| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676477 | A. Building<br>B. Wing | 04/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Caraday of Mount Vernon | 501 Yates Street<br>Mount Vernon, TX 75457 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047<br><br>Based on interviews, and record review the facility failed to treat each resident with respect and dignity and provide care in a manner that promotes maintenance or enhancement of his or her quality of life for 1 of 1 resident (Resident #1) reviewed for resident rights.<br><br>1. The facility did not ensure CNA B removed her earbuds prior to providing care to Resident #1.<br><br>2. The facility did not ensure CNA D spoke in a manner of respect to Resident #1.<br><br>These failures could place residents at an increased risk of embarrassment, isolation, and diminished quality of life.<br><br>Findings included:<br><br>Record review of Resident #1's face sheet, dated 04/14/25, reflected Resident #1 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included rheumatoid arthritis (chronic autoimmune disease that primarily affects the joints, causing inflammation, pain, stiffness, and swelling), and PTSD (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event).<br><br>Record review of Resident #1's quarterly MDS, dated [DATE], reflected Resident #1 usually made herself understood, and usually understood others. Resident #1's BIMS score was 15, which indicated her cognition was intact. Resident #1 required supervision/touching assistance with oral care and substantial/maximum assistance with personal hygiene and upper body dressing. Resident #1 was dependent with shower/bathing, toileting, and lower body dressing.<br><br>Record review of the comprehensive care plan, revised 07/22/24, reflected Resident #1 had a history of fabrication against staff at times regarding care and how they talk to her, and periodically makes derogatory posts regarding facility on social media without informing the Administrator of a care issue. The care plan interventions included Resident #1 will be encouraged to be honest/truthful in all situations, and two staff members will be present, if possible, when interacting with the resident and/or providing care.<br><br>1. Record review of a witness statement dated 07/18/24 written by CNA R reflected CNA B had her earbuds in and really did not address Resident #1 much more.<br><br>(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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Record review of an undated witness statement written by CNA K reflected CNA D told Resident #1 she would not be coming into her room being friendly anymore because Resident #1 was not going to lie on her to get her fired.<br><br>During an interview on 04/10/25 at 8:15 a.m., Resident #1 stated she could not remember back that far if CNA B had earbuds on while providing care to her. Resident #1 stated she did remember CNA D making that statement and it made her feel awful.<br><br>During an interview on 04/10/25 at 11:38 a.m., CNA R stated on 07/18/24 when she and CNA B were providing incontinent care to Resident #1, CNA B had her earbuds in and was not paying too much attention to Resident #1. CNA R stated earbuds should not be worn at the bedside. CNA R stated this failure was a respect issue.<br><br>During an interview on 04/10/25 at 3:27 p.m., the DON stated she expected staff not to have their earbuds or cell phones on the floor while providing care. The DON stated there had been issues in the past and they were addressed immediately. The DON stated the ADON, Administrator and herself were responsible for monitoring and overseeing staff while they were proving care and not using communication devices while providing care by random spot checks. The DON stated this failure did not allow staff to provide the care that was needed because it was a distraction and respect issue.<br><br>During an interview on 04/10/25 at 3:46 p.m., the Administrator stated he expected staff to wear earbuds outside of care. The Administrator stated there really had not been any issues in the past. The Administrator stated he did daily random spot checks to monitor and ensure all residents were treated with respect. The Administrator stated this failure was a dignity issue.<br><br>During a telephone interview on 04/11/25 at 9:32 a.m., CNA B stated she had never worn earbuds into a resident room. CNA B stated she did not know why someone would say that she did.