STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676371	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Quail Valley Post-Acute Healthcare	3640 Hampton Dr Missouri City, TX 77459

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47277 Abbreviations: ADMIN - Administrator ADON-Assistant Director of Nursing AS-Agency Staff BIMS-Brief Interview for Mental Status MA- Medical Aides CNA-Certified Nursing Assistant CR-Closed Record CW-Confidential Witness DON - Director of Nursing DORC - Director of Resident Care ED - Executive Director ERN - emergency room Nurse EMS-Emergency Medical Services EMT-Emergency Medical Technician FM-Family Member HHSC-Health and Human Services Commission (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/29/2024

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	IJ-Immediate Jeopardy IT-Immediate Threat LE-Law Enforcement LVN-Licensed Vocational Nurse PD- Police Dept MD-Medical Doctor MT - Resident Med Tech NP- Nurse Practitioner R-Resident RA-Resident Assistant RN-Registered Nurse RP-Responsible Party Based on observations, interviews, and record review, the facility failed to ensure residents were free from abuse for 1 resident (CR#1) of 5 residents reviewed for abuse. The facility failed to ensure each resident was free from abuse when CR#1 was physically abused by CNA C on 2/20/2024 around 6:30am, which was the time CNA A started her morning shift and observed the bruising to CR#1's face. An Immediate Jeopardy (IJ) was identified on 02/25/2024 at 5:23 p.m. While the IJ was removed on 02/27/2024 at 6:00pm, the facility remained out of compliance at the severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems. These failures placed residents at risk of physical harm, emotional distress, mental anguish and death from possible abuse and neglect. Findings Include: (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#1's face sheet revealed a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted [DATE]. CR#1 has a diagnosis of Anoxic Brain Damage (lack of oxygen to the brain causing death of brain cells), Type 2 diabetes mellitus hypoglycemia w/o coma (low blood sugar levels), hypertension (high blood pressure), dysphagia (difficult swallowing), major depression disorder (low or depressed mood), chronic kidney disease (damaged kidneys and/or loss of kidney function), cognitive communication deficit (difficulty thinking and using language), anxiety disorder (pounding heart and sweating when responding to certain situations), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). Record review of CR#1's MDS assessment dated [DATE], revealed a BIMS score of 4 (severe cognitive impairment). Cognitive skills for daily decision making further revealed, resident can repeat at least three words heard, resident is able to recall prior questions after cueing, resident does not have any psychosis behaviors, which includes physical behaviors, verbal behavior, or any other behavior symptoms directed at others and the resident was able to participate in an activity preference interview of her interest while in the facility. Record Review of the Progress Notes for CR#1: There was only one progress note entered since 1/3/2024 and that was on 2/21/2024 at 16:17 (4:17pm), which was titled Admin Note and stated the Administrator notified FM of the HHSC investigation on 2/21/2024 with allegations of abuse. Record review of CR#1's care plan updated 03/31/2022 revealed, the resident has a communication problem r/t expressive Aphasia, Hearing deficit, Neurological symptoms. The goal was the resident will maintain current level of communication function by making sound, using appropriate gestures, responding to yes/no questions appropriately through the review date. The interventions are to allow adequate time to respond, repeat as necessary, do not rush, request clarification from the resident to ensure understanding, face when speaking, make eye contact. Ask yes/no questions if appropriate, use simple, brief, consistent words/cues, use alternative communication tools as needed. Resident is a one (1) person total assist and two (2) person transfer using a mechanical lift. Further review of Resident #1's care plan updated revealed no documentation regarding the facial injuries on 2/21/2024 or any plan initiated to keep her safe while in the facility going forward. (continued on next page)

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F 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Record Review of CR#1's orders dated 2/1/2024 - 2/29/2024 revealed calcium tablet-1 tablet by mouth for type 2 diabetes (last taken 2/21/24 at 2000 (8PM) hours); magnesium oxide (last taken 2/22/2024 at 0730 (7:30AM); sertraline (1 tablet daily for anxiety); vitamin D2 (1 tablet daily); Coreg oral tablet by mouth one time daily (hold if <110HR<60); Depakote capsule 2 times daily); Janumet oral tablet two times daily for mood disorder. Hold if drowsy; Janumet oral tablet by mouth two times daily (d/c date 2/6/2024); refresh tears solution (carboxymethylcellulose sodium) instilled one drop in both eyes two times a day for dry eye syndrome (start date 6/30/2022 1700 (5PM)). -The orders reflected a code 7 at 1700 hours, indicating the resident is sleeping and see progress notes (FM observed nurse putting eye drops in CR#1's eyes when she arrived during this time); Lorazepam 1 tablet by mouth three times daily; Accucheck one time a day related to diabetes (notify MD if bs <70 or >250); monitor vital signs every two weeks one time a day every 2 weeks on Mondays for Health monitoring (start 2/19/2024); Behavior monitoring for antianxiety from 2/1/2024 until 2/21/2024 reflected a code of 0, indicating CR#1 did not have any behaviors noted during all shifts; Behavior monitoring for antidepressants from 2/1/2024 until 2/21/2024 reflected a code of 0, indicating CR#1 did not have any behaviors noted during all shifts. Behavior monitoring for antipsychotic from 2/1/2024 until 2/21/2024 reflected a code of 0, indicating CR#1 did not have any behaviors noted during all shifts and on 2/21/24; Behavior monitoring for Busplrone (anxiolytic medication to treat anxiety) from 2/1/2024 until 2/21/2024 reflected a code of 0, indicating CR#1 received a 1, which indicated mania (mental health marked by periods of great excitement or euphoria, delusions and overactivity); in the EVE2 and a 6-grandiosity (unrealistic sense of superiority in which someone believes themselves to be unique and better than others) in the NOC1; Assess pain on each shift; monitoring antianxiety received a 1 and 6 on 2/21/24; Monitoring side effects for antidepressants codes indicated none, but on 2/21/24 there is a 1 in evening and 6 NOC 1

Record Review of R#2's MDS assessment dated [DATE] revealed, BIMS score of 8 (moderate cognitive impairment). Cognitive skills for daily decision making further revealed, resident can repeat at least three words heard after first attempt, was accurate when asked about the current month, resident is able to recall prior questions after cueing, able to recall a color without cueing. Resident has no symptoms of delirium, she is attentive, organized thinking and has a level of consciousness, resident has no symptoms of feeling down, depressed or hopeless; resident has no indicators of psychosis, hallucinations or delusions; Resident's active diagnoses are progressive neurological conditions, hypertension, anxiety disorder, depression (other than bipolar), psychotic disorder (other than schizophrenia).

Record Review of R#2's psychological progress note dated 2/10/2024 revealed, improved coping. No issues.

Record Review of R#2's psychological progress note dated 2/20/2024 revealed no change in mental status, specifically stressor or changes in mental status that may affect functioning. Noted during psychotherapy were improved coping skills, adjustment to illness-decline-loss. Resident noted she is hopeful that her family member will be taking her home soon, which she is looking forward to. No issues. The clinician will follow up with patient in 1-2 weeks to continue to address client's symptoms.

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F 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Record Review of R#2's psychological progress note dated 2/26/2024 revealed, client's BIMS score was reduced from 8 to 4 (indicating cognitive decline); client reported year as 2020, could only recall 0 of the 3 words. Clinician explored with client what happened to her roommate, which client didn't want to discuss, but stated she has already told it too many times. Stated resident stated the night before she found out her roommate had a black eye, she heard the CNA C changing the roommate and heard a scuffle and the roommate said no and stop. She further stated she did not see anything and did not hear anyone being hit. Client stated she was shocked to learn her roommate had an injury the next day. States client was tearful and spoke of her roommate not coming back and that she will miss her as they were together for a long time.

Record Review of L.E. report dated 2/21/2024 from PD. According to the police report, based on the age of the resident and the injury, Adult Protective Services was contacted. The report indicated that the resident did not inform the officers of the nature of her injuries but did report she had been assaulted to the EMS personnel.

Record Review of EMS report FB. According to the EMS report, they arrived at the facility on 2/21/2024 at 10:34am. CR#1 was noted to have a periorbital hematoma to the right eye. CR#1 was noted to be warm to the touch. According to the EMS responder, R#2 mentioned, that yesterday evening CR#1 was yelling and she assumed that she was being changed as she usually yells when being changed. The EMS responder stated, CR#1 stated she was hit when he asked her what happened. She further states she was hit by a staff after he asked her if she was hit by another patient or staff. CR#1 was transported, non-emergency, to hospital. EMS Responder stated during transport he took her vitals and the right pupil was noted to be 2mm and the left pupil 4mm.

Record Review of Progress note created on 2/21/2024 at 13:46 (1:36pm), effective 2/21/2024 at 10:41am revealed, CR#1 transferred to hospital for evaluation and CT scan per FM request. Resident left the facility via stretcher and two EMT in stable condition.

On 2/22/2024 at 10:53am Interview with R#2 - Stated she was the room mate of CR#1. She stated she was in the room with CR#1 when CNA C came in the room to change them both. She stated she was changed first. She stated she heard CR#1 scream and tell CNA C that she was hurting her. She stated CR#1 continued to say, stop, stop you're hurting me. She stated the CNA C responded, Just be quiet its all your imagination! CR#2 stated that prior to Tuesday 2/20/2024, CR#1 did not have those bruises. She stated she was afraid that something may happen to her. She stated CR#1s FM came to the facility yesterday, 2/20/2024 and when she entered the room she asked R#2 if she had seen what happened to CR#1. At that time R#2 stated she was able to look at CR#1 face and saw those horrible bruises.

According to R#2, this incident occurred the morning on 2/20/2024. She stated that the CNA comes in to change them right before her shift ends. She further stated that the morning shift CNA comes in to check and change both, CR#1 and R#2, at the beginning of their shift. She reiterated that the CNA that she heard CR#1 screaming at was the lady whose shift was ending. This, according to R#2 was the night shift CNA (CNA C).

