STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745019	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
James L West Center for Dementia Care	1111 Summit Ave Fort Worth, TX 76102

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for 1 of 7 residents (Resident #1) reviewed for abuse. The facility failed to ensure Resident #1 was free from physical and verbal abuse when CNA B pinned Resident #1's hands and arms to the bed, used his body weight on Resident #1 to force him to comply with receiving care and told Resident #1 not to play with him on 08/06/24. An IJ was identified on 09/25/24. The IJ template was provided to the facility on [DATE] at 5:17 PM. While the IJ was removed on 09/26/24, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because all staff had not been trained on the plan of removal. This failure placed residents at risk for abuse. Findings included: Record review of Resident #1's face sheet, dated 09/26/24, reflected the resident was an [AGE] year-old male who admitted to the facility on [DATE]. Record review of Resident #1's Quarterly MDS Assessment, dated 07/22/24, reflected he had a BIMS score of 4 indicating severe cognitive impairment. Under the behavior section, there were no behaviors exhibited towards others nor were there any refusals or rejection of care. Under the functional abilities and goals section, it was noted that Resident #1 required partial/moderate assistance for upper and lower body dressing. Resident #1 had diagnoses of non-Alzheimer's Disease (any form of dementia other than Alzheimer's disease), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and muscle weakness (generalized). Record review of Resident #1's care plan reflected the following: - Focus: [Resident #1] has an ADL self-care performance deficit r/t dementia .Goal: [Resident #1] will be encouraged to perform self care as his ability allows and will receive adequate assistance from staff to complete self-care tasks that he is not able to do on his own throughout this review period .Interventions: DRESSING: Allow sufficient time for dressing and undressing. (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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(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	- Focus: [Resident #1] has a behavior problem r/t Dementia (Sometimes resistant to assistance with person care/ bathing. Strikes out and yells at staff) .Goal: [Resident #1] will have fewer behavior episodes by the review date .Interventions: Explain all procedures to [Resident #1] before starting and allow him time to adjust to changes. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Utilize dementia-specific care techniques to help alleviate [Resident #1's] fear and frustration during care. Use Positive Approach to Care, Validation techniques, Compassionate Tough, distraction, and redirection. - Focus: [Resident #1] is resistive to care on occasions r/t Dementia .Goal: [Resident #1] will cooperate with care through the review date .Interventions: If [Resident #1] resists with ADLs, reassure him, leave and return 5-10 minutes later and try again. If possible, negotiate a time for ADLs so that [Resident #1] participates in the decision making process. Return at the agreed upon time. Interview on 09/25/24 at 9:58 AM, Resident #1's RP revealed she saw through the camera in the resident's room on 08/06/24 that CNA B had abused Resident #1. Resident #1's RP said when she got to the facility she went straight to the DON's office and showed both the DON and ADON A the video on 08/06/24. Resident #1's RP said the DON told her she couldn't watch anymore of the video but the ADON watched the rest. Resident #1's RP said she was told they were going to remove CNA B from the floor. Resident #1's RP said she was sent down to talk to the Administrator. Resident #1's RP said the Administrator watched a little bit of the videos and Resident #1's RP told her that it wasn't the worst part, but that the Administrator did not want to see anymore. Resident #1's RP said the Administrator told her that CNA B would not be allowed to work at the facility again and they would report the information back to the agency where he worked. Resident #1's RP said she had asked them to have a nurse or someone to look at him for injuries because when she saw him he had a reddened area to his face. Resident #1's RP said she took a picture of the reddened area and showed the facility staff the picture from that day as well. Resident #1's RP said immediately after the incident, Resident #1 was very jumpy and acted scared when she or others got close to him which was unusual behavior for him. Observation of Video #1 provided by Resident #1's RP revealed the following occurred and was dated 08/06/24 at 10:27:21 AM through 10:29:06 AM: Resident #1 (who was a small and frail resident) was seen in bed, CNA B (who was a tall, heavy set man) walked into the frame of the camera and walked to the right side of the bed, opened up the cabinet and took a brief out and put