STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676488	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hollow Rehabilitation Center	5011 North US Hwy 75 Sherman, TX 75090

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45831 Based on interviews and record review, the facility failed to ensure each resident had the right to be free from abuse for 1 (Resident #1) of 5 residents reviewed for abuse. The facility failed to ensure a safe environment free from abuse for Resident #1 when CNA A entered his room and cut and stabbed him multiple times which caused him to sustained stab wounds to his right neck, left chest, and left arm on [DATE]. The noncompliance was identified as PNC. The IJ was from [DATE] to [DATE]. The facility had corrected the noncompliance before the survey began. This failure caused serious injury resulting in hospitalization and placed the resident at risk of death. Findings included: Review of Resident #1's undated face sheet reflected the resident was a [AGE] year-old male that was admitted to the facility on [DATE]. The diagnoses included unspecified nondisplaced fracture of second cervical vertebra (neck fracture); age-related osteoporosis without current pathological fracture (reduced bone mass); depression (mood disorder); unspecified sequelae of other cerebrovascular disease (affect blood flow and the blood vessels in the brain); polyneuropathy (nerve damage); dysphagia (difficulty swallowing); chronic obstructive pulmonary disease (lung disease); muscle wasting and atrophy (wasting or thinning of muscle mass); and malignant neoplasm of prostate (prostate cancer). Review of Resident #1's Quarterly MDS dated [DATE] revealed a BIMS score of 15 indicating he was cognitively intact. In Section E (Behavior) it stated that Resident #1 did not exhibit physical, nor verbal behavioral symptoms directed towards others. In Section GG (Functional Abilities and Goals) it stated Resident #1 required substantial/maximal assistance with his personal hygiene and toileting hygiene. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's undated Care Plan, revealed Resident #1 was on anticoagulant therapy related to CAD (coronary artery disease). His goal was to be free from discomfort or adverse reactions related to anticoagulant use with interventions in place to monitor for bruising, significant or sudden changes in vital status and avoid activities that could result in injury. It also revealed Resident #1 is on oxygen therapy related to COPD (lung disease). His goal was to have no signs or symptoms of poor oxygen absorption with interventions in place to monitor for signs and symptoms of respiratory distress, increased heart rate and atelectasis (a collapse of the whole lung or an area of the lung). Further review revealed he was care planned for chest pain related to angina. His goal was to be pain free as evidenced by verbalization of comfort with interventions in place to encourage Resident #1 to avoid activities which increase the risk for chest pain. Review of Resident #1's Progress Notes on EHR revealed a progress note written by LVN A with an effective date of [DATE] at 07:52 am that revealed at approximately 4:45 am, this nurse entered Resident #1's room in response to a CNA questioning why another CNA had come back to work so early. Upon entering the room, I asked CNA A and she said she had just come in early to help I said thank you and walked back out of the room. The CNAs in the hall said that wasn't true and that she had a knife. I rushed back into the room, while CNA A ran out. I saw Resident #1 and he was bleeding profusely from his chest and the right side of his neck. I yelled for help and found a clean pillowcase and applied it to his neck. I ran back out Resident 1's door and yelled for help and to stop CNA A, to call 911 and get me more help, clean towels and to get other nurses. Myself and CNA C continued to apply pressure to Resident 1's wounds. The largest wound being across his throat on the right side to up around his ear to the right jaw. Resident #1's other wounds were a slashing type wound to his left forearm and a stabbing type wound to his left chest area with multiple wounds to his arms or hands. We continued to hold pressure until EMS arrived and Resident #1 was transported to the hospital. Record review of the hospital paperwork provider notes dated [DATE] with a hospital admission time of 07:09 am revealed Resident #1 was admitted for multiple stab wounds. A [AGE] year-old gentleman transferred as a trauma level 1 after sustaining stab wounds to his right neck, left chest and left arm at the skilled nursing facility. He is alert and awake with significant bleeding from his right neck. Pressure is being held to slow the hemorrhage. He states that he does take Plavix. All 12 systems negative other than mentioned above. The Assessment/Plan listed: Stab