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation and attempted interview with CR#1 on 02/22/2024 at 12:50 p.m. while in the hospital, revealed she was in bed eating lunch. CR #1 briefly looked up but she did not respond to any questions. The redness under CR#2's right eye was not as profound as the photos shown the day of FM's observation in the facility. The bruising on her right jaw still had a discoloration, while mild, still noticeable. Hospital Nursing staff came into to the room to change her and when they asked her to turn toward them, she responded by doing what they asked. On 02/22/2024 at 1:00p.m. 2/22/24 at 12:30pm- Interview with LE. stated he arrived at the facility on 2/21/2024 at 8:50am. and met with FM, another family member and CR #1. He stated FM requested for CR#1 to be transported to ER. He stated during the time of gathering information from all involved, the EMS worker informed him the resident stated she was assaulted. He stated when he questioned resident, she would not respond to him. He further stated that he spoke to the DON Wednesday, yesterday, after being contacted by the resident's family member. He stated that the timeline was on Friday the FM saw the resident and she had no bruises and when she arrived on Tuesday evening, the resident had bruises. On 2/22/24 at 1:00pm Interview with FM - FM stated she visited CR#1 on Friday 2/16/24, 4:00pm - 4:30pm and left that evening around 7:30pm and CR#1 had no bruises. She stated she returned Tuesday 2/20/24, between 5:00pm - 5:30pm and CR#1 was in the cafeteria. She stated at this time she noticed CR#1's bruised eye. She stated she left the cafeteria area and went into the ADON's office to inquire about what happened to CR#1 face. She stated both ADON's (A & B) were in the office. She stated she told them that CR#1 looked like she has been assaulted. She stated the ADON A responded, Now no one has hit CR#1. She may have hit her head on the wall area. FM felt the ADON A was being condescending, which angered her. FM responded, that analogy is not true and she asked why she wasn't notified CR#1 had marks and bruises on her face. FM stated at this time the ADON B got up and accompanied her to the cafeteria. She stated at that time the CR# 1 was asked who hit her. She stated a male. The ADON B stated at that time that there were no male CNA's working on the night shift. She stated the ADON B continued to tell her CR# 1 may have hit her head on the wall. FM told the ADON B that it was not possible to do that based on how her Geri Chair (padded reclining geriatric chair) was positioned. She stated she asked ADON B again why she was not notified (CR#1) had bruises. FM stated she did not get an answer. FM stated she spoke with the Admin who told her that he was doing an abuse investigation. He stated he did not know about the accusations of abuse or about the resident's eye. The Admin went to get the DON to ask what was going on. She stated the DON began saying CR#1 could be combative and this may be the reason for her injury. FM stated at this time she disagreed with them and left the facility. She stated CR#1 began to cry and beg her not to leave, but she had to leave at that time and made a decision to return in the morning with LE. FM stated she called LE on her way to the facility. FM stated she arrived at the facility on Wednesday 2/21/24, around 8:30am at which time CR# 1 was seated in her geri chair at the nurses' station. FM witnessed a nurse putting eye drops in CR#1s eyes. She spoke with the DON. She stated the DON initially told her that he had no idea and was not notified of the bruising. She stated after she told the DON she had contacted the police, the DON told her she received a photo while she was off of CR#1s eye and she was going to do an investigation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/22/24 at 2:48pm Interview with CW - CW stated that on Monday evening CR #1 was in her room seated in a chair slumped over about to fall out. CW stated that there were two CNA's in another resident's room just talking and laughing. CW stated CW called the CNA's to go help CR#1 and they did. CW stated on Monday CW did not see bruising on CR#1s 's face. CW stated Tuesday morning around 8:30am CW observed the bruising on CR#1s face, her eye was swollen and really red and her jaw was black and blue and swollen going down towards her neck. CW stated the injuries were unbelievable and looked as if someone had beat her up. CW stated CW typically goes into CR#1s room and says hello because CW has gotten an opportunity to meet CR#1's FM and CW has told her CW is there with CW's own FM all the time and CW will check on her CR#1. CW stated each day CW arrives at the facility; CW will go to CR#1s room and kiss her on the forehead and tell her CW is just checking on her. On 2/22/24 at 5:05pm Interview with RN B- stated she works 2-10 shift and is familiar with CR# 1. LVN A stated CR#1's FM spoke to her about the redness around CR# 1's eyes. She stated she did not see anything on the face of CR #1. LVN A said she did not see the bruise prior to the 2/22/2024. She states she saw the redness on CR #1's eye and believes it was on the left eye. On 2/22/2024 at 5:17pm Interview with CNA B - stated she always work 2-10 shift. She did see CR #1 on Monday 2/19/24, and Tuesday 2/20/24, and did not notice any marks or bruises on resident face. She stated she was not assigned to CR #1 but saw her two days ago. CN A B said she did not notice marks or bruises on her face on Tuesday and CR#1 had a red eye. CNA B stated she reported her observation to the nurse in charge, LVN A. CNA B stated CR# 1 has never been combative when she worked with her. CNA B stated, If I see a resident with injury I will report to the nurse in charge. On 2/23/24 at 7:41am Telephone Interview with CNA A - Stated CR#1 was usually trying to fight while changing her, but she just tensed up her body. CNA A stated she was able to change her. CNA A stated she was training CNA L who had just started. CNA A stated she did noticed bruising on CR#1. CNA A stated her eye was swollen, and she believes it was the right eye. Did not ask what happened to her eye. She stated she informed the charge nurse, LVN B. CNA A stated CR#1 never screamed she was being hurt while changing her. She stated the last training on abuse and neglect was 2-3 weeks ago. She said she did not know why she was trained. The in-service was conducted by DON and Abuse coordinator. In an interview with CNA C on 2/23/24 at 4:28am revealed, she worked with CR#1 on Monday evening and did not notice bruises. CNA C said she changed her in the morning. She stated if her face looked like this it would have been noticed. CNA C stated resident does talk a little. She can say what she wants and if she wants to get in her chair and go to the nurse's station. CNA C will take her to the nursing station when she requests throughout her shift. She stated at no time did CR# 1 tell her to stop or she was hurting while changing her. In an interview with RN C on 2/23/24 at 4:58am revealed, he worked the weekend and did see CR# 1. RN C stated he did not observe CR #1 with any marks or bruises on her face. When shown a photo of resident's marks/bruises, RN C stated he has never seen her face like that and if he had he would have been alarmed and written an incident report. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/23/24 at 7:52am - Telephone Interview with LVN B - Stated during the earlier morning hours of her shift, 2/20/2024, around breakfast, the CNA A came to her and told her that CR#1's eye was red and swollen. She stated at this time CNA A had pushed CR#1 to the nursing area. She stated she observed the eye to be red and swollen and reported it to the LVN C.She again stated when CNA A told her about CR#1, she was already in her Geri Chair located in the hallway. She looked at CR#1 and then proceeded to speak with LVN C around 9:45am. She stated she attended the nursing morning meeting and told everyone (including both ADON's and Administrator that CR#1's eye appeared red and swollen. On 2/23/24 at 8:35am -Telephone interview with LVN C.- LVN C indicated that on Tuesday, 2/20/24, she was the treatment nurse. She said in the morning between 10 AM and 11 AM, LVN B came to her, while she was documenting on another resident in the office and told her that CR#1's eye was red and somewhat raised. She said that the LVN B was the charge nurse. She stated that she looked at the CR#1s eye while she was seated in her geri chair by the nurse's station. She stated that the eye was a little red but told LVN B to keep observing the eye LVN C stated that her last in-service for abuse and neglect was Wednesday with the Administrator, HR and DON. On 2/23/2024 at 9:50am Interview with Admin - Stated he is the coordinator for abuse and neglect at the facility. Stated on Wednesday, 2/21/24, CR#1's injuries appeared to have gotten worse. On 2/23/24 at 5:58pm Interview with DON. Stated CR#1 went to the hospital on Wednesday 2/21/24. She stated she had not worked on Tuesday 2/20/24, and had no idea what was going on until CR#1's FM came to the facility on [DATE] and told her she had called the police. She stated FM told her to look at CR#1's eye. She did. She stated she told FM that she would check on the issues and that she had not been informed of any type of injuries. The DON stated the resident was always rubbing her eyes and this may have caused bruising. FM brought the bruising to her attention and said CR#1 was abused. The DON stated she conducted an in-service for abuse. She stated the resident has a history of taking psychiatric medication because of her behavior problems. She indicated CR#1 has been combative lately. The DON stated the FM requested CR#1 be sent to the hospital, which the facility had no other option but to comply. She stated the bruises may have come from CR#1 vigorously rubbing her eyes. The DON was shown a photo of the CR#1's facial area and she stated the resident's bruises were not there when she left the facility. It was like a scratch when she left the facility. The DON brought in an in-service that was signed by some staff and not by others. She stated she completed the Abuse and Neglect and Exploitation in-service on Wednesday after the FM, brought it to her attention. The DON continued to deny the CR#1's face had those bruises when she left the facility. The DON stated, if FM was so upset about CR#1 why did she leave her on Tuesday? The DON stated if there is suspected abuse, protocol will be to ask all the residents if they feel safe. She stated she would call the police and make an incident report. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with ERN on 2/24/24 at 9:35am. revealed she was the emergency room nurse that evaluated CR#1 upon her arrival by EMS. She stated per EMT, the FM requested that the resident be seen due to possible assault. The EMT said that family found CR# 1with unexplained bruising and the facility was dismissive. ERN stated the EMT further stated CR# 1 told him someone hit her, but there was not a lot of detail. ERN is also forensic interviewer. She stated she spoke with CR#1. She stated when speaking to CR#1, you have to wait and allow her time to process what you are saying for at least 30 seconds. CR#1 was asked her name and she responded accurately. She asked her if she knew where she was (ER) and after about 30 seconds responded in the affirmative and said where (ER) she was. ERN stated she has taken photos of CR#1 and completed a forensic report. She stated HHSC can send in a request and obtain all photos and other pertinent information. ERN stated that in her professional opinion, CR#1's facial injuries are consistent with someone who has been assaulted. Record review of In-service training dated 2/21/2024 by the Admin on Abuse and neglect and exploitation signed by some staff members. Record review of LVN B's timecard reflected she was suspended on 2/24/24. Record review of CNA C's counseling report reflected she was suspended on 2/25/2024. On 02/25/2024 at 5:43pm the Facility's Administrator and DON notified, via telephone, of the Immediate Jeopardy for Abuse (F-600). The Template was signed by the Bus Mgr and MDS. The POR was immediately requested at this time. The following plan of removal was accepted on 2/27/24 at 12:01 p.m. REMOVAL OF IMMEDIATE JEOPARDY On February 25, 2024, the facility was notified by the surveyor, that an immediate jeopardy had been called and the facility needed to submit a Plan of Removal pursuant to Federal and State regulatory requirements. The immediate jeopardy allegations are as follows: F- Tag 600: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The facility failed to ensure each resident was free from abuse when CR#1 was physically abused by CNA C on 2/20/24 around 6:30am resulting in bruising to CR#1's face. Done for those affected: Resident CR#1 was assessed by licensed nurse on 2/21/2024. MD was notified by licensed nurse on 2/21/2024. Resident CR#1 was transferred to the hospital for evaluation on 2/21/2024 and remains at the hospital. An Allegation of Abuse was reported to HHSC for Resident CR#1 on 2/21/2024. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Windsor Quail Valley Post-Acute Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 3640 Hampton Dr Missouri City, TX 77459	

