STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676380	A. Building B. Wing	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Spring Center for Skilled Care	3701 Wasson Rd Big Spring, TX 79720

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344 Based on interviews and record review, the facility failed to implement written policies and procedures that prohibit and prevent abuse and neglect for 2 of 5 residents (Resident #1, and #2) reviewed for abuse. A. The Former ADM (Abuse Preventionist) failed to follow the facility's abuse policy by not reporting the allegation of abuse to HHSC regarding the Resident-to-Resident altercation (between Resident #1 and Resident #2) that occurred on 3/14/25. B. The facility staff (CNA A, E, and LVN C) failed to follow the facility's abuse policy by not reporting the allegation of abuse to the Former ADM (Abuse Preventionist) regarding the Resident-to-Resident altercation (between Resident #1 and Resident #2) that occurred on 3/14/25. C. The facility (the ADON) failed to follow the facility's abuse policy by not assessing Resident #1 and #2 at the time of a Resident-to-Resident altercation that occurred on 03/14/25. These failures could place residents as risk for abuse and neglect. Findings included: Resident #1 Record review of Resident #1's face sheet, dated 03/28/25, revealed a [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include dementia (memory loss). Record review of Resident #1's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 2, which indicated the resident's cognition was severely impaired. Section B Hearing, Speech, and Vision revealed Resident #1 had clear speech, usually could make self-understood, and sometimes had the ability to understand others. Section E Behavior revealed Resident #1 had exhibited verbal behaviors (1-3 days) that impacted the resident's care and had impacted the privacy or activity of others. The behaviors indicated had significantly disrupted the care or living environment. Resident #1 also had a presence of wandering behavior that occurred daily, significantly impacted the privacy or activities of others and had worsened. Section V Care Area Assessment (CAA) Summary: Section V CAA Results: 09. Behavioral Symptoms. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's physician order's, active as of 3/28/25, revealed: Resident #1 was prescribed Donepezil 10 mg once a day for dementia (start date 2/07/25). Record review of Resident #1's care plan, dated 2/6/25, revealed: Focus (initiated 02/06/25; revised 3/17/25): Resident #1 had a behavior of wandering d/t dementia. Goal (initiated 02/06/25; revised 3/17/25): Resident #1 would not leave the facility unattended through the review period (target date: 5/20/25). Interventions: Distract Resident #1 from wandering by offering pleasant diversions. Identify patterns of wandering. Focus (initiated 03/17/25; revised 3/17/25): Resident #1 had a potential to demonstrate physical behaviors d/t dementia. Goal (initiated 03/17/25; revised 3/17/25): Resident #1 would not harm himself or others through the review period (target date: 5/20/25). Interventions: Assess and address for contributing sensory deficits. Assess and anticipate resident needs. If Resident #1 has physical behaviors immediately intervene. Monitor and notify doctor if he is a danger to himself or others. Record review of Resident #1's progress notes, dated 1/27/25-03/28/25, revealed: On 03/15/25 at 7:00 AM the ADON documented: During rounds this morning CNA A informed me (the ADON) that before she left yesterday (03/14/25) she found Resident #1 and Resident #2 in another resident's room and they were involved in an altercation. CNA A saw Resident #1 hit Resident #2 in the face with his shoe and he (Resident #1) had Resident #2 on the bed where he (Resident #2) couldn't get up. Resident #2 was yelling for help. CNA A separated the residents in different areas, CNA A then went to main nurses station to report and the nurses were not available so she returned to the unit where she kept the residents separated. On 03/15/25 at 7:49 AM the ADON documented: Assessed resident VSS, A/O x 1, ambulatory, speech is appropriate for him, PERRLA, HRRR, BBS clear x 4, Abd soft nondistended, skin assessment- resident denies any injury and no visible injuries noted. During an interview on 03/28/25 at 3:20 PM Resident #1 recalled hitting someone but was unable to report pertinent information such as when, who, or why. Resident #2 Record review of Resident #2's face sheet, dated 03/28/25, revealed a [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include Alzheimer's (memory loss), dementia (memory loss), cognitive communication deficit (impaired thought process that allow humans to function successfully and interact meaningfully with each other), and wandering. Record review of Resident #2's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 00, which indicated the resident's cognition was unable to complete the interview. Section B Hearing, Speech, and Vision revealed Resident 2 had clear speech, sometimes could make self-understood, and sometimes had the ability to understand others. Section E Behavior revealed Resident #2 had no behaviors documented other than wandering which occurred daily. Resident #2's wandering significantly intruded on the privacy of others. Section V Care Area Assessment (CAA) Summary: Section V CAA Results: 09. Behavioral Symptoms. Record review of Resident #2's physician order's, dated active as of 03/28/25, revealed: Resident #2 did not take any medication related to behaviors. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's care plan, dated 3/25/25, revealed: Focus (initiated 06/01/24; revised 10/29/24): Resident #2 had a behavior of wandering in and out of other's rooms. Goal (initiated 06/01/24; revised 6/21/24): Resident #2 would have fewer behaviors by review date (target date: 6/23/25). Interventions: Anticipate the resident needs, intervene as necessary to protect the rights and safety of others, monitor behavior. Record review of Resident #2's progress notes, dated 1/27/25- 03/28/25, revealed: On 03/15/25 at 7:00 AM the ADON documented: During rounds this morning CNA A informed me (the ADON) that before she (CNA A) left yesterday she found Resident #1 and Resident #2 another resident room and they were involved in an altercation. CNA A saw Resident #1 hit Resident #2 in the face with his shoe. He (Resident #1) had Resident #2 on the bed where he couldn't get up. Resident #2 was yelling for help. CNA A separated the residents in different areas, CNA A then went to main nurses station to report and the nurses were not available so she returned to the unit where she kept the residents separated. I (the ADON) informed administration as so as it was reported to me. On 3/15/25 at 8:22 AM the ADON documented: Assessed resident VSS, A/O x 1, ambulatory, speech is appropriate for him, PERRLA, HRRR, BBS clear x 4, Abd soft nondistended, skin assessment, old scarring and bruising to bilateral arms Resident has new abrasion on top of his nose. No other visible injuries were noted. Cleansed nose with wound cleaner. On 03/17/25 at 4:28 the SW documented: Incident reported on 3/14/25 with resident on resident. SW administered Safe Survey to staff and to POA/RP/families of residents on 400 hall. Trauma Informed assessment completed. Secure Care Pack consult with held with Former ADM, Plan in place to encourage resident to participate in activities off the unit. Resident #2 enjoys helping others and staff can monitor resident while safely assisting others during mealtime. During an interview on 03/28/25 at 3:27 PM, Resident #2 was unable to answer any questions regarding the altercation that occurred on 3/14/25 involving him and Resident #1. During an interview on 3/28/25 at 9:00 AM, the Regional Compliance Nurse stated she was notified on the morning of 3/15/25 that Resident #1 threw a shoe at Resident #2 while being in another resident's room. She said CNA A separated both Resident #1 and #2. CNA A reported that she went to report the incident to the nurse, but no one was at the nurse's station. The Regional Compliance Nurse stated once it was reported to her on 3/15/25, she started her investigation and placed Resident #1 on 1:1 monitoring as he was reported as the aggressor. She said they consulted with psychiatric services to address the behaviors of Resident #1. She said both residents were assessed on 03/15/25. She said CNA A was suspended as a result of the incident (failure to report when the incident occurred on 03/14/25). The Regional Compliance nurse said the Former ADM was terminated for failing to suspend CNA A immediately and for failing to report. The Regional Compliance Nurse stated she suspended CNA A because she failed to report the Resident-to Resident altercation but did not have concerns with her being involved. She said she started in-servicing on ANE to include reporting. She stated she coached CNA A on reporting timely. She stated the altercation between Resident #1 and #2 was a one-time occurrence. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/28/25 at 9:05 AM the Interim ADM stated she had no information regarding the altercation between Resident #1 and #2. She said she had only been at the facility for three days. During an interview on 03/28/25 at 10:00 AM, CNA A was able to name who the abuse coordinator was at the time of the interview, and at the time Resident #1 and #2 had their altercation. She stated she had received ANE training. She said she had been trained on what to do during a resident-to-resident altercation. She stated she knew to separate the residents, prevent and protect them, and report the incident to the charge nurse. She stated the residents involved should be assessed. CNA A stated Resident #1 and #2 had never had an altercation. She stated on 03/14/25, while attending to another resident/task, she heard Resident #1 holler for help. She went to another resident's room, where the noise was coming from. She stated she observed Resident #1 standing over Resident #2, hitting him (alternating with his hand and a shoe in the other hand). She stated she separated the two residents and placed them in their rooms. She stated she went to the nurse's station to call for assistance and to report it, but no one was there. She said she returned to the memory unit, where both residents were in their rooms. She asked Resident #2 if he was ok and in any pain. He (Resident #2) stated no. She stated she proceeded with her day and never saw the nurse for the remainder of the night until she was leaving. She stated there was no further incident