

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676497	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/20/2024
NAME OF PROVIDER OR SUPPLIER  Lakeside Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  110 N State Hwy 274 Kemp, TX 75143	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30527</p> <p>Based on interview and record review the facility failed to ensure residents were free from abuse for 1 of 7 residents (Resident #1) reviewed for resident abuse.</p> <p>1. The facility failed to ensure Resident # 1, was free from physical abuse on 04/03/2024, when CNA A used excessive rubbing force across Resident #1's chest while providing a shower which resulted in a 5 cm superficial laceration (cut or tear in the skin) across her chest at the level of the 2-3rd rib with surrounding ecchymosis (bruising), tenderness, and closed fractures of the 2nd and 3rd rib.</p> <p>2. The facility failed to protect Resident #1 by not ensuring CNA A did not continue to provide care to Resident #1 after the shower room incident on 04/03/2024.</p> <p>The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 04/03/2024 and ended on 04/04/2024. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place residents at risk of physical harm, mental anguish, and/or emotional distress.</p> <p>The findings included:</p> <p>Record review of a face sheet dated 09/20/2024 indicated Resident #1 was an [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), contracture of muscle of the left and right forearm, muscle weakness, dependence of a wheelchair, rheumatoid arthritis of hands (chronic swelling of the small joints), speech and language deficits following cerebrovascular disease (weakness on one side of the body).</p> <p>Record review of the quarterly MDS assessment dated [DATE] revealed Resident #1 had a BIMS score of 12, which indicated mild cognitive deficit. Resident #1 required maximum assistance for ADLs such as toileting, showering and dressing.</p> <p>Record review of a care plan revised on 11/09/2023 titled ADL assistance indicated Resident #1 had an ADL self-deficit and required maximum assistance with dressing, toileting and showering. The interventions for Resident #1 included: Transfer - The resident required mechanical lift - Hoyer Lift with 2 staff assistance for transfers.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Incident Report dated 04/03/2024 indicated Resident #1 experienced a 1.5 x 1.5 x .5 cm laceration across her chest while in the shower room on 04/03/2024.</p> <p>Record review of the hospital Encounter Summary for Resident #1 dated 04/04/2024 documented the Final Diagnosis: abrasion to skin, closed fracture of multiple ribs of right side, assault. Assessment: 5 cm linear (a line) superficial laceration across anterior chest at level of 2-3rd rib. Piece of skin separated down middle of laceration, attached to right side of laceration, no jagged edges. Surrounding ecchymosis (discoloration of the skin resulting from bleeding underneath, typically caused by bruising) and tenderness. Medical Decision Making: [AGE] year-old female presents with primary history of cerebrovascular accident with residual left sided deficits (wheelchair bound at baseline) who suffered unfortunate traumatic skin tears to her chest yesterday evening at the hands of her CNA. The CNA is new, currently training, and seemingly became too aggressive while giving the patient a bath. Per patient, bath water was too hot, and she was scrubbing her too aggressively. Skin tear to middle chest noted. Chest X-Ray suggestive of Right sided rib fracture. Will clean skin tear thoroughly and apply dermabond. (skin adhesive). Of greater concern is the possibility of elder abuse. Patient and [family member] would like to discharge. Medically ready, just waiting on Social Worker for assault case. [family member] and patient would like to leave and will file report outpatient.