<br><br>During an interview on 04/10/25 at 11:16 a.m., CNA K stated Resident #1 had been crying all day on 03/09/25 but would not voice what was wrong when she and other staff members went in to check on her. CNA K stated she, and CNA D went into Resident #1's room to start their last round of changes and Resident #1 had mentioned that an aide (CNA B) poorly treated her the night before. CNA K stated as soon as Resident #1 stated she was treated poorly CNA D sighed and started huffing her breath and rolling her eyes, stating Resident #1 you do this all the time and I'm not going to be coming in here being friendly if you're going to be getting everyone in trouble. CNA K stated when CNA D asked Resident #1 what CNA B did, Resident #1 stated CNA B shoved her into the bed rail once as Resident #1 told her it was uncomfortable and hurting her hand, CNA B again shoved her into the bed rail. CNA K stated Resident #1 told CNA D she was not trying to get anyone in trouble.<br><br>During an interview on 04/10/25 at 3:27 p.m., the DON stated she expected all residents to be treated with kindness and get the care they need. The DON stated she, and the Administrator were responsible for monitoring and overseeing by daily rounds. The DON stated residents usually would report if the staff has been rude or said anything was uncomfortable. The DON stated this failure was a respect issue.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 04/10/25 at 3:46 p.m., the Administrator stated he expected staff to treat every resident with respect and dignity like they would treat their own parents. The Administrator stated he monitored by daily random rounds by listening outside the resident door if a staff member is in the resident room and by speaking with residents and communicating with staff to ensure that they know the proper reporting procedures. The Administrator stated this failure was a respect issue.<br><br>During a return telephone interview on 04/14/25 at 7:55 a.m., CNA D stated she was told she was terminated for an accusation bullying Resident #1 which she still did not know what it was about. CNA D stated she had never told Resident #1 she would not be friendly to her. CNA D stated she had always treated Resident #1 with respect and dignity.<br><br>Record review of the facility's Resident Rights, revised 12/16 indicated, . Team members shall treat all residents with kindness, respect, and dignity . 1. Federal and state laws guarantee certain basics rights to all residents of this facility. These rights include the resident's right to: b. be treated with respect, kindness, and dignity . |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047<br><br>Based on interview and record review, the facility failed to implement written policies and procedures that prohibit and prevent, neglect, and abuse of residents, for 1 of 7 residents (Resident #1) reviewed for abuse.<br><br>1. Resident #1 alleged CNA B was rough, while providing incontinent care as pushed her left shoulder causing her to almost hit her head on the rail during care. CNA A witnessed the alleged abuse and failed to report timely to the abuse coordinator on 03/09/2025.<br><br>2. The facility did not ensure the ADON and DON notified the abuse coordinator of an allegation of abuse reported by CNA C on 3/09/2025 at 6:07 a.m. via a text message concerning Resident #1. The Abuse coordinator was made aware of the ADON and DON's knowledge of the abuse allegation on 4/10/2025 by the surveyor.<br><br>3. The ADON and DON failed to protect Resident #1 by allowing CNA B to provide care to residents starting on 3/09/2025 at 10:00 p.m. and ending on 3/10/2025 at 6:00 a.m.<br><br>4. The facility failed to ensure CNAs A, B and D received abuse training upon hire prior to receiving care duties.<br><br>An Immediate Jeopardy (IJ) was identified on 04/10/25 at 4:40 p.m. The IJ template was provided to the facility on [DATE] at 5:16 p.m. While the IJ was removed on 04/11/25, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy and a scope of pattern due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.<br><br>These failures could place residents at risk of unreported abuse, neglect, exploitation, and a decreased quality of life.<br><br>Findings included:<br><br>Record review of the facility's policy Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 4/2021 indicated, . Residents have the right to be free from abuse . This included but is not limited to freedom from . verbal or physical abuse . 1. Protect residents from abuse . by anyone including, but not necessarily limited to a. facility staff .6. Provide staff orientation and training/orientation programs that included topics such as abuse prevention, identification and reporting of abuse .<br><br>Record review of the facility's policy Abuse Investigation and Reporting, revised 7/2017, reflected . All reports of resident abuse . shall be promptly reported to local, state, and federal agencies and thoroughly investigated by facility management . Reporting . 2. An alleged violation of abuse . will be reported immediately, but not later than: a. Two hours if the alleged violation involves abuse .