for the remainder of the night. She stated the incident occurred at 3:00 PM and had her note in the system by 3:13 PM. She stated the two had never had an altercation but had wandering behaviors. She stated she was trained with her experience to redirect them in the appropriate areas. She stated that Resident #1 would wander, but he was very helpful in helping to get other residents to their beds. She stated Resident #2 also wandered and would go into other residents' rooms and sleep on their beds. She stated she had been trained through experience to redirect him and encourage him to go to his room. She stated on 03/14/25, she did not report the altercation that occurred between Resident #1 and #2 to the charge nurse because no one was at the nurse's station. She stated that night, CNA B relieved her, and she did tell her because it was a part of the report and wanted her to keep an eye on them. She stated the next day when she came in, the ADON came in, and she reported the incident to her. She stated the ADON immediately assessed the resident (Resident #2), and he did not recall the incident. She stated she did not say anything to LVN D because they usually give reports to the staff in the same roles. She stated after she reported the incident to the ADON, she (the ADON) reported it to the Former ADM. CNA A stated the Former ADM thought the incident occurred on the morning of 03/15/25. She stated she completed a witness statement. She stated the following morning, the Regional Compliance Nurse came in and coached her on reporting promptly. She stated although she did not report the incident the day of, she thought she had 24 hours to report. She stated she did not report the incident because after the residents were separated and safe, she became busy and forgot to report it after her first attempt . (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/31/25 at 10:36 AM, the ADON was able to name who the abuse coordinator was at the time Resident #1 and #2 had their altercation. She stated she had abuse training. She stated if there was a resident-to-resident altercation, the residents had been trained to separate them. The nurse should complete a head-to-toe assessment for all residents involved. She stated on the afternoon (03/14/25), CNA A went to the nurse's station, but no one was there. She stated CNA A told her that she forgot to tell her that Resident #1 and #2 had an altercation. She stated on 03/14/25, she had gone to the memory unit after the incident and had never been told anything about the altercation between Resident #1 and #2. She stated she was unsure if the oncoming staff was told about the incident. She stated she left on 3/14/25 around 7-8 PM and was never told anything about the altercation. She stated she returned to work the following morning (03/15/25) and was told around 6 or 7 AM by CNA A that Resident #1 and Resident #2 had an altercation. She ensured Resident #1 and #2 were separated, and they were. She stated she assessed both residents. Resident #1 did not have any injuries. Resident #2 did have a mark on his nose. She stated outside of the delay in reporting, she felt that the altercation had been handled correctly. She stated she assessed the residents, but there could have been a delay in treatment if there had been an injury. She stated Resident #1 and #2 had never had an altercation. She stated both residents' wander. She stated Resident #1 would wander but also help other residents get to their rooms. She stated Resident #2 was quiet but would wander and had to be redirected out of the other room. She stated Resident #1 had never exhibited aggression. During an interview on 03/31/25 at 11:15 AM, CNA E stated she relieved CNA A of her duties on 03/14/25. She stated she was told by CNA A Resident #1 and #2 had a physical altercation and to watch them. She said there was no incident the remainder of the evening. She said she did not tell anyone about the incident because she thought it had already been reported. She said she was told by CNA A that the incident had been reported. She said LVN C also knew about it because he had come into the memory unit to check on the residents. She said Resident #1 and #2 were in their rooms the majority of the night. During an interview on 03/31/25 at 11:30 AM, LVN C stated he worked the night of 03/14/25, but the incident between Resident #1 and #2 did not happen during his shift. He stated it was reported to him that Resident #1 and #2 had an altercation. He stated he could not remember by whom, but it had to be the nurse that was going off duty. He stated it was reported to him that Resident #2 had come into Resident #1's room, and Resident #1 told him to get out. He stated he checked on them throughout the night, and there was no incident. He stated both residents were in their rooms throughout the night. He stated he did not report the incident to management because it did not happen on his shift. He stated that he generally would ask if it had been reported but could not say if it had been reported to the abuse coordinator. He was able to report who the abuse coordinator was and who he would report a resident-to-resident altercation to if it occurred on his shift. He stated he would report the incident to the ADM, the ADON, and the DON. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/31/25 at 11:46 AM, the Former ADM stated she was no longer the administrator at the facility. She stated on Saturday (03/15/25) the ADON texted her. She said CNA A heard a noise and followed it to find Resident #1 hitting Resident #2 with a shoe. She stated that neither resident was in their assigned room. CNA A separated the residents. CNA A went to locate a nurse but could not find one. She stated CNA A reported that the incident happened Friday (3/14/25) but reported the incident on Saturday (03/15/25). She stated as soon as CNA A reported the incident, she then reported the incident to HHSC and the Regional Compliance Nurse. She stated they met about the incident and discussed the resident's behaviors. She stated Resident #1 had never done anything aggressive before but had the existing wandering behavior. She stated Resident #2 also had wandering behaviors. She said he would go into others' rooms and lay in their bed, and staff knew to redirect him. She said the altercation between Resident #1 and #2 was a one-off. She stated there were no additional incidents, and the residents sat together during lunch since the incident. She said the staff were doing additional rounds for monitoring. She said CNA A was suspended because of the failure to report. She said she did not suspend her initially that morning because she was unaware that the incident had occurred the day before, and after she found out, she just did not think about it (suspending CNA A). During an interview on 3/31/25 at 1:14 PM with the Regional Compliance Nurse, she stated she was familiar with the facility's abuse policy. She stated the purpose of the abuse policy was to prevent abuse to the residents. She stated the potential negative outcome of not following the abuse policy was that a resident could have been harmed. She stated she was aware that they failed to follow the abuse policy when CNA A did not report the incident to the charge nurse. She stated she was aware that the residents were not assessed at the time of the incident but were assessed as soon as it was reported with no significant injuries. She stated that no other staff knew about the incident before 03/15/25. She stated not reporting the incident could delay treatment if needed and they should report to the appropriate agencies. She said the system they use to monitor following the abuse policy was educating staff. She stated that she had been trained on the abuse policy, and all of the staff had been trained. She stated there were no staff members who have not been trained on the abuse policy. She stated the facility staff were trained annually upon hire. She stated that she expected the abuse policy to be followed. She stated the residents involved should be assessed immediately, and the incident should be reported immediately. She said they were all responsible for following the abuse policy. She said there was no reason why CNA A did not report the incident to the charge nurse. She said the charge nurse (the ADON) did not assess the residents at the time of the incident because she was not notified. During an interview on 03/31/25 at 2:10 PM, the ADM stated she was familiar with the facility's abuse policy. She stated the purpose of the abuse policy was so that the facility staff had guidelines to go by when there was an allegation of abuse or when there was a resident-to-resident altercation. She stated that the potential negative outcome of not following the abuse policy was a resident could get injured, or there could be alternative poor outcomes for the other residents. She stated she was not the Interim ADM at the time of the incident, but since her arrival at the facility, she was made aware that the incident report was not made timely. She stated she was unaware the residents involved were not assessed at the time of the incident. She stated she had been trained on the facility abuse policy, and all staff had been trained. She stated she expected all staff to follow the abuse policy. She stated the administrator was ultimately responsible, but all staff, including department heads, were responsible for following the abuse policy. She stated she was unaware of a reason why the abuse policy was not followed and was shocked that it was not followed. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy, Abuse/Neglect, dated 03/29/18, revealed: The resident has the right to be free from abuse, neglect Residents should not be subjected to abuse by anyone, including, but not limited to other residents. It is each individual's responsibility to recognize and report actual or alleged abuse. Reporting Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect must report this to the DON, administrator, state and or adult protective services. Facility employees must report all allegations of abuse to the facility administrator. The facility administrator or designee will report to HHSC . If the allegations involve abuse or result in serious bodily injury the report must be made within 2 hours of the allegation. Resident- to Resident The above policy will apply to potential-to-resident abuse. Record review of the facility's policy, Resident to Resident Abuse Investigation Checklist, dated 2003, revealed: Assess resident injury Notify charge nurse and or DON See reporting guidelines to state .