it on the counter. CNA B moved the bedside table that was up against the wall so he could open the closet to get Resident #1's clothes out. CNA B set clothes on the bedside table. CNA B opened the cabinet again to get gloves out and set them on the bedside table. CNA B walked to a chair in the corner of Resident #1's room and sat down. CNA B said good morning and put the gloves on his hands. CNA B said We gotta get you up. Resident #1 said You can't get me up. You can't get me up. You can't get me up. The video ended. Observation of Video #2 provided by Resident #1's RP revealed the following occurred and was dated 08/06/24 at 10:29:32 AM through 10:29:57 AM: CNA B is still sitting in the chair in the corner of the room putting gloves on and said You don't think I can pick you up? We'll see. CNA B stood up. The video ended. Observation of Video #3 provided by Resident #1's RP revealed the following occurred and was dated 08/06/24 at 10:30:02 AM through 10:35:25 AM: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA B walked to the left side of the resident's bed and turned the lights on. CNA B said My name is [CNA B's name]. and he leaned towards the resident. CNA B picked up the bed remote and started to raise the bed and head of Resident #1's bed. Resident #1 said something unintelligible. CNA B said something unintelligible. CNA B then pulled the covers away from Resident #1 while Resident #1 pulled them back. CNA B grabbed Resident #1's arms and held them away from the covers and told Resident #1 Hold on a second, hold on. CNA B kept taking the covers off of Resident #1 and then grabbed both of his arms and put them above the resident's head to hold them there while CNA B pulled his leg up to the bed and told Resident #1 I'm not playing with you. I'm not playing with you. I'm not playing with you. CNA B also said [something unintelligible] your friend. and then took the covers completely off of Resident #1 and laid them over the footboard of the bed. Resident #1 used his hands to grab at the sheet underneath him to try and cover himself and CNA B grabbed the sheet from the resident. CNA B pinned Resident #1's arms to the side of his head and held the resident there. Resident #1 said Get out the way. Get out the way. CNA B said I'm getting you up. Resident #1 said No. CNA B said Yes, I am. Resident #1 said something unintelligible. Resident #1 then turned to the side with the sheet in his hand where the aide was holding it and CNA B took his other hand and used it to check Resident #1's brief by pulling the back part of it out near his bottom area. CNA B took Resident #1's left hand and put it on his chest while CNA B put his knee on Resident #1's bed. CNA B then took his knee off the bed and turned the resident to the other side so he could use his other hand to remove the resident's brief from the right side. Resident #1's hands can be seen shaking in the video as he tried to reach down to stop CNA B. CNA B put his knee back on the bed while still holding the resident's hands down with his other hand. CNA B said [something unintelligible]. Do you want the sheet or do you want me to change you? What do you want to do? Pick one. You want the sheet or do you want me to change you? Do you want the sheet or do you want me to change you? Do you want the sheet or do you want me to change you? Resident #1 said No. CNA B said You want the sheet? You can have the sheet, I'm gonna change you. Resident #1 took his hands and tried pulling CNA B's hands away. CNA B took Resident #1's hands and tried pinning them above the residents head. Resident #1 said Hey! CNA B said I gotta change you. Resident #1 said No. CNA B said Yes. Resident #1 said No, you don't have to change me. CNA B said I do. CNA B crossed Resident #1's hands on his chest and held them there. Resident #1 tried to stop CNA B but he pushed his hands away. CNA B said Be careful now, be careful. CNA B took Resident #1's brief off and disappeared from the camera view with it then went to the right side of the bed to get Resident #1's pants and brief. CNA B walked to the left side of the bed, took the sheet from the bed and put it at the end of the bed. CNA B then opened up the brief. CNA B put the brief underneath Resident #1 and tried to turn him towards the aide but the resident started to try to pull the aide's hands off of him. CNA B then got on the bed again and forced Resident #1's hands and arms to his chest and told the resident Don't play with me repeatedly while holding the resident's hands and arms down. CNA B got on the resident's bed still holding onto the resident's upper arm. CNA B used his other hand to close the side of the resident's brief. The video ended. Observation of Video #4 provided by Resident #1's RP revealed the following and was dated 08/06/24 at 10:35:33 AM through 10:36:11 AM: CNA B was on the resident's bed putting his brief on him but the residents hands kept trying to stop him. CNA B pinned Resident #1's hands to his face and when the resident resisted, he used his full body weight to lean on Resident #1, holding his arms down and said Don't bite me. CNA B got off Resident #1 but was still on the bed holding the resident's arms away from him and down on the bed while he used his other hand to secure the side of the resident's brief. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation of Video #5 provided by Resident #1's RP revealed the following and was dated 08/06/24 at 10:36:10 AM through 10:38:11 AM: CNA B was closing the side of the residents brief while Resident #1 had reached for the aides hand to stop him. CNA B leaned on the resident again with his full body weight and pinned the resident to the side of the bed. CNA B then faced away from the resident and had his knee tucked under him and his leg kicked out hanging off the bed. Resident #1 was laying on his right side and said something unintelligible. CNA B had his left elbow holding the residents arms down so the aide could attach the brief on the side. Resident #1 said Get out of my room. CNA B leaned off of the resident and then put his knees down on the bed and used his body weight on the resident to hold his arms down. CNA B and Resident #1 begin to physically struggle and the resident is heard grunting. CNA B took Resident #1's hands and held his arms down at the bedside. CNA B leans back and has his phone in his hand and gets off the bed and puts the phone in the pocket on the front of his scrubs. CNA B took Resident #1's pants from the left side of the bed and walked out of the frame with them. A door is heard being closed in the background. Resident #1 was seen trying to use the pillow between his legs to cover himself by putting it on top of his legs. CNA B came back into the frame of the camera and walks to the right side of the resident's bed and said Turn to the other side. Turn to the other side. CNA B took his phone out of his pocket to look at it and then put it back in his pocket. CNA B said Turn to the other side. Turn to the other side. Resident #1 held his hand up and shook his head no. CNA B said I've got to get you up, the doctor told me to get you up. CNA B then took the pillow off of the resident. Observation of Video #6 provided by Resident #1's RP revealed the following and was dated 08/06/24 at 10:38:15 AM through 10:40:17 AM: CNA B took the incontinent pad from under the resident and folded it towards the resident's body and said This ain't me, it's the doctor. Resident #1 was using his hands to stop the aide. CNA B said It's the doctor. Resident #1 held his hands up in the air while the aide touched the side of his brief. CNA B said Hey, listen to me. [unintelligible words]. while Resident #1 tried to push the aide away and CNA B held the resident's arms down. CNA B put his left knee on the bed and started to hold the resident's arms down. Resident #1 said No. CNA B said something unintelligible while holding the resident's arms down. CNA B said Stop. Stop that alright. Resident #1 said something unintelligible to the aide. CNA B said [something unintelligible] good sense, okay. Resident #1 said Get out of my room. CNA B took his leg off the bed while still holding the residents arms down. Resident #1 said something unintelligible. CNA B let go of Resident #1 and put his finger near his face and said Don't do it. Resident #1 said something unintelligible as CNA B adjusted the side of his brief. Resident #1 can be seen breathing very heavily and had a scared look on his face. CNA B finished securing the side of the resident's brief and said Turn to the other side. While pointing to the other side of the room. CNA B turned the resident's body to the other side of the bed while the resident reached towards him to stop. CNA B said Didn't I tell you don't play with me? Resident #1 said something unintelligible. CNA B leaned towards Resident #1 and said something unintelligible to him. CNA B then pulled back from the resident and pulled his legs towards the middle of the bed and Resident #1 tried using his hands to stop the aide. CNA B got back on the bed with both of his knees and used his body weight to hold Resident #1 down on the left side of the bed. Resident #1 can be heard grunting while CNA B used his body weight to hold the resident down. CNA B tried to get Resident #1's brief up on the side of him. Resident #1 can be heard moaning and CNA B said I'm almost done. The video ended. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation of Video #7 provided by Resident #1's RP revealed the following and was dated 08/06/24 at 10:40:44 AM through 10:42:43 AM: CNA B was leaning on the resident and had the resident's pants on the bed and was trying to put them on the resident. Resident #1 can be seen struggling behind CNA B as the resident is pinned against the bed. CNA B used his elbow to hold the resident's arms down. CNA B said I told you not to do that. Resident #1 said No. and mumbled loudly. CNA B continued to put the resident's pants on his left leg and Resident #1 is still moaning. Resident #1 said something unintelligible as aide put his pants on his left leg. CNA B was still leaning on the resident pinning him against the side of the bed. Resident #1 said get out of my room. CNA B continued to put the pants on the resident and said Are you crazy? CNA B said something unintelligible twice. CNA B was holding onto the resident's grab bar on the left side of the resident's bed while using his elbow to keep the resident's arm from coming near him. CNA B was putting the resident's pants on. CNA B stopped and looked at the resident and then lifted off of him. Resident #1 put himself near the middle of the bed where his legs were and his pants were at his ankles. CNA B pulled the resident's legs towards him on the right side of the bed and the resident tried pulling his legs towards his chest and attempted to grab his legs from the aide. Resident #1 said Leave me alone. CNA B kept putting the resident's pants on his on his right leg while Resident #1 tried pulling the pants up on his leg to cover himself. Resident #1's hands were seen shaking. The video ended. Observation of Video #8 provided by Resident #1's RP revealed the following and was dated 08/06/24 at 10:42:51 AM through 10:43:26 AM: CNA B was putting Resident #1's pants over his knees. Resident #1 tried grabbing the aide and the aide grabbed the resident back. CNA B put his knee on the bed to lean over the resident and took Resident #1's arms to cross them over his chest. CNA B said I don't play with you. I already told you. I don't told you. I already told you. Do not play with me. as he was leaning over the resident holding his arms to his chest. The video ended. Observation of Video #9 provided by Resident #1's RP revealed the following and was dated 08/06/24 at 10:43:26 AM through 10:45:24 AM: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA B eventually let go of the resident's arms that were crossed on his chest. CNA B got off the bed and started pulling the resident's pants up. CNA B walked to the other side of the bed to pull his pants up from the left side of the bed and pulled the residents legs towards him to lift the resident up under to pull the pants up on the backside. Resident #1's hands were shaking and he said something unintelligible. CNA B turned the resident away from him so Resident #1 was facing the right side of the bed and pulled the resident's pants up on the backside of him. Resident #1 turned his upper body towards CNA B. CNA B turned the residents legs towards him on the left side of the bed to pull his pants up on that side. CNA B let the resident's legs fall to the bed and walked around to the right side of the bed. Resident #1 can be seen heavily breathing and had a scared look on his face. CNA B took the shirt that was taken from the closet earlier from the bedside table and told the resident You're wearing something different. and put the shirt back in the closet. CNA B said I'm going to put you in something blue. and grabbed a blue shirt from the closet. CNA B walked around to the left side of the bed with the blue shirt. CNA B put the blue shirt on the footboard of the bed and said C'mon. Put your shirt on. and started to pull the resident's legs towards the left side of the bed towards the aide. CNA B then pulled the resident's arms to lift him to a more seated position on the side of the bed. CNA B said I got you. and started to pull the resident's shirt off of him. CNA B started to pull the shirt over his head and Resident #1 started to shake and breathe loudly. CNA B said I got you. and pulled the shirt off of Resident #1. The resident fell back onto the bed. CNA B rolled up the shirt and tossed it to the side of the room out of camera view. The video ended. Observation of Video #10 provided by Resident #1's RP revealed the following and was dated 08/06/24 at 10:45:29 AM through 10:47:28 AM: CNA B was holding Resident #1's left arm down and said You're going to hurt yourself. CNA B used his right knee to hold the resident's left arm down by putting his knee on the resident's arm on the bed while he pulled the resident's left arm through the sleeve of the shirt. CNA B said Shit. CNA B got off the bed and said C'mon. while he pulled the residents arms to sit him up on the side of the bed. Resident #1 started punching the aide in his stomach area. CNA B took the resident's left arm and put it through the sleeve hole in the shirt. Resident #1 fell back to the bed and CNA B said I'm not playing with you. While he tried to get the resident's shirt on. Resident #1 said No. CNA B said something unintelligible twice. CNA B pulled the resident's shirt down and leaned back to stand in front of the resident and said You want your shoes on? Want your shoes on? Resident #1 nodded yes. CNA B walked out of the camera angle towards the wall in the room and Resident #1 was sitting on the side of the bed. CNA B sat next to the resident on the bed with his shoes in his hands. CNA B kicked his leg out to look at something, then put I back under him. CNA B took the Velcro straps off the resident's