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/25/2024, the facility suspended the Certified Nurse Aide who worked with resident CR#1 on the 2/19/2024 10pm to 6am shift, pending investigation. If CNA C is found to be guilty of abusing CR#1, the facility will terminate employment immediately. Identify residents who could be affected: Beginning 2/21/2024, the Facility Social Worker(s) completed 100% of interviews of interviewable residents to assess for potential abuse. Date of completion is 2/23/2024. Findings: No additional concerns were identified. Effective 2/25/2024, Administrator and/or designee notified facility residents of abuse and neglect reporting. Reeducation included who the abuse coordinator is and how to report concerns and/ or allegation of abuse, neglect, mistreatment and/ or misappropriation to facility personnel. Date of completion is 2/26/2024. Effective 2/26/24, Administrator and/or designee notified families via alert media of the facility abuse and neglect reporting process. Reeducation included who the abuse coordinator is and how to report concerns and/ or allegation of abuse, neglect, mistreatment and/ or misappropriation to facility personnel. Date of Completion is 2/26/2024. On 2/23/2024, head to toe assessments were completed by the Licensed Nurse on all residents to identify any signs of injuries of unknown source. All other residents were assessed head to toe by a licensed nurse related to abuse, neglect and mistreatment with no concerns identified. Date of completion is 2/23/2024. Findings: No additional concerns were identified. On 2/23/2024, the DON/designee reviewed the resident progress notes for the last 30 days to ensure concerns related to abuse and neglect were identified and an investigation initiated, and the incident reported to HHSC. Findings: No additional concerns were identified. On 2/23/2024, the DON/ Designee reviewed incident/accidents in the last 30 days to ensure that investigations, timely reporting to HHSC as indicated, and resident assessments to include head to toe assessments were completed. Findings: No additional concerns were identified. Systemic Process: On 2/23/2024, the Regional [NAME] President of Operations reeducated the Administrator (Abuse Coordinator) on Abuse and Neglect and Abuse Policy. Abuse and Neglect and Abuse Policy to include timely Investigation and HHSC Reporting to ensure that all alleged violations involving abuse (with or without serious bodily injury); or neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, that result in serious bodily injury are reported immediately, but not later than two hours after the incident occurs or is suspected. Date of Completion is 2/23/2024. -On 2/23/2024, the Administrator/ DON and/ or designee began reeducation to 100% of facility staff on the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*Abuse and Neglect and Abuse Policy to include timely Investigation and HHSC Reporting to ensure that all alleged violations involving abuse (with or without serious bodily injury); or neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, that result in serious bodily injury are reported immediately, but not later than two hours after the incident occurs or is suspected. An incident that does not result in serious bodily injury and involves neglect, exploitation, missing resident, misappropriation, drug theft, fire, emergency situations that pose a threat to resident health and safety, a death under unusual circumstances will be reported immediately, but not later than 24 hours after the incident occurs or is suspected. The Administrator who is the Abuse Prevention Coordinator will be immediately notified for any concerns with Abuse, Neglect and Misappropriation. Date of completion is 2/23/2024. *Resident assessment to include head to toe assessments and documentation with each resident incident/accidents. Date of completion is 2/23/2024. -Effective 2/24/2024, any facility staff on FMLA, Leave of Absence, non-scheduled workday or PTO will be reeducated by the Administrator and/or designee prior to the start of their next scheduled shift. -The facility maintains an onsite Weekend Manager and Nursing Supervisor that conduct rounds and may initiate and address resident incidents and will escalate to the appropriate administrative staff when required. The Administrator who is the Abuse Prevention Coordinator will be immediately notified for any concerns with Abuse, Neglect and Misappropriation. -To monitor, the Director of Nursing/ designee will review the 24-hour report and resident incidents in facility Stand-up Morning Meeting, attended Monday - Friday. 24 Hour Report and resident incidents will be reviewed for potential abuse situations and need for reporting as per HHSC guidelines. Review will also include to ensure investigation, resident assessments to include a head-to-toe assessments were completed and provided. Date of implementation is 2/23/2024. -The Administrator will monitor to ensure new resident incidents are reviewed daily Monday-Friday to ensure concerns are addressed timely and if necessary, reported per HHSC guidelines, investigation was completed, resident assessments were completed and provided. Date of implementation is 2/23/2024. -Administrator/designee will conduct quarterly and as needed on Abuse, Neglect, & Exploitation education to ensure facility staff remains knowledgeable on the identification and reporting of abuse/neglect/exploitation. Date of Implementation is 2/23/2024. -The facility has the Wellsential Ambassador Rounds Program in place where administrative staff is assigned to residents. Staff will round and visit to ensure resident wellness and safety Monday through Friday. Findings will be reported during Morning Stand-up meetings to address and follow up on concerns/grievances. Date of Implementation is 2/23/2024. Monitoring: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-An AdHoc (as needed) QAPI meeting was conducted on 2/25/2024, attended by the Administrator, DON, Medical Director and Regional Clinical Specialist to discuss the Immediate Jeopardy concerning F- Tag 600 - the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Each resident has the right to be free from abuse, neglect and corporal punishment of any type by anyone. Please accept this letter as our plan of removal for the determination of Immediate Jeopardy issued on 2/25/2024. The surveyor confirmed the facility implemented their plan of removal and Monitoring began on 2/26/2024 - 2/27/2024. Residents were interviewed regarding skin assessments, abuse and neglect and reporting. 8 residents interviewed indicated the DON and other nursing staff completed a skin assessment, the social worker spoke with each resident about abuse, neglect, exploitation and reporting. Each resident was asked who the abuse coordinator was and each resident stated the administrator. Each resident confirmed the assessments completed by nurses. Confirmed that the administrator alerted families, via alert media, of the facility's abuse, neglect and reporting process. The alert listed the Abuse Coordinator. I . Received and reviewed the completed weekly skin assessment evaluation form that was completed by the SW. Head to toe assessments were completed by LVN on all residents in the facility on 2/23/2024.< [TRUNCATED]

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47277 Based on Interview, and record review, the facility failed to implement abuse and neglect policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents for 1 (CR#1) of 5 residents reviewed for abuse by not implementing their abuse policy to prohibit and prevent abuse by conducting an investigation immediately; thus, failing to protect resident when there is a warranted suspicion of abuse and identifying staff responsible for the investigation. The facility failed to ensure each resident was free from abuse when CR#1 was physically abused by CNA C on 2/20/2024 around 6:30am, which was the time CNA A started her morning shift and observed the bruising to CR#1's face. These failures placed residents at risk of physical harm, emotional distress, mental anguish and death from possible abuse and neglect. An Immediate Jeopardy (IJ) was identified on 02/23/2024 at 5:42 PM. While the IJ was removed on 02/24/2024 at 8:43PM, the facility remained out of compliance at a scope of isolated with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of their corrective actions. Findings Include: Record review of the ANE policy dated 8/12/2024 revealed, it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. V. Investigation of alleged abuse, neglect and exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation 2. Exercising caution and handling evidence that could be used in a criminal investigation; I 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations, 5. focusing the investigation on determining, if abuse, neglect, exploitation, and or mistreatment, has occurred, the extent, and calls; and (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. Providing complete and thorough documentation of the investigation Record Review of CR#1's face sheet revealed a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted [DATE]. CR#1 has a diagnosis of Anoxic Brain Damage (lack of oxygen to the brain causing death of brain cells), Type 2 diabetes mellitus hypoglycemia w/o coma (low blood sugar levels), hypertension (high blood pressure), dysphagia (difficult swallowing), major depression disorder (low or depressed mood), chronic kidney disease (damaged kidney's and/or loss of kidney function), cognitive communication deficit (difficulty thinking and using language), anxiety disorder (pounding heart and sweating when responding to certain situations), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). Record Review of CR#1's MDS dated [DATE], revealed a BIMS score of 4 (Severe Cognitive Impairment). Cognitive skills for daily decision making further revealed, resident can repeat at least three words heard, resident is able to recall prior questions after cueing, resident does not have any psychosis behaviors, which includes physical behaviors, verbal behavior, or any other behavior symptoms directed at others and the resident was able to participate in an activity preference interview of her interest while in the facility. Record Review of CR#1's care plan updated 03/31/2022 revealed, the resident has a communication problem r/t expressive Aphasia, Hearing deficit, Neurological symptoms. The goal was the resident will maintain current level of communication function by making sound, using appropriated gestures, responding to yes/no questions appropriately through the review date. The interventions are to allow adequate time to respond, repeat as necessary, do not rush, request clarification from the resident to ensure understanding, face when speaking, make eye contact. Ask yes/no questions if appropriate, use simple, brief, consistent words/cues, use alternative communication tools as needed. Resident is a one (1) person total assist and two (2) person transfer using a mechanical lift. Further review of Resident #1's care plan updated revealed no documentation regarding the facial injuries on 2/21/2024 or any plan initiated to keep her safe while in the facility going forward. Record Review of CR#1'sVitals revealed the following: *CR#1's last weight taken was 2/1/2024 at 21:57. She weighed *150.6. *CR#1's last Blood Pressure taken at the following times: 2/19/2024 at 07:02 *133/70 2/19/2024 at 15:44 *129/64 2/20/2024 at 07:43 *132/71 2/20/2024 at 15:21 *122/101 2/21/2024 at 07:05 *130/72 *CR#1's pain levels: 2/19/2024 at 09:05 *0 value (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2/21/2024 at 11:12 *0 value *CR#1's Temperature 2/18/2024 at 18:43 *97.6 2/19/2024 at 09:05 *97.6 *CR#1's Head Circumference None noted *CR#1's 02 sats 11/22/2023 10:05 at *96.0% 02/19/2024 09:05 at *97.0 *CR#1's Pulse 2/19/2024 at 07:02 *74 2/19/2024 at 09:05 *78 2/19/2024 at 15:44 *57 2/20/2024 at 07:43 *66 2/20/2024 at 15:21 *65 2/21/2024 at 07:05 *74 *CR#1's Respirations 11/22/2023 10:05 at 18 Breaths/min 02/19/2024 09:05 at 18 Breaths/min *CR#1's Blood Sugar 2/18/2024 110.0 mg/dl 2/19/2024 111.0 mg/dl 2/20/2024 148.0 mg/dl 2/21/2024 130.0 mg/dl (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#1's orders dated 2/1/2024 - 2/29/2024 revealed, calcium tablet-1 tablet by mouth for type 2 diabetes (last taken 2/21/24 at 2000 hours); magnesium oxide (last taken 2/22/2024 at 0730); sertraline (1 tablet daily for anxiety); vitamin D2 (1 tablet daily); Coreg oral tablet by mouth one time daily (hold if <110HR<60); Depakote capsule02 times daily); Janumet oral tablet9two times daily for mood disorder. Hold if drowsy; Janumet oral tablet by mouth two times daily (d/c date 2/6/2024); refresh tears solution (carboxymethylcellulose sodium) instill one drop in both eyes tow time a day for dry eye syndrome (start dated 6/30/2022 1700) - according to the orders, there is a code 7 at the 1700 hours with initials AMD-Code 7 according to the charts states the resident is sleeping and see progress notes (FM observed nurse putting eye drops in CR#1's eyes when she arrived during this time; Lorazepam 1 tablet by mouth three times daily; Accucheck one time a day related to diabetes (notify MD if bs <70 or >250); monitor vital sign every two weeks one time a day every 2 weeks on Mon for Health monitoring (start 2/19/2024); Behavior monitoring for antianxiety from 2/1/2024 until 2/21/2024 there is a code of 0, which according to staff CR#1 did not have any behaviors noted during all shifts; Behavior monitoring for antidepressants from 2/1/2024 until 2/21/2024 there is a code of 0, which according to staff cR#1 did not have any behaviors noted during all shifts. Behavior monitoring for antipsychotic from 2/1/2024 until 2/21/2024 there is a code of 0, which according to staff CR#1 did not have any behaviors noted during all shifts and on the February 21st; Behavior monitoring for Busplrone (anxiolytic medication to treat anxiety) from 2/1/2024 until 2/21/2024 there is a code of 0, which according to staff CR#1she received a 1-mania (mental health marked by periods of great excitement or euphoria, delusions and overactivity) in the EVE2 and a 6-grandiosity (unrealistic sense of superiority in which someone believes themselves to be unique and better than others) in the NOC1; Assess pain on each shift; monitoring antianxiety received a 1 and 6 on February 21, 2024; Monitoring side effects for antidepressants codes indicated none, but on February 21, 2024 there is a 1 in evening and 6 NOC 1; Record Review of the Progress Notes for CR#1: There was no only one progress note entered since 1/3/2024 and that was on 2/21/2024 at 16:17 (4:17pm), which was titled Admin Note and stated the Administrator notified FM of the HHSC investigation on 2/21/2024 with allegations of abuse. Record Review of R#2 MDS dated [DATE] revealed, BIMS score of 8 (moderate cognitive impaired). Cognitive skills for daily decision making further revealed, resident can repeat at least three words heard after first attempt, was accurate when asked about the current month, resident is able to recall prior questions after cueing, able to recall a color without cueing. Resident has no symptoms of delirium, she is attentive, organized thinking and has a level of consciousness, resident has no symptoms of feeling down, depressed or hopeless; resident has no indicators of psychosis, hallucinations or delusions; Residents active diagnoses is progressive neurological conditions, hypertension, anxiety disorder, depression (other than bipolar), psychotic disorder (other than schizophrenia). Record Review of R#2's psychological progress note dated 2/10/2024 revealed, improved coping. No issues. Record Review of R#2's psychological progress note dated 2/20/2024 revealed no change in mental status, specifically stressor or changes in mental status that may affect functioning. Noted during psychotherapy were improved coping skills, adjustment to illness-decline-loss. Resident noted she is hopeful that her son will be taking her home soon, which she is looking forward to. No issues. The clinician will follow up with patient in 1-2 weeks to continue to address client's symptoms. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record Review of R#2's psychological progress note dated 2/26/2024 revealed, clients BIMS score was reduced from 8 (Moderate Cognitive Impairment) to 4 (Severe Cognitive Impairment); client reported year as 2020, could only recall 0 of the 3 words. Clinician explored with client what happened to her roommate, which client didn't want to discuss, but stated she has already told it too many times. Stated resident stated the night before she found out her roommate had a black eye, she heard the CAN changing the roommate and heard a scuffle and the roommate said no and stop. She further stated she did not see anything and did not hear anyone being hit. Client stated she was shocked to learn her roommate had an injury the next day. States client was tearful and spoke of her roommate not coming back and that she will miss her as they were together for a long time. Record Review of L.E. report dated 2/21/2024 from PD. According to the police report, based on the age of the resident and the injury, Adult Protective Services was contacted (Intake#485517). The report indicated that the resident did not inform the officers of the nature of her injuries but did report she had been assaulted to the EMS #608 personnel. Record Review of EMS report FB. According to the EMS report, they arrived at the facility on 2/21/2024 at 10:34am. CR#1 was noted to have a periorbital hematoma to the right eye. CR#1 was noted to be warm to the touch. According to the EMS responder, R#2 mentioned, that yesterday evening CR#1 was yelling and she assumed that she was being changed as she usually yells when being changed. The EMS responder stated, CR#1 stated she was hit when he asked her what happened. She further states she was hit by a staff after he asked her if she was hit by another patient or staff. CR#1 was transported, non-emergency, to hospital. EMS Responder stated during transport he took her vitals and the right pupil was noted to be 2mm and the left pupil 4mm. On 2/22/2024 at 10:53am Interview with R#2 - Revealed she is the room mate of CR#1. She states she was in the room with CR#1 when CNA C came in the room to change them both. She states she was changed first. She stated she heard CR#1 scream and tell CNA C that she was hurting her. She stated CR#1 continued to say, stop, stop you're hurting me. She stated the CNA C responded, Just be quiet its all your imagination! CR#2 stated that prior to Tuesday 2/20/2024, CR#1 did not have those bruising. She stated she was afraid that something may happen to her. She stated CR#1s FM came to the facility yesterday, 2/20/2024 and when she entered the room she asked R#2 if she had seen what happened to CR#1. At that time R#2 stated she was able to looked at CR#1 face and seen those horrible bruises. I asked R#2 if this incident occurred with the night shift or morning shift? According to R#2, this incident occurred the morning on 2/20/2024. She stated that the CNA comes in to change right before her shift ends. She further stated that the morning shift CNA comes in to check and change both, CR#1 and R#2, at the beginning of their shift. She reiterated that the CNA that she heard CR#1 screaming at was the lady whose shift was ending. This, according to R#2 is the night shift CNA (CNA C). Observation and attempted interview with CR#1 on 02/22/2022 at 12:50 p.m. while in the hospital. CR#1 was in bed eating lunch. CR #1 briefly looked up at me but did not respond to any questions. The redness under CR#1's right eye was not as profound as the photos shown the day of FM observation in the facility. The bruising on her right jaw still had a discoloration, while mild, still noticeable. Hospital Nursing staff came into to the room to change her and when they asked her to turn toward them, she responded by doing what they asked. (continued on next page)