<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Record review of Resident #1's face sheet, dated 04/14/25, reflected Resident #1 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included rheumatoid arthritis (chronic autoimmune disease that primarily affects the joints, causing inflammation, pain, stiffness, and swelling), and PTSD (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event).<br><br>Record review of Resident #1's quarterly MDS, dated [DATE], reflected Resident #1 usually made herself understood, and usually understood others. Resident #1's BIMS score was 15, which indicated her cognition was intact. Resident #1 required supervision/touching assistance with oral care and substantial/maximum assistance with personal hygiene and upper body dressing. Resident #1 was dependent with shower/bathing, toileting, and lower body dressing.<br><br>Record review of the comprehensive care plan, revised 07/22/24, reflected Resident #1 had a history of fabrication against staff at times regarding care and how they talk to her, and periodically makes derogatory posts regarding facility on social media without informing the Administrator of a care issue. The care plan interventions included Resident #1 will be encouraged to be honest/truthful in all situations, and two staff members will be present, if possible, when interacting with the resident and/or providing care.<br><br>Record review of a text message dated 3/09/2025 at 6:07 a.m., reflected CNA C sent a message to the DON and ADON stating Hey, I had some stuff reported to me. The message reflected CNA A told CNA C that she was wanting to leave because the way CNA B treated patient and she did not want to report it because CNA A was new, and she did not like conflict. The message stated, she said nothing physical but there is a way you treat patients and there is not, she kept telling me don't say nothing, but these are people. The message reflected the ADON responded first by saying Yes ma'am. Thank you. I appreciate anything being reported. We will follow up. Can you tell the nurse that's there right now I am getting dressed to head that way . The message reflected the DON responded by saying Thank you!!! Tell CNA A it is ok, and it will be fixed, and I will text her as well .<br><br>Record review of a witness statement dated 03/09/25 written by CNA C reflected it was reported to CNA C by CNA A that CNA B was inappropriate to patients. The statement reflected that CNA A felt so uncomfortable to witness what she had witnessed by CNA B that she would just quit.<br><br>Record review of a witness statement dated 03/10/25 written by CNA A reflected she witnessed CNA B being rough when handing Resident #1 when it came to changing Resident #1's brief and making rude comments towards Resident #1. The statement also stated that CNA B pushed Resident #1 and shoved her too close to the bed rail where she could hear Resident #1 stating she was having trouble being handled roughly.<br><br>Record review of a March 2025 schedule reflected CNA B provided care to residents starting on 3/09/2025 at 10:00 p.m. and ending on 3/10/2025 at 6:00 a.m.<br><br>Record review of CNA A's personnel file indicated she was hired on 01/27/25 and did not receive her abuse training until 03/26/25.<br><br>Record review of CNA B's personnel file indicated she was hired on 03/21/24 and did not receive her abuse training until 03/27/24.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Record review of CNA D's personnel file indicated she was hired on 02/14/24 and did not receive her abuse training until 03/02/25.<br><br>During an interview on 04/10/25 at 8:15 a.m., Resident #1 stated an incident occurred about a month ago where two staff members came in to provide incontinent care and CNA B pushed her left shoulder causing her to almost hit her head on the rail. Resident #1 stated the staff member also called me lazy.<br><br>During an interview on 04/10/25 at 8:44 a.m., the Administrator stated he was the abuse coordinator. The Administrator stated he learned of the incident between CNA A, CNA B and Resident #1 the morning of 03/10/25. The Administrator stated the DON told him on 03/10/25 CNA C called her to let her know CNA A was going to quit because she witnessed CNA B been rough to Resident #1 during incontinent care. The Administrator stated the DON called CNA A on 03/10/25 to the facility to gather more information and that was when he learned CNA B shoved Resident #1 to the bed rail. The Administrator stated he called CNA B on 03/10/25 and suspended her pending investigation.<br><br>During an interview on 04/10/25 at 9:08 a.m., the ADON stated when she came in the morning of 03/10/25 she found a statement written by CNA C stating during shift report on 03/09/25 CNA A reported to her that she witnessed CNA B being inappropriate to residents. The ADON stated at that time she found the statement on 03/10/25 the Administrator and DON were already made aware of the allegation.