</p> <p>During an interview on 09/17/2024 at 11:10 AM, Resident #1 said she reminded CNA A that she did not want her hair washed, but the CNA A did not acknowledge her. Resident #1 said CNA A proceeded to use the shower hose and sprayed the water in her face. Resident #1 repeated she did not want her hair wet because she used the salon for her hair care. CNA A squeezed soap onto Resident #1's chest area and rubbed aggressively back and forth. Resident #1 told CNA A to stop because she was hurting her. CNA A continued to rub the front of Resident #1's body aggressively. Resident #1 attempted to kick at CNA A to get CNA A away from her. CNA A turned the water back on and sprayed Resident #1 all over her face again. Resident #1 stated she was yelling for CNA A to stop. Resident #1 said that CNA C entered the shower room and Resident #1 said to CNA C, I did not want my hair wet/washed. Resident #1 said that CNA C said, no, you just don't like our color and turned and left the shower room. Resident #1 said she noticed blood on the washcloth laying on the floor and asked CNA A where the blood was coming from. CNA A never responded to Resident #1. Resident #1 said she did not recall anything that hurt besides the rubbing on her chest area with the washcloth by CNA A and the water spraying hard on her face. Resident #1 stated that LVN D entered the shower room and asked what happened. Resident #1 said CNA A was yelling, she done that to herself. Resident #1 said LVN D told CNA A to leave the shower room. Resident #1 said LVN D dried her off and put her gown on. Resident #1 said several towels that were laying on the floor were stained with blood. Resident #1 said LVN D pushed her on shower chair into the hallway where CNA A, CNA B, and CNA C were standing. Resident #1 stated CNA A was talking loudly and kept repeating, she did that to herself and pulled the shower hose out of my hand and the showerhead hit her. Resident #1 said she tried to talk but CNA A kept talking over her and interrupted her several times. Resident #1 said LVN D told the CNAs to put her back into her bed because she had to call the administrator. Resident #1 said she was scared when CNA A and CNA B placed her back in her bed. Resident #1 said she asked CNA A not to hurt her. Resident #1 said she was scared of new staff and requested not to be in the shower room with new staff. Resident #1 said she did not utilize the same shower room where the incident with CNA A happened because it made her anxious and scared to go in there.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/17/2024 at 11:58 AM, CNA B said she was training CNA A as a new employee to the facility. CNA A had previously worked at the facility through a staffing agency. CNA B was going to shower Resident #1, but CNA A insisted on doing the shower by herself and was arguing about it in front of Resident #1. CNA B said she did not want to argue in front of Resident #1. CNA B said everything seemed fine, and she left CNA A and Resident #1 alone in the shower room. CNA B said a different resident on the hall needed help, so she went into that resident's room. CNA B stated when she come out of the other resident's room (located closer to the nurse's desk), she heard some yelling from the shower room. CNA B said she notified LVN D of the yelling. CNA B said LVN D left the nurses' desk and headed toward the shower room. CNA B said she was in the hallway outside of the shower room when LVN D brought out Resident #1, and Resident #1 was bleeding from the chest area. CNA B said LVN D asked Resident #1 what happened, but CNA A was yelling and talked over Resident #1. CNA B said Resident #1 was bleeding from her chest area and was very upset, crying, and short of breath. CNA B said LVN D instructed her and CNA A to place Resident #1 back in the bed while she called for the ambulance due to the excessive bleeding. CNA B said Resident #1 was very quiet and scared during the transfer process. CNA B said when they were in Resident #1's room, CNA A never said anything more to Resident #1. CNA B said after CNA A left the room, she remained with Resident #1. CNA B said Resident #1 cried and told her she was so scared. CNA B said Resident #1 said she had told CNA A not to wash her hair or get her hair wet, but she continued to spray her in the face area. CNA B stated Resident #1 explained CNA A was rubbing her chest with the washcloth so hard and it was hurting her, and CNA A would not stop when she asked her to. CNA B said Resident #1 kept repeating I was so scared. CNA B stated Resident #1 always wanted her showers just not her hair washed because she used the hair salon. CNA B stated CNA A left the facility soon after the incident occurred. CNA B stated EMS took Resident #1 to the hospital. CNA B said the police came but CNA A had already left the facility at that time. CNA B said in-services for abuse and neglect and how to respond to certain behaviors such as aggression were started with the working staff the same night the incident occurred. CNA B said if a resident requested the staff to stop, the staff should honor the resident's request. CNA B