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F 0607

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

In an interview with LE on 02/22/2024 at 12:30p.m. revealed he did not want to add anything to his report. He stated he arrived at the facility on 2/21/2024 at 8:50am. and met with FM, her granddaughter and CR #1. He stated FM requested for her sister to be transported to ER. He stated during the time of gathering information from all involved, the EMS worker informed him the resident stated she was assaulted. He stated when he questioned resident, she would not respond to him. He further stated that he spoke to the DON Wednesday, yesterday, after being contacted by the residence sister, Mrs. [NAME]. He stated that the timeline was on Friday the sister seen the resident and she had no bruises and when she arrived on Tuesday evening, the resident had bruises. He stated that he submitted the report to the CID unit who will investigate further.

In an interview with FM on 2/22/24 at 1:00pm revealed she visited CR#1 on Friday February 16, 2024, 4:00pm - 4:30pm and left that evening around 7:30pm and CR#1 had no bruises. She states she returned Tuesday February 20, 2024, between 5:00pm - 5:30pm and CR#1 was in the cafeteria. She stated at this time she noticed CR#1s bruised eye. She stated she left the cafeteria area and went into the ADON's office to inquire about what happened to CR#1 face. She stated both ADON's (A & B) were in the office. She stated she told them that CR#1 looked like she has been assaulted. She stated the ADON A responded, Now no one has hit Ms. [NAME]. She may have hit her head on the wall area. FM member felt the ADON A was being condescending, which angered her. FM responded, that analogy is not true and she asked why she wasn't notified her sister had marks and bruises on her face. FM stated at this time the ADON B got up and accompanied her to the cafeteria. She states at that time the CR# 1 was asked who hit her. She stated a male. The ADON B stated at that time that there were no male CNA's working on the night shift. She stated the ADON B continued to tell her CR# 1 may have hit her head on the wall. FM told the ADON B that it was not possible to do that based on how her Geri Chair was positioned. She states she asked ADON B again why she wasn't notified her sister had bruises? FM stated she did not get an answer.

FM stated she spoke with the Admin who told her that he was doing an abuse investigation. He stated he did not know about the accusations of abuse or about the residents' eye. The Admin went to get the DON to ask what is going on. She stated the DON began saying CR#1 could be combative and this may be the reason for her injury. FM states at this time she disagreed with them and left the facility. She stated her sister began to cry and beg her not to leave, but she had to leave at that time and made a decision to return in the morning with LE.

FM stated she called LE on her way to the facility. FM stated she arrived at the facility on Wednesday February 21, 2024, around 8:30am at which time CR# 1 was seated in her geri chair at the nurses' station. FM witnessed a nurse putting eye drops in CR#1s eyes. She spoke with the DON. She stated the DON initially told her that he had no idea and was not notified of the bruising. She stated after she told the DON she had contacted the police, the DON told her she received a photo while she was off of CR#1s eye and she was going to do an investigation.

In an interview with CW on 2/22/24 at 2:48pm revealed on Monday evening (during 2-10 shift) she did not see bruising on CR#1s 's face. She states Tuesday morning around 8:30am she observed the bruising on CR#1s face, her eye was swollen and red and her jaw was black and blue and swollen going down towards her neck. She states the injuries were unbelievable and looked as if someone had beat her up.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Quail Valley Post-Acute Healthcare	3640 Hampton Dr Missouri City, TX 77459

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	

CW stated she typically goes into CR#1s room and say hello because she has gotten an opportunity to meet FM and she has told her she's there with her own FM all the time and she will check on her CR#1. She states each day she arrives at the facility; she will go to CR#1s room and kiss her on the forehead and tell her she's just checking on her.

In an interview with RN B on 2/22/24 at 5:05pm revealed, stated she works 2-10 shift and is familiar with CR# 1. States CR#1's FM spoke to her about the redness around CR# 1's eyes. She stated she did not see anything on the face of CR #1. RN B said she did not see the bruise prior to the 2/22/2024. She states she saw the redness on CR #1's eye and believes it was on the left eye.

In an interview with CNA B on 2/22/2024 at 5:17pm revealed, she always work 2-10 shift. She did see CR #1 on Monday February 19, 2024, and Tuesday February 20, 2024 and did not notice and marks or bruises on resident face. She stated she was not assigned to CR #1 but saw her two days ago. Did not notice marks or bruises on her face on Tuesday and CR#1 had a red eye. States she reported her observation to the nurse in charge, RN B. I asked if the CR# 1 was combative when she seen her and she stated CR# 1 has never been combative when she worked with her. When asked what the policy on a change in condition is, CNA B stated, If I see a resident with injury I will report to the nurse in charge.

In an interview with CNA A on 2/23/24 at 7:41am revealed, CR#1 was usually trying to fight while changing her, but she just tensed up her body. States she was able to change her. States she was training CNA L who had just started. States she did noticed bruising on CR#1. Stated her eye was swollen, believes it was the right eye. Did not ask what happened to her eye. She states she informed the charge nurse, LVN B. States CR#1 never screamed she was being hurt while changing her. States last training on abuse and neglect was 2-3 weeks ago. She doesn't know why she was trained. The in-service was conducted by DON and Abuse coordinator.

In an interview with CNA C on 2/23/24 at 4:28am revealed, she worked with CR#1 on Monday evening and did not notice bruises. Changed her in the morning. States she did not inspect or assess; however, if her face looked like this it would have been noticed. States resident does talk a little. She can say what she wants and if she wants to get in her chair and go to the nurse's station. CNA C will take her to the nursing station when she requests throughout her shift. She stated at no time did CR# 1 tell her to stop or she was hurting while changing her.

In an interview with LVN E on 2/23/22 at 4:58am revealed, he worked the weekend and did see CR# 1. States he did not observe CR #1 with any marks or bruises on her face. When shown a photo of resident's marks/bruises, LVN E stated he has never seen her face like that and if he had he would have been alarmed and written an incident report.

