decision to not provide care to Resident#1 on the night shift and further stated that she assumed LVN C was aware of her previous incident with the family and her decision to not care for Resident #1. She also stated that it was her fault for assuming and not communicating with the Charge Nurse regarding her decision to not provide care. She reported that the risk to dependent resident for not providing ADL care, including incontinent care over a period of 8-hour shift, could lead to skin breakdown and diaper rash. She also revealed she has been provided Inservice education regarding abuse and neglect. She defined neglect as not providing service to the resident. She acknowledged that her decision of not providing ADL care to Resident #1 and not communicating her decision to the charge Nurse on the night of 12/31/23 was a form of neglect. She reported that when she worked on the night shift of 1/1/24 at the facility, she had a conversation with LVN C about care not being provided on 12/31/23. She also stated that she continued to work in the facility on 1/1/24 on a different hall and was not assigned to care for Resident #1. In an interview with CNA B on 1/4/24 9:28 AM revealed that she worked the morning shift 6 AM-2PM on 1/1/24 and was assigned to care for residents on three halls that included Resident#1. She reported that when she came to work in the morning, call lights for most residents were on and she was trying her best to take care of the resident needs one by one. It took her some time, after breakfast, around 10 am to go and check on Resident #1. She reported since Resident #1 was a two person assist for ADL's, including incontinent care, she called for help from Staffing Coordinator , who is also an LVN to change the resident. She reported that as soon as she moved the support pillow it was soaking wet in urine. Then they removed the covers, Resident #1 was covered with urine from head to toe, the brief was saturated with urine, and had a small bowel movement as well. They proceeded to clean, change and repositioned Resident #1. She reported that Resident #1 was not verbal but had distressed look on his face She also stated that the support pillow was left on the chair in the resident's room to dry and sheets were taken to laundry since they were saturated in urine. She also reported that when she came back to the resident's hall, she saw that the call light for Resident #1 was on, and the Family Member A was coming out of Resident #1 room to the nurse's station. The Family Member A looked very upset and stated to CNA B that resident# 1 was not changed through the entire night shift and showed CNA B the video recording of last time the resident was changed, which was around 9 pm on 12/31/23. She also asked for Nystatin cream to apply on Resident#1. CNA B reported that she would inform LVN D and left the room. She then communicated with LVN D regarding Family Member A 's request for Nystatin cream. CNA B left to pass out Lunch trays after that. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	CNA B reported that she has been trained on abuse and neglect and defined neglect as not providing care to the resident. She also stated that she was aware any allegation of abuse and neglect needed to be reported to Abuse Coordinator immediately. She also stated that Family Member A alleged Resident#1 had not been provided care during the night shift was an example of neglect. She stated that she told the Staffing Coordinator to bring it up in the morning meeting for the next day but did not report it to the Abuse Coordinator immediately per policy since she was very busy on her shift. In an interview with Staffing Coordinator on 1/4/24 9:45 AM, she revealed she worked on 1/1/24 from around 8:30 am to 7PM and was providing care on the floor. She reported that she was called by CNA A to assist with ADL care for Resident#1. Around 10 am, when CNA A and Staffing Coordinator went to Resident#1, they found that Resident #1's sheet and pillows, support pillows were soaked in urine and had some feces in his brief. They cleaned, changed, and repositioned Resident #1. She was then called around noon by LVN D to help apply nystatin cream to Resident#1. She reported Resident#1's Family Member A was present in the room, was visibly upset and complained that Resident#1 was not changed or repositioned for the entire night shift of 12/31/23. Staffing Coordinator reported she had been provided several in services about abuse and neglect and defined neglect as resident not being provided goods and services. She revealed that Family Member A 's allegation of not providing care to the resident was an example of neglect and she failed to report it to the Abuse Coordinator immediately per facility policy. She also reported that most residents should be checked or provided care every 2-3 hours but stated it also depended on staffing ratios. She was not sure if there was a facility policy on how often resident should be provided ADL care by the Nursing staff. She reported that if a resident is not provided ADL care including incontinent care, it can lead to skin breakdown and possible infections. The Staffing Coordinator also reported that she was responsible for scheduling and was not aware of CNA A's concern with providing care to Resident #1. She stated that if she was made aware she would have not had CNA A work in the unit; Resident #1 was present. Record Review of Nurse and CNA Assignments for 12/31/23 revealed that there was a total of 4 CNA's (CNA A, CNA F, CNA G, CNA H that were scheduled on the 10 pm - 6am shift on 12/31/23. In a phone interview with CNA F on 1/4/24 at 10:25 AM revealed that she worked the night shift on 12/31/23 on Unit 1 and did not take care of Resident #1 who was in Unit 2. She has worked Unit 2 on prior nights and was aware of care needs for Resident #1 and that he was on 2 persons assist for ADL's. She also revealed that she has been provided Inservice on abuse and neglect and knows she needed to report any allegations of abuse or neglect immediately. In a phone interview with CNA G on 1/4/24 at 11:05 AM; she revealed that she worked the night shift on 12/31/23 on Unit 1 and she does not remember going to Unit 2 on 12/31/23 where Resident #1 was. She also stated that about a week or two ago, she remembered changing assignments and taking care of Resident #1 as instructed by LVN I since CNA A had issues with the family; so CNA G and CNA H took care of the resident since Resident#1 was two-person assist. She also stated that on the night of 12/31/23, no one instructed them to change assignments, hence she did not take care of the Resident #1. She revealed she was provided abuse and neglect in service and defined neglect as not taking care of resident needs. She stated she knows she needed to report any allegation of abuse and neglect to the Abuse Coordinator immediately. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	In a phone interview with CNA H on 1/4/24 11:21 AM revealed that she called out on 12/31/23 and did not work that night at the facility. She also reported that some days back, she does not remember the date but recollected that she and CNA G took care of Resident #1 as instructed by LVN I since Resident #1's family had some concerns with CNA's care to Resident #1. She reported that she has been provided numerous in services on abuse and neglect; and defined neglect as not providing care to resident and to report any abuse or neglect to the Abuse Coordinator immediately. Attempted phone interview for LVN I on 1/4/24 at 1:48 PM, left voicemail to call back the writer. In an interview with DON interview on 1/4/24 2:30 PM revealed that her expectation for dependent resident with incontinence was that there was no facility policy on how often residents should be checked for continence or nursing rounds. She expected that dependent resident who needed incontinent care be changed when they are visibly spoiled or as needed and Nursing to round throughout the shift. DON also stated that as a Registered Nurse, she would check on resident at least three times per shift. DON stated that CNA and Nurses were responsible for providing ADL care including incontinent care. She also reported that if CNA did not provide care to resident, it was her expectation that she would notify Charge Nurse or Nursing Administration immediately. She also stated that Staffing Coordinator was responsible for scheduling and assigning CNAs to the residents for all the shifts. The DON also stated there she was not aware of any restrictions for any CNA's that cannot go to resident room and if there were any restrictions Staffing Coordinator should have been aware. If there were any changes to be made, Charge Nurses can reassign CNAs on duty as needed. DON reported that she was not aware if CNA A had any restrictions on caring for Resident#1 and hence there was no communication to Nurses on the floor. She also stated that CNAs cannot decide about not caring for Resident that they were assigned to. If a CNA had any reservation regarding resident's care, she should be communicating it with charge nurses or nursing administration. The DON stated that she was aware Resident#1's family had some concerns with care provided by CNA A since the family spoke to the DON about it on the 12/18/23 and 12/21/23. DON reported that Resident#1 family was speaking to CNA A over the camera that Resident #1 was a two person assist and that she was providing care by herself. She also reported that family came to the facility midnight and verbal threats that were made by family and CNA A. DON reported she was not sure if any grievances were filed regarding the incident, but she was still investigating the incident at the time of this interview. DON reported that management had not provided any direction to CNA to not enter Resident #1's room or provide care to Resident #1. DON also stated Resident #1 was on therapy and needed maximum assistance for transfers, however not for all ADL care. DON reported that maximum assistance was defined as resident needing 2 people to provide care. She stated that Resident#1's family requested two persons assist on all ADL cares. DON reported the risk to resident for not providing ADL care that included incontinent care for dependent resident may lead to skin breakdown and infections. DON defined Abuse and Neglect as follows : Abuse is willfully doing something wrong to the resident that may result in harm. Neglect defined as not providing service or goods to resident. DON also stated that if CNA does not provide care to the resident assigned to her is an example of neglect. She sated she expected staff to report any allegation of abuse and neglect immediately to the Abuse Coordinator , who is the Facility Administrator and DON was the backup for Abuse Coordinator . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Accel at Willow Bend		STREET ADDRESS, CITY, STATE, ZIP CODE: 2620 Communications Parkway Plano, TX 75093	

