

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676406	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2025
NAME OF PROVIDER OR SUPPLIER Trucare Living Centers - Selma		STREET ADDRESS, CITY, STATE, ZIP CODE 16550 Retama Parkway Selma, TX 78154	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957</p> <p>Based on observation, interview and record review, the facility failed to ensure that all allegations involving abuse, neglect, and misappropriation were reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse, to the State Survey Agency for 1 of 4 residents (Resident #1) reviewed for abuse.</p> <p>The facility did not report to the State Survey Agency (HHSC) an incident of Resident #1 being physically abused by the RP in the facility.</p> <p>This failure could place residents at risk for harm to include physical abuse, a diminished quality of life, and psychosocial harm.</p> <p>The findings included:</p> <p>Record review of Resident #1 's face sheet, dated 4/11/25 reflected resident was a female aged 81 admitted on [DATE] with diagnoses that included: UTI and sepsis (infection) at admissions, and dementia (disease leading to decline in memory, cognition, and activity of daily living). The RP was listed as: a family member.</p> <p>Record review of Resident#1's quarterly MDS, dated [DATE], revealed: the resident's BIMS score was zero (severely impaired in cognition). The resident was incontinent of both bowel and bladder and required maximum assistance with incontinent care. As for transfer and mobility, the resident required maximum assistance with two staff in transferring and bed mobility.</p> <p>Record review of Resident# 1's Care Plan, undated, revealed, the goals and interventions included: monitoring of combative and aggressive behaviors due to dementia. Interventions included: providing verbal cues, engage in calmed conversations, and re-direction.</p> <p>Record review of facility's incident log for the month of March 2025 reflected it did not document an incident of a family member or RP physically abusing Resident #1 in the presence of CNA A on 3/29/25.</p> <p>Record review of Resident#1's Skin Assessments completed by LVN B reflected: 3/29/25: Resident's skin was thoroughly inspected during routine assessment. No skin abnormalities, redness, bruising, or open areas were observed. Skin is intact and within normal limits.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's vitals on 3/19/25 reflected vitals within normal limits.</p> <p>Observation and interview on 4/10/25 at 11:00 AM, revealed Resident#1 was in bed, alert and oriented to person. There were no injuries, skin tears or bruises present. Her disposition was one of anxiety. The Resident had difficulties answering direct questions. Resident #1 said she did not remember how staff placed the brief when they change her. Resident #1 said she sometimes felt bad when staff turn her. No response was given by the resident regarding any complaints involving staff. [Resident became exhausted, and interview was ended by the surveyor]</p> <p>Observation and interview on 4/10/25 at 2:40 PM, revealed Resident #1 and RP were present for a joint interview. Resident #1 was sitting in a W/C and disengaged from the conversation. The RP stated he was restricted in his movements in the facility. The RP stated, the facility alleged that, the RP slapped her (Resident #1). The RP denied physically abusing Resident #1 on 3/29/25.</p> <p>During a brief interview on 4/10/25 at 3:15 PM, in a private setting without the presence of the RP, Resident #1 said she did not know if she was afraid of the RP or whether she had ever been abused by the RP in the facility.</p> <p>During an interview on 4/11/25 at 11:47 AM, the SW stated: there was an allegation by a CNA [A] . the RP slapping the resident in the face in the resident's room. The SW stated, the facility decided to restrict the RP's' movement to common areas. The restriction was verbal and the RP agreed to visit the resident in the common area. The SW stated, the RP was informed that the facility needed to complete an investigation before allowing RP liberal visits in the resident's room. The SW stated that the allegation the RP slapped the resident was a reportable event to HHSC. The SW stated that she did not know why the event was not reported. The SW stated she fully knew the regulations on reporting abuse either by a staff member, resident, visitor, or a family member.</p> <p>During an interview on 4/11/25 at 1:04 PM, LVN B, stated: on 3/29/25, they were alerted by CNA A and LVN C that while Resident #1 was repositioned and agitated, the RP slapped the resident in the face and jaw to control the resident's agitation. LVN B stated that CNA A witnessed the physical abuse of Resident #1 by the RP. LVN B said it was absolutely a reportable event if a family member slapped a resident; and could be reportable to police as an assault. LVN B stated, the said incident was reported to the DON and the Administrator at the time of the incident.