LVN E was asked if the CNA's complete documentation of what they do for a resident, and he stated yes. I asked if he could show me. RN C attempted to gain access as to what CNA assisted CR #1 and it (point click care in computer) was locked. He stated this is unusual as the nurses have access to what the CNA has completed during their shift. He stated the only person that has access to the computer is the DON.

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with LVN B on 2/23/24 at 7:52am revealed, during the earlier morning hours of her shift, 2/20/2024, around breakfast, the CNA A came to her and told her that CR#1's eye was red and swollen. She stated at this time CNA A had pushed CR#1 to the nursing area. She states she observed the eye to be red and swollen and reported it to the LVN C. She stated there was no assessment completed. She stated she did not document in PCC even though she had access. She stated she felt it was enough just to relay the information to the LVN C. LVN B appeared to get agitated with me and began asking me my name and who did I work for. I again identified myself and suggested that she call her DON, who was in the facility, to confirm who she was talking to. I continued my questioning. When asked concerning Change of condition protocol, LVN B stated she is supposed to let her supervisor know concerning the resident and document in PCC. She stated there was not an issue with PCC and she confirmed that she did have access to PCC. She stated there was a lot going on during this time (breakfast, etc.). She again stated when CNA A told her about CR#1, she was already in her Geri Chair located in the hallway. She looked at CR#1 and then proceeded to speak with LVN C around 9:45am. She states she attended the nursing morning meeting and told everyone (both ADON's, Administrator, can't think of the other staff who were in attendance) that CR#1's eye appeared red and swollen. In an interview with LVN C on 2/23/24 at 8:35am revealed on Tuesday, February 20, 2024, she was the treatment nurse. She states she comes in early, and she leaves a little early. She said in the morning between 10 AM and 11 AM, LVN B came to her, while she was documenting on another resident in the office and told her that CR#1 eye was red and somewhat raised. She said that the LVN B was the charge nurse. She stated that she looked at the CR#1s eye while she was seated in her geri chair by the nurse's station. She stated that the eye was a little red but told LVN B to keep observing the eye. She stated that she did not complete any documentation, nor did she complete an assessment and the reason was because she was not the charge nurse. She stated if she was the charge nurse, she would have followed protocol. She states she would have completed a full assessment of the resident then, checking vitals, diagnosis, then call the MD. She states she would have completed the change of condition form and documented doctor's recommendation as per the change of condition policy. LVN C states that her last in-service for abuse and neglect was Wednesday with the Administrator, HR and DON. In an interview with Admin on 2/23/2024 at 9:50am revealed he is the coordinator for abuse and neglect at the facility. Stated on Wednesday, February 21, 2024, CR#1 injuries appeared to have gotten worse and at this time he instituted a facility investigation report and filed with health and human services. Administrator stated he is not done with his investigation, but he has begun to interview residents in the same hallway (100) as CR #1 resided by asking them if they felt safe in the facility if they were ever threatened by staff or other residents and if they were ever assaulted or misused. He stated CNA A Followed protocol when she informed LVN B of the change and condition. He states that the issue here appears to be a breakdown in communications and that there should have been more detailed documentation. States that there should've been an appropriate assessment of the resident and an incident report should have been filed. He stated he wasn't given the 5 days to complete the Provider Investigation. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with DON on 2/23/24 at 5:58pm revealed, CR#1 went to the hospital on Wednesday February 21, 2024. She stated she had not worked on Tuesday February 20, 2024, and had no idea what was going on until Ms. [NAME] came to the facility on [DATE] and told her she had called the police. She stated FM told her to look at CR#1's eye. She did. She states she told Ms. [NAME] that she would check on the issues that she had not been informed of any type of injuries. The DON states the resident was always rubbing her eyes and this may have caused bruising. Ms. [NAME] brought the bruising to her attention and said her sister was abused. The DON stated she told Ms. [NAME] she was going to do an investigation, but that was too late because she has already called police. The DON stated the nurse practitioner checked the resident on Tuesday 2/20/24 morning and documented. I indicated that the documentation from the NP is not in PCC. The DON indicated she must not have uploaded her notes yet. The DON stated she conducted an in-service for abuse. Stated the resident has a history of psych medication because of her behavior problem. The DON indicated that resident was on psych meds and the facility was trying to reduce the medication. She indicated CR#1 has been combative lately but could not give any reason why this behavior hasn't been documented by nursing staff in PCC. The DON stated the FM requested CR#1 be sent to the hospital, which the facility had no other option but to comply. She stated the bruises may have come from CR#1 vigorously rubbing her eyes. The DON was shown a photo of the CR#1 facial area and she stated the resident bruises were not there when she left the facility. It was like a scratch when she left the facility. The DON brought in an in-service that was signed by some staff and not by others. She stated she completed the Abuse and Neglect and Exploitation on Wednesday after the FM, brought it to her attention. The DON continued to deny the CR#1s face had those bruises when she left the facility. During the conversation, the DON became angry and stated, if FM was so upset about CR#1 why did she leave her on Tuesday? I replied, I don't know that is a question that only FM could answer. The DON stated if there is suspected abuse, protocol will be to ask all the residents if they feel safe. She stated she would call the police and make an incident report. In a telephone interview with ERN on 2/24/24 at 9:35am. revealed she was the emergency room nurse that evaluated CR#1 upon her arrival by EMS. She states per EMT, the FM requested that the resident be seen due to possible assault. The EMT said that family found CR# 1with unexplained bruising and the facility was dismissive. ERN stated the EMT further stated CR# 1 told him someone hit her, but there was not a lot of detail. ERN is also forensic interviewer. She stated she spoke with CR#1. She stated when speaking to CR#1, you have to wait and allow her time to process what you are saying for at least 30 seconds. CR#1 was asked her name and she responded accurately. She asked her if she knew where she was (ER) and after about 30 seconds responded in the affirmative and said where (ER)she was. ERRN stated she has taken photos of CR#1 and completed a forensic report. She stated HHSC can send in a request and obtain all photos and other pertinent information. ERN stated that in her professional opinion, CR#1's facial injuries are consistent with someone who has been assaulted. (continued on next page)

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F 0607

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

On 2/29/2024 at 2:15pm an interview with ADON A revealed, FM was in her office. The FM asked what was going on with CR#1 eye. ADON A stated she told her that it could have been from FM leaning on rail from GERI Chair. ADON A stated ADON B walked in the office and told FM that he's responsible for the 100 hall. When asked what the protocol is when issues arise with residents having unknown injuries, the ADON A stated usually the charge nurse document in PCC and call the FM or RP. Depending how serious, the charge nurse will notify ADON, DON, Admin.

On 2/29/2024 at 2:19pm an interview with ADON B revealed, FM was in the office on 2/20/2024 talking to ADON A, as he was entering the office. At this time, he stated ADON A introduced him to FM. Stated FM told him she did not believe CR#1's injury was from the rail. FM accompanied ADON B to CR# 1's room and showed the halo. The halo enabler is used for resident to pull herself up and reposition. FM suggested may be her sister laid her face on the halo enabler and that caused injury. ADON B stated the FM was not upset.

On 02/23/2024 at 5:42pm the Facility's Administrator and DON notified of the Immediate Jeopardy for Abuse (F-607). The Template was signed.and the POR was immediately requested at this time.

REMOVAL OF IMMEDIATE JEOPARDY

On February 23, 2024, the facility was notified by the surveyor, that an immediate jeopardy had been called and the facility needed to submit a Plan of Removal pursuant to Federal and State regulatory requirements.

The immediate jeopardy allegations are as follows:

F- Tag 607: The facility must develop and implement written policies and

procedures that: Prohibit and prevent abuse, neglect, and exploitation of residents a

misappropriation of resident property, of residents and misappropriation of resident property

Done for those affected:

Resident CR#1 was assessed by licensed nurse on 2/21/2024. MD was notified by licensed nurse on 2/21/2024. Resident CR#1 was transferred to the hospital for evaluation on 2/21/2024 and remains at the hospital.

An Allegation of Abuse was reported to HHSC for Resident CR#1 on 2/21/2024.

Identify residents who could be affected:

Beginning 2/21/2024, the Facility Social Worker(s) completed 100% of interviews of interviewable residents to assess for potential abuse. Date of completion is 2/23/2024. Findings: No additional concerns were identified.

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/23/2024, head to toe assessments were completed by the Licensed Nurse on all residents to identify any signs of injuries of unknown source. All other residents were assessed head to toe by a licensed nurse related to abuse, neglect and mistreatment with no concerns identified. Date of completion is 2/23/2024. Findings: No additional concerns were identified. On 2/23/2024, the DON/designee reviewed the resident progress notes for the last 30 days to ensure concerns related to abuse and neglect were identified and an investigation initiated, and the incident reported to HHSC. Findings: No additional concerns were identified. On 2/23/2024, the DON/ Designee reviewed incident/accidents in the last 30 days to ensure that investigations, timely reporting to HHSC as indicated, and resident assessments to include head to toe assessments were completed. Findings: No additional concerns were identified. Systemic Process: On 2/23/2024, the Regional [NAME] President of Operations reeducated the Administrator (Abuse Coordinator) on Abuse and Neglect and Abuse Policy. Abuse and Neglect and Abuse Policy to include timely Investigation and HHSC Reporting to ensure that all alleged violations involving abuse (with or without serious bodily injury); or neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, that result in serious bodily injury are reported immediately, but not later than two hours after the incident occurs or is suspected. On 2/23/2024, the Administrator/ DON and/ or designee began reeducation to 100% of facility staff on the following: o Abuse and Neglect and Abuse Policy to include timely Investigation and HHSC Reporting to ensure that all alleged violations involving abuse (with or without serious bodily injury); or neglec [TRUNCATED]