wound of neck (S11.91XA): Will proceed emergently to the operating room for a wound exploration washout and closure. Multiple stab sounds (T07.XXXA): Left chest wound does not appear to have penetrated the thorax as chest x-ray and ultrasound do not show any pneumothorax or pericardial effusion. During an interview on [DATE] at 4:40 pm with PD #1, she stated she cannot provide an update now as it was an ongoing investigation. PD #1 confirmed CNA A had been arrested and was in jail. During an interview on [DATE] at 04:49 pm with the MD, he stated he did not know CNA A. The MD stated Resident #1 got along with everyone and was lovable. The MD stated Resident #1 was 95yo and healthy for his age. The MD stated when Resident #1 first admitted to the facility in 2022, he had a fracture of the vertebrae. The MD said other than that, Resident #1 was doing well for his age. The MD stated he visited Resident #1 in the hospital, and he was doing great. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 5:00 pm with Resident #2 (Resident #1's roommate), he stated he was doing okay. Resident #2 stated the incident did not affect him as he was sleeping. Resident #2 stated he cannot understand how he slept through everything. Resident #2 stated when he woke up, the room was full of police and he asked, What did I do? Resident #2 stated he and Resident #1 were like brothers, and they loved each other. Resident #2 stated the Lord kept him asleep because he would have gotten up and jumped in and probably would have gotten hurt. During an interview on [DATE] at 05:05 pm with the MTD, he stated he changed all the door codes internally. The MTD stated whenever there was an incident, or a termination, they change the door codes. The MTD stated he goes to every keypad and wipe all the memory and a new randomly generated code was created. The MTD stated unfortunately there was no printout to provide. The MTD stated the system prompts you for each step, but it does not generate a record. The MTD stated you would have to videotape him going through the process of changing the codes. The MTD stated he was in-serviced on Abuse and Neglect and Emergency Preparedness on [DATE]. The MTD stated he was instructed you always report any concerns to the Abuse Coordinator. The MTD stated for the Emergency Preparedness in-service, they went over the different color codes and identifiable signs. The MTD stated he does not recall ever seeing CNA A. The MTD stated he believed the facility was taking the necessary precautions. The MTD stated the facility changed all the door codes, the facility was in the process of hiring off-duty law enforcement as security (right now they have staff volunteers) to man the front desk after hours, they have implemented only using the front entrance, they were reassuring families, residents and staff, and they were completing in-services with everyone. The MTD stated the facility was putting a new system in place for when visitors come after hours there was going to be a camera involved. The MTD stated the facility was also having someone certified by the State to come out and teach Emergency and Disaster training. The MTD stated he does not have to confirm if he was on the schedule, just staff. The MTD stated he believed the facility was doing everything in their power to comfort everyone and prevent abuse from happening again. The MTD stated he spoke with the Chaplain briefly, but he was doing okay. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 05:10 pm with the DON, she stated she was informed by LVN A that on [DATE] at approximately 11:45 PM, CNA A entered the facility and walked to the long-term care side, looked at the staffing book and then left the facility. The DON stated staff working initially believed when CNA A returned to the facility around 04:45 am, she had returned to clock out and was trying to steal time as she was not scheduled to work. The DON further stated CNA B saw CNA A enter the facility dressed in black scrubs and gave the impression she was there to help. The DON stated CNA C informed LVN A that CNA A was in the building and went into Resident #1's room. The DON stated LVN A said the first time she entered the room, CNA A said, patient care, so she exited the room. She stated CNA B went into the room to inform CNA A that she had already provided care and that was when she saw a knife and LVN A was alerted again. The DON stated as LVN A was going back into Resident #1's room, CNA A was hastily leaving out of the room and exited the facility. LVN A noticed Resident #1 bleeding and started first aide and called out for help. The DON stated 911 was called and alerted a suspicious person in the building and a resident had been stabbed. The DON stated staff provided CNA A's address to law enforcement and they located and arrested her later in the day. The DON stated they had video