STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676467	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cypress Creek Rehabilitation and Healthcare Center	13600 Birdcall Lane Cypress, TX 77429

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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	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** Based on observations, interviews, and record review, the facility failed to ensure each resident was free from abuse for 1 of 6 residents (Resident #1) reviewed for abuse. CNA A was physically abusive to Resident #1 on 1/28/2025 when he slapped her on the left cheek with an open hand and pointed at her twice aggressively. The noncompliance was identified as past noncompliance (PNC). The IJ (immediate jeopardy) began on 1/28/2025 and ended on 4/22/2025. The facility corrected the noncompliance before the survey began. Resident #2 was physically abusive to Resident #1 on 4/21/2025 when she punched her in the arm with a closed fist three times. The noncompliance was identified as past noncompliance (PNC). The noncompliance began on 4/21/25 and ended on 4/22/2025. The facility corrected the noncompliance before the survey began. These failures placed residents, who resided in the facility, at risk of abuse, and mental anguish caused by fear. The findings included: Resident #1 Record review of Resident #1's undated admission Record revealed she admitted to the facility on [DATE] with diagnoses of colon cancer, hemiplegia (partial paralysis on one side of body), vascular dementia and adjustment disorder with depressed mood. She was [AGE] years of age. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed she had a BIMS score of 3, indicating severe cognitive impairment. She was dependent on staff for activities of daily living, including oral hygiene, toileting, bathing, and required substantial/maximum assistance for transfers. Record review of Resident #1's Care Plan Report, undated, revealed the following focuses, goals and interventions: - (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Focus: (Resident #1) had impaired cognitive function and impaired thought processes. Initiated on 12/6/24. Goal: The resident would maintain at current level of cognitive function through the review date. Target date 3/16/25. Interventions: Administer medications as ordered, ask yes/no questions to determine resident's needs, communicate with the resident regarding resident's capabilities and needs, and identify yourself at each interaction, face the resident when speaking and make eye contact. - Focus: (Resident #1) had unwanted behaviors related to yelling, combative with staff, refuses care, medications and meals and transfers independently without assistance. Initiated on 12/6/24. Goal: The resident would have fewer episodes of behavior by review date. Target date 3/16/25. Interventions: Caregivers to provide opportunity for positive interaction and attention, explain all procedures to the resident before starting, give 1:1 assistance (individualized attention provided by one person to the resident) to try and calm resident down, intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner, remove from situation and take to alternate location as needed and re-direct resident when combative, explaining this is inappropriate behavior. Record review of Resident #1's Incident/Accident Investigation Worksheet dated 1/29/2025 at 8:45am revealed an incident of abuse occurred. There were no witnesses listed. The pain assessment revealed she complained of a headache, Tylenol (a medication for pain management) was offered but refused. The conclusion/root cause was described as possible physical abuse .recommendations/interventions: Ask (family member) to check camera footage. Record review of an Abuse-Investigation Statement dated 1/29/25 revealed CNA A made the statement: (Resident #1) called asking to be changed around 9:00pm, after letter her know that I was in the middle of my round & that I would be assisting her afterward, (Resident #1) continued to call out. When I changed her/provided pericare, she asked for Tylenol & for the lights to be turned off. Approximately 5 min later (Resident #1) called out again, but she was not making any sense. In a continuance of the statement, CNA A reported that he entered Resident #1's room and asked what was wrong. I placed my hand down near her head on her bed, due to her bed being so low to the ground. (Resident #1) began to start jostling & throwing her head around. She hit her head against my hand. After that she shouted that I hit her & I moved my hand away & walked out of the room . Record review of a provider investigation report dated 2/5/2025 described an allegation of abuse in that CNA A hit Resident #1. A video from the incident shows a timestamp of 1/28/25 at 9:48pm and revealed CNA A hit Resident #1 on her left cheek. The police were notified, and CNA A was terminated on 1/30/25. The resident was assessed with no new injuries noted. An assessment was completed, and Resident #1 complained that her head hurt from the fall. The resident had a fall on 1/26/25 that resulted in a contusion (a bruise) to her right eye/cheek area. The provider investigation report was signed by the Former Administrator. The allegation of abuse was confirmed. Surveyor attempted interviews with Resident #1 on 5/13/25 at 11:11am and 5/14/2025 at 10:50 am with no success as she refused to be interviewed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation of the video footage sent by the Administrator to the surveyor by email on 5/14/2025 at 11:29am revealed the following: CNA A approached Resident #1 pointing at her face and talking, then hit her on her left cheek with his open right hand, then pointed at her face again, aggressively. After the slap, Resident #1 was yelling and pointing at CNA A. Conversation can be heard in the video, but it was difficult to determine what was said. In an interview on 5/14/25 at 1:48pm with CNA A, he said he recalled the incident with Resident #1. He said it was near the end of his shift, and she was the last person he cared for before charting and going home. He said Resident #1 never used her call light and she called out when she needed to be changed. He said he walked out, then walked back in and asked, I just changed you, are you sure you need to be changed. He said he then hit Resident #1 on the side of the face. When asked to describe how he hit her, he said he smacked her on the side of her cheek. He said she was screaming and irate. He said he slapped her to get her attention, but said it was not malicious. He said what he did to Resident #1 was physical abuse. In an interview on 5/13/2025 at 11:22pm, LVN C stated she was working the night of the incident between CNA A and Resident #1. She said CNA B reported to her that CNA A hit Resident #1. She said she approached the nurse who was caring for Resident #1 and shared with her what CNA B said. She said she noticed that the LVN was on her phone making notifications. She said she did not follow-up afterwards. She said she could not remember the other LVN's name. In an interview with CNA B on 5/14/2025 at 11:34am, she said she was at the facility at the time of the incident. She said CNA A approached her and told her that Resident #1 said he hit her. She looked into Resident #1's room and Resident #1 said, he hit me, he hit me! She said she was terrified, scared, yelling, crying, and asking for help. She said she and CNA A went to the break room to find Resident #1's nurse, then reported what happened. She said she stayed with CNA A until he went home. In a telephone interview on 5/15/25 at 9:15am, LVN D said she was assigned to Resident #1 when there was an allegation of abuse. She said she was on a lunch break, and LVN C came in and told her about the abuse allegation between CNA A and Resident #1. She said she assessed Resident #1, but did not see that she was fearful or upset. She said the incident occured at the end of CNA A's shift, and he completed charting, then went home. She said he did not care for other residents. In an interview on 5/14/25 at 1:28pm, MD A stated she was not aware that Resident #1 was distressed after the abuse incident. She stated residents who are abused could be fearful of caregivers and hesitant to receive care. In an interview on 5/14/25 at 3:20pm, The DON said she was aware of the incident regarding CNA A and Resident #1. She said the administrator watched video footage of CNA A slapping Resident #1 in the face. She said they suspended him the day after the incident and he was terminated after the investigation. She said they completed an assessment of Resident #1, notified police, ombudsman, HHSC, completed safety surveys with residents, took statements and in-serviced on abuse and neglect policies and procedures. She said CNA A worked from 2:30pm-10:30pm that evening, and the incident occured at 9:45pm. She said after the incident occured and notifications were made, it was time for him to go home. Resident #1 and Resident #2 (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 Resident #2's admission Record (undated) revealed she admitted to the facility on [DATE] with diagnoses of dementia with behavioral disturbance, diabetes, major depressive disorder with psychotic symptoms, cerebral aneurysm (a bulge in a blood vessel in the brain), adjustment disorder and history of transient ischemic attack (temporary blockage of blood flow to the brain). She was [AGE] years of age. Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed she had a BIMS score of 3, indicating she had severe cognitive impairment. She did not exhibit behavior symptoms during the review period. She used a wheelchair and required supervision to wheel 50 feet with two turns. Record review of Resident #2's care plan report (undated) revealed the following focuses, goals and interventions: - Focus: Resident #2 was a risk for delirium and reports of hallucinations. Initiated on 6/6/23. Goal: Cause of delirium will be resolved through the next review. Target date: 5/23/25. Interventions: Approach in calm manner, assess vital signs, medications, document changes noted. - Focus: Resident #2 had impaired cognitive function and impaired thought processes related to dementia. Initiated on 5/13/22. Goal: Resident will maintain current level of cognitive function through review dated. The resident would be able to communicate basic needs on a daily basis through the review date. Target date: 5/23/25. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Cue, reorient and supervise as needed. Monitor as needed for changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness and mental status. - Focus: Resident #2 had unwanted behaviors related to delusions and hallucinations. Initiated on 9/5/24 and revised on 4/23/25. Goal: Behavior episodes would be reduced to less than daily until the next review. Target date: 5/23/25. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Anticipate and meet the resident's needs. Give 1:1 assistance to try to calm resident down as needed. Record review of Resident #2's progress note dated 4/21/25 at 7:00pm revealed Resident #2 was at the nurse's station with another resident, and the other resident was mumbling to herself. At 6:30pm, Resident #2 struck the other resident with a closed fist three times. Record review of Resident #1's progress note dated 4/21/25 at 7:10pm revealed Resident #1 was involved in a physical altercation with a resident at the nurse's station. Resident sustained 3 hits to the (L) arm from the other individual. The resident attempted to retaliate, however made no physical contact. No visible injuries noted upon assessment . (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 Resident #2's Incident/Accident Investigation Worksheet dated 4/21/25 at 6:30pm revealed Resident #2 reported that another resident was talking to her in a different language, and she asked her to stop. Resident #2 said whenthe other resident refused, she said she tried to get away from her, but did not hit her. LVN E was listed as a witness. LVN E reported seeing Resident #2 strike another resident with a closed fist three times. Further review of the worksheet revealed Resident #2 was separated from the other resident, was placed on 1:1 supervision, MD ordered a urinalysis and ammonia levels, and notifications were made to psychiatric nurse practitioner, DON, Administrator, and resident's responsible party. Record review of Resident #1's Incident/Accident Investigation Worksheet dated 4/21/25 revealed on 4/21/25 at 6:45pm, Resident #1 received verbal aggression. The incident was witnessed by LVN E who saw that Resident #1 was hit by another resident. In the section for What did the resident say happened, it stated, I don't know .I don't argue. There were no injuries or recent medical changes reported. Recommendations/Interventions included the following: Resident redirected and monitored closely for any changes in behavior or physical condition .safety precautions reinforced to prevent further occurrences. Record review of Resident #1's Behavioral Health Progress Note dated 4/22/25 revealed Resident #1 had a short attention span and had neurological symptoms such as cognitive deficits and memory problems. The progress note revealed she was being assessed after an altercation with another resident. No distress was noted during the assessment. Record review of Resident #2's Med Management Clinical Note dated 4/21/25 revealed the Psychological Services NP assessed the resident after she attempted to strike another resident. It was determined that the behavior was not repeated, and the behavioral disturbance was likely related to elevated Ammonia levels. In an interview on 5/13/2025 at 3:39pm, the Social Worker stated on the day that Resident #2 hit Resident #1, Resident #2 stole her phone. She said a family member called her phone and she heard it ring near Resident #2. She said after she retrieved her phone, she left Resident #2 near the nurse's station because she said she wanted to stay out in the halls. She said moments later she heard a commotion and found out that Resident #2 hit Resident #1. She said the nurse witnessed the interaction. She said that Resident #2 had occasional agitation, but not physical aggression. She said both incidents were outside of her baseline. She said the facility determined she had a urinary tract infection. In an observation and attempted interview on 5/13/2025 at 10:12pm, Resident #2 was in bed watching television. She was unable to answer surveyor's questions. When asked a question, she would talk about her past and her family. In an interview on 5/15/25 at 1:50pm, the DON said she was notified of the incident between Resident #2 and Resident #1 by phone. She said she believed they were too close together and Resident #2 hit Resident #1 in the arm. She said neither resident remembered the incident. She said the behavior was outside of Resident #2's baseline, and stated she was not aggressive. She said it was determined that she had a urinary tract infection at the time. She said Resident #2 as placed on 1:1 supervision until a staff member of the psychology services company visited and determined she was not a threat to others. (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 on 5/15/25 at 4:02pm, LVN E said she witnessed the incident between Resident #1 and Resident #2. She said she had just retrieved Resident #2 from the 300 hall when she let her stay near the nurse's station. She said Resident #1 was yelling and saying something, then Resident #2 started talking back and hit Resident #1 three times in the arm with a closed fist. She said it was outside of Resident #2's baseline to hit someone. She said she had not experienced a situation like this before. She said to prevent something like this from occurring, staff need to stay vigilant, be aware of changes of condition and keep lines of communication open. In an interview on 5/15/25 at 4:10pm, the Administrator said Resident #2 struck Resident #1 in the arm a few times. She said in response to the altercation, the facility separated the residents, placed Resident #2 on 1:1 supervision, completed assessments of both residents, asked psychological services to assess both residents, completed an ad hoc QAPI IDT meeting, completed in-services with staff on abuse and behaviors, contacted the police department. She said she trained staff on how to monitor for aggressive behaviors and take