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47277 Based on observation, interview, and record review, the facility failed to have evidence that all alleged violations of abuse were thoroughly investigated, to prevent further potential abuse or mistreatment while the investigation was in progress, and report the result of all investigations to other officials in accordance with State law, including to the State Survey Agency within 5 working days of the incident for 1 of 5 residents (CR #1) reviewed for abuse. The facility failed to complete the investigation of the allegation of abuse, report the results of the investigation to HHSC within 5 days, and prevent further potential abuse while the investigation was in progress when CR #1 was found with suspicious injuries of unknown origin. An Immediate Jeopardy (IJ) was identified on 02/26/2024 at 1:48pm. While the IJ was lowered on 02/27/2024 at 6:00pm, the facility remained out of compliance at a scope of isolated with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of their corrective actions. These failures placed resident(s) involved in abuse incidents at risk of continued abuse, mistreatment, further injury, pain and physical and emotional distress contributing to further serious injuries. Findings Include: Record review of CR#1's undated face sheet revealed a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted [DATE]. CR#1 has a diagnosis of Anoxic Brain Damage (lack of oxygen to the brain causing death of brain cells), Type 2 diabetes mellitus hypoglycemia w/o coma (low blood sugar levels), hypertension (high blood pressure), dysphagia (difficult swallowing), major depression disorder (low or depressed mood), chronic kidney disease (damaged kidneys and/or loss of kidney function), cognitive communication deficit (difficulty thinking and using language), anxiety disorder (pounding heart and sweating when responding to certain situations), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). Record review of CR#1's MDS assessment dated [DATE], revealed a BIMS score of 4 (severe cognitive impairment). Cognitive skills for daily decision making further revealed, resident can repeat at least three words heard, resident is able to recall prior questions after cueing, resident does not have any psychosis behaviors, which includes physical behaviors, verbal behavior, or any other behavior symptoms directed at others and the resident was able to participate in an activity preference interview of her interest while in the facility. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#1's care plan updated 03/31/2022 revealed, the resident has a communication problem r/t expressive Aphasia, Hearing deficit, Neurological symptoms. The goal was the resident will maintain current level of communication function by making sound, using appropriate gestures, responding to yes/no questions appropriately through the review date. The interventions are to allow adequate time to respond, repeat as necessary, do not rush, request clarification from the resident to ensure understanding, face when speaking, make eye contact. Ask yes/no questions if appropriate, use simple, brief, consistent words/cues, use alternative communication tools as needed. Resident is a one (1) person total assist and two (2) person transfer using a mechanical lift. Further review of Resident #1's care plan updated revealed no documentation regarding the facial injuries on 2/21/2024 or any plan initiated to keep her safe while in the facility going forward. Record Review of CR#1's orders dated 2/1/2024 - 2/29/2024 revealed calcium tablet-1 tablet by mouth for type 2 diabetes (last taken 2/21/24 at 2000 (8PM) hours); magnesium oxide (last taken 2/22/2024 at 0730 (7:30AM); sertraline (1 tablet daily for anxiety); vitamin D2 (1 tablet daily); Coreg oral tablet by mouth one time daily (hold if <110HR<60); Depakote capsule 2 times daily); Janumet oral tablet two times daily for mood disorder. Hold if drowsy; Janumet oral tablet by mouth two times daily (d/c date 2/6/2024); refresh tears solution (carboxymethylcellulose sodium) instill one drop in both eyes two times a day for dry eye syndrome (start date 6/30/2022 1700 (5PM)). -The orders reflected a code 7 at 1700 hours, indicating the resident is sleeping and see progress notes (FM observed nurse putting eye drops in CR#1's eyes when she arrived during this time); Lorazepam 1 tablet by mouth three times daily; Accucheck one time a day related to diabetes (notify MD if bs <70 or >250); monitor vital signs every two weeks one time a day every 2 weeks on Mondays for Health monitoring (start 2/19/2024); Behavior monitoring for antianxiety from 2/1/2024 until 2/21/2024 reflected a code of 0, indicating CR#1 did not have any behaviors noted during all shifts; Behavior monitoring for antidepressants from 2/1/2024 until 2/21/2024 reflected a code of 0, indicating CR#1 did not have any behaviors noted during all shifts. Behavior monitoring for antipsychotic from 2/1/2024 until 2/21/2024 reflected a code of 0, indicating CR#1 did not have any behaviors noted during all shifts and on 2/21/24; Behavior monitoring for Busplrone (anxiolytic medication to treat anxiety) from 2/1/2024 until 2/21/2024 reflected a code of 0, indicating CR#1 received a 1, which indicated mania (mental health marked by periods of great excitement or euphoria, delusions and overactivity); in the EVE2 and a 6-grandiosity (unrealistic sense of superiority in which someone believes themselves to be unique and better than others) in the NOC1; Assess pain on each shift; monitoring antianxiety received a 1 and 6 on 2/21/24; Monitoring side effects for antidepressants codes indicated none, but on 2/21/24 there is a 1 in evening and 6 NOC 1 Record Review of the Progress Notes for CR#1: There was no only one progress note entered since 1/3/2024 and that was on 2/21/2024 at 16:17 (4:17pm), which was titled Admin Note and stated the Administrator notified FM of the HHSC investigation on 2/21/2024 with allegations of abuse. Record Review of R#2's MDS assessment dated [DATE] revealed, BIMS score of 8 (moderate cognitive impairment). Cognitive skills for daily decision making further revealed, resident can repeat at least three words heard after first attempt, was accurate when asked about the current month, resident is able to recall prior questions after cueing, able to recall a color without cueing. Resident has no symptoms of delirium, she is attentive, organized thinking and has a level of consciousness, resident has no symptoms of feeling down, depressed or hopeless; resident has no indicators of psychosis, hallucinations or delusions; Resident's active diagnoses are progressive neurological conditions, hypertension, anxiety disorder, depression (other than bipolar), psychotic disorder (other than schizophrenia). (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record Review of R#2's psychological progress note dated 2/10/2024 revealed, improved coping. No issues. Record Review of R#2's psychological progress note dated 2/20/2024 revealed no change in mental status, specifically stressor or changes in mental status that may affect functioning. Noted during psychotherapy were improved coping skills, adjustment to illness-decline-loss. Resident noted she is hopeful that her family member will be taking her home soon, which she is looking forward to. No issues. The clinician will follow up with patient in 1-2 weeks to continue to address client's symptoms. Record Review of R#2's psychological progress note dated 2/26/2024 revealed, client's BIMS score was reduced from 8 to 4 (indicating cognitive decline); client reported year as 2020, could only recall 0 of the 3 words. Clinician explored with client what happened to her roommate, which client didn't want to discuss, but stated she has already told it too many times. Stated resident stated the night before she found out her roommate had a black eye, she heard the CNA C changing the roommate and heard a scuffle and the roommate said no and stop. She further stated she did not see anything and did not hear anyone being hit. Client stated she was shocked to learn her roommate had an injury the next day. States client was tearful and spoke of her roommate not coming back and that she will miss her as they were together for a long time. Record Review of L.E. report dated 2/21/2024 from PD. According to the police report, based on the age of the resident and the injury, Adult Protective Services was contacted. The report indicated that the resident did not inform the officers of the nature of her injuries but did report she had been assaulted to the EMS personnel. Record Review of CNA C's timesheet reveal she last worked on 02/22/2024 9:46pm - 6:32am hours. She was suspended on 2/25/2024. On 2/22/2024 at 10:53am Interview with R#2 - Stated she was the room mate of CR#1. She stated she was in the room with CR#1 when CNA C came in the room to change them both. She stated she was changed first. She stated she heard CR#1 scream and tell CNA C that she was hurting her. She stated CR#1 continued to say, stop, stop you're hurting me. She stated the CNA C responded, Just be quiet its all your imagination! CR#2 stated that prior to Tuesday 2/20/2024, CR#1 did not have those bruises. She stated she was afraid that something may happen to her. She stated CR#1s FM came to the facility yesterday, 2/20/2024 and when she entered the room she asked R#2 if she had seen what happened to CR#1. At that time R#2 stated she was able to look at CR#1 face and saw those horrible bruises. According to R#2, this incident occurred the morning on 2/20/2024. She stated that the CNA comes in to change them right before her shift ends. She further stated that the morning shift CNA comes in to check and change both, CR#1 and R#2, at the beginning of their shift. She reiterated that the CNA that she heard CR#1 screaming at was the lady whose shift was ending. This, according to R#2 was the night shift CNA (CNA C). Observation and attempted interview with CR#1 on 02/22/2024 at 12:50 p.m. while in the hospital, revealed she was in bed eating lunch. CR #1 briefly looked up but she did not respond to any questions. The redness under CR#2's right eye was not as profound as the photos shown the day of FM's observation in the facility. The bruising on her right jaw still had a discoloration, while mild, still noticeable. Hospital Nursing staff came into to the room to change her and when they asked her to turn toward them, she responded by doing what they asked. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Quail Valley Post-Acute Healthcare	3640 Hampton Dr Missouri City, TX 77459

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/22/2024 at 1:00p.m. 2/22/24 at 12:30pm- Interview with LE. stated he arrived at the facility on 2/21/2024 at 8:50am. and met with FM, another family member and CR #1. He stated FM requested for CR#1 to be transported to ER. He stated during the time of gathering information from all involved, the EMS worker informed him the resident stated she was assaulted. He stated when he questioned resident, she would not respond to him. He further stated that he spoke to the DON Wednesday, yesterday, after being contacted by the resident's family member. He stated that the timeline was on Friday the FM saw the resident and she had no bruises and when she arrived on Tuesday evening, the resident had bruises. On 2/22/24 at 1:00pm Interview with FM - FM stated she visited CR#1 on Friday 2/16/24, 4:00pm - 4:30pm and left that evening around 7:30pm and CR#1 had no bruises. She stated she returned Tuesday 2/20/24, between 5:00pm - 5:30pm and CR#1 was in the cafeteria. She stated at this time she noticed CR#1's bruised eye. She stated she left the cafeteria area and went into the ADON's office to inquire about what happened to CR#1 face. She stated both ADON's (A & B) were in the office. She stated she told them that CR#1 looked like she has been assaulted. She stated the ADON A responded, Now no one has hit CR#1. She may have hit her head on the wall area. FM felt the ADON A was being condescending, which angered her. FM responded, that analogy is not true and she asked why she wasn't notified CR#1 had marks and bruises on her face. FM stated at this time the ADON B got up and accompanied her to the cafeteria. She stated at that time the CR# 1 was asked who hit her. She stated a male. The ADON B stated at that time that there were no male CNA's working on the night shift. She stated the ADON B continued to tell her CR# 1 may have hit her head on the wall. FM told the ADON B that it was not possible to do that based on how her Geri Chair (padded reclining geriatric chair) was positioned. She stated she asked ADON B again why she was not notified (CR#1) had bruises. FM stated she did not get an answer. FM stated she spoke with the Admin who told her that he was doing an abuse investigation. He stated he did not know about the accusations of abuse or about the resident's eye. The Admin went to get the DON to ask what was going on. She stated the DON began saying CR#1 could be combative and this may be the reason for her injury. FM stated at this time she disagreed with them and left the facility. She stated CR#1 began to cry and beg her not to leave, but she had to leave at that time and decided to return in the morning with LE. FM stated she called LE on her way to the facility. FM stated she arrived at the facility on Wednesday 2/21/24, around 8:30am at which time CR# 1 was seated in her geri chair at the nurses' station. FM witnessed a nurse putting eye drops in CR#1s eyes. She spoke with the DON. She stated the DON initially told her that he had no idea and was not notified of the bruising. She stated after she told the DON she had contacted the police, the DON told her she received a photo while she was off of CR#1s eye and she was going to do an investigation. On 2/22/24 at 2:48pm Interview with CW - CW stated that on Monday evening CR #1 was in her room seated in a chair slumped over about to fall out. CW stated that there were two CNA's in another resident's room just talking and laughing. CW stated CW called the CNA's to go help CR#1 and they did. CW stated on Monday CW did not see bruising on CR#1s 's face. CW stated Tuesday morning around 8:30am CW observed the bruising on CR#1s face, her eye was swollen and really red and her jaw was black and blue and swollen going down towards her neck. CW stated the injuries were unbelievable and looked as if someone had beat her up. (continued on next page)

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F 0610

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

On 2/23/24 at 8:35am -Telephone interview with LVN C.- LVN C indicated that on Tuesday, 2/20/24, she was the treatment nurse. She said in the morning between 10 AM and 11 AM, LVN B came to her, while she was documenting on another resident in the office and told her that CR#1's eye was red and somewhat raised. She said that the LVN B was the charge nurse. She stated that she looked at the CR#1s eye while she was seated in her geri chair by the nurse's station. She stated that the eye was a little red but told LVN B to keep observing the eye LVN C stated that her last in-service for abuse and neglect was Wednesday with the Administrator, HR and DON.