said if a resident refuses care, you could ask the resident later, get assistance from another staff member to see if the resident was more open to them, notify the family and get their help but you would not continue the process because that would be abuse. CNA B said if she witnessed abuse, she would always separate the people having the altercation and be sure no contact had occurred. CNA B said she did not understand why LVN D sent CNA A back to assist with Resident #1's transfer after this incident occurred. CNA B stated that prior to Resident #1's shower she had discussed with CNA A that Resident #1 did not get her hair washed during the shower. CNA B stated she had not experienced any episodes of aggression from Resident #1 while providing care to her or giving her showers. CNA B stated Resident #1 did not refuse her showers or care. CNA B stated Resident #1 would not be able to grab or hold the showerhead hose due to the contracture (a permanent or temporary shortening of muscles, tendons, and other soft tissues that causes joint stiffen and limited movements) of her hands and limited movement.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/18/2024 at 10:34 AM, Resident # 1's family member stated she had received a call on the GrandPad (tablet) from Resident #1. The family member stated Resident #1 was crying during the call. Resident #1's family member stated that CNA B was in the room and had assisted Resident #1 to make the call. The family member stated that during the call she saw EMS arrive to Resident #1's room. Resident #1's family member stated when she arrived at the facility Resident #1 was in the ambulance. The family member stated she went into the facility and took pictures of the shower room, shower hose and shower head, and the blood stain towels that were on the floor. Resident #1's family member said LVN D said CNA C stated that Resident #1 and CNA A were fighting over the shower head. Resident #1 family member asked CNA C if she had observed Resident #1 and CNA A fighting, and CNA C responded no. Resident #1's family member said that CNA C said, I don't have to talk to you. Resident #1's family member said Resident #1 was interviewed multiple times by different staff at the hospital and the story never changed. Resident #1's family member said she told CNA A not to get her hair wet, but CNA A refused to listen or acknowledge her and continued and sprayed her roughly with the water. CNA A then placed a large amount of soap on Resident #1's chest area and rubbed her aggressively with a washcloth. Resident #1 's family member stated Resident #1 said she asked CNA A to stop because it hurt but CNA A did not stop and proceeded to rinse her with hot water. Resident #1 stated she tried to kick at CNA A to get away from her, but CNA A backed up and no contact was made. Resident #1's family member stated that Resident #1 had limited range of motion of her upper extremities and only uses her thumb and index finger on the left and cannot pick up anything with the right hand. Resident #1's family member stated she had provided the pictures with the time stamp from the camera in Resident #1's room to the police and the facility. Resident #1's family member stated she had also provided a detailed timeline of the events that took place in Resident #1's room from the camera pictures. Resident #1 's family member stated at 07:33 PM CNA A, CNA B, and CNA C come into Resident #1's room and got Resident #1 for her shower. Resident #1's family member further stated that at 07:55 PM on the camera, CNA A and CNA B placed a brief on Resident #1 after they transferred her back in bed.</p> <p>Attempted telephone call on 09/18/2024 at 11:31 AM to CNA A, unable to reach or leave a message due to no voice mail had been set up.</p> <p>Record review of CNA C's written witness statement dated 04/03/24 at 7:50 PM indicated, heard yelling from CNA A and she opened the door to the shower room and seen CNA A's clothes were wet and the skin tear around Resident #1's neck. CNA C asked Resident #1 what happened? But Resident #1 started yelling for me to shut up and tried to kick me. By that time, I helped CNA A roll her out of the shower room and CNA B went a got the LVN D. LVN D questioned CNA B while she (CNA C) and CNA A helped Resident #1 to bed. Then I left out to do the other patient</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/18/2024 at 11:40 AM, CNA C said on 04/03/2024 was her first shift as the facilities employee. CNA C said she had previously