appropriate actions before it leads to abuse. She said even with Resident #2's cognitive impairment, it was a willful act at the time of the incident according to the Appendix PP (The State Operations Manual provided by CMS that provides guidance to surveyors for Long Term Care Facilities). The facility took the following action to correct the non-compliance between 1/28/2025 and 4/23/2025: Record review of the Provider Investigation Report dated 2/5/25 revealed facility staff completed a skin, pain and psychological assessment for Resident #1 on 1/29/25. CNA A was suspended on 1/29/25 pending an investigation and terminated on 1/30/25. The police were notified and the facility changed their external access codes. Record review of multiple Resident Interviews dated 1/29/25 revealed facility staff interviewed residents .to determine their awareness of their rights and their experience at the facility. Some residents reported they wre unaware of their reports or knowledge on how to report abuse. They were educated during the interview. All residents reported no knowledge or evidence of abuse. Record review of a facility list of residents titled, 300's Hall Skin Sweep, 1/29/25 revealed skin assessments were completed for residents who resided on the 300 hall. Record review of a facility list of residents titled, 2/3/25 Skin Sweep revealed skin assessments were completed for residents who resided on the 100 hall. The findings indicated that no new or suspicious skin issues were observed. Record review of an email from the Former Administrator dated 1/31/25 revealed the Former Administrator notified the Long-Term Care Ombudsman of the allegation of abuse. Record review of a Resident Council Minutes dated 2/3/25 revealed the Former Administrator discussed the following topics with the residents in attendance: resident rights, identifying the abuse coordinator (Former Administrator) and how to report problems. Record review of In-Services dated 1/29/25-2/3/25 revealed all staff were educated on abuse and neglect identification and abuse and neglect policies and procedures. Staff completed an abuse quiz after completion of the in-service. It was noted that after completion of the quiz, the answers were reviewed with the group and corrections were made following the discussion. (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 Resident #1's care plan (updated) revealed it was updated on 3/13/25 to reflect that she was physically aggressive toward staff related to poor impulse control and agitation. Interventions included analyzing circumstances, triggers of behavior, assess and address for contributing sensory deficits, assess and anticipate resident's needs, provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, give the resident as many choices as possible about care and activities, when the resident becomes agitated, intervene before agitation escalates, guide away from source of distress, engage calmly in conversation, and if response is aggressive, staff were to walk away calmly and approach later. Record review of the Provider Investigation Report dated 4/28/25 revealed the allegation of resident-to-resident abuse between Resident #2 and Resident #1 was confirmed. Resident #1 was assessed after the incident on 4/21/25 at 6:30pm by LVN E. The police were notified. Record review of an attachment to the Provider Investigation Report that included a detailed summary of the facility's response (undated) revealed Resident #2 was placed on 1:1 supervision pending a psychology evaluation. The physician ordered labs that indicated Resident #2 had elevated ammonia levels, which could have contributed to Resident #2's behaviors. The psychologist cleared the resident to remove 1;1 supervision. Record review of Behavioral Health Progress Note dated 4/22/25 revealed Resident #1 was assessed by a nurse practitioner. The nurse practitioner noted she was not in distress and did not sustain any injuries. Record review of Inservice Attendance Records dated 4/22/25 revealed staff were educated regarding caring for residents with aggressive behaviors, resident rights and abuse, neglect and exploitation. Record review of Resident #2's care plan revealed it was revised on 4/22/25 to include additional interventions for aggressive behaviors, including administer medications as ordered, analyze times of day, place and circumstances to determine what de-escalates behavior, assess and anticipate resident needs, provide physical and verbal cues to alleviate anxiety, give positive feedback, give the resident as many choices as possible, place resident on one-to-one monitoring following aggressive behaviors until resident can be assessed by the physician. Observations between 5/13/25 and 5/15/25 revealed interactions between residents were pleasant, with no signs of abuse. Interviews with facility staff between 5/13/25 and 5/15/25, including CNA B, LVN A, LVN B, Unit Manager A, LVN C, LVN E, CNA K, CNA E, CNA S, CNA T and CNA L revealed they were aware of the types of abuse and what to do if they were aware of abuse in the facility. They reported how they would monitor and care for residents with behaviors that may lead to abusive actions. Interviews with facility staff on 5/29/25, including LVN S, Social Worker, CNA B, CNA R, LVN I and CNA O revealed they could state how to intervene when Resident #1 had behaviors that was consistent with her care plan. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observations between 5/13/25 and 5/15/25 revealed interactions between staff and residents were pleasant, with no signs of abuse. Interviews with 15 residents between 5/13/25 and 5/15/25 revealed no reports of abuse. Record review of the facility's Abuse, Neglect and Exploitation policy revised on 1/8/2023 read in part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing writing policies and procedures that prohibit and prevent abuse, neglect . 'physical abuse' includes, but is not limited to hitting, slapping, punching, biting and kicking . The facility administrator is the Abuse Prevention Coordinator in the facility and is responsible for reporting allegations or suspected abuse, neglect or exploitation to the state survey agency and other officials in accordance with state law .the facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves . identifying, correcting and intervening in situations in which abuse, neglect, exploitation and/or misappropriation of resident property is more likely to occur with the deployment of training and qualified, registered, licensed and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record view the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or result in serious bodily injury to the administer of the facility and to other officials including the State Survey Agency in accordance with State law through established procedures for 2 of 6 residents (Residents #3, #1) reviewed for abuse and neglect. The facility failed to report a significant injury of unknown origin to HHSC when Resident #3 was found to have scattered bruising of different colors and a fractured arm. The facility failed to report a significant injury of unknown origin to the Former Administrator, who was the abuse coordinator, when Resident #3 was found to have scattered bruising of different colors and a fractured arm. The facility staff failed to immediately report an allegation of abuse to the administrator, who was the abuse coordinator, when CNA A slapped Resident #1 on her left cheek. The facility failed to report an allegation of abuse to HHSC within 2 hours when CNA A slapped Resident #1 on her left cheek. The incident was reported 15 hours after the incident occurred. These failures could place residents at risk for abuse/neglect and could lead to a diminished quality of life. Findings included: Resident #3 Record review of Resident #3's admission Record (updated) revealed she was admitted to the facility on [DATE] with diagnoses of dementia, diabetes, osteoarthritis of left knee and other disorders of bone density and structure. She was [AGE] years of age. Record review of Resident #3's Care Plan Report, undated, revealed the following focuses, goals and interventions: - Focus: (Resident #3) had impaired cognitive function and impaired thought processes. Initiated on 5/8/23. Goal: The resident would maintain at current level of cognitive function through the review date. Target date 10/16/24. Interventions: Administer medications as ordered, ask yes/no questions to determine resident's needs, keep the resident's routine consistent and try to provide consistent caregivers as much as possible in order to decrease confusion. - (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Focus: (Resident #3) required assistance to perform functional abilities in self-care and mobility. Initiated on 4/30/24. Goal: The resident would maintain their highest practical usual functional ability status in self-care and mobility by next review date. Target date: 10/16/24. Interventions: provide the following self-care assistance- shower/bathe: substantial; upper body dressing: partial; lower body dressing: substantial; transfers: substantial to partial. - Focus: (Resident #3) was at risk for falls. Initiated on 5/8/23. Goal: The resident would not sustain serious injury through the review date. Target date: 10/16/24. Interventions: Anticipate needs, provide prompt assistance with ADLs. Coordinate with appropriate staff to ensure a safe environment. Record review of Resident #3's quarterly MDS assessment dated [DATE] revealed she had a BIMS score of 0, indicating severe cognitive impairment. She required partial/moderate assistance with bathing and dressing and required supervision for transfers. Record review of Resident #3's Incident/Accident Investigation Worksheet dated 9/27/24 revealed at 9:00pm, Resident #3 had an un-witnessed fall when she was found on the floor in front of the bathroom door. The worksheet was signed by LVN A. Record review of Resident #3's Progress Notes dated 9/28/24, 9/29/24, 9/30/24, 10/3/24, 10/4/24, 10/5/24, 10/6/24, 10/7/24, 10/8/24 and 10/9/24, revealed resident was observed with no pain and no injuries were reported. Record review of Resident #3's Skin Observation Tool signed by LVN B on 10/2/24 revealed the resident had no skin issues. Record review of Resident #3's SBAR Progress Note dated 10/10/24 at 6:15pm revealed Resident #3 was noted to have scattered yellow, red and purple discoloration to upper right arm. The nurse noted it started on 10/10/24. Moving her arm made the condition worse. The nurse noted, .notified by (CNA A) of scattered yellow, red and purple discoloration to resident's right upper arm that was reported two weeks ago. Nurse manager on duty notified . Record review of Resident #3's Skin Observation Tool signed by ADON A on 10/14/24 revealed a skin assessment was completed on 10/10/24 that showed a scattered yellow, red and purple discoloration to upper right arm. Record review of Resident #3's Final X-ray Report dated 10/11/24 revealed an x-ray result of the right shoulder, elbow and wrist. Findings of the x-ray determined there was an age-indeterminate, obliquely oriented (meaning positioned at a slant or diagonal angle) mildly comminuted (reduced to minute particles or fragments), mildly displaced fracture of surgical neck of humerus (an area of the upper arm). There was a handwritten note on the document that stated, Noted 10/12/24. MD aware. (New order) transfer to (local hospital). Record review of Resident #3's Hospital Patient Visit Information report dated 10/12/24 revealed she was seen for humeral head fracture, acute pain due to trauma and blunt trauma. There was a new order for Gabapentin, a medication for neuropathic pain. (continued on next page)