<br><br>During an interview on 04/10/25 at 9:15 a.m., the DON stated she received a call from CNA C on 03/10/25 stating CNA A was wanting to quit because she witnessed CNA B being inappropriate to residents. The DON stated she called and asked her to come in on 03/10/25 to speak to her and the Administrator and that was when they learned of the incident.<br><br>During a telephone interview on 04/10/25 at 1:08 p.m., CNA A stated she witnessed CNA B on 03/09/25 being rough and shoving Resident #1 to the bed rail almost hitting her head while providing incontinent care. CNA A stated she could hear Resident #1 telling CNA B she was being too rough, but CNA B continued to provide care. CNA A stated CNA B would never let her assist her with providing care to Resident #1. CNA A stated she just stood there and kept Resident #1 from hitting her head on the pull up bar. CNA A stated this incident occurred after midnight on 03/09/25 during rounds. CNA A stated she had just started working at the facility and did not feel comfortable reporting the issue to the Administrator or DON because she felt like there would be repercussions so instead, she reported the incident to CNA C during shift report.<br><br>During a telephone interview on 04/10/25 at 1:30 p.m., CNA C stated during shift report on 03/09/25 CNA A told her she had witnessed CNA B being inappropriate to residents. CNA C stated CNA A would not go into details what she had witnessed but she knew it was bad enough for CNA A wanting to quit. CNA C stated as soon as CNA A reported the allegation to her, she sent a group text to the DON and ADON informing them of the allegation. CNA C stated she did not know the proper protocol regarding how to report the allegation and she did not want to bother the Administrator. CNA C stated the ADON came in the morning of 03/09/25 to work the floor and told CNA C to write a statement and she would give it to the Administrator. CNA C stated she wrote the statement and handed to the ADON.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview on 04/10/25 at 2:44 p.m., the ADON stated she did not remember receiving a text from CNA C on 03/09/25 reporting the allegation between CNA B and Resident #1. The ADON stated she did come in on 03/09/25 for a short period but she did not recall telling CNA C to write a statement re: the incident. The ADON stated she did not go in Resident #1's room while she was at the facility on 03/09/25. After the state surveyor showed her the text message, she continued to state she did not remember receiving or responding to the text message. The ADON stated she should have notified the Administrator immediately. The ADON stated not reporting an allegation of abuse put residents at risk for further abuse.<br><br>During an interview on 04/10/25 at 3:27 p.m., the DON stated she did not remember receiving a text from CNA C until the state surveyor brought it to her attention. The DON stated she went back and read the message and realized she had responded. The DON stated she was probably still asleep when she responded to the text when CNA C sent at 6 a.m. The DON stated she received text messages all day, every day and it was hard to remember every conversation with her staff especially if she was half asleep. The DON stated she should have notified the Administrator immediately. The DON stated not reporting an allegation of abuse put residents at risk for possible harm and abuse.<br><br>During an interview on 04/10/25 at 3:46 p.m., the Administrator stated he was not aware of the text between CNA C, DON and the ADON until the state surveyor brought it to his attention. The Administrator stated he expected to be notified immediately to report to HHSC and start an investigation. The Administrator stated if he had of known about the allegation on 03/09/25, CNA B would have not worked the 10:00 p.m. shift starting on 3/09/2025 and ending on 3/10/2025 at 6:00 a.m. The Administrator stated he monitored abuse by daily random rounds and ensured staff was in serviced on abuse and neglect monthly and instructed all staff to notify him any time doesn't matter 24/7. The Administrator stated he expected abuse training to be completed upon hire before the employee takes the floor. The Administrator stated not reporting an allegation of abuse or completing abuse trainings could potentially put residents at risk for continued abuse.