footage that they turned over to law enforcement showing CNA A entering and leaving the facility both times and entering and exiting the resident's room. The DON stated CNA A had been arrested and the facility had already completed (medical director was notified; wellness checks on all residents; changed all door codes to the facility; started in-services on Emergency Response and Abuse, Neglect and Exploitation; secured an Active Shooter Training for families, residents, and staff for [DATE]; implemented 24-hour around the clock management for the foreseeable future; in the process of getting off-duty cops to use after-hours as security for the foreseeable future for reassurance; had a Psychologist here today to meet with any family, residents, and staff; a Chaplain was here to speak with the roommate, residents, and staff; all families were notified of the incident via the Communication Blast; completed Safe Surveys with residents and had all management on the floor making rounds ensuring wellness; reviewed/modified current policies as applicable to ensure appropriate procedures are in place to prevent harm/potential harm; held an Ad Hoc QAPI meeting to discuss the incident and plan of correction moving forward). During an interview on [DATE] at 08:48 pm with FAM A, she stated Resident #1 lost a lot of blood and the doctor said they need to stabilize his blood pressure. FAM A stated CNA A sliced across Resident #1's neck from the right side and then sliced his chest. FAM A stated Resident #1 also had some defensive wounds on his left arm. FAM A stated LVN A probably saved Resident #1's life. FAM A stated LVN A walked into Resident #1's room as CNA A was exiting the room. FAM A stated she only allows Resident #1 to keep $5 on him to tip the hairdresser. FAM A stated Resident #1 does not keep anything of value in his room. FAM A stated she knows a lot of employees at the facility, and they were wonderful people. FAM A stated the staff loves Resident #1 and he loves them. FAM A stated she has never had any issues with the facility. FAM A stated Resident #1 admitted to the facility for rehabilitation in 2022, and they were so pleased with the facility, they transferred him to the long-term care side. FAM A stated Resident #1 was strong for someone that is about to turn 96-years-old, and he wants to return to the facility. During an interview on [DATE] at 11:15 am, Resident #3 stated she was okay. Resident #3 stated staff conducted a questionnaire about feeling safe. Resident #3 stated she does not need to speak with a counselor or a Priest. During an interview on [DATE] at 11:30 am, Resident #4 stated she felt safe at the facility and was not afraid of anyone. Resident #4 stated no one has threatened or harmed her. Resident #4 stated she answered some questions about feeling safe. Resident #4 stated she was satisfied with her care. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 11:45 am, Resident #5 stated she felt safe at the facility and was not afraid of anyone. Resident #5 stated no one has threatened or harmed her. Resident #5 stated she completed a questionnaire about safety. Resident #5 stated the staff take good care of her and she was satisfied here. During an interview on [DATE] at 12:00 pm, the [NAME] stated he was at the facility to encourage and support people through their workday. The Chaplain stated he has let everyone know they can call him privately to speak freely. The Chaplain stated he has been administering to the staff since 5:00 am. The Chaplain stated he hates to see tragedy and it was so sad. The Chaplain stated it was a blessing that a facility was so quick to invite them in to minister. The Chaplain stated for him, he does not push a faith-based answer to anyone, and he has been telling them there were 3 ways he can encourage them: listen for as long as they need, he can share if he has a similar life experience, or they can allow him to offer a faith-based approach. The Chaplain stated he believes it creates opportunity for processing and healing to know the facility was making space regardless of what they need or just his presence. During an interview on [DATE] at 12:20 pm, CNA B stated CNA A normally worked during her shift from 10:00 pm until 06:00 am. CNA B stated CNA A arrived at the facility the first time after their shift started around 11:45 pm. CNA B stated she told CNA A she was not on the schedule tonight, but jokingly said You can stay, and I will go home. CNA B stated she saw CNA A walk towards the exit and did not see her anymore. CNA B stated around 04:30 am she was completing her last round. CNA B stated she was in a different resident's room and CNA A poked her head in and asked her if she was okay. CNA B stated she thought to herself, I guess she did not leave. CNA B stated she proceeded to walk out of the room, and she saw CNA A enter Resident #1's