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F 0600 Level of Harm - Actual harm Residents Affected - Some	In an interview with Facility Administrator on 1/4/24 at 3:03 PM revealed that he was made aware of the incident regarding allegation that CNA A did not provide ADL care including incontinent care to Resident #1 on 1/3/24 at 3:45 PM. He reported that he was in the process of investigating the incident and was talking to Nursing Staff from Night shift of 12/32/23 and Morning shift of 1/1/24. He also reported that CNA A was suspended yesterday pending outcome of the investigation. The Administrator stated that he had provided numerous in-services to all staff for abuse and neglect, and it was his expectation to report any allegation of abuse and neglect to him immediately. He defined abuse willfully, regardless of intent, harming the resident and Neglect was when good or services are not provided to the resident. He added that he explained that his simple explanation to staff regarding abuse and neglect was To abuse to occur - I must be facing you. To neglect - I actively turn my back on you. He stated that as an Abuse Coordinator, his role was to investigate the allegation thoroughly and report to TX HHS within 2 hours of the incident . He also reported that he was not aware of any grievance filed by Resident # 1 family. He stated that about a week after Resident #1 admission, around 17th or 18th of December , family had concerns with care provided by CNA A and requested two persons assist for all ADL care. DON spoke with the family and provided Inservice that Resident #1 will need two persons assist for all ADL care. He also stated that Management had not told CNA A that she could not go to Resident #1 room or take care of the resident. He continued I think it's her (CNA A) impression that she could not go to the room. Administrator also reported that risk to a dependent resident for not providing ADL care, including incontinent care, was potential skin breakdown and infections. Record reviews of Employee files for CNA A revealed she was provided Abuse and neglect policy and reporting requirements upon hire on 11/4/23. Record Review of Employee file for CNA B revealed she was provided Abuse and neglect policy and reporting requirements upon hire on 11/4/23. Record Review of Employee file for LVN D revealed she was provided Abuse and neglect policy and reporting requirements upon hire on 11/4/23. Record Review of Employee file of Staffing Coordinator revealed she was provided Abuse and neglect policy and reporting requirements upon hire on 11/14/23. Record review of Facility's Resident abuse, neglect and Exploitation and misappropriation of resident property dated 06/23/2017 revealed that Resident Rights. Each resident has the right to be free from abuse, neglect, exploitation, misappropriation of resident's property, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse, neglect, exploitation, misappropriation of resident's property by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, staff of other agencies serv [TRUNCATED]

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F 0607 Level of Harm - Actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 Based on interview and record review, the facility failed to implement written policies and procedures to prevent abuse to ensure residents were free from abuse for one (Resident #1) of 10 residents reviewed for abuse. 1) The facility deprived goods abuse for Resident #1. 2) CNA B, LVN C, LVN D, and Staffing Coordinator reported an allegation of abuse and neglect on 01/01/24 to the Administrator, who is the Abuse Coordinator immediately when they found Resident #1 soaked in urine and bowel movement. These failures could affect the residents by placing them at risk for a delay in intervention and Providing ADL care including incontinent care and life-saving treatments that could lead to psychosocial harm. Findings included: Review of facility's policy Abuse, Neglect and Exploitation and Misappropriation of Resident Property dated 06/23/17 reflected, The purpose of this policy is to ensure that all healthcare facilities comply with federal and state regulations regarding (i) protecting facility patients and residents from abuse, neglect, exploitation and misappropriation of resident property, and (Unit) timely investigation of and reporting to state and local agencies all allegations of abuse, neglect, exploitation and misappropriation of resident property . 3.2 All facility staff members have a duty to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to the Administrator of the facility, who serves as the Abuse Coordinator . In the Administrator's absence, the Director of Nursing (DON) or another designee will be appointed to function as the interim Abuse Coordinator . Upon learning of a suspected incident of resident abuse, neglect, exploitation, and/or misappropriation of resident property, the Charge Nurse or other Department Manager or Supervisor must immediately notify the Abuse Coordinator or the DON of the incident. The person receiving the report or designee must document all incidents of alleged abuse/neglect on incident reports, which are to forwarded directly to the Abuse Coordinator . Review of Resident #1's Admission MDS assessment dated [DATE] revealed he was [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Critical illness myopathy (significant slowing of the muscle fiber) , hypertension, pneumonia, Diabetes mellitus, aphasia (loss of ability to understand or express speech, caused by brain damage) , Cerebrovascular Attack , Respiratory Failure, Dysphagia (difficult swallowing) , tube feeding dependent (Tube feeding is a therapy where a feeding tube in inserted into the abdomen ans supplied nutrients to people who cannot get enough nutrition through eating). Resident #1 required extensive assistance of at least two people with Activities of Daily Living. He was totally dependent with transfers and bathing. It revealed that resident#1 was always incontinent of urine and bowel. MDS assessment revealed BIMS of 99 indicating resident had sever cognitive impairment. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #1 Admission Care plan dated 12/9/2023 revealed Resident #1 at risk for problems with Elimination (updated 1/6/24) . Administer stool softeners, laxatives, suppositories or enemas as ordered; Monitor for signs and symptoms of urinary tract infection; Requires two-person assistance with bowel, bladder, and ADL; Uses brief. Review of Resident #1's physician order dated 12/20/23 revealed Resident #1 was on Furosemide 20 mg tablet 1 tablet by mouth per day which was prescribed for DX of primary hypertension (high blood pressure). (Furosemide is a diuretic will make a resident urinate more often to remove the body of excess fluid/fluid retention). Review of Resident #1's physician order dated 12/23023 revealed Resident #1 was on Nystatin 100,000 unit/gram topical cream 2 times per day for rash on the perineal area. Review of Resident # 1 ADL Documentation on EHR for 12/31/23- 1/1/24 revealed incontinent care documented at 9 pm on 12/31/23 and 10 am on 1/1/24. There was no documentation of incontinent care on the ADL in the electronic health record or paper documentation. Observation on 1/3/24 at 2:18 PM of Resident #1 room revealed resident had Blink camera in the room that detects any motion close to the resident in the room. Observed Resident #1 was lying in the bed and covered with sheets. Resident #1 looked groomed, and no odors noted. Also observed tube feeding pump next to the bed and infusing tube feed formula. Observed call light within reach. Interview with Resident #1 attempted on 1/3/24 at 2:20 PM revealed resident is not verbal and cannot respond as stated by the resident's #1 Family Member A that was present in the room. Interview with Resident#1's Family Member A and Family Member B on 1/3/24 at 2:18 PM revealed that she was very concerned that Resident#1 was not changed during the night shift of 12/31/23. Resident# 1 admitted to the facility on [DATE]. She stated when she came to the facility around 11am on 1/1/24, she noted that resident#1's side support pillow and other pillow was placed on the chair in the room and was soaking wet and smelled of urine. She picked up the pillow from the chair and saw the chair was wet from the pillow. Shen then called Resident#1 Family Member B to check if she could review the camera to see when Resident#1 was last changed. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Some	Family Member A also stated that per camera placed in the room revealed Resident#1 was not changed or repositioned from 12/31/23 at 9:05 PM until 1/4/24 at 10:20 AM. She also stated that she had requested LVN D to reposition Resident#1 around 7 AM on 1/1/24 through the camera. She then stated that she went to LVN D who told her he started his shift at 6 AM on 1/1/24 and did not know which nursing staff was assigned for Resident #1 that worked on night shift of 10am - 6AM on 12/31/23. Family Member A asked LVN D if he received shift report in the morning for Resident# 1's care and which nursing staff provided the report. Per Family Member A , LVN D refused to talk to the Family Member A and directed her to the front office. She stated that she was not able to find any Admin nursing staff and was told ADON B had left for the day. Family Member A also revealed that she had complained to the DON regarding her concerns with Resident# 1 ADL care earlier on 12/18/23 and approached the DON that Resident#1 needed two people assist on all ADL's including incontinent care. She also stated that on the night shift on 12/17-12/18/23 CNA A was changing and repositioning the resident by herself incorrectly when Resident #1's Family Member B intervened from the camera and had to come to the facility at midnight to make sure that Resident #1 was okay. She stated that resident's Family Member B spoke with Charge Nurse LVN I on 12/18/23 who stated that she will have another CNA care for the resident for that night. She also stated that Resident#1's Family Member B spoke with the DON on 12/21/23 regarding needing two people assist on all ADL care including incontinent care and repositioning. She stated DON reported it was not the facility policy to turn the resident every 2 hours, but the DON and wife agreed on checking on the resident every four hours. Interview with LVN D on 1/4/24 at 2:36 PM revealed that he had started working in the facility around November 2023, he reported he was the LVN who was taking care of Resident #1 on 1/1/24 morning shift from 6am-2 pm. He reported that he checked on Resident #1 around 7am on 1/1/24 and administered his G-tube (meds and checked Resident#1's blood glucose. He also reported that he briefly lifted Resident#1 sheets and it appeared that Resident #1's brief was dry. He stated that he did not physically check on Resident#1 for incontinence. He also stated that Family Member A talked to him from the camera around 7 am on 1/1/24 when he was providing G-tube care to the resident and asked him to reposition Resident#1. He reported that since Resident#1 was a 2-person assist, LVN D went to look for CNA and could not find the CNA, so he continued with his med pass and blood glucose checks to other residents in the hall. LVN D reported he did not reposition Resident #1. LVN D also stated that the Staffing Coordinator and CNA B provided incontinent care and repositioning around 10 am on 1/1/24. He also reported that Resident #1 Family Member A came to him at the nurse's station around 11am on 1/1/24 stating that Resident #1 was not changed on the night shift of 12/31/23 and asked for nursing staff that took care of the resident the previous night. LVN D redirected the Family Member A to the front office. He reported that Family Member A came to him again after some time (around noon) asking to put nystatin ointment on resident's peri-area by herself. LVN D informed Family Member A that since the ointment is a prescribed medication, it will need to be applied by a nursing staff. LVN D stated he did not feel comfortable entering the resident's room by himself and hence he, along with Staffing Coordinator entered the Resident's room and applied Nystatin ointment for resident#1. LVN D reported that nystatin was applied to resident's peri care area between 12:15 PM - 12:30 PM on 1/1/24. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Some	LVN D reported that Nystatin was started on Resident #1 on 12/30/23 for diaper rash and it was usually used for fungal infection or skin irritation and can be caused if area was wet for a long time. LVN D stated that he did not report the allegation from the Family Member A that the resident was not changed over several hours of night shift to anyone. LVN D reported when he started at the facility about a month ago, he was provided with several in services that included abuse and neglect as well. He defined neglect as resident not being provided the needed care and services by the facility. He stated he knew to report any allegation of abuse and neglect to the Abuse Coordinator immediately. He stated that if the allegation from the Family Member A was true that the resident indeed did not receive incontinent or ADL care during the night shift, it looked like neglect to him, and he should have reported it then. Interview with CNA E on 1/3/24 at 2:42 PM revealed that she worked in the facility for last 8-9 months. She usually worked the 2PM -10 PM shift. She had taken care of Resident #1 in the past and was aware with Resident #1 care needs. She reported that Resident #1 needed two-person assist with all ADL care and she always takes help from the Nurse or CNA from other halls for changing or repositioning the resident. She reported that she was not aware of rounding policy for the facility, but she rounded on her residents at least every two hours. She also reported that Resident#1 has Nystatin cream for diaper rash that was always applied by Nursing staff when they change the resident. She also reported that he was provided abuse and neglect in services in the past and defined neglect as resident not getting the needed goods or services. She also stated that if a resident had not been provided ADL care may result in neglect and should be reported to the administration team immediately. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Some	Interview with LVN C on 1/3/24 at 2:50 PM revealed that he worked at the facility for about 2 years. He reported that he worked the night shift 10PM - 6AM on 12/31/23. He reported that he hung a new tube feeding bag and reprogrammed the feeding pump around 10:30-11 PM on 12/31/23, but he did not check resident for incontinent care at that time nor did he repositioned Resident #1 at that time. LVN C also stated that he did not repositioned or provided incontinent care to Resident #1 at all during his shift because he thought the CNA would have provided that care. He also reported that he was the Charge Nurse for the unit on the night of 12/31/23. He reported as a Charge Nurse, he assigned residents to CNA's that they need to take care of during their shift. He reported that Resident #1 was assigned to CNA A along with all other residents on 500, 600, 700 Hall. He reported he became aware of the incident that family alleged that resident was not provided ADL care including incontinent care on the night shift of 12/31/23 when Resident #1's Family Member A approached him during his afternoon shift 2PM- 10 PM on 1/1/24. LVN C also stated that CNA A did not tell him that she will not be caring for Resident#1 anytime during the night shift of 12/31/23 when they worked the halls together. He stated that when he spoke with CNA A around 10 PM on 1/1/24 she told him she assumed he knew that she will not take care of Resident#1 because of some prior concerns that CNA A had with resident#1's family. He further added that he asked CNA A if she communicated this with him beforehand OR ask for swapping residents so other CNA could take care of the resident OR made nursing administration aware of her dispute or displeasure to work with Resident #1, CNA A replied NO to all his questions. He also stated that since CNA's usually take care of all ADL's, he did not check whether Resident #1 was provided ADL care including incontinent care. He also stated that Resident #1 was two persons assist and that most CNA's will ask for help from Nurses on the floor or CNAs from other halls. LVN C reported that he had received in-services on abuse and neglect and defined neglect as not providing good and services to the resident. He also said that CNA A not providing care was an example of neglect. He also stated that he was going to report the alleged Neglect to the Abuse Coordinator soon but waited to speak with CNA A about the incident. Interview with ADON B on 1/3/24 at 3:05 PM revealed that she was familiar with Resident#1's care. She stated she spoke with Resident#1's Family Member B during the admission care conference. She had not spoken with the Family Member regarding family's concern for two persons assist for ADL's; however, she was aware of family requesting two-person assist with ADL care from the DON. She stated that she was not aware if DON had filed any grievance report regarding family concern of resident care. She also reported that family approached her about 30 minutes before this interview regarding their allegation of Resident#1 not being provided ADL care included incontinent care during the night shift of 12/31/23. She also stated that no other staff member including Charge nurses, CNA or floor Nurses reported the allegation to her before the Family Member . She reported she will file a grievance report and investigate the incident soon. She also reported that she was the on-call Nurse Manager for night shifts of 12/30/23, 12/31/23 and 1/1/24. She also stated that she had not reported the allegation of potential neglect for not providing care to the resident at the time of this interview and was preparing to send the email to the Abuse Coordinator . ADON B stated that if Family Member A 's allegation of not providing resident with ADL care throughout the night shift was true, that would be an example of neglect since the resident was not provided with service he needed. She also reported that any resident can have rash in peri area if the area was wet for long time. She also stated that resident#1 cannot reposition himself and her expectation was staff checked on resident every two hours for ADL care. She stated that if ADL care including incontinent care was not provided in a timely manner it can lead to rash, skin breakdown and Resident's dignity and comfort can be compromised. Attempted phone interview with CNA A on 1/3/24 3:16 PM, left Voicemail to call back. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Some	In a phone interview with CNA A on 1/4/24 9:03 AM she revealed she was aware of Resident#1's care. She stated she worked the night shift 10PM -6AM on 12/31/23 and was assigned to the Resident#1's care per assignments provided to her by the Charge Nurse, LVN C. She also stated that she did not provide any ADL care including incontinent care or repositioning to Resident #1 on the night shift from 10PM-6AM on 12/31/23. She did not know if any other CNA or LVN provided care to the resident that night. She reported that she had a situation with the Family Member s of Resident#1 roughly 2 weeks ago, she did not remember the exact date - but thought it was around 18/19th of December. CNA A stated that the family was rude to her and was not happy with the ADL care she provided to the resident the night of December 18th. She stated the incident was reported to LVN I who was charge Nurse that shift since the family came to the facility at midnight. She reported she failed to communicate with LVN C about her decision to not provide care to Resident#1 on the night shift and further stated that she assumed LVN C was aware of her previous incident with the family and her decision to not care for Resident #1. She also stated that it was her fault for assuming and not communicating with the Charge Nurse regarding her decision to not provide care. She reported that the risk to dependent resident for not providing ADL care including incontinent care over a period of 8-hour shift could lead to skin breakdown and diaper rash. She also revealed she has been provided Inservice regarding abuse and neglect. She defined neglect as not providing service to the resident. She acknowledged that her decision of not providing ADL care to Resident #1 and not communicating her decision to the Charge Nurse on the night of 12/31/23 was a form of neglect. She reported that when she worked on the night shift of 1/1/24 at the facility, she had a conversation with LVN C about care not being provided on 12/31/23. She also stated that she continued to work in the facility on 1/1/24 on a different hall and was not assigned to care for Resident #1. In an interview with CNA B on 1/4/24 9:28 AM revealed that she worked the morning shift 6 AM-2PM on 1/1/24 and was assigned to care for residents on three halls that included Resident#1. She reported that when she came to work in the morning, call lights for most residents were on and she was trying her best to take care of the resident needs one by one. It took her some time, after breakfast, around 10 AM to go and check on Resident #1. She reported since Resident #1 was a two person assist for ADL's including incontinent care, she called for help from Staffing Coordinator , who was also an LVN to change the resident. She reported that as soon as she moved the support pillow it was soaking wet in urine. Then they removed the covers, Resident #1 was covered with urine from head to toe, brief was saturated with urine, and had a small bowel movement as well. They proceeded to clean, change and