On 2/23/2024 at 9:50am Interview with Admin - Stated he is the coordinator for abuse and neglect at the facility. He stated on Wednesday, 2/21/24, CR#1's injuries appeared to have gotten worse and at this time he completed a provider self-reporting of LTC incident report with health and human services.

On 2/23/24 at 5:58pm Interview with DON. Stated CR#1 went to the hospital on Wednesday 2/21/24. She stated she had not worked on Tuesday 2/20/24 and had no idea what was going on until CR#1's FM came to the facility on [DATE] and told her she had called the police. She stated FM told her to look at CR#1's eye. She did. She stated she told FM that she would check on the issues and that she had not been informed of any type of injuries. The DON stated the resident was always rubbing her eyes and this may have caused bruising. FM brought the bruising to her attention and said CR#1 was abused. The DON stated she told FM she was going to do an investigation, but that was too late because she has already called police.

The DON stated she conducted an in-service training to nursing staff for abuse and neglect.

The DON stated the FM requested CR#1 be sent to the hospital, which the facility had no other option but to comply. She stated the bruises may have come from CR#1 vigorously rubbing her eyes. The DON was shown a photo of the CR#1's facial area and she stated the resident's bruises were not there when she left the facility. It was like a scratch when she left the facility. The DON continued to deny the CR#1's face had those bruises when she left the facility. During the interview the DON appeared irritated by my questions, she stated, if FM was so upset about CR#1 why did she (FM) leave her on Tuesday?

The DON stated if there is suspected abuse, protocol will be to ask all the residents if they feel safe. She stated she would call the police and make an incident report.

In an interview with ERN on 2/24/24 at 9:35am. revealed she was the emergency room nurse that evaluated CR#1 upon her arrival by EMS. She stated per EMT, the FM requested that the resident be seen due to possible assault. The EMT said that family found CR# 1with unexplained bruising and the facility was dismissive. ERN stated the EMT further stated CR# 1 told him someone hit her, but there was not a lot of detail. ERN is also forensic interviewer. She stated she spoke with CR#1. She stated when speaking to CR#1, you have to wait and allow her time to process what you are saying for at least 30 seconds. CR#1 was asked her name and she responded accurately. She asked her if she knew where she was (ER) and after about 30 seconds responded in the affirmative and said where (ER) she was. ERN stated she has taken photos of CR#1 and completed a forensic report. She stated HHSC can send in a request and obtain all photos and other pertinent information.

ERN stated that in her professional opinion, CR#1's facial injuries are consistent with someone who has been assaulted.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/26/2024 at 6:00pm, A request to view the unfinished investigation currently. The Admin provided the following: oRecord review of the current investigation revealed, Employees who did not witness the incident concerning CR#1 to sign the form dated 2/21/2024 titled, EMPLOYEES IN INCIDENT AREA HAVING NO KNOWLEDGE OF INCIDENT. oRecord review revealed, a form employees signed titled, Interview Record dated 2/21/2024 in which the admin Interviewed the NP who stated CR#1 was observed by her with discoloration alongside of right eye on 2/20/24. The NP stated the impacted area appeared as CR#1 bumped the side orbital eye area against her bed halo rail or fell asleep in bed with side eye against the rail. NP stated impacted area was slightly discolored, no bruising along lower eye lid observed. Stated CR#1 likely did not sustain fall b/c she requires total assistance to get up. Record review of the unfinished investigation lacked any interviews of nursing staff that cared for CR#1, there was no immediate nursing staff in-service training for abuse and neglect. The DON brought in an in-service that was signed by some staff and not by others. She stated she completed the Abuse and Neglect and Exploitation in-service on Wednesday after the FM, brought it to her attention. Record review of electronic signed document dated 2/20/2024 and signed on 2/23/2024 by NP, revealed the NP conducted rounds on 2/20/24 and seen CR#1 sitting in her Geri Chair in nurses' station outside of the dining room. Stated CR#1 was seen with very slight discoloration to right lower orbital below eye and above cheek. Mild swelling present. CR#1 denies pain/discomfort. EOM Intact. Mild erythema presents on sclera of right eye. CR#1 states she wants to go to the dining room with activities. No distress noted. CR#1 vitals stable. Discussed findings with ADONs and treatment team. No fall occurred. CR#1 frequently in Geri-chair during the daytime hours found with head lying on right side. Discussed possibility of CR#1 hitting face on hand rale on the wall next to her chair. CR#1 has history of anxiety, cognitive impairment. CR#1 has history of dry eye syndrome requiring artificial tears scheduled twice daily. CR#1 mood and behavior at her baseline. Record review of interview record for LVN A without a time of interview and dated 2/21/24. The form was titled Injury of Unknown Origin and signed by Admin and DON. It revealed, LVN A stated CR#1 was in her Geri chair when she began her 2-10 shift. LVN A stated CR#2 right eye was slight red and swollen with no discoloration. LVN A stated eye drop was administered by CMA (unknown) as ordered. Record review of interview record for CNA A without a time of interview and dated 2/21/24. The form was titled Injury of Unknown Origin and signed by Admin and DON. It revealed, she worked with CR#1 on 2/20/24 6am-2pm shift. States she went into CR#1's room and observed resident right eye was red and a lot swollen. States she notified the charge nurse who observed CR#1's eye. Record review of interview record for CNA A without a time of interview and dated 2/21/24. The form was titled Injury of Unknown Origin and signed only by Admin. It revealed, he interviews with CNA, via phone. He was informed that CNA A observed CR#1's right eye at approximately 6:20-6:30 upon entering her room. CNA states the eye was red around the pupil. States CR#1 made on allegations to who the person who may have caused injury. States CNA stated she immediately reported it to LVN B. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review revealed admin investigation was to interview staff who cared for and or interacted with CR#1 during the dates and shifts below (2/19/2024, 2/20/2024 and 2/21/2024) during day shift, evening shift and night shift on the 100 hall, which is where CR#1 room was. Record review of In-service training dated 2/21/2024 by the Admin on Abuse and neglect and exploitation lacked signatures for all nursing staff members. Record review of LVN B's timecard shows she was suspended on 2/24/24. Record review of CNA C's counseling report states she was suspended on 2/25/2024. On 02/26/2024 at 1:48pm the Facility's Administrator notified of the Immediate Jeopardy for Abuse (F-610). The Template was signed and POR was immediately requested at this time. The following plan of removal was accepted on 2/27/24 at 12:01 p.m. REMOVAL OF IMMEDIATE JEOPARDY On February 26, 2024, the facility was notified by the surveyor, that an immediate jeopardy had been called and the facility needed to submit a Plan of Removal pursuant to Federal and State regulatory requirements. The immediate jeopardy allegations are as follows: F- Tag 610: The facility failed to investigate, suspend suspected staff member accused of abuse after resident injuries were reported by FM, CNA A and LE. The facility is placing current residents at risk of abuse and neglect by CNA C's continuous access. The facility failed to immediately investigate, report, and protect the resident when CR#2 was found with suspicious injuries of unknown origin. Done for those affected: Resident CR#1 was assessed by licensed nurse on 2/21/2024. MD was notified by licensed nurse on 2/21/2024. Resident CR#1 was transferred to the hospital for evaluation on 2/21/2024 and remains at the hospital. An Allegation of Abuse was reported to HHSC for Resident CR#2 on 2/21/2024. On 2/25/2024, the facility suspended the Certified Nurse Aide who worked with resident CR#1 on the 2/19/2024 10pm to 6am shift, pending investigation. If CNA C is found to be guilty of abusing CR#1, the facility will terminate employment immediately. Identify residents who could be affected: Beginning 2/21/2024, the Facility Social Worker(s) completed 100% of interviews of interviewable residents to assess for potential abuse. Date of completion is 2/23/2024. Findings: No additional concerns were identified. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Effective 2/25/2024, Administrator and/or designee notified facility residents of abuse and neglect reporting. Reeducation included who the abuse coordinator is and how to report concerns and/ or allegation of abuse, neglect, mistreatment and/ or misappropriation to facility personnel. Date of completion is 2/26/2024. oEffective 2/26/24, Administrator and/or designee notified families via alert media of the facility abuse and neglect reporting process. Reeducation included who the abuse coordinator is and how to report concerns and/ or allegation of abuse, neglect, mistreatment and/ or misappropriation to facility personnel. Date of Completion is 2/26/2024. oOn 2/23/2024, head to toe assessments were completed by the Licensed Nurse on all residents to identify any signs of injuries of unknown source. All other residents were assessed head to toe by a licensed nurse related to abuse, neglect and mistreatment with no concerns identified. Date of completion is 2/23/2024. Findings: No additional concerns were identified. oOn 2/23/2024, the DON/designee reviewed the resident progress notes for the last 30 days to ensure concerns related to abuse and neglect were identified and an investigation initiated, and the incident reported to HHSC. Findings: No additional concerns were identified. oOn 2/23/2024, the DON/ Designee reviewed incident/accidents in the last 30 days to ensure that investigations, timely reporting to HHSC as indicated, and resident assessments to include head to toe assessments were completed. Findings: No additional concerns were identified. Systemic Process: On 2/23/2024, the Regional [NAME] President of Operations reeducated the Administrator (Abuse Coordinator) on Abuse and Neglect and Abuse Policy. Abuse and Neglect and Abuse Policy to include timely Investigation and HHSC Reporting to ensure that all alleged violations involving abuse (with or without serious bodily injury); or neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, that result in serious bodily injury are reported immediately, but not later than two hours after the incident occurs or is suspected. Date of Completion is 2/23/2024. On 2/23/2024, the Administrator/ DON and/ or designee began reeducation to 100% of facility staff on the following: Abuse and Neglect and Abuse Policy to include timely Investigation and HHSC Reporting to ensure that all alleged violations involving abuse (with or without serious bodily injury); or neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, that result in serious bodily injury are reported immediately, but not later than two hours after the incident occurs or is suspected. An incident that does not result in serious bodily injury and involves: neglect, exploitation, missing resident, misappropriation, drug theft, fire, emergency situations that pose a threat to resident health and safety, a death under unusual circumstances will be reported immediately, but not later than 24 hours after the incident occurs or is suspected. The Administrator who is the Abuse Prevention Coordinator will be immediately notified for any concerns with Abuse, Neglect and Misappropriation. Date of completion is 2/23/2024. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident assessment to include head to toe assessments and documentation with each resident incident/accident. Date of completion is 2/23/2024 Effective 2/24/2024, any facility staff on FMLA, Leave of Absence, non-scheduled workday or PTO will be reeducated by the Administrator and/or designee prior to the start of their next scheduled shift. The facility maintains an onsite Weekend Manager and Nursing Supervisor that conduct rounds and may initiate and address resident incidents and will escalate to the appropriate administrative staff when required. The Administrator who is the Abuse Prevention Coordinator will be immediately notified for any concerns with Abuse, Neglect and Misappropriation. To monitor, the Director of Nursing/ designee will review the 24-hour report and resident incidents in facility Stand-up Morning Meeting, attended Monday - Friday. 24 Hour Report and resident incidents will be reviewed for potential abuse situations and need for reporting as per HHSC guidelines. Review will also include to ensure investigation, resident assessments to include head-to-toe assessments were completed and provided. Date of implementation is 2/23/2024. The Administrator will m [TRUNCATED]

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F 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47277

Tag:842 S/S= D

Surveyor Name(s): Najiyyah Shadee

Immediate Supervisor: [NAME]

Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 5 Residents (CR#1) reviewed for clinical records accuracy, there was only one progress note Record Review of the Progress Notes for CR#1: There was only one progress note entered since 1/3/2024; then, on 2/21/2024 at 16:17 (4:17pm), there was a note which was titled Admin Note and stated the Administrator notified FM of the HHSC investigation on 2/21/2024 with allegations of abuse.