worked at the facility through a staffing agency. CNA C said she heard yelling from the shower room from the hallway. CNA C said she opened the shower room door and seen CNA A and Resident #1 tugging the shower head back and forth between each other. CNA C said she saw CNA A's clothes were wet. CNA C said she did not enter the shower room. CNA C said she got LVN D because Resident #1 was yelling at her. CNA C said CNA B did not want to shower Resident #1. CNA C said CNA B told CNA A to shower Resident #1 after Resident #1 told her she did not want the black girl to shower her. CNA C said Resident #1 had refused in the hallway. CNA C said after the incident occurred in the shower room, she and CNA B put Resident #1 back in the bed and dressed her alone. CNA C said she was educated on abuse and neglect and proper reactions to aggressive behaviors. CNA C said it was important to separate and not allow any contact with the alleged victim to keep them safe from abuse. CNA C said she had never come back to the facility after the night that the incident occurred.</p> <p>Attempted telephone call on 09/18/2024 at 02:45 PM to CNA A, unable to reach or leave a message due to no voice mail had been set up.</p> <p>During an interview on 09/18/2024 at 3:00 PM, the DON stated when she arrived at the facility CNA A had already left. The DON stated Resident #1 was at the hospital. The DON stated she had examined the shower head and shower hose for bodily tissue or blood but seen no indication of either. The DON stated she was unsure who placed Resident #1 back to bed after the incident in the shower room occurred. The DON stated she had been educated on abuse and neglect after the incident as well as aggressive behaviors and how to respond. The DON stated that the perpetrator or alleged perpetrator should immediately be removed from the facility and not allowed access to residents pending the investigation to ensure no harm to the alleged victim or other resident occurs.</p> <p>During an interview on 09/19/2024 at 08:23 AM, the Administrator stated that he had re-enacted the scenario and agreed Resident #1 had pulled the shower hose from CNA A and caused the shower head to hit her in the chest resulting in the laceration and fracture of the ribs. The Administrator stated Resident #1 could have pulled the shower hose with the use of her one finger and limited arm movement. The Administrator said CNA A was being an ass and spraying the water crazily and Resident #1 wanted CNA A to stop. CNA A did not stop as Resident #1 had requested. The Administrator stated he had tried to get the hall camera's video as requested by the police, but the video only saves for 10 days, and he was not able to get it timely from the IT (information technology) department. The administrator stated that he was not aware that LVN D had sent CNA A back into the room to transfer Resident #1 into bed after the incident had occurred. The Administrator stated if CNA B said that she and CNA A had transferred Resident #1 back into the bed after the shower room incident then that would be true because CNA B was as honest as the day is long. The Administrator said in-services on abuse and neglect, aggressive behavior and appropriate responses, and once an alleged perpetrator is identified there should be no access to the alleged victim or any resident to prevent harm and provide safety. The Administrator said he expected all staff to follow the Abuse and Neglect Policy. The Administrator said CNA A was terminated on 04/03/2024. The Administrator said CNA C was also terminated and had not worked at the facility after the incident on 04/03/2024. The Administrator said he expected CNA A would not have provided any more resident care and left the facility immediately to prevent further possibilities of abuse. The Administrator stated CNA A and CNA C come back to the facility on [DATE] for interviews by the police department. The Administrator stated the family of Resident #1 filed charges on CNA A.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of grievances from January 2024 to September 2024 did not reveal any abuse concerns related to CNA A or CNA C.</p> <p>Record review of the facility's policy and procedure, titled Reporting Abuse and Neglect Policy, dated 2021, indicated .Our facility will protect residents from harm during investigations of abuse allegations. 