repositioned Resident #1. She reported that Resident #1 was not verbal but had a distressed look on his face She also stated that the support pillow was left on the chair in the resident's room to dry and sheets were taken to laundry since they were saturated in urine. She also reported that when she came back to the resident's hall, she saw that the call light for Resident #1 was on, and the Family Member A was coming out of Resident #1 room to the nurse's station. The Family Member A looked very upset and stated to CNA B that Resident# 1 was not changed through the entire night shift and showed CNA B the video recording of last time the resident was changed, which was around 9 pm on 12/31/23. She also asked for Nystatin cream to apply on Resident#1. CNA B reported that she would inform LVN D and left the room. She then communicated with LVN D regarding Family Member (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Some	A 's request for Nystatin cream. CNA B left to pass out Lunch trays after that. CNA B reported that she has been trained on abuse and neglect and defined neglect as not providing care to the resident. She also stated that she was aware any allegation of abuse and neglect needed to be reported to Abuse Coordinator immediately. She also stated that Family Member A alleged of resident#1 not been provided care during the night shift was an example of neglect. She stated that she told the Staffing Coordinator to bring it up in the morning meeting for the next day but did not report it to the Abuse Coordinator immediately per policy since she was very busy on her shift. In an interview with Staffing Coordinator on 1/4/24 9:45 AM, she revealed she worked on 1/1/24 from around 8:30 am to 7PM and was providing care on the floor. She reported that she was called by CNA A to assist with ADL care for Resident#1. Around 10 am, when CNA A and Staffing Coordinator went to Resident#1, they found that Resident #1's sheet and pillows, support pillows were soaked in urine and had some feces in his brief. They cleaned, changed, and repositioned Resident #1. She was then called around noon by LVN D to help apply Nystatin cream to Resident#1. She reported Resident#1's Family Member A was present in the room, was visibly upset and complained that resident#1 was not changed or repositioned for the entire night shift of 12/31/23. Staffing Coordinator reported she had been provided several in services about abuse and neglect and defined neglect as resident not being provided goods and services. She revealed that Family Member A 's allegation of not providing care to the resident was an example of neglect and failed to report it to the Abuse Coordinator immediately per facility policy. She also reported that most residents should be checked or provided care every 2-3 hours but stated it also depended on staffing ratios. She was not sure if there was a facility policy on how often resident should be provided ADL care by the Nursing staff. She reported that if a resident is not provided ADL care including incontinent care, it can lead to skin breakdown and possible infections. She also reported that she was responsible for scheduling and was not aware of CNA A's concern with providing care to Resident #1. She stated that if she was made aware she would have not had CNA A work in the unit; Resident #1 was present. In an interview with DON interview on 1/4/24 2:30 PM revealed that her expectation for dependent resident with incontinence was that there was no facility policy on how often residents should be checked for continence or nursing rounds. She expected that dependent resident who need incontinent care be changed when they were visibly spoiled or as needed and Nursing to round throughout the shift. DON also stated that as a Registered Nurse, she would check on resident at least three times per shift. DON stated that CNA and Nurses were responsible for providing ADL care, including incontinent care. She also reported that if CNA did not provide care to a resident, it was her expectation that she would notify Charge Nurse or Nursing administration immediately. She also stated that Staffing Coordinator was responsible for scheduling and assigning CNAs to the residents for all the shifts. The DON also stated there she was not aware of any restrictions for any CNA's that cannot go to resident room and if there were any restrictions Staffing Coordinator should have been aware. If there were any changes to be made, Charge Nurses can reassign CNAs on duty as needed. DON reported that she was not aware if CNA A had any restrictions on caring for Resident#1 and hence there was no communication to Nurses on the floor. She also stated that CNAs cannot make a decision about not caring for Resident that they were assigned to. If CNA had any reservation regarding resident's care, she should be communicating it with charge nurses or nursing administration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676349	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Willow Bend	2620 Communications Parkway Plano, TX 75093

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Actual harm Residents Affected - Some	DON stated that she was aware Resident#1's family had some concerns with care provided by CNA A since the family spoke to the DON about it on the 12/18/23 and 12/21/23. DON reported that resident#1 family was speaking to CNA A over the camera that Resident #1 was a two person assist and that she was providing care by herself. She also reported that family came to the facility midnight and verbal threats that were made by family and CNA A. DON reported she was not sure if any grievances were filed regarding the incident, but she was still investigating the incident at the time of this interview. DON reported that management had not provided any direction to CNA to not enter Resident #1's room or provide care to Resident #1. DON also stated Resident #1 is on therapy and needed maximum assistance for transfers, however not for all ADL care. DON reported that maximum assistance was defined as resident needing 2 people to provide care. She stated that Resident#1's family requested two persons assist on all ADL cares. DON reported the risk to resident for not providing ADL care that included incontinent care for dependent resident may lead to skin breakdown and infections. DON defined Abuse and Neglect as follows : Abuse is willfully doing something wrong to the resident that may result in harm. Neglect defined as not providing service or goods to resident. DON also stated that if CNA does not provide care to the resident assigned to her is an example of neglect. She sated she expected staff to report any allegation of abuse and neglect immediately to the Abuse Coordinator , who is the Facility Administrator and DON was the backup for Abuse Coordinator . In an interview with Facility Administrator on 1/4/24 at 3:03 PM revealed that he was made aware of the incident regarding allegation that CNA A did not provide ADL care including incontinent care to Resident #1 on 1/3/24 at 3:45 PM. He reported that he was in the process of investigating the incident and was talking to Nursing Staff from Night shift of 12/32/23 and Morning shift of 1/1/24. He also reported that CNA A was suspended yesterday (1/03/24) pending outcome of the investigation. Administrator stated that he had provided numerous in-services to all staff for abuse and neglect, and it was his expectation to report any allegation of abuse and neglect to him immediately. He defined abuse willfully, regardless of intent, harming the resident and Neglect was when good or services are not provided to the resident. He added that he explained that his simple explanation to staff regarding abuse and neglect was To abuse to occur - I must be facing you. To neglect - I actively turn my back on you. He stated that as an Abuse Coordinator , his role was to investigate the allegation thoroughly and report to TX HHS within 2 hours of the incident . He also reported that he was not aware of any grievance filed by resident # 1 family. He stated that about a week after Resident #1 admission, around 17th or 18th of December , family had concerns with care provided by CNA A and requested two persons assist for all ADL care. DON spoke with the family and provided Inservice that Resident #1 will need two persons assist for all ADL care. He also stated that Management had not tell CNA A that she could not go to Resident #1 room or take care of the resident. He continued I think it's her (CNA A)impression that she could not go to the room. Administrator also reported that risk to a dependent resident for not providing ADL care including incontinent care is potential skin breakdown and infections. Review of CNA A's timesheet from 12/30/23-01/01/24 revealed CNA A worked on the 10pm-6 am shift. CNA was scheduled to work on 01/03/24 but was suspended after surveyor intervention on 1/3/24. 48560

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NAME OF PROVIDER OR SUPPLIER: Accel at Willow Bend		STREET ADDRESS, CITY, STATE, ZIP CODE: 2620 Communications Parkway Plano, TX 75093	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42971 48560 Based on interview and record review the facility failed to ensure all alleged violations involving neglect were reported immediately, but not later than 2 hours after the allegations were 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, for one (Resident #1) of 10 residents reviewed for neglect. The facility staff failed to immediately report a 13 hour delay in incontinent care for Resident # 1 to the abuse coordinator. This deficient practice could place residents at risk for not having potential neglect reported and investigated by the abuse coordinator. Findings included: Review of Resident #1's Admission MDS assessment dated [DATE] revealed he was [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Critical illness myopathy (significant slowing of the muscle fiber) , hypertension, pneumonia, Diabetes mellitus, aphasia (loss of ability to understand or express speech, caused by brain damage) , Cerebrovascular Attack , Respiratory Failure, Dysphagia (difficult swallowing) , tube feeding dependent (Tube feeding is a therapy where a feeding tube inserted into the belly, supplies nutrients to people who cannot get enough nutrition through eating). Resident #1 required extensive assistance of at least two people with Activities of Daily Living. He was totally dependent with transfers and bathing. It revealed that Resident #1 was always incontinent of urine and bowel. MDS assessment revealed BIMS of 99 indicating resident had severe cognitive impairment. Review of Resident #1's Comprehensive Care Plan reflected the following dated 12/14/2023 revealed: Review of Resident #1's physician order dated 12/20/23 revealed resident #1 was on Furosemide 20 mg tablet 1 tablet by mouth per day prescribed for dx of high blood pressure. (Furosemide will make a resident urinate more often to remove the body of excess fluid/fluid retention). Review of Resident #1's physician order dated 12/23023 revealed resident #1 was on Nystatin 100,000 unit/gram topical cream 2 times per day for rash. Review of Resident # 1 ADL Documentation on EHR for 12/31/23- 1/1/24 revealed incontinent care documented at 9 pm on 12/31/23 and 10 am on 1/1/24. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1 Nurses note on the EHR revealed that there was no documentation for 12/31/23. Record Review of LVN D Nurse's progress noted dated 1/1/24 charted on 12:32 PM on 1/1/24 revealed Resident #1 family member A came to nurse station upset and yelling that Resident #1 was not changed overnight. This nurse informed family member A that his shift started at 0600 and was unsure who worked last night. Family member A stated that nobody was on camera and wanted to talk to manager. Told resident to go to front and speak to secretary. Resident also stated she saw this nurse give meds and asked for Resident #1 to be pulled up. Resident is a TWO PERSON ASSIST with everything per family request. This LVN C could not find CNA at the time and continued with my med pass and FSBS checks. Resident is clean and dry. Resting comfortably in bed with call light within reach. Interview with LVN C on 1/3/24 at 2:50 PM revealed he worked on the 10PM-6AM night shift on 12/31/23. Interview revealed he did not reposition or provide incontinent care to Resident # 1 because he thought the CNA would provide the care. LVN C stated family member A approached him on 01/01/24 on his afternoon shift of 2PM -10PM about the resident not receiving incontinent care. LVN C also stated that CNA A did not tell him that she will not be caring for Resident #1 anytime during the night shift of 12/31/23 when they worked the halls together. He stated that when he spoke with CNA A around 10 PM on 1/1/24 she told him she assumed he knew that she will not take care of Resident #1 because of some prior concerns that CNA A had with Resident #1's family. He further added that he asked CNA A if she communicated this with him beforehand OR ask for swapping residents so other CNA could take care of the resident OR made nursing administration aware of her dispute or displeasure to work with Resident #1, CNA A replied NO to all his questions. He also stated that since CNA's usually took care of all ADL's, he did not check whether Resident #1 was provided ADL care including incontinent care. He also stated that Resident #1 was two persons assist and that most CNA's will ask for help from Nurses on the floor or CNAs from other halls. LVN C reported that he had received in-services on abuse and neglect and defined neglect as not providing good and services to the resident. He also said that CNA A not providing care was an example of neglect. He also stated that he was going to report the alleged Neglect to the Abuse coordinator soon but waited to speak with CNA A about the incident. Interview with LVN D on 01/04/24 at 2:36 PM revealed he was the charge nurse responsible for Resident # 1 on 01/01/24 for the 6am-2pm day shift. LVN D stated that the Staffing coordinator and CNA B provided incontinent care and repositioning around 10 am on 1/1/24. Interview revealed he talked with family member A around 11AM on 01/01/24 about Resident # 1 not being provided incontinent care on the night shift on 12/31/23. LVN D stated he redirected the family member A to the front office . Interview with LVN D revealed he did not immediately report the delay in care to anyone. He stated that if the allegation from the family member A was true that the resident indeed did not receive incontinent or ADL care during the night shift, it looked like neglect to him, and he should have reported it then. Interview with ADON B on 1/3/24 at 3:05 PM revealed that she was familiar with Resident #1's care. She also reported that family approached her about 30 minutes before this interview regarding their allegation of Resident #1 not being provided ADL care, including incontinent care, during the night shift of 12/31/23. She also stated that no other staff member including Charge nurses, CNA or floor Nurses reported the allegation to her before the family member. She reported she will file a grievance report and investigate the incident soon. She also reported that she was the on-call Nurse Manager for night shifts of 12/30/23, 12/31/23 and 1/1/24. She also stated that she had not reported the allegation of potential neglect for not providing care to the resident at the time of this interview and was preparing to send the email to the Abuse coordinator. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a phone interview with CNA A on 1/4/24 9:03 AM she revealed she was aware of Resident #1's care. She stated she worked the night shift 10pm-6am on 12/31/23 and was assigned to the Resident #1's care per assignments provided to her by the Charge Nurse, LVN C. She also stated that she did not provide any ADL care including incontinent care or repositioning to resident #1 on the night shift from 10pm-6am on 12/31/23. She does not know if any other CNA or LVN provided care to the resident that night. She reported that she had a situation with the family members of Resident #1 roughly 2 weeks ago, she does not remember the exact date - but thought it was around 18/19th of December. CNA A stated that the family was rude to her and was not happy with the ADL care she provided to the resident the night of December 18th. She stated the incident was reported to LVN I who was charge Nurse that shift since the family came to the facility at midnight. She reported she failed to communicate with LVN C about her decision to not provide care to Resident #1 on the night shift and further stated that she assumed LVN C was aware of her previous incident with the family and her decision to not care for Resident #1. She also stated that it was her fault for assuming and not communicating with the charge Nurse regarding her decision to not provide care. She reported that the risk to dependent resident for not providing ADL care including incontinent care over a period of 8-hour shift could lead to skin breakdown and diaper rash. She also revealed she has been provided Inservice regarding abuse and neglect. She defined neglect as not providing service to the resident. She acknowledged that her decision of not providing ADL care to resident #1 and not communicating her decision to the charge Nurse on the night of 12/31/23 was a form of neglect. She reported that when she worked on the night shift of 1/1/24 at the facility, she had a conversation with LVN C about care not being provided on 12/31/23. She also stated that she continued to work in the facility on 1/1/24 on a different hall and was not assigned to care for Resident #1. In an interview with CNA B on 1/4/24 9:28 AM revealed that she worked the morning shift 6 AM-2PM on 1/1/24 and was assigned to care for residents on three halls that included Resident #1. She reported that when she came to work in the morning, call lights for most residents were on and she was trying her best to take care of the resident needs one by one. It took her some time, after breakfast, around 10 AM to go and check on Resident #1. She reported since Resident #1 was a two person assist for ADL's including incontinent care, she called for help from Staffing Coordinator, who was also an LVN to change the resident. She reported that as soon as she moved the support pillow it was soaking wet in urine. Then they removed the covers, Resident #1 was covered with urine from head to toe, brief was saturated with urine, and had a small bowel movement as well. They proceeded to clean, change and repositioned Resident #1. She reported that Resident #1 was not verbal but had distressed look on his face. She also stated that the support pillow was left on the chair in the resident's room to dry and sheets were taken to laundry since they were saturated in urine. She also reported that when she came back to the resident's hall, she saw that the call light for Resident #1 was on, and the family member A was coming out of Resident #1 room to the nurse's station. The family member A looked very upset and stated to CNA B that Resident# 1 was not changed through the entire night shift and showed CNA B the video recording of last time the resident was changed, which was around 9 pm on 12/31/23. She also asked for Nystatin cream to apply on Resident #1. CNA B reported that she would inform LVN D and left the room. She then communicated with LVN D regarding family member A 's request for Nystatin cream. CNA B left to pass out Lunch trays after that. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA B reported that she has been trained on abuse and neglect and defined neglect as not providing care to the resident. She also stated that she was aware any allegation of abuse and neglect needed to be reported to Abuse coordinator immediately. She also stated that family member A alleged of Resident #1 not been provided care during the night shift was an example of neglect. She stated that she told the Staffing coordinator to bring it up in the morning meeting for the next day but did not report it to the abuse coordinator immediately per policy since she was very busy on her shift. In an interview with Staffing Coordinator on 1/4/24 9:45 AM, she revealed she worked on 1/1/24 from around 8:30 AM to 7PM and was providing care on the floor. She reported that she was called by CNA A to assist with ADL care for Resident #1. Around 10 am, when CNA A and Staffing coordinator went to Resident #1, they found that Resident #1's sheet and pillows, support pillows were soaked in urine and had some feces in his brief. They cleaned, changed, and repositioned Resident #1. She was then called around noon by LVN D to help apply Nystatin cream to Resident #1. She reported Resident #1 family member A was present in the room, was visibly upset and complained that Resident #1 was not changed or repositioned for the entire night shift of 12/31/23. Staffing coordinator reported she had been provided several in services about abuse and neglect and defined neglect as resident not being provided goods and services. She revealed that Family Member A 's allegation of not providing care to the resident was an example of neglect and failed to report it to the abuse coordinator immediately per facility policy. She also reported that most residents should be checked or provided care every 2-3 hours but stated it also depended on staffing ratios. She was not sure if there was a facility policy on how often resident should be provided ADL care by the Nursing staff. She reported that if a resident is not provided ADL care including incontinent care, it can lead to skin breakdown and possible infections. She also reported that she was responsible for scheduling and was not aware of CNA A's concern with providing care to Resident #1. She stated