The facility failed to maintain an accurate record by indicating CR #1's unexplained or unknown eye injury, what medical staff did after observing the injury, who they called and the type of assessment completed.

This deficient practice could affect residents whose records are maintained by the facility and could place resident(s) at risk for errors in care and treatment.

Findings Include:

Record review of CR#1's undated face sheet revealed a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted [DATE]. CR#1 has a diagnosis of Anoxic Brain Damage (lack of oxygen to the brain causing death of brain cells), Type 2 diabetes mellitus hypoglycemia w/o coma (low blood sugar levels), hypertension (high blood pressure), dysphagia (difficult swallowing), major depression disorder (low or depressed mood), chronic kidney disease (damaged kidneys and/or loss of kidney function), cognitive communication deficit (difficulty thinking and using language), anxiety disorder (pounding heart and sweating when responding to certain situations), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities).

Record review of CR#1's MDS assessment dated [DATE], revealed a BIMS score of 4 (severe cognitive impairment). Cognitive skills for daily decision making further revealed, resident can repeat at least three words heard, resident is able to recall prior questions after cueing, resident does not have any psychosis behaviors, which includes physical behaviors, verbal behavior, or any other behavior symptoms directed at others and the resident was able to participate in an activity preference interview of her interest while in the facility.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/29/2024
NAME OF PROVIDER OR SUPPLIER: Windsor Quail Valley Post-Acute Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE: 3640 Hampton Dr Missouri City, TX 77459	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CR#1's care plan updated 03/31/2022 revealed, the resident has a communication problem r/t expressive Aphasia, Hearing deficit, Neurological symptoms. The goal was the resident will maintain current level of communication function by making sound, using appropriate gestures, responding to yes/no questions appropriately through the review date. The interventions are to allow adequate time to respond, repeat as necessary, do not rush, request clarification from the resident to ensure understanding, face when speaking, make eye contact. Ask yes/no questions if appropriate, use simple, brief, consistent words/cues, use alternative communication tools as needed. Resident is a one (1) person total assist and two (2) person transfer using a mechanical lift. Further review of Resident #1's care plan updated revealed no documentation regarding the facial injuries on 2/21/2024 or any plan initiated to keep her safe while in the facility going forward. Record Review of CR#1's orders dated 2/1/2024 - 2/29/2024 revealed calcium tablet-1 tablet by mouth for type 2 diabetes (last taken 2/21/24 at 2000 (8PM) hours); magnesium oxide (last taken 2/22/2024 at 0730 (7:30AM); sertraline (1 tablet daily for anxiety); vitamin D2 (1 tablet daily); Coreg oral tablet by mouth one time daily (hold if <110HR<60); Depakote capsule 2 times daily); Janumet oral tablet two times daily for mood disorder. Hold if drowsy; Janumet oral tablet by mouth two times daily (d/c date 2/6/2024); refresh tears solution (carboxymethylcellulose sodium) instill one drop in both eyes two times a day for dry eye syndrome (start date 6/30/2022 1700 (5PM)). -The orders reflected a code 7 at 1700 hours, indicating the resident is sleeping and see progress notes (FM observed nurse putting eye drops in CR#1's eyes when she arrived during this time); Lorazepam 1 tablet by mouth three times daily; Accucheck one time a day related to diabetes (notify MD if bs <70 or >250); monitor vital signs every two weeks one time a day every 2 weeks on Mondays for Health monitoring (start 2/19/2024); Behavior monitoring for antianxiety from 2/1/2024 until 2/21/2024 reflected a code of 0, indicating CR#1 did not have any behaviors noted during all shifts; Behavior monitoring for antidepressants from 2/1/2024 until 2/21/2024 reflected a code of 0, indicating CR#1 did not have any behaviors noted during all shifts. Behavior monitoring for antipsychotic from 2/1/2024 until 2/21/2024 reflected a code of 0, indicating CR#1 did not have any behaviors noted during all shifts and on 2/21/24; Behavior monitoring for Busplrone (anxiolytic medication to treat anxiety) from 2/1/2024 until 2/21/2024 reflected a code of 0, indicating CR#1 received a 1, which indicated mania (mental health marked by periods of great excitement or euphoria, delusions and overactivity); in the EVE2 and a 6-grandiosity (unrealistic sense of superiority in which someone believes themselves to be unique and better than others) in the NOC1; Assess pain on each shift; monitoring antianxiety received a 1 and 6 on 2/21/24; Monitoring side effects for antidepressants codes indicated none, but on 2/21/24 there is a 1 in evening and 6 NOC 1 (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/22/24 at 1:00pm Interview with FM - FM stated she visited CR#1 on Friday 2/16/24, 4:00pm - 4:30pm and left that evening around 7:30pm and CR#1 had no bruises. She stated she returned Tuesday 2/20/24, between 5:00pm - 5:30pm and CR#1 was in the cafeteria. She stated at this time she noticed CR#1's bruised eye. She stated she left the cafeteria area and went into the ADON's office to inquire about what happened to CR#1 face. She stated both ADON's (A & B) were in the office. She stated she told them that CR#1 looked like she has been assaulted. She stated the ADON A responded, Now no one has hit CR#1. She may have hit her head on the wall area. FM felt the ADON A was being condescending, which angered her. FM responded, that analogy is not true and she asked why she wasn't notified CR#1 had marks and bruises on her face. FM stated at this time the ADON B got up and accompanied her to the cafeteria. She stated at that time the CR# 1 was asked who hit her. She stated a male. The ADON B stated at that time that there were no male CNA's working on the night shift. She stated the ADON B continued to tell her CR# 1 may have hit her head on the wall. FM told the ADON B that it was not possible to do that based on how her Geri Chair (padded reclining geriatric chair) was positioned. She stated she asked ADON B again why she was not notified (CR#1) had bruises. FM stated she did not get an answer. FM stated she spoke with the Admin who told her that he was doing an abuse investigation. He stated he did not know about the accusations of abuse or about the resident's eye. The Admin went to get the DON to ask what was going on. She stated the DON began saying CR#1 could be combative and this may be the reason for her injury. FM stated at this time she disagreed with them and left the facility. She stated CR#1 began to cry and beg her not to leave, but she had to leave at that time and made a decision to return in the morning with LE. FM stated she called LE on her way to the facility. FM stated she arrived at the facility on Wednesday 2/21/24, around 8:30am at which time CR# 1 was seated in her geri chair at the nurses' station. FM witnessed a nurse putting eye drops in CR#1s eyes. She spoke with the DON. She stated the DON initially told her that he had no idea and was not notified of the bruising. She stated after she told the DON she had contacted the police, the DON told her she received a photo while she was off of CR#1s eye and she was going to do an investigation. On 2/23/24 at 7:52am - Telephone Interview with LVN B - Stated during the earlier morning hours of her shift, 2/20/2024, around breakfast, the CNA A came to her and told her that CR#1's eye was red and swollen. She stated at this time CNA A had pushed CR#1 to the nursing area. She stated she observed the eye to be red and swollen and reported it to the LVN C. She again stated when CNA A told her about CR#1, she was already in her Geri Chair located in the hallway. She looked at CR#1 and then proceeded to speak with LVN C around 9:45am. She stated she attended the nursing morning meeting and told everyone (including both ADON's and Administrator that CR#1's eye appeared red and swollen. She states she did not complete any documentation regarding CR#1's unexplained injuries. On 2/23/24 at 8:35am -Telephone interview with LVN C.- LVN C indicated that on Tuesday, 2/20/24, she was the treatment nurse. She said in the morning between 10 AM and 11 AM, LVN B came to her, while she was documenting on another resident in the office and told her that CR#1's eye was red and somewhat raised. She said that the LVN B was the charge nurse. She stated that she looked at the CR#1s eye while she was seated in her geri chair by the nurse's station. She stated that the eye was a little red but told LVN B to keep observing the eye. LVN C stated that her last in-service for abuse and neglect was Wednesday with the Administrator, HR and DON. She stated she did not complete any documentation regarding CR#1's unexplained injuries. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/23/2024 at 9:50am Interview with Admin - Stated he is the coordinator for abuse and neglect at the facility. He stated on Wednesday, 2/21/24, CR#1's injuries appeared to have gotten worse and at this time he instituted a facility (Provider) investigation report and filed with HHSC. He did not complete any documentation regarding CR#1's unexplained injuries On 2/23/24 at 5:58pm Interview with DON. Stated CR#1 went to the hospital on Wednesday 2/21/24. She stated she had not worked on Tuesday 2/20/24 and had no idea what was going on until CR#1's FM came to the facility on [DATE] and told her she had called the police. She stated FM told her to look at CR#1's eye. She did. She stated she told FM that she would check on the issues and that she had not been informed of any type of injuries. The DON stated the resident was always rubbing her eyes and this may have caused bruising. FM brought the bruising to her attention and said CR#1 was abused. The DON stated she told FM she was going to do an investigation, but that was too late because she has already called police. She stated she did not complete documentation regarding CR#1's injuries. 2/26/2024 at 4:27pm Interview with ADON A-States the LVN [NAME] stated there was something going on with the resident's eye. She stated ADON B said he would look at the eye. Stated she believes ADON B called the DON. ADON A stated if she had seen her face like the photo shown on Investigator's computer, she would have immediately told Admin, DON, and NP. She would have completed documentation in PCC. However, she did not complete any documentation regarding CR#1's eye. 2/26/2024 at 4:46pm Interview with ADON B - States he was in the meeting when LVN [NAME] stated it was something going on with CR#1's eye. States he told the nurse to let the NP know and document. States he checked her face. He stated he didn't see much. States the LVN told him that the NP was on it and recommend monitoring. He stated he did not document in PCC because it is usually the nurse on duty who documents. States he called the DON and let her know. Told her the NP had seen the resident.