1. During abuse investigations, residents will be protected from harm by the following measure:</p> <p>Employees accused of participating in the alleged abuse will be immediately re-assigned to duties that do not involve resident contact or will be suspended without pay until the findings of the investigation have been reviewed and a determination made by the Administrator/designee.</p> <p>a)Should the team member(s) be reassigned to non-resident care duties, such assignment will not be in any part of the building which the resident frequents.</p> <p>b)If the alleged abuse involves the resident's family member or visitor, such persons(s) will not be permitted to have unsupervised visits with the resident.</p> <p>c)If the alleged abuse involves another resident, please see Resident-to- Resident .</p> <p>The Administrator was notified on 09/19/2024 at 01:43 p.m., that a past non-compliance IJ situation had been identified due to the above failures.</p> <p>It was determined these failures placed Residents #1 in an IJ situation on 04/03/2024.</p> <p>The facility had corrected the noncompliance on 04/04/2024 by the following:</p> <ul style="list-style-type: none"> <li>- Termination of CNA A who was responsible for the abuse</li> <li>- Written counseling of the LVN D the education on the Abuse and Neglect Policy</li> <li>- Safe surveys of 15 residents in the facility</li> <li>- 100% staff in-service on abuse and neglect and proper responses to aggressive behaviors</li> <li>- QAPI sign in sheet dated 05/01/2024 completed with Administrator, DON, Infection Preventionist, Medical Director, Floor Staff Representative, and Director of Maintenance with opportunities of improvement with Abuse Policy attached.</li> </ul> <p>Record review of Inservice dated 04/03/2024 indicated education to all staff was completed on the Abuse and Neglect Policy, Resident Rights, and Resident's with Combative Behavior.</p> <p>Record review of LVN D's written counseling dated 04/04/2024.</p> <p>Record review of CNA A's termination notice dated 04/04/2024.</p> <p>Interviews on 04/20/2024 from 08:30 AM - 10:48 AM of the sampled residents (Resident #2, Resident #3, Resident #4, Resident #5, Resident #6 and Resident #7) revealed no abuse occurred.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527</b></p> <p>Based on interview and record review, the facility failed to implement written policies and procedures that prohibit and prevent abuse, neglect, exploitation, or mistreatment of residents for 1 of 7 residents (Resident #1) reviewed for abuse and neglect.</p> <p>The facility failed to implement their abuse policies by not ensuring CNA A did not continue to provide care to Resident #1 after CNA physically abused Resident #1 in the shower room on 04/03/2024.</p> <p>The noncompliance was identified as PNC. The Immediate Jeopardy (IJ) began on 04/03/2024 and ended on 04/04/2024. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place residents at risk for continued abuse and neglect due to inappropriate interventions and failure to report the allegations of abuse.</p> <p>Findings included:</p> <p>Record review of the facility's policy and procedure, titled Reporting Abuse and Neglect Policy, dated 2021, indicated .Our facility will protect residents from harm during investigations of abuse allegations. 1. During abuse investigations, residents will be protected from harm by the following measure:</p> <p>Employees accused of participating in the alleged abuse will be immediately re-assigned to duties that do not involve resident contact or will be suspended without pay until the findings of the investigation have been reviewed and a determination made by the Administrator/designee.</p> <p>a)Should the team member(s) be reassigned to non-resident care duties, such assignment will not be in any part of the building which the resident frequents.</p> <p>b)If the alleged abuse involves the resident's family member or visitor, such persons(s) will not be permitted to have unsupervised visits with the resident.</p> <p>c)If the alleged abuse involves another resident, please see Resident-to- Resident .</p> <p>Record review of a face sheet dated 09/20/2024 indicated Resident #1 was an [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), contracture of muscle of the left and right forearm, muscle weakness, dependence of a wheelchair, rheumatoid arthritis of hands (chronic swelling of the small joints), speech and language deficits following cerebrovascular disease (weakness on one side of the body).</p> <p>Record review of the quarterly MDS assessment dated [DATE] revealed Resident #1 had a BIMS score of 12, which indicated mild cognitive deficit. Resident #1 required maximum assistance for ADLs such as toileting, showering and dressing.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Lakeside Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE  110 N State Hwy 274 Kemp, TX 75143	