that if she was made aware she would have not had CNA A work in the unit; Resident #1 was present. In an interview with DON interview on 1/4/24 2:30 PM revealed she was aware Resident #1's family had some concerns with care provided by CNA A since the family spoke to the DON about it on the 12/18/23 and 12/21/23. DON reported that Resident #1 family was speaking to CNA A over the camera that Resident #1 was a two person assist and that she was providing care by herself. She also reported that family came to the facility midnight and verbal threats that were made by family and CNA A. DON reported she was not sure if any grievances were filed regarding the incident, but she was still investigating the incident at the time of this interview. She stated she expected staff to report any allegation of abuse and neglect immediately to the Abuse coordinator, who is the Facility Administrator and DON was the backup for Abuse Coordinator. The DON also added that facility administrator was responsible for reporting abuse and neglect allegation to TX HHS and the incident was reported to the TX HHS on 1/3/24. In an interview with Facility Administrator on 1/4/24 at 3:03 PM revealed that he was made aware of the incident regarding allegation that CNA A did not provide ADL care including incontinent care to Resident #1 on 1/3/24 at 3:45 PM. He reported that he was in the process of investigating the incident and was talking to Nursing Staff from Night shift of 12/32/23 and Morning shift of 1/1/24. He also reported that CNA A was suspended yesterday (1/3/24) pending outcome of the investigation. Administrator stated that he had provided numerous in-services to all staff for abuse and neglect, and it was his expectation to report any allegation of abuse and neglect to him immediately. He defined abuse willfully, regardless of intent, harming the resident and Neglect was when good or services are not provided to the resident. He added that he explained that his simple explanation to staff regarding abuse and neglect was To abuse to occur - I must be facing you. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	To neglect - I actively turn my back on you. He stated that as an abuse coordinator , his role was to investigate the allegation thoroughly and report to TX HHS within 2 hours of the incident . He also reported that he was not aware of any grievance filed by resident # 1 family. Administrator added that he reported the incident to TX HHS within 2 hours of him being notified , he provided the Intake #47443. TULIP was checked to see if the intake was received by TX HHS. Record reviews of Employee files for CNA A revealed she was provided Abuse and neglect policy and reporting requirements upon hire on 11/4/23. Record Review of Employee file for CNA B revealed she was provided Abuse and neglect policy and reporting requirements upon hire on 11/4/23. Record Review of Employee file for LVN D revealed she was provided Abuse and neglect policy and reporting requirements upon hire on 11/4/23. Record Review of Employee file of Staffing Coordinator revealed she was provided Abuse and neglect policy and reporting requirements upon hire on 11/14/23. Record review of Facility's Resident abuse, neglect and Exploitation and misappropriation of resident property dated 06/23/2017 revealed that Resident Rights. Each resident has the right to be free from abuse, neglect, exploitation, misappropriation of resident's property, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse, neglect, exploitation, misappropriation of resident's property by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, resident representative, friends, or other individuals. 3.2 All facility staff members have a duty to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to the Administrator of the facility, who serves as the Abuse Coordinator. In the Administrator's absence, the Director of Nursing (DON) or another designee will be appointed to function as the interim Abuse Coordinator. Upon learning of a suspected incident of resident abuse, neglect, exploitation, and/or misappropriation of resident property, the Charge Nurse or other Department Manager or Supervisor must immediately notify the Abuse Coordinator or the DON of the incident. The person receiving the report or designee must document all incidents of alleged abuse/neglect on incident reports, which are to forwarded directly to the Abuse Coordinator . 3.3 Upon receiving an allegation abuse, neglect, exploitation or misappropriation, the Abuse Coordinator will a) notify the Regional Director of Operations and Regional Nurse Consultant, b) initiate an investigation into the allegation, c) in conjunction with the Regional Director of Operations and Regional Nurse Consultant determine whether the allegation is reportable under federal and state regulations, and d) if the allegation is reportable, report such allegation to the State Regulatory Agency, Adult Protective Services (where state law provides for jurisdiction in skilled nursing or assisted living facilities), and in certain cases, local law enforcement, within the following timeframes: 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for one (Resident #1) of 10 residents reviewed for ADLs. The facility failed to provide incontinent care to Resident #1 for 13 hours on 12/31/23 9:05 pm to 01/01/24 at 10:22 AM. CNA A was assigned to Resident #1 and failed to provide care to Resident #1 on night shift. Resident #1 was not provided incontinent care for over 13 hours (including 8 hours of night shift of 12/31/23 and part of 1/1/24 day shift) on 12/31/23 9:05 pm to 01/01/24 at 10:22 AM. On 01/01/24 when Staffing Coordinator and CNA B provided incontinent care and found Resident #1's clothing and bedding soaked urine. Resident #1's brief was soaked in urine and had bowel movement. These failures could place residents at risk of delay in ADL care including incontinent care and life-saving treatments, which could result in psychosocial harm. Findings included: Review of Resident #1's Admission MDS assessment dated [DATE] revealed he was [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Critical illness myopathy (significant slowing of the muscle fiber) , hypertension, pneumonia, Diabetes mellitus, aphasia (loss of ability to understand or express speech, caused by brain damage) , Cerebrovascular Attack , Respiratory Failure, Dysphagia (difficult swallowing) , G-tube feeding dependent (G-tube is a tube inserted through the belly that brings nutrition directly to the stomach). Resident #1 required extensive assistance of at least two people with Activities of Daily Living. He was totally dependent with transfers and bathing. It revealed that resident#1 was always incontinent of urine and bowel. MDS assessment revealed BIMS of 99 indicating resident had severe cognitive impairment. Review of Resident #1 Admission Care Plan dated 12/9/2023 revealed Resident #1 is on Diuretic therapy , Furosemide 20 mg tablet 1 tablet 1 time per day; Resident will have decrease in edema during drug therapy. (Furosemide is a diuretic will make a resident urinate more often to remove the body of excess fluid/fluid retention). Review of Resident # 1 ADL Documentation on EHR for 12/31/23- 1/1/24 revealed incontinent care documented at 9 pm on 12/31/23 and 10 am on 1/1/24. There was no documentation of incontinent care on the ADL in the electronic health record or paper documentation. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Some	Interview with Resident#1's Family Member A and Family Member B on 1/3/24 at 2:18 PM revealed that she was very concerned that Resident#1 was not changed during the night shift of 12/31/23. Resident# 1 admitted to the facility on [DATE]. She stated when she came to the facility around 11am on 1/1/24, she noted that resident#1's side support pillow and other pillow was placed on the chair in the room and was soaking wet and smelled of urine. She picked up the pillow from the chair and saw the chair was wet from the pillow. Shen then called Resident#1 Family Member B to check if she could review the camera to see when Resident#1 was last changed. Family Member A also stated that per camera placed in the room revealed Resident#1 was not changed or repositioned from 12/31/23 at 9:05 PM until 1/4/24 at 10:20 AM. She also stated that she had requested LVN D to reposition Resident#1 around 7 am on 1/1/24 through the camera. She then stated that she went to LVN D who told her he started his shift at 6 AM on 1/1/24 and did not know which nursing staff was assigned for Resident #1 that worked on night shift of 10am -6AM on 12/31/23. Family Member A asked LVN D if he received shift report in the morning for resident# 1's care and which nursing staff provided the report. Per Family Member A , LVN D refused to talk to the Family Member A and directed her to the front office. She stated that she was not able to find any Administration nursing staff and was told ADON B had left for the day. Family Member A also revealed that she had complained to the DON regarding her concerns with Resident# 1 ADL care earlier on 12/18/23 and approach the DON that Resident#1 needed two people assist on all ADL's including incontinent care. She also stated that on the night shift on 12/17-12/18/23 CNA A was changing and repositioning the resident by herself incorrectly when resident's Family Member B intervened from the camera and had to come to the facility at midnight to make sure that Resident #1 was okay. She stated that resident's Family Member B spoke with Charge Nurse LVN I on 12/18/23 who stated that she will have another CNA care for the resident for that night. She also stated that Resident#1 Family Member B spoke with the DON on 12/21/23 regarding needing two people assist on all ADL care including incontinent care and repositioning. She stated DON reported it was not the facility policy to turn the resident every 2 hours, but the DON and wife agreed on checking on the resident every four hours. Interview with LVN D on 1/4/24 at 2:36 PM revealed that he had started working in the facility around November 2023, he reported he was the LVN who was taking care of Resident #1 on 1/1/24 morning shift from 6am-2 pm. He reported that he checked on Resident #1 around 7am on 1/1/24 and administered his G-tube (meds and check resident#1's blood glucose. He also reported that he briefly lifted Resident#1 sheets and it appeared that Resident #1 brief was dry. He stated that he did not physically check on Resident#1 for incontinence. He also stated that Family Member A talked to him from the camera around 7 am on 1/1/24 when he was providing G-tube care to the resident and asked him to reposition resident#1. He reported that since Resident#1 was 2-person assist, LVN D went to look for CNA and could not find the CNA, so he continued with his med pass and blood glucose checks to other residents in the hall. LVN D reported he did not reposition Resident #1. LVN D also stated that the Staffing Coordinator and CNA B provided incontinent care and repositioning around 10 AM on 1/1/24. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Some	He also reported that Resident#1's Family Member A came to him at the nurse's station around 11am on 1/1/24 stating that Resident #1 was not changed on the night shift of 12/31/23 and asked for nursing staff that took care of the resident the previous night. LVN D redirected the Family Member A to the front office. He reported that Family Member A came to him again after some time (around noon) asking to put nystatin ointment on resident's peri-area by herself. LVN D informed Family Member A that since the ointment is a prescribed medication, it will need to be applied by a nursing staff. LVN D stated he did not feel comfortable entering the resident's room by himself and hence he, along with Staffing Coordinator entered the Resident's room and applied Nystatin ointment for resident#1. LVN D reported that nystatin was applied to resident's peri care area between 12:15 PM - 12:30 PM on 1/1/24. LVN D reported that Nystatin was started on Resident #1 on 12/30/23 for diaper rash and it is usually used for fungal infection or skin irritation and can be caused if area is wet for a long time. LVN D stated that he did not report the allegation from the Family Member A that the resident was not changed over several hours of night shift to anyone. LVN D reported when he started at the facility about a month ago, he was provided with several in services that included abuse and neglect as well. He defined neglect as resident not being provided the needed care and services by the facility. He stated he knew to report any allegation of abuse and neglect to the Abuse Coordinator immediately. He stated that if the allegation from the Family Member A was true that the resident indeed did not receive incontinent or ADL care during the night shift, it looked like neglect to him, and he should have reported it then. Interview with CNA E on 1/3/24 at 2:42 PM revealed that she worked in the facility for last 8-9 months. She stated that she did not work on the night shift from 10PM to 6 AM on 12/31/23 in the facility and She usually worked the 2PM -10 PM shift. She had taken care of Resident #1 in the past and was aware with Resident #1 care needs. She reported that Resident #1 needed two-person assist with all ADL care and she always takes help from the Nurse or CNA from other halls for changing or repositioning the resident. She reported that she was not aware of rounding policy for the facility, but she rounded on her residents at least every two hours. She also reported that resident#1 has Nystatin cream for diaper rash that was always applied by Nursing staff when they change the resident. She also reported that he was provided abuse and neglect in services in the past and defined neglect as resident not getting the needed goods or services. She also stated that if a resident had not been provided ADL care may result in neglect and should be reported to the administration team immediately. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Some	Interview with LVN C on 1/3/24 at 2:50 PM revealed that he worked at the facility for about 2 years. He reported that he worked the night shift 10PM - 6AM on 12/31/23. He reported that he hung a new tube feeding bag and reprogrammed the feeding pump around 10:30-11 PM on 12/31/23, but he did not check resident for incontinent care at that time nor did he repositioned Resident #1 at that time. LVN C also stated that he did not repositioned or provided incontinent care to Resident #1 at all during his shift because he thought the CNA would have provided that care. He also reported that he was the Charge Nurse for the unit on the night of 12/31/23. He reported as a Charge Nurse, he assigned residents to CNAs that they need to take care of during their shift. He reported that Resident #1 was assigned to CNA A along with all other residents on 500, 600, 700 Hall. He reported he became aware of the incident that family alleged that resident was not provided ADL care including incontinent care on the night shift of 12/31/23 when Resident #1's Family Member A approached him during his afternoon shift 2PM- 10 PM on 1/1/24. LVN C also stated that CNA A did not tell him that she will not be caring for Resident#1 anytime during the night shift of 12/31/23 when they worked the halls together. He stated that when he spoke with CNA A around 10 PM on 1/1/24 she told him she assumed he knew that she will not take care of Resident#1 because of some prior concerns that CNA A had with resident#1's family. He further added that he asked CNA A if she communicated this with him beforehand OR ask for swapping residents so other CNA could take care of the resident OR made nursing administration aware of her dispute or displeasure to work with Resident #1, CNA A replied NO to all his questions. He also stated that since CNA's usually take care of all ADL's, he did not check whether Resident #1 was provided ADL care including incontinent care. He also stated that Resident #1 was two persons assist and that most CNA's will ask for help from Nurses on the floor or CNAs from other halls. LVN C reported that he had received in-services on abuse and neglect and defined neglect as not providing good and services to the resident. He also said that CNA A not providing care was an example of neglect. He also stated that he was going to report the alleged Neglect to the Abuse Coordinator soon but waited to speak with CNA A about the incident. In a phone interview with CNA A on 1/4/24 9:03 AM she revealed she was aware of Resident#1's care. She stated she worked the night shift 10pm-6am on 12/31/23 and was assigned to the Resident#1's care per assignments provided to her by the Charge Nurse, LVN C. She also stated that she did not provide any ADL care including incontinent care or repositioning to Resident #1 on the night shift from 10pm-6am on 12/31/23. She does not know if any other CNA or LVN provided care to the resident that night. She reported that she had a situation with the Family Member s of Resident#1 roughly 2 weeks ago, she does not remember the exact date - but thought it was around 18/19th of December. CNA A stated that the family was rude to her and was not happy with the ADL care she provided to the resident the night of December 18th. She stated the incident was reported to LVN I who was charge Nurse that shift since the family came to the facility at midnight. She reported she failed to communicate with LVN C about her decision to not provide care to Resident#1 on the night shift and further stated that she assumed LVN C was aware of her previous incident with the family and her decision to not care for Resident #1. She also stated that it was her fault for assuming and not communicating with the charge Nurse regarding her decision to not provide care. She reported that the risk to dependent resident for not providing ADL care including incontinent care over a period of 8-hour shift could lead to skin breakdown and diaper rash. She also revealed she has been provided Inservice regarding abuse and neglect. She defined neglect as not providing service to the resident. She acknowledged that her decision of not providing ADL care to Resident #1 and not communicating her decision to the charge Nurse on the night of 12/31/23 was a form of neglect. She reported that when she worked on the night shift of 1/1/24 at the facility, she had a conversation with LVN C about care not being provided on 12/31/23. She also stated that she continued to work in the facility on 1/1/24 on a different hall and was not assigned to care for Resident #1. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Some	In an interview with CNA B on 1/4/24 9:28 AM revealed that she worked the morning shift 6 AM-2PM on 1/1/24 and was assigned to care for residents on three halls that included Resident#1. She reported that when she came to work in the morning, call lights for most residents were on and she was trying her best to take care of the resident needs one by one. It took her some time, after breakfast, around 10 am to go and check on Resident #1. She reported since Resident #1 was a two person assist for ADL's including incontinent care, she called for help from Staffing Coordinator , who was also an LVN to change the resident. She reported that as soon as she moved the support pillow it was soaking wet in urine. Then they removed the covers, Resident #1 was covered with urine from head to toe, brief was saturated with urine, and had a small bowel movement as well. They proceeded to clean, change and repositioned Resident #1. She reported that Resident #1 was not verbal but had distressed look on his face She also stated that the support pillow was left on the chair in the resident's room to dry and sheets were taken to laundry since they were saturated in urine. She also reported that when she came back to the resident's hall, she saw that the call light for Resident #1 was on, and the Family Member A was coming out of Resident #1 room to the nurse's station. The Family Member A looked very upset and stated to CNA B that resident# 1 was not changed through the entire night shift and showed CNA A the video recording of last time the resident was changed, which was around 9 pm on 12/31/23. She also asked for Nystatin cream to apply on Resident#1. CNA B reported that she would inform LVN D and left the room. She then communicated with LVN D regarding Family Member A 's request for Nystatin cream. CNA B left to pass out Lunch trays after that. CNA B reported that she has been trained on abuse and neglect and defined neglect as not providing care to the resident. She also stated that she was aware any allegation of abuse and neglect needed to be reported to Abuse Coordinator immediately. She also stated that Family Member A alleged of resident#1 not been provided care during the night shift was an example of neglect. She stated that she told the Staffing Coordinator to bring it up in the morning meeting for the next day but did not report it to the Abuse Coordinator immediately per policy since she was very busy on her shift. In an interview with Staffing Coordinator on 1/4/24 9:45 AM, she revealed she worked on 1/1/24 from around 8:30 AM to 7PM and was providing care on the floor. She reported that she was called by CNA A to assist with ADL care for resident#1. Around 10 am, when CNA A and Staffing Coordinator went to Resident#1, they found that Resident #1's sheet and pillows, support pillows were soaked in urine and had some feces in his brief. They cleaned, changed, and repositioned Resident #1. She was then called around noon by LVN D to help apply Nystatin cream to Resident#1. She reported Resident#1's Family Member A was present in the room, was visibly upset and complained that resident#1 was not changed or repositioned for the entire night shift of 12/31/23. Staffing Coordinator reported she had been provided several in services about abuse and neglect and defined neglect as resident not being provided goods and services. She revealed that Family Member A 's allegation of not providing care to the resident was an example of neglect and failed to report it to the Abuse Coordinator immediately per facility policy. She also reported that most residents should be checked or provided care every 2-3 hours but stated it also depended on staffing ratios. She was not sure if there was a facility policy on how often resident should be provided ADL care by the Nursing staff. She reported that if a resident is not provided ADL care including incontinent care, it can lead to skin breakdown and possible infections. She also reported that she was responsible for scheduling and was not aware of CNA A's concern with providing care to Resident #1. She stated that if she was made aware she would have not had CNA A work in the unit; Resident #1 was present. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Some	In an interview with DON interview on 1/4/24 2:30 PM revealed that her expectation for dependent resident with incontinence was that there was no facility policy on how often residents should be checked for continence or nursing rounds. She expected that dependent resident who need incontinent care be changed when they were visibly spoiled or as needed and Nursing to round throughout the shift. DON also stated that as a Registered Nurse, she would check on resident at least three times per shift. DON stated that CNA and Nurses are responsible for providing ADL care including incontinent care. She also reported that if CNA does not provide care to resident, it was her expectation that she would notify Charge Nurse or Nursing administration immediately. She also stated that Staffing Coordinator was responsible for scheduling and assigning CNAs to the residents for all the shifts. She also stated there she was not aware of any restrictions for any CNA's that cannot go to resident room and if there were any restrictions Staffing Coordinator should have been aware. If there were any changes to be made, Charge nurses can reassign CNAs on duty as needed. DON reported that she was not aware if CNA A had any restrictions on caring for Resident#1 and hence there was no communication to Nurses on the floor. She also stated that CNAs cannot decide about not caring for Resident that they are assigned to. If CNA had any reservation regarding resident's care, she should be communicating it with charge nurses or nursing administration. DON stated that she was aware Resident#1's family had some concerns with care provided by CNA A since the family spoke to the DON about it on the 12/18/23 and 12/21/23. DON reported that Resident#1 family was speaking to CNA A over the camera that Resident #1 was a two person assist and that she was providing care by herself. She also reported that family came to the facility midnight and verbal threats that were made by family and CNA A. DON reported she was not sure if any grievances were filed regarding the incident, but she was still investigating the incident at the time of this interview. DON reported that management had not provided any direction to CNA to not enter Resident #1's room or provide care to Resident #1. DON also stated Resident #1 was on therapy and needed maximum assistance for transfers, however not for all ADL care. DON reported that maximum assistance was defined as resident needing 2 people to provide care. She stated that Resident#1's family requested two persons assist on all ADL cares. DON reported the risk to resident for not providing ADL care that included incontinent care for dependent resident may lead to skin breakdown and infections. DON defined Abuse and Neglect as follows : Abuse is willfully doing something wrong to the resident that may result in harm. Neglect defined as not providing service or goods to resident. DON also stated that if CNA does not provide care to the resident assigned to her is an example of neglect. She sated she expected staff to report any allegation of abuse and neglect immediately to the Abuse Coordinator , who is the Facility Administrator and DON was the backup for Abuse Coordinator . Review of facility's Restorative Policy titled Perineal care/Incontinence Care Dated April, 2012, revised 01/06/2024 stated Staff will perform perineal/incontinent care with each bath and after each incontinent episode. Care will be provided frequently as defined as every 2 to 3 hours and as needed to meet resident needs, prevent skin breakdown, and infection. Staff will document in EHR after care has been provided for incontinent episodes. In the event that POC devices are not operable, paper documentation will be utilized. 48560

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34399 42971 Based on observation, interview and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 2 of seven residents (Resident #1 and Resident #3) observed for infection control. The facility failed to ensure: 1-MA BB donned the face mask correctly when she entered Resident#3' isolation room. 2-ADON B and CNA O performed hand hygiene during incontinence care for Resident # 1. These failures could place the residents at risk for infection. Findings include: 1- Review of Resident #3's significant change MDS dated [DATE] reflected Resident #3 was an [AGE] year-old female readmitted to the facility on [DATE] with diagnoses of cancer, heart failure, hypertension, diabetes. Resident #3 required partial/moderate assistance with ADLs except for eating, oral hygiene and upper body dressing. Review of Resident #3's physician order dated 12/28/23 for Resident #3 on droplet precaution for 10 days. Observation on 01/03/24 at 10:57 AM revealed MA BB had PPE gown with gloves and had surgical face mask under her N95 mask with the N95 mask lower strap hanging down. She did not have any goggles or face shield when entering Resident #3's room to give Resident #3 her medications. Interview on 01/03/24 at 11:04 AM with RN V revealed facility staff should be wearing full PPE when entering resident room on droplet precautions and positive for COVID. He stated full PPE included gown, gloves, N95 and face shield or goggles. Interview on 01/03/24 at 11:06 AM with MA BB revealed she should have worn the N95 mask properly without the surgical mask underneath along with face shield or goggles when giving Resident #3 her medications and taking her blood pressure. She stated Resident #3 was on droplet precautions due to covid positive status. She stated it was important to wear proper PPE when going into resident room on droplet precautions so not to contaminate. Review of facility's staff Inservice for Isolation for droplet infection and days on isolation dated 12/24/23 reflected MA BB was in-serviced by DON along with other facility staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2- Review of Resident #1's Admission MDS assessment dated [DATE] revealed he was [AGE] year-old male admitted to the facility on [DATE] with diagnoses included critical illness myopathy (significant slowing of the muscle fiber), diabetes mellitus, aphasia (loss of ability to understand or express speech, caused by brain damage), tube feeding dependent (a feeding tube supplies nutrients to people who cannot get enough nutrition through eating). Resident #1 required extensive assistance of at least two people with Activities of Daily Living. He was totally dependent, 2 persons assist with transfers and bathing, Toileting hygiene, and dressing. Resident#1 was always incontinent of bowel and bladder. assessment revealed BIMS of 99 indicating resident had severe cognitive impairment. Observation on 01/04/23 at 9:15 AM revealed CNA O providing incontinent care to Resident #1. CNA O was observed cleaning Resident #1's front area with wipes. CNA O with the help of ADON B positioned the resident on the side and cleaned the resident's bottom area. Observation revealed small bowel movement. After cleaning the resident CNA O took off and discarded the dirty brief and without any form of change of gloves or hand hygiene, CNA O applied the clean brief. ADON B applies skin cream to the resident bottom area. ADON B changed gloves without any form of hand hygiene. CNA O and ADON B positioned resident on his back; ADON B applied skin cream to the resident's front pubic area. ADON B changed gloves without any form of hand hygiene. CNA O and ADON B positioned resident in bed, they changed his gown. ADON B changed gloves without any form of hand hygiene, she turned on the feeding pump. She removed and discarded dirty gloves and completed hand hygiene. CNA O without any change of gloves and without any form of hand hygiene she positioned pillows to support resident's position. CNA O removed and discarded gloves and completed hand hygiene. In an interview on 01/04/24 at 9:30 AM, CNA O stated she was to wash hands before and after care. CNA O also stated she was supposed to change gloves and complete hand hygiene after taking the resident's dirty brief off. CNA O stated she did not complete hand hygiene or change gloves after cleaning the resident because she forgot. CNA O stated she was supposed to change gloves and complete hand hygiene to prevent the spread of infection. CNA O stated she had an in-service on infection control about two weeks ago. In an interview on 01/04/24 at 10:00 AM, the ADON B stated she supposed to perform hand hygiene between gloves change. She stated she did not sanitize her hand between change of gloves because she forgot to bring the sanitizer with her in the room. She stated failing to do these steps risk cross contamination and increased the risk of infections. In an interview on 01/04/23 at 02:04 PM with the DON she stated during incontinent care the staff were to complete hand hygiene before and after care. DON also stated in between care staff were to complete hand hygiene and change gloves because the hands were considered dirty after cleaning the resident. The DON stated the staff were to complete hand hygiene during care to prevent the spread of infection. Record review of the facility's policy COVID - 19, revised August 2023, reflected .H- PPE . 2. COVID - 19 PPE. a. The required PPE for COVID - 19 isolation rooms or when providing care or services to a COVID - 19 positive resident or a resident suspected of having COVID - 19, staff should wear an N95, face shield or goggles, gown and gloves Record review of the facility's policy titled, Perineal Care, revised January 2018, reflected, .8. Turn resident to clean all areas of buttocks with new wipe or section of washcloth. 9. Dispose of gloves and used supplies and perform hand hygiene. 10. Apply new gloves and place new brief . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy Hand Hygiene, revised January 2022, reflected .Procedure: 1. Hand hygiene is done: . After . H. Removal of medical/surgical or utility gloves