</p> <p>During an interview on 4/11/25 at 1:42 pm, CNA D stated: she assisted CNA A in transferring Resident #1 after lunch to her room to check on peri-care. CNA D stated, we explained the transfer procedures to the Resident and the RP who was present. CNA D stated, the resident attempted to strike the CNAs and the RP held the resident's hand. CNA D stated, the RP informed her that he was going to assist CNA A and no need existed for CNA D to stay in the room. CNA D stated, shortly after leaving Resident #1's room, she heard CNA A tell the RP that he could not slap the resident on the face. CNA D stated that she was trained on ANE and one of the highlights of the training was to report abuse.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/11/25 at 2:37 PM, the DON stated that there was an allegation made by CNA A that the RP slapped Resident #1 in the face during a transfer on 3/29/25 around 5:00 PM. The DON stated, CNA A informed LVN C of the alleged physical abuse of the resident by the RP. The DON was notified, and he notified the Abuse Coordinator. The DON stated law enforcement was not called. The DON stated the abuse incident by the RP was still under investigation by the facility. The DON stated that he was not sure whether the incident on 3/29/25 was reported to HHSC. The DON stated that all incidents of abuse whether from a staff member, visitor, or family member were reportable to HHSC; and could be reported to law enforcement.</p> <p>During a telephone interview on 4/11/25 at 2:45 PM, CNA A, stated: she witnessed Resident #1's RP slap her in the face on 3/29/25 in the late afternoon during a transfer from W/C to bed. CNA A stated, she and CNA D transferred Resident #1 back to her room and the RP was present. CNA A stated Resident #1 was agitated and combative. CNA A stated that the RP excused CNA D from the room and that he was going to assist CNA A with the transfer. CNA A stated that Resident #1 was resistant to the transfer and the RP slapped her on the face. CNA A stated, I told him it was abuse and he (the RP) should not have engaged in the abusive behavior. CNA A stated, she then informed LVN C about the abuse. CNA A stated that she was trained on ANE and learned to immediately report any incidents of abuse.</p> <p>During a telephone interview on 4/11/25 at 3:00 PM, LVN C stated: CNA A reported to her on 3/29/25 that she witnessed the RP slap Resident #1 in the face and chin during a transfer. LVN C stated she reported the alleged abuse to the DON. LVN C stated, she assessed the resident, and the resident's vitals were within limits, there was no psychosocial harm, and the skin was intact. The resident also did not exhibit any pain. LVN C stated she confronted the RP about the alleged abuse and he said nothing and left the facility. LVN C stated that she reminded the RP that he could not cause injury to a resident. LVN C stated she attended ANE in-service, and the highlight of the training was to report abuse to the Abuse Coordinator (the Administrator).</p> <p>During a telephone interview on 4/11/25 at 3:15 PM, the Administrator stated: she was informed of the incident on 3/29/25 where the RP slapped R#1 in the face witnessed by CNA A. The Administrator stated, on 4/1/25 she interviewed the RP, and he denied the abuse of Resident #1. The Administrator stated, that pending a facility investigation [not completed as of 4/11/25], out of safety for Resident#1, the RP needed to visit the resident in common areas. The Administrator stated the incident was not reported to law enforcement or HHSC. The Administrator stated that all allegations of abuse were reportable to HHSC. The Administrator did not provide a reason for not reporting the incident of physical abuse by the RP on 3/29/25 to HHSC within the 2 hours after an allegation of physical abuse of a resident was made by a staff member.</p> <p>Record review of Facility's policy titled. Abuse Neglect, dated revised 8/10/2022, read . Abuse is defined as the willful inflection of injury .resulting in physical harm, pain or mental anguish .Any employee or individual in the facility engages with that witness, suspect, or receive alleged statements of abuse .must report to the Administrator or Designated Representative according to the following: a. Immediately after the allegation is made, .The Administrator, DON, or Designated Representative will be responsible to report according to regulations including: a. DADS no later than 2 hours following discover[y] .</p>		