room. CNA B stated she saw 2 other CNAs on the hall, and they asked her why CNA A was at the facility. CNA B stated they thought CNA A was trying to steal time and hiding in rooms until 6AM. CNA B stated she sent CNA D in the room, and CNA A said she was providing care. CNA B said she responded, I already changed him. CNA B stated she walked to Resident #1's room and as soon as she opened the door, she saw CNA A with a hunter's knife with a black blade (about the length of her forearm). CNA B stated CNA A said, Get back. CNA B stated as she was closing the door, she saw CNA A put the knife in a cover and place it inside of her scrubs. CNA B stated as soon as she closed the door, she told the other two CNAs, and one of the CNAs ran and told LVN A. CNA B stated LVN A went to enter the room and CNA A was coming out. LVN A asked CNA A for her name, and CNA A just kept walking and exited the building. LVN A went back into the room to check on the residents and she started screaming for help. CNA B stated when she first saw CNA A with the knife, CNA A was standing in front of the resident, so she did not see that she had harmed him. CNA B stated the police arrived and searched the entire facility and looked in all the rooms. CNA B stated she has not returned to work. CNA B stated she was informed they have changed the locks and the codes and when she returns to work, she will have to complete some in-services. CNA B stated she never thought anything negative about CNA A. CNA B stated CNA A was a bit stand-offish and did not talk a lot. CNA B stated when she and CNA A worked on the same hall, she would have to start a conversation with CNA A. CNA B stated CNA A never gave her a vibe as though she would hurt a resident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 12:40 pm with LVN B, she stated the day of the incident, she was told a staff member entered the facility and attacked a resident. LVN B stated Resident #1 was stable, but critical. LVN B stated CNA A trained during one of her shifts when she was the Charge Nurse and everything appeared to be normal this day and she had no concerns for CNA A. LVN B stated since the incident, they have completed in-services on Emergency Preparedness and Abuse and Neglect. LVN B stated they went over what to do in the event of an active shooter or an emergency. LVN B stated they read the policy and addressed any questions. LVN B stated you do not engage with the perpetrator; you notify the police. LVN B stated they have had in-services on it in the past. LVN B stated she did not learn anything new, and it was more of a refresher. LVN B stated from the incident itself, she was more vigilant of the behavior of others. LVN B stated they also discussed what constitutes ANE and what to do if you witness it. LVN B said you must remove the resident from the area and ensure their safety. LVN B stated you must assess the resident and make proper notifications. LVN B said this was also a refresher due to being in the medical field for [AGE] years. LVN B stated the IADM checked on her to see how she was doing and if she had any questions. LVN B stated the DON checked in with all staff and informed them the Chaplain would be at the facility to speak with them if needed. LVN B stated both VPs walked throughout the facility checking on residents as well. LVN B stated they were now only allowed to enter and exit via the front doors and only Management were in possession of the door codes. LVN B stated she does not know if anything could have been done different. LVN B stated the AP was a staff member. LVN B stated LVN A took control of the situation and did what needed to be done. LVN B stated the Resident #1 could have died if it was not for LVN A's rapid response. During an interview on [DATE] at 12:55 pm with the SW, she stated they were using Angel Rounds to check in with residents to complete assessments and make any referrals. The SW said the Chaplain left cards to give to anyone in need. The SW stated if they had residents that were feeling overwhelmed or concerned, they will be referred to the PNP. The SW stated they were more aware of the incident and the effects it has on the residents so they can make appropriate referrals. The SW stated they will continue to assess residents and staff due to signs and symptoms may show up later and to be aware that they can develop stressors once the details settle in more. The SW stated Resident #1 was on her Angel Rounds list. The SW stated he was alert and very pleasant. The SW stated he was always out and about. The SW stated Resident #1 loved to do crafts and would pass key chain crosses that he made out to staff and other residents. The SW stated Resident #1 would even teach the other residents how to make things. The SW stated she had never seen Resident #1 have an outburst. The SW stated this incident was never going to make sense to a normal rational person. The SW stated she does not believe the why will ever be a sufficient answer. The SW stated the Resident could have died , and more than one resident or staff could have been hurt. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:10 pm with LVN C, he stated he does not recall ever working with CNA A. LVN C stated he was not informed a lot of details about the incident. LVN C said he just heard a CNA attacked a resident and the resident was sent out. LVN C stated on [DATE], he completed in-services on Abuse and Neglect and Emergency Preparedness. LVN C stated they always had the Emergency Color Codes attached to the back of their ID. LVN C stated the trainings were more of a refresher for him as he used to conduct all the in-servicing at his prior facility. LVN C stated the only difference was the color codes due to the colors not being universal. LVN C stated they discussed the definition of Abuse (physical, emotional, verbal, misappropriation, etc.). LVN C stated they discussed examples and answered questions. LVN C stated staff had to repeat back what they understood. LVN C stated they also discussed proper reporting. LVN C stated they then discussed to always refer to the card on the back of their IDs for any incidents. LVN C stated everything was a refresher for him. LVN C stated Resident #1 could have died . LVN C stated other residents or staff could have been injured. LVN C stated if CNA A had walked up to him, or if anyone that would have seen her in her uniform would not have questioned her. LVN C stated he was unsure of what could have been done different due to not knowing her intentions. During an interview on [DATE] at 1:50 pm with CNA E, she stated she was not working this day. CNA E said they were in-serviced on Abuse and Neglect and Emergency Preparedness on [DATE]. CNA E said they discussed the various types of abuse and how to handle each one. CNA E said if they see something they were to report it immediately to the Charge Nurse and the IADM. CNA E said it was information she already knew. CNA E stated they discussed the different color codes and their purpose. CNA E stated everything was a refresher. CNA E stated CNA A could have hit an artery and Resident #1 could have died . CNA E stated she does not understand why this happened. CNA E said she cannot comprehend it at all. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 02:55 pm with VP A, she stated they received the notification of the incident, staff called 911 and rendered first aid. VP A stated the police were still at the facility when she arrived at 7:45 AM on [DATE]. VP A stated they had already started Safe Surveys with the Residents to make sure they felt safe and comfortable. VP A stated they were able to have a psychologist and Chaplain Services to meet onsite with family, residents and staff to provide support. VP A stated the MD changed all the door codes. VP A stated for now, only the Department Heads had the door codes. VP A stated they notified the doctor and Resident #1's family. VP A stated the remaining families were notified via their Communication Blast. VP A stated during the Ad Hoc QAPI Meeting with the MD this morning, they looked over their policies and procedures, but did not identify any necessary changes. VP A stated on [DATE], they completed in-services on Abuse and Neglect and How to Respond to Emergencies and Traumatic Incidents. VP A stated she re-educated the DON on Abuse and Neglect and Emergency Response and they all in-serviced staff on the same information. VP A identified how things would look moving forward and were working on obtaining off-duty law enforcement to work as security officers after-hours. VP A stated she does not believe anything could have been done different unless they had a crystal ball to foresee the future. VP A stated she believes policy was followed to the best of the facility's ability. VP A stated Resident #1 could have expired. During an interview on [DATE] at 3:25 pm with VP B, she stated she was notified about the incident by the DON on [DATE] around 5:25 am. VP B stated she was told Resident #1 had been injured by CNA A and transported to the hospital. VP B stated CNA A had fled the facility and the police was present and starting an investigation. VP B said they have ensured all doors were secure and changed the codes. VP B said the front entrance was now always staffed and employees must confirm they were scheduled to work. VP B said they have a daytime receptionist, but now the front entrance will be staffed 24 hours. VP B said they completed a facility sweep to verify the wellness of the residents, completed Safe Surveys and began in-servicing on Abuse and Neglect and Facility Emergency Events (Active Shooter/Incidents). VP B said she has conducted in-services with staff and Administration. VP B stated the in-servicing was on-going and any employee that has not been in-serviced will be in-serviced at the start of their shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676488	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hollow Rehabilitation Center	5011 North US Hwy 75 Sherman, TX 75090