shoe and pulled the resident's leg up to put the shoe on. The video ended. Observation and interview on 09/25/24 at 10:40 AM, with Resident #1 revealed he was laying in his bed in his room. Resident #1 said he was doing okay and was not in any pain. Resident #1 did not have any bruises or marks to his face. Resident #1 said someone was mean to him and hurt him, but could not specify who it was. Resident #1 said that he had seen the person who hurt him recently but was not able to say when he last saw them. Resident #1 appeared tired and stopped answering questions so the surveyor left the room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 09/25/24 at 12:00 PM with LVN G revealed she cared for Resident #1. LVN G said Resident #1 had a behavior of refusing care and fighting staff when trying to care for him. LVN G said she never forced Resident #1 to receive care and instead would make sure he was safe and try again at a later time to provide him care if he refused. LVN G said she knew that physically forcing a resident to receive care was considered abuse. Interview on 09/25/24 at 12:20 PM with RA C revealed he cared for Resident #1. RA C said Resident #1 did refuse care at times, so he would leave him alone and come back at a later time to try to provide care again. RA C said he would never force Resident #1 to receive care because that was a right the resident had to refuse. Interview on 09/25/24 at 12:33 PM with CNA D revealed she cared for Resident #1. CNA D said Resident #1 sometimes refused care. CNA D said she would make sure Resident #1 was safe and would not force him to receive care. CNA D explained that she would try to provide care at a later time to Resident #1 and would not force him to receive care. Interview on 09/25/24 at 12:44 PM with CNA E revealed he cared for Resident #1. CNA E said Resident #1 refused care sometimes. CNA E said he would not force Resident #1 to receive care and instead would make sure he was safe and try again at a later time to give care to him. Interview on 09/25/24 at 12:53 PM with LVN F revealed she cared for Resident #1. LVN F said Resident #1 did refuse care at times. LVN F said she never forced Resident #1 to receive care and instead would make sure he was safe and would try again at a later time to provide the care to him. LVN F explained that physically forcing a resident to receive care was considered a form of abuse. Interview on 09/25/24 at 1:44 PM with ADON A revealed she was familiar with Resident #1. ADON A said Resident #1 refused care but staff had been trained to come back at a different time if a resident refused care. ADON A said Resident #1's RP came to the facility on e day and told her and the DON that she wanted to show them something. ADON A said Resident #1's RP showed a video of the aide attempting to provide care to Resident #1 but she could not recall the details of the video. ADON A said Resident #1's RP told them that she did not like the way the aide handled Resident #1 and did not want the aide to continue caring for the resident. ADON A said Resident #1's RP also showed them the picture of his face where there was redness to his face but she did not ask the RP how he got the redness. ADON A said Resident #1's RP expressed the redness was from the way the aide handled the resident. ADON A said she saw Resident #1 later that day and he did not have any redness noted to his face. ADON A said since she did not see the redness noted to Resident #1's face like in the picture she could not say that was how it happened or what caused it. ADON A said after she watched the videos, she went upstairs to take CNA B off the floor. ADON A said when she spoke with CNA B, he explained that Resident #1 was refusing care and being combative and he was trained to continue providing care when that happened. ADON A said after she talked with CNA B, he left the facility. ADON A said her impression of the video was that the aide was from an agency and that was not how the facility trained their own staff to handle resident refusals. ADON A said agency aides did not get any trainings from the facility when they pick up shifts for the facility. ADON A said their staff had been trained by the facility to make sure a resident was safe and then stop trying to provide care when they refused . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 09/25/24 at 2:11 PM with the DON revealed Resident #1 refused care at times and staff was supposed to give him a break and come back to reapproach or swap out with someone else to continue and provide care to him. The DON said one day Resident #1's RP came to her office and wanted to share a video with her. The DON said she asked Resident #1's RP to send the video to her but Resident #1's RP did not know how to do that. The DON said Resident #1's RP pulled up a video and the DON saw in the video Resident #1 put his hand up to say stop and that was enough for her to see. The DON said she told Resident #1's RP that if she wanted to share more about the situation, the best thing to do was to get the Administrator involved. The DON said Resident #1's RP also showed her the picture of Resident #1 that showed the redness on his face. The DON said when she went to see Resident #1 later that day she did not see any redness to his face, so whatever it was, it had resolved by the time she saw him. The DON said when she spoke with CNA B he said Resident #1 was fighting him during care and she explained to him that any time a resident refused care CNA B should stop. The DON said CNA B explained that he had been trained to continue providing care for a resident even if they had refused. The DON said there was no training provided to agency staff and she did not check their training before they picked up a shift at the facility. The DON said the facility used agency staff about one to three times per month, but it depended on staffing. The DON said it was appropriate for CNA B to continue providing care to Resident #1 even if he refused if that was how he had been trained even though it was not how the facility trained their staff. The DON said it was considered abuse if a staff member pinned a residents hands to the side of their head, above their head, and to their chest. The DON said another form of abuse could be a staff putting their body weight against a resident and using that to force the resident to comply while the staff ripped off the resident's brief and sheets . Interview on 09/25/24 at 2:41 PM with the Administrator revealed Resident #1 refused care. The Administrator said facility staff had been trained to redirect a resident or give them a minute to try to get the resident focused on something else instead. The Administrator said Resident #1's RP came to her office to show her the videos and said that ADON A and the DON had already seen them. The Administrator said she saw there was a large male and he went into the room and provided care to Resident #1. The Administrator said she did not see anything on the video that was abusive. The Administrator said she asked Resident #1's RP if there was something worse on the video and was told no but it was not how the facility's staff would have handled the situation. The Administrator said Resident #1's RP brought up something about Resident #1's face and the DON told her that they did not see anything on his face. The Administrator said she never saw any other video but said the video she did see concerned her. The Administrator said agency staff were not given any training from the facility. The Administrator said the facility used agency staff about four to six times per month, but they tried to use their own staff as much as possible. The Administrator said if she thought anything CNA B did at that time was abusive, she would have reported it and completed an investigation. The Administrator began to watch the first part of video #3 that was provided by Resident #1's RP to the surveyor. The Administrator did not want to watch the whole video and only watched the first part of it where Resident #1 and CNA B were physically struggling with the covers. The Administrator said based on what she saw and what the surveyor told her had happened, that was considered abuse. The Administrator revealed she was the abuse coordinator for the facility. The Administrator explained that she was responsible for reporting and investigating allegations of abuse. The Administrator said all staff were responsible for ensuring residents were free from abuse and she expected all staff to follow the facility's abuse and neglect policy. The Administrator said if the facility's abuse policy was not followed that put residents at risk of injuries and psychological issues. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview via phone on 09/25/24 at 5:18 PM with CNA B revealed he was upset because the facility refused to allow him to write a statement about what happened. CNA B said he was working with an aggressive resident who bit him and hit him when he was working at the facility. CNA B said he restrained the resident while this was happening. CNA B said he did not receive any information on how to care for the resident before the start of his shift. CNA B said he guessed the resident was having PTSD since he was a veteran. CNA B said the residents at this facility were individuals who were aggressive on dementia wings. CNA B said he was told to get the resident ready and when he went into the room, the resident was ultra aggressive but once he calmed down everything was okay. CNA B said he walked into the resident's room and felt like he was blindsided. CNA B said he had been trained on caring for residents with dementia previously but he expected to be prepared to care for residents who fought and fought aggressively. CNA B said the resident struck him in the face and bit his arm while he was getting him prepared to sit in the chair to eat. CNA B said he had to restrain the resident to hold him back from hitting the aide. CNA B said he had been trained that if a resident was highly