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	676467	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's Emergency Provider Report dated 10/12/24 from a local hospital revealed she was seen in the emergency room for concerns about a right upper extremity fracture. Patient has bruising on her right upper extremity for an unknown amount of time and is complaining about pain. The facility is unsure about potential fall. Patient cannot contribute interview because of dementia . Stated complaint: Right shoulder pain since Thursday .CAT Scan .impression . there is significant angulation (meaning the formation of angles) and displacement between the head and shaft fragments. There is also a displaced greater tuberosity fragment (a break in the bony bump on the outside of the upper arm bone). The humeral head is inferiorly subluxed (meaning partially dislocated where the bones in the joint are making contact)/dislocated . In an observation and attempted interview on 5/13/2025, Resident #3 was lying in bed, resting. An attempted interview revealed that she could not answer any type of questions. She spoke with random words strung together in phrases. In a telephone interview on 5/13/2025 at 5:42pm, LVN A said he worked the night in September 2024 when Resident #3 fell. He said he was doing rounds and tried to open Resident #3's door but noticed some resistance. He said he observed Resident #3 sitting on the floor next to the door, in the corner of the door frame. He said he completed a head-to-toe assessment and neurochecks (a physical evaluation completed after a head or neck injury to determine the functioning of the nervous system). He said he asked her to move her extremities and her movement was normal. He stated she had no complaints of pain. In a telephone interview on 5/13/2025 at 6:26pm, LVN T said she remembered when Resident #3 experienced a fall in September 2024. She said she cared for her a few times after the incident, and she did not notice any pain, range of motion issues, or bruising. She said she completed a skin assessment sometime between the fall and the day a bruise was found on her arm. She said she gave Resident #3 a shower, and again stated there was no pain, skin issues or range of motion issues. She said when she heard the bruise was identified, and the CNA reported it was two weeks old, she said that it was definitely incorrect. She said she believed she returned to work on a Friday and saw the bruise. She said the discoloration started right at her shoulder, above her elbow on the back side of her arm and coming over the top part of her arm. She said it was red, burgundy, yellow and green. She said most of the bruise was red/burgundy and the older yellow/green spots were small. She said starting on a Friday, Resident #3 retracted her arm and held it with her other hand to protect it. She said based on her observation, there was no way the injury was 2 weeks old, and it did not seem right. She said she reported her concerns to ADON A. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 5/13/2025 at 11:22pm, LVN C stated she was working the night Resident #3's bruises were discovered. She said CNA A told her that Resident #3 had a little bruise and it should be going away. She said when she heard that, they both observed the bruise on her arm. She said she observed a large bruise that was on her outer and inner arm, that was purple, red, and green in color. She said some of the bruises were healing. She could not say if they were fresh bruises. She said CNA A asked her to stay and help him change her, because she had become more agitated since the injury occurred. They changed her, then she completed the SBAR assessment and made notifications to the doctor and family member about the injury. She said CNA A told her the injury occurred a few weeks ago, and he reported it someone, but could not remember who. She said CNA A reported the injury occurred when she got stuck in her bed rails. She said in hindsight, there were two items in CNA A's story that were confusing: he reported it was a small bruise, but it was a large bruise that did not appear to be fading; he reported that he notified someone of the injury a few weeks ago but could not remember who he told. She said the next day, she was asked about the injury from upper management, because Resident #3 did not have bed rails. She said she did not think to report the injury to the abuse coordinator, who was the Former Administrator. In an interview on 5/13/2025 at 10:11am, Resident #3's RP said she was unsure how Resident #3 broke her arm. She said she first learned of the injury on a Wednesday. She said when she saw the bruise, it looked like streaks that were red at first. She said she was not aware