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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of a care plan revised on 11/09/2023 titled ADL assistance indicated Resident #1 had an ADL self-deficit and required maximum assistance with dressing, toileting and showering. The interventions for Resident #1 included: Transfer - The resident required mechanical lift - Hoyer Lift with 2 staff assistance for transfers.</p> <p>Record review of the hospital Encounter Summary dated 04/04/2024 documented the Final Diagnosis: abrasion to skin, closed fracture of multiple ribs of right side, assault. Assessment: 5 cm linear (a line) superficial laceration across anterior chest at level of 2-3rd rib. Piece of skin separated down middle of laceration, attached to right side of laceration, no jagged edges. Surrounding ecchymosis and tenderness. Medical Decision Making: [AGE] year-old female presents with primary history of cerebrovascular accident with residual left sided deficits (wheelchair bound at baseline) who suffered unfortunate traumatic skin tears to her chest yesterday evening at the hands of her CNA. The CNA is new, currently training, and seemingly became too aggressive while giving the patient a bath. Per patient, bath water was too hot, and she was scrubbing her too aggressively. Skin tear to middle chest noted. Chest X-Ray suggestive of Right sided rib fracture. Will clean skin tear thoroughly and apply dermabond. (skin adhesive). Of greater concern is the possibility of elder abuse. Patient and daughter would like to discharge. Medically ready, just waiting on Social Worker for assault case. Daughter and patient would like to leave and will file report outpatient.</p> <p>During an interview on 09/17/2024 at 11:10 AM, Resident #1 said she reminded CNA A that she did not want her hair washed, but the CNA A did not acknowledge her. Resident #1 said CNA A proceeded to use the shower hose and sprayed the water in her face. Resident #1 repeated she did not want her hair wet because she used the salon for her hair care. CNA A squeezed soap onto Resident #1's chest area and rubbed aggressively back and forth. Resident #1 told CNA A to stop because she was hurting her. CNA A continued to rub the front of Resident #1's body aggressively. Resident #1 attempted to kick at CNA A to get CNA A away from her. CNA A turned the water back on and sprayed Resident #1 all over her face again. Resident #1 stated she was yelling for CNA A to stop. Resident #1 said that CNA C entered the shower room and Resident #1 said to CNA C, I did not want my hair wet/washed. Resident #1 said that CNA C said, no, you just don't like our color and turned and left the shower room. Resident #1 said she noticed blood on the washcloth laying on the floor and asked CNA A where the blood was coming from. CNA A never responded to Resident #1. Resident #1 said she did not recall anything that hurt besides the rubbing on her chest area with the washcloth by CNA A and the water spraying hard on her face. Resident #1 stated that LVN D entered the shower room and asked what happened. Resident #1 said CNA A was yelling, she done that to herself. Resident #1 said LVN D told CNA A to leave the shower room. Resident #1 said LVN D dried her off and put her gown on. Resident #1 said several towels that were laying on the floor were stained with blood. Resident #1 said LVN D pushed her on shower chair into the hallway where CNA A, CNA B, and CNA C were standing. Resident #1 stated CNA A was talking loudly and kept repeating, she did that to herself and pulled the shower hose out of my hand and the showerhead hit her. Resident #1 said she tried to talk but CNA A kept talking over her and interrupted her several times. Resident #1 said LVN D told the CNAs to put her back into her bed because she had to call the administrator. Resident #1 said she was scared when CNA A and CNA B placed her back in her bed. Resident #1 said she asked CNA A not to hurt her. Resident #1 said she was scared of new staff and requested not to be in the shower room with new staff. Resident #1 said she did not utilize the same shower room where the incident with CNA A happened because it made her anxious and scared to go in there.