<br><br>During an interview on 04/10/25 at 5:00 p.m., the BOM stated she was responsible for ensuring staff completed their training upon hire. The BOM stated corporate manually put the trainings in a system and sometimes there was a delay. The BOM stated she did an audit back in March and realized abuse trainings had not been completed for CNAs A and D. The BOM stated it was not much of a risk for staff not to complete their trainings upon hire because they were verbally educated on Abuse and Neglect on hire. The BOM stated there was not a policy specific to when abuse training should be conducted.<br><br>During a telephone interview on 04/11/25 at 9:32 a.m., CNA B stated she was not handling Resident #1 roughly or trying to hit her head on the pull up bar during incontinent care. CNA B stated she never heard Resident #1 stating she was rough during care. CNA B stated she always rolled Resident #1 over, lifted her hip a little and had her to grab the pull up bar to place a brief under her. CNA B stated she has never told any staff member not to assist them. CNA B stated she still did not know why she was terminated on 03/17/25.<br><br>This was determined to be an Immediate Jeopardy (IJ) on 04/10/25 at 4:40 p.m., The Administrator was notified, provided with the IJ template on 04/10/25 at 5:16 p.m. and a Plan of Removal was requested.<br><br>The facility's plan of removal was accepted on 04/11/25 at 8:10 a.m. and included the following:<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 04/10/25 an abbreviated survey was initiated at the facility.<br><br>On 04/10/25 A surveyor provided an IJ Template notification that the Survey Agency has determined that the conditions at the center constitute immediate jeopardy to resident health.<br><br>The notification of the alleged immediate jeopardy states as follows:<br><br>F 607 Develop/Implement Abuse/Neglect<br><br>The facility failed to:<br><br>C.N.A. A failed to notify the Abuse Coordinator immediately of an abuse allegation.<br><br>Protect Resident #1 and other vulnerable residents from the alleged perpetrator. The perpetrator was allowed to continue working their shift.<br><br>Facility DON and ADON failed to notify Abuse Coordinator of alleged abuse on 3/9/25 when it was reported to them at approximately 6am on March 9th.<br><br>Facility failed to ensure that all employees received Abuse training prior to working on the floor.<br><br>Identify residents who could be affected.<br><br>All Residents have the potential to be affected. The Facility census on 04/10/25 was 32.<br><br>Resident #1 was interviewed by the Administrator, DON and ADON on 3/10/25 to determine if there were any negative outcome, resident was showing no signs visible signs of emotional distress and did not verbalize any feelings of fear and denied any physical contact by the perpetrator. On 3/11/25 the Psychologist interviewed resident and she did not voice any concerns to him. The facility SW also interviewed the resident on 3-11-25 and she voiced no physical harm was done. On 3/12/25 resident stated to night nurse that she was happy with staff now. A care plan meeting was also held with resident and her family memeber on 3/13/25 and no new concerns were brought forward.<br><br>Identify responsible staff/ what action taken to prevent further abuse:<br><br>.<br><br>ADON, MDS coordinator and Administrator will conduct 100% resident rounds to determine if further allegations of abuse are alleged. This will be completed by 04/11/25.<br><br>Safe surveys will be conducted by Social Worker, Human Resources and Activity Director for all cognitive residents. This will be completed by 04/11/25.<br><br>C.N.A. A was a new employee and was educated on Abuse, neglect and reporting by DON on 3/10/25.<br><br>C.N.A. B and D were suspended on 3/10/25 and terminated on 3/17/25.<br><br>(continued on next page) |

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|---|---|
| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | DON and ADON were given a final written warning stating any further failures would result in termination and were re-educated by Administrator on 4/10/25.<br><br>In-Service conducted.<br><br>The Abuse Coordinator was educated on 04/10/25 by the Regional Director of Clinical Services on how to investigate allegations of abuse, reporting of abuse and the importance of a thorough investigation and written documentation of statements and in-services.<br><br>In-servicing was initiated by Administrator on Abuse investigation, notification, and immediate removal of the perpetrator 04/10/25 for the DON and ADON.<br><br>In-service will be provided to all staff on Immediate Notification of Allegations to Facility Abuse Coordinator or designee when not in facility or available, Investigating Allegations of Abuse and Neglect, Reporting of Abuse Neglect and Misappropriation, and notification of proper local and state entities by DON and ADON on 4/10/25 and completed by 4/11/25.<br><br>Agency staff that work in the facility or staff on PTO or LOA will have in-servicing completed prior to working the floor by the DON/ADON.