if the injury was investigated. She said no one witnessed what happened. In an interview on 5/13/2025 at 12:15pm, ADON A stated when Resident #3 fell in September 2024, LVN C did not document any outward injuries. She said when she saw Resident #3 after the fall, she did not notice anything at that time. She said she ambulated with a wheelchair and could propel herself using her feet. She said on 10/10/2024, they discovered the bruising. She said it was a faded bruise that was different colors. She said it was possible for her to have a fall on 9/27/2024 and not show any injuries until 10/10/2024. When asked why she did not report pain prior to 10/12/2024 according to the nurse progress notes, she said it was because they started to manipulate her arm in the hospital and at her orthopedic appointment. She said the DON and Former Administrator investigated the injury. She said no one reported any concerns to her about Resident #3's injury. In a telephone interview on 5/14/25 at 1:28pm, MD A, when asked about Resident #3's broken arm and bruising, she said, I don't think they could conclude what occurred. In a follow-up telephone interview on 5/14/25 at 4:31pm, MD A said there could have been a number of reasons why Resident #3's injury was not identified after the fall for about two weeks. She gave a few examples, including Resident #3's poor cognition and possible high-pain tolerance. When asked if it could have occurred any other way, she said it was hard to say, and was hypothetical. In a telephone interview on 5/14/25 at 1:48pm, CNA A said he was at the facility the night Resident #3 fell in September 2024. He said she fell on her way to the bathroom, and she was confused. He said he thinks the bruising that was on her arm was a result of hitting the door frame. He said when they put her back in bed, there was a little redness on her arm. He said it kept getting worse. He said it was on the top of her elbow covering a 3-4 inch space, on the back and front arm near the bicep area. He said that was all he could remember about Resident #3's fall and injury. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 5/14/25 at 3:20pm, the DON stated it was her understanding that Resident #3 broke her arm when she fell in September 2024. She said when Resident #3 fell, a resident across the hall saw her fall by the restroom door trying to transfer herself. When asked about LVN A's statement that he felt resistance while trying to open the door, she said that it would not make sense, because then the other resident could not have seen the fall. During the interview, the DON reviewed the records showing the bruising was evident about two weeks after the fall, and the skin assessment on 10/2/25 showed no skin issues. She said Resident #3 did not have another fall before the bruising was visible. When asked if there could be another explanation for the bruising and fracture to her arm, she said her family takes her out occasionally, and she could have bumped her arm on something while ambulating. She said she did not think it could have been a result of abuse. When asked why it was not reported to HHSC, she stated the Administrator would make the determination to report. She further stated that if the cause of an injury was known, then it would not be reported to HHSC. In an interview on 5/14/25 at 4:45pm, the Administrator stated Resident #3's injury identified in October 2024 should have been reported. She said, you report now and investigate after. Resident #1 Record review of Resident #1's undated admission Record revealed she admitted to the facility on [DATE] with diagnoses of colon cancer, hemiplegia (partial paralysis on one side of body), vascular dementia and adjustment disorder with depressed mood. She was [AGE] years of age. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed she had a BIMS score of 3, indicating severe cognitive impairment. She was dependent on staff for activities of daily living, including oral hygiene, toileting, bathing, and required substantial/maximum assistance for transfers. Record review of Resident #1's Care Plan Report, undated, revealed the following focuses, goals and interventions: - Focus: (Resident #1) had impaired cognitive function and impaired thought processes. Initiated on 12/6/24. Goal: The resident will maintain at current level of cognitive function through the review date. Target date 3/16/25. Interventions: Administer medications as ordered, ask yes/no questions to determine resident's needs, communicate with the resident regarding resident's capabilities and needs, and identify yourself at each interaction, face the resident when speaking and make eye contact. - Focus: (Resident #1) had unwanted behaviors related to yelling, combative with staff, refuses care, medications and meals and transfers independently without assistance. Initiated on 12/6/24. Goal: The resident will have fewer episodes of behavior by review date. Target date 3/16/25. Interventions: Caregivers to provide opportunity for positive interaction and attention, explain all procedures to the resident before starting, give 1:1 (individualized attention provided by one person to the resident) assistance to try and calm resident down, intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner, remove from situation and take to alternate location as needed and re-direct resident when combative, explaining this is inappropriate behavior. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's Incident/Accident Investigation Worksheet dated 1/29/2025 at 8:45am revealed an incident of abuse occurred. There were no witnesses listed. The pain assessment revealed she complained of a headache, Tylenol (a medication for pain management) was offered but refused. The conclusion/root cause was described as possible physical abuse .recommendations/interventions: Ask (family member) to check camera footage. Record review of an Abuse-Investigation Statement dated 1/29/25 revealed CNA A made the statement: (Resident #1) called asking to be changed around 9:00pm, after letter her know that I was in the middle of my round & that I would be assisting her afterward, (Resident #1) continued to call out. When I changed her/provided pericare, she asked for Tylenol & for the lights to be turned off. Approximately 5 min later (Resident #1) called out again, but she was not making any sense. In a continuance of the statement, CNA A reported that he entered Resident #1's room and asked what was wrong. I placed my hand down near her head on her bed, due to her bed being so low to the ground. (Resident #1) began to start jostling & throwing her head around. She hit her head against my hand. After that she shouted that I hit her & I moved my hand away & walked out of the room . Record review of a provider investigation report dated 2/5/2025 described an allegation of abuse in that CNA A hit Resident #1. A video from the incident shows a timestamp of 1/28/25 at 9:48pm and revealed CNA A hit Resident #1 on her left cheek. The police were notified, and CNA A was terminated on 1/30/25. The resident was assessed with no new injuries noted. An assessment was completed, and Resident #1 complained that her head hurt from the fall. The resident had a fall on 1/26/25 that resulted in a contusion (a bruise) to her right eye/cheek area. The provider investigation report was signed by the Former Administrator. The allegation of abuse was confirmed. Surveyor attempted interviews with Resident #1 on 5/13/25 at 11:11am and 5/14/2025 at 10:50 am with no success as she refused to be interviewed. In an interview with CNA B on 5/14/2025 at 11:34am, she said she was at the facility at the time of the incident. She said CNA A approached her and told her that Resident #1 said he hit her. She looked into Resident #1's room and Resident #1 said, he hit me, he hit me! She said she was terrified, scared, yelling, crying, and asking for help. She said she and CNA A went to the break room to find Resident #1's nurse, then reported what happened. She said LVN C told LVN D to call the administrator rather than send a text message. In an interview on 5/13/2025 at 11:22pm, LVN C stated she was working the night of the incident between CNA A and Resident #1. She said on the night of the incident, CNA B reported to her that CNA A hit Resident #1. She said she approached the nurse who was caring for Resident #1 and shared with her what CNA B said. Then she noticed that the LVN was on her phone making notifications. She said she did not follow-up afterwards. She said she could not remember the other LVN's name. In a telephone interview on 5/15/25 at 9:15am, LVN D said she was assigned to Resident #1 when there was an allegation of abuse. She said she was on a lunch break, and LVN C came in and told her about the abuse allegation between CNA A and Resident #1. She said she assessed Resident #1, then tried to call the Former Administrator and the Former ADON. She said they did not pick up, so she texted them. She said during orientation, she remembered that they told her a text was an appropriate method of communication. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 5/14/25 at 3:20pm, The DON said she expected staff to contact the Administrator or the DON by phone when there was an allegation of abuse. She said staff should try to call until someone answered the phone. She said the abuse incident between CNA A and Resident #1 should have been reported to HHSC within 2 hours. She said the Administrator became aware of the allegation at about 7:10am the morning of 1/29/25, and the incident was not reported to HHSC until 12:45pm on 1/29/25, which was more than a 2-hour time difference. In a telephone interview on 5/15/25 at 10:23am, the Former Administrator, when asked about the notification she received from nursing staff about an allegation of abuse involving CNA A and Resident #1, she said it was super delayed. She said she received a text early in the morning the day after the incident occurred, but it did not have any context. She said she visited with Resident #1 who could not remember the incident, then called Resident #1's family member to ask her to view the camera footage. She said once Resident #1's family member confirmed that CNA A hit Resident #1, she called the police and HHSC. Record review of a Quality Assurance and Performance Improvement Committee Monthly Meeting Minutes dated 1/30/25 revealed the facility department heads met to discuss communication failure on allegation of abuse on 1/28/25. Facility made aware of allegation of abuse in untimely fashion. Nurse failed to call Admin or any other management to notify of abuse allegation . Record review of the facility's Abuse, Neglect and Exploitation policy revised on 1/8/2023 read in part, .If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown origin source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility . Immediately is defined as: within two hours of an allegation involving abuse or result of serious bodily injury .