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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	During an interview on [DATE] at 3:40 pm with the PNP, she stated she went to the facility the next day on Friday, ,d+[DATE]. The PNP stated on Thursday, ,d+[DATE] she was called by her employer and was asked to go out to the facility to check in on the staff and the residents to see where she could be of assistance and see if they needed help with anything. The PNP stated her primary reason for coming in on Friday was to assess the residents to see how they were doing emotionally. The PNP stated all the residents she spoke with on Friday were okay. The PNP stated a lot of the feedback she received was a lot of them were asleep and was not aware of the situation until the aftermath. The PNP stated she questioned the residents about how they felt about the situation, if they felt safe, assessed what they knew about the situation and made sure they had accurate information about the incident from what she had been told from staff. The PNP stated she informed the residents about the safety measures that she was informed the facility was currently implementing as well. The PNP stated she did not have any residents that communicated to her not wanting to be at the facility, nor any PTSD-type symptoms. The PNP stated some of the residents were just upset that it happened. The PNP stated Resident #1 was one of her patients. The PNP stated Resident #1 had never voiced any concerns about the facility, nor staff leading up to the incident. The PNP stated Resident #1 was a very well-known resident, and his family was very involved with his care at the facility. The PNP stated Resident #1 was diagnosed with depression and that was why she was seeing him. The PNP stated admission to a nursing home was an adjustment for a lot of the LTC residents. The PNP stated the Residents have gone their entire life living independently on their own to sharing a room with a roommate. The PNP stated Residents must navigate that relationship, being provided care by staff and being away from their families. The PNP restated the victim's family was very involved in his care and they were at the facility quite often. The PNP stated she did not assess any staff or families. The PNP stated the facility Psychologist came in the day of the incident to speak with staff and she also rounded on the residents. The PNP stated they were working with the facility to see how they can provide care for the staff too. The PNP stated some staff informed her that a Chaplain came out to visit with them and the residents too. The PNP stated she believes the facility was handling the situation appropriately. During an interview on [DATE] at 3:55 pm with CNA C, she stated on (Wednesday ([DATE]), CNA A showed up to the facility at 11:44 pm. CNA C stated she works on the skilled side and CNA A works on the long-term care side. CNA C stated you must enter the facility after hours on the skilled side where she works. CNA C stated CNA A walked past them on the skilled side and walked towards long-term care. CNA C stated CNA A was on the long-term care side for about 30 minutes and does not know what she did while down there. CNA C stated CNA A eventually walked back out of the building between 12:30 am and 01:00 am. CNA C stated she then went outside to get her lunch from her family member, and she saw CNA A sitting in her car parked under the awning. CNA C stated she assumed CNA A was on break since they work on different sides of the building. CNA C stated CNA A saw her, but she did not think CNA A was doing anything wrong. CNA C stated she then went back into the facility. CNA C stated later during her shift, she remembered she was in a Resident's room, and she told the Resident it was 4:54 am. CNA C stated when she walked out of the Resident's room, she saw CNA A walking back into the facility. CNA C stated she and CNA D said, CNA A must be stealing time. CNA C stated CNA A had been gone this entire time and came back to change a few people and clock out. CNA C stated her, and CNA D waited a few minutes after CNA A walked down the hall to long-term care, and they decided they would go and catch her. CNA C stated looking back at it, the incident must have occurred while they were waiting outside of the rooms. CNA C stated they never heard any noises. CNA C stated CNA B told them which room CNA A was in, so CNA D knocked on the door and started to walk in and CNA A said, I am changing them. CNA C stated CNA B said Well, if she is in there changing them, I am going to go in a[TRUNCATED]