<br><br>Abuse and Neglect training will be a part of the new hire orientation effective immediately and no staff will be allowed to work until the Administrator has verified that training has occurred. This training will include all aspects of Reporting Abuse, Investigating Abuse and resident protection from abuse and will be completed at time of hire by HR/DON and verified by Administrator.<br><br>Any staff member who is an alleged perpetrator for any allegation will be suspended immediately pending investigation and will be escorted out of the facility immediately by the senior staff member on duty or law enforcement and will not be allowed to return to the building until the investigation is complete.<br><br>The police were notified of the allegation of abuse on 4/10/25 by the Administrator.<br><br>Implementation Date of Changes<br><br>04/10/25<br><br>Involvement of Medical Director<br><br>The Medical Director was notified about the immediate Jeopardy on 04/10/25.<br><br>Involvement of QA<br><br>QAPI will review and approve Plan of Removal on 04/11/25.<br><br>Who is responsible for the implementation of the process?<br><br>Administrator<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676477 | A. Building<br>B. Wing | 04/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Caraday of Mount Vernon | 501 Yates Street<br>Mount Vernon, TX 75457 |

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

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|---|---|
| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 04/11/25 the state surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by:<br><br>Record review of the safe surveys for all residents who were cognitively intact were completed on 04/11/25. No additional concerns were identified.<br><br>Record review of a resident list reflected 100% resident rounds was initiated on 04/10/25 and completed on 04/11/25 to determine if further allegations of abuse were alleged. No additional concerns were identified.<br><br>Record review of a form titled Team Member Counseling Form reflected the DON and ADON were given a final written warning stating any further failures would result in termination and were re-educated by Administrator on 4/10/25.<br><br>Record review of the facility orientation checklist reflected abuse and neglect training will be a part of the new hire orientation.<br><br>During an interview on 04/11/25 at 9:46 a.m., Resident #1 was lying in bed tearful related to the law enforcement called out to the facility to speak to her about the abuse. Resident #1 stated she spoke to someone yesterday and did not want to speak about it today. Resident #1 stated the staff here has treated her nice and was good to her.<br><br>During interviews conducted on 04/11/25 between 9:56 a.m. and 11:54 a.m., reflected CNA A, CNA E, CNA F, CNA K, MA G, RN H, RN Q, Housekeeping L, [NAME] M, Housekeeping N, COTA O, CNA P, BOM, Dietary Manager, MDS Coordinator, Maintenance Director from all shifts were in-serviced on and could verbalize understanding of in-service on immediate notification of allegations to facility abuse coordinator or designee when not in facility or available, investigating allegations of abuse and neglect, reporting of abuse neglect and misappropriation, and notification of proper local and state entities on 04/10/25.<br><br>During a telephone interview on 04/11/25 at 10:10 a.m., the Medical Director stated he was notified of the IJ on 04/10/25 and attended a QAPI meeting via phone over the IJ and subsequent plan of removal on 04/11/25.<br><br>During an interview and record review of the in-service presented by the Administrator on 04/11/25 beginning at 10:39 a.m. and 10:52 a.m., reflected the DON and ADON were in-serviced on and could verbalize understanding of in-serviced on abuse investigation, notification, and immediate removal of the perpetrator on 4/10/25.<br><br>During an interview and record review of the in-service presented by the Regional Director of Clinical Services on 04/11/25 at 10:56 a.m., reflected the Administrator was in-serviced on and could verbalize understanding on how to investigate allegations of abuse, reporting of abuse and the importance of a thorough investigation and written documentation of statements and in-services on 04/10/25.<br><br>During an interview on 04/11/25 at 10:39 a.m., the DON stated there has not been any new admits currently.<br><br>(continued on next page) |

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| | 676477 | A. Building<br>B. Wing | 04/14/2025 |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | The Administrator was notified the Immediate Jeopardy was removed on 04/11/25 at 12:15 p.m., the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm with a scope of pattern due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. |