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/17/2024 at 11:58 AM, CNA B said LVN D instructed her and CNA A to place Resident #1 back in the bed while she called for the ambulance due to the excessive bleeding. CNA B said Resident #1 was very quiet and scared during the transfer process. CNA B said when they were in Resident #1's room, CNA A never said anything more to Resident #1. CNA B said after CNA A left the room, she remained with Resident #1. CNA B said Resident #1 cried and told her she was so scared. CNA B said Resident #1 said she had told CNA A not to wash her hair or get her hair wet, but she continued to spray her in the face area. CNA B stated Resident #1 stated CNA A was rubbing her chest with the washcloth so hard, and it was hurting her, and CNA A would not stop when she asked her to. CNA B said Resident #1 kept repeating I was so scared. CNA B said in-services for abuse and neglect and how to respond to certain behaviors such as aggression were started with the working staff the same night the incident occurred. CNA B said she did not understand why LVN D sent CNA A back to assist with Resident #1's transfer after this incident occurred.</p> <p>During an interview on 09/17/2024 at 2:29 PM, LVN D said she was the charge nurse for Resident #1 on 04/03/2024. LVN D said she was at the nurses' desk when she was alerted by CNA B that she heard yelling. LVN D said she immediately went down to the shower room and opened the door, and she saw several towels laying on the floor with blood stains. LVN D said she asked Resident #1 what happened. LVN D said Resident #1 was immediately interrupted by CNA A yelling she did that to herself repeatedly. LVN D said she told CNA A to get out of the shower room, and she dried off and dressed Resident #1. LVN D said Resident #1 was still bleeding profusely. LVN D said she rolled Resident #1 into the hallway where CNA A continued to yell out, she pulled the shower hose and the shower head hit her. LVN D said that CNA A was being mouthy about skin color but could not recall what was said. LVN D said Resident #1 said, I don't get my hair washed in the shower and you sprayed me hard. LVN D said she told two CNAs to place Resident #1 back in the bed. LVN D said she could not recall who she told because everything became a blur. LVN D said she would not have told CNA A to put Resident #1 back in bed because you would separate them to protect the resident, but it was all a blur at that point. LVN D said she had to call the administrator first and he told her to immediately remove CNA A from the facility. LVN D said she had to get CNA A from another resident's room where she was providing incontinent care and told her to leave. LVN D said in-services for abuse and neglect and how to respond to certain behaviors such as aggression was completed for the staff working.</p> <p>Attempted telephone call on 09/17/2024 at 02:43 PM to CNA A, unable to reach or leave a message due to no voice mail had been set up.</p> <p>During an interview on 09/18/2024 at 10:34 AM, Resident #1's family member further stated that at 07:55 PM on the camera, CNA A and CNA B placed a brief on Resident #1 after they transferred her back in bed.</p> <p>Attempted telephone call on 09/18/2024 at 11:31 AM to CNA A, unable to reach or leave a message due to no voice mail had been set up.</p> <p>Record review of the CNA C's written witness statement dated 04/03/24 at 7 :50 PM indicated, heard yelling form CNA A and she opened the door to the shower room and seen CNA A's clothes were wet and the skin tear around Resident #1's neck. CNA C asked Resident #1 what happened? But Resident #1 started yelling for me to shut up and tried to kick me. By that time, I helped CNA A roll her out of the shower room and CNA B went a got the LVN D. LVN D questioned CNA B while she (CNA C) and CNA A helped Resident #1 to bed. Then I left out to do the other patient</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/18/2024 at 11:40 AM, CNA C said 04/03/2024 CNA C said after the incident occurred in the shower room, she and CNA B put Resident #1 back in the bed and dressed her alone. CNA C said she was educated on abuse and neglect and proper reactions to aggressive behaviors. CNA C said it was important to separate and not allow any contact with the alleged victim to keep them safe from abuse. CNA C said she had never come back to the facility after the night that the incident occurred.</p> <p>Attempted telephone call on 09/18/2024 at 02:45 PM to CNA A, unable to reach or leave a message due to no voice mail had been set up.</p> <p>During an interview on 09/18/2024 at 3:00 PM, the DON stated when she arrived at the facility CNA A had already left. The DON stated Resident #1 was at the hospital. The DON stated she had examined the shower head and shower hose for bodily tissue or blood but seen no indication of either. The DON stated she was unsure who placed Resident #1 back to bed after the incident in the shower room occurred. The DON stated she had been educated on abuse and neglect after the incident as well as aggressive behaviors and how to respond. The DON stated that the perpetrator or alleged perpetrator should immediately be removed from the facility and not allowed access to residents pending the investigation to ensure no harm to the alleged victim or other resident occurs. The DON said LVN D should have told CNA A to not provide any resident care immediately.</p> <p>During an interview on 09/19/2024 at 08:23 AM, the Administrator he was not aware that LVN D had sent CNA A back into the room to transfer Resident #1 into bed after the incident had occurred. The Administrator stated if CNA B said that she and CNA A had transferred Resident #1 back into the bed after the shower room incident then that would be true because CNA B was as honest as the day is long. The Administrator said in-services on abuse and neglect, aggressive behavior and appropriate responses, and once an alleged perpetrator is identified there should be no access to the alleged victim or any resident to prevent harm and provide safety. The Administrator said he expected all staff to follow the Abuse and Neglect Policy. The Administrator said CNA A was terminated on 04/03/2024. The Administrator said CNA C was also terminated and had not worked at the facility after the incident on 04/03/2024. The Administrator said he expected CNA A would not have provided any more resident care and left the facility immediately to prevent further possibilities of abuse.</p> <p>Record review of grievances from January 2024 to September 2024 did not reveal any abuse concerns related to CNA A or CNA C.</p> <p>The Administrator was notified on 09/19/2024 at 01:43 p.m., that a past non-compliance IJ situation had been identified due to the above failures.</p> <p>It was determined these failures placed Residents #1 in an IJ situation on 04/03/2024.</p> <p>The facility had corrected the noncompliance on 04/04/2024 by the following:</p> <ul style="list-style-type: none"> <li>- Termination of CNA A who was responsible for the abuse</li> <li>- Written counseling of the LVN D the education on the Abuse and Neglect Policy</li> <li>- Safe surveys of 15 residents in the facility</li> </ul> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>- 100% staff in-service on abuse and neglect and proper responses to aggressive behaviors</p> <p>- QAPI sign in sheet dated 05/01/2024 completed with Administrator, DON, Infection Preventionist, Medical Director, Floor Staff Representative, and Director of Maintenance with opportunities of improvement with Abuse Policy attached.</p> <p>Record review of Inservice dated 04/03/2024 indicated education to all staff was completed on the Abuse and Neglect Policy, Resident Rights, and Resident's with Combative Behavior.</p> <p>Record review of LVN D's written counseling dated 04/04/2024 regarding the procedures of the Abuse and Neglect Policy.</p> <p>Record review of CNA A's termination notice dated 04/04/2024.</p> <p>Interviews on 04/20/2024 from 08:30 AM - 10:48 AM of the sampled residents (Resident #2, Resident #3, Resident #4, Resident #5, Resident #6 and Resident #7) revealed no abuse occurred.</p> <p>All staff interviewed (LVN E, CNA F, LVN G, LVN H, LVN J, CNA K, CNA L, CNA M, LVN N, LVN P, CNA Q, RN R, 2 ADONs, Activity Director, Social Worker, MDS Coordinator, Staffing Coordinator on 09/20/2024 08:30 AM - 10:48 AM verbalized any allegation of abuse should be reported to the administrator immediately. They verbalized understanding of the types of abuse and the facility's obligation to report abuse to HHS within 2 hours and removing the alleged perpetrator from the victim or any potential victims immediately.</p> <p>The noncompliance was identified as PNC. The noncompliance began on 04/03/2024 and ended on 04/04/2024. The facility had corrected the noncompliance before the survey began.</p> <p>The noncompliance was identified as PNC. The noncompliance began on 04/03/2024 and ended on 04/04/2024. The facility had corrected the noncompliance before the survey began.</p>