resistant to care to just back off and let them be but was in midst of caring for the resident before figuring out what happened. CNA B said he did not walk away from caring for the resident because he would pause in between incidents as if the episode was over and once the resident was dressed he stopped. CNA B said he did not feel he abused the resident by restraining him. When CNA B was asked about what he said to the resident in the video, he refused to answer. CNA B said he was not originally assigned to this resident but was asked to get him ready for the day so he did. The Administrator revealed she was the abuse coordinator for the facility and would be responsible for investigation and reporting any allegation of abuse. The Administrator said all staff were responsible for ensuring that residents were free from abuse. The Administrator said she expected all staff to follow the facility's abuse policy and not following it put residents at risk of injuries and psychological issues. Record review of the facility's policy, revised March 2018, and titled Abuse and Neglect- Clinical Protocol reflected: 1. 'Abuse' is defined at [symbol]483.5 as 'the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse facilitated or enabled through the use of technology.' .4. 'willful' as defined at [symbol]483.5 and as used in the definition of 'abuse,' means the 'individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.' Cause Identification, 1. The staff, with the physician's input as needed, will investigate alleged abuse and neglect to clarify what happened and identify possible causes .Treatment/Management, 1. The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect. 2. The management and staff, with physician support, will address situations of suspected or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations Monitoring and Follow-up .3. The physician will advise the facility and help review and[TRUNCATED]

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observation, interview and record review, the facility failed to ensure the right to be free from physical restraints imposed for purpose of convenience and not required to treat the resident's medical symptoms was provided for 1 of 7 residents (Resident #1) reviewed for restraints. The facility failed to ensure Resident #1 had the right to be free from restraints when CNA B physically pinned the resident's hands and arms to the bed while he provided care to him on 08/06/24. After administrative review and IJ was identified on 10/11/24. The IJ template was provided to the facility on [DATE] at 8:30 AM. While the IJ was removed on 10/11/24, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because all staff had not been trained on the plan of removal. This failure could place resident at risk of not being treated with respect and dignity, limit residents right to choose, take away independence, or cause severe injury. Findings included: Review of Resident #1's Quarterly MDS Assessment, dated 07/22/24, reflected the resident was an [AGE] year-old male who admitted to the facility on [DATE]. The MDS also reflected he had a BIMS of 4 indicating severe cognitive impairment. Under the behavior section, there were no behaviors exhibited towards others nor were there any refusals or rejection of care. Under the functional abilities and goals section, it was noted that Resident #1 required partial/moderate assistance for upper and lower body dressing. Resident #1 had diagnoses of non-Alzheimer's Disease (any form of dementia other than Alzheimer's disease), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and muscle weakness (generalized). Review of Resident #1's care plan reflected the following: - Focus: [Resident #1] has an ADL self-care performance deficit r/t dementia .Goal: [Resident #1] will be encouraged to perform self-care as his ability allows and will receive adequate assistance from staff to complete self-care tasks that he is not able to do on his own throughout this review period .Interventions: DRESSING: Allow sufficient time for dressing and undressing. - Focus: [Resident #1] has a behavior problem r/t Dementia (Sometimes resistant to assistance with person care/ bathing. Strikes out and yells at staff) .Goal: [Resident #1] will have fewer behavior episodes by the review date .Interventions: Explain all procedures to [Resident #1] before starting and allow him time to adjust to changes. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Utilize dementia-specific care techniques to help alleviate [Resident #1's] fear and frustration during care. Use Positive Approach to Care, Validation techniques, Compassionate Tough, distraction, and redirection. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Focus: [Resident #1] is resistive to care on occasions r/t Dementia .Goal: [Resident #1] will cooperate with care through the review date .Interventions: If [Resident #1] resists with ADLs, reassure him, leave and return 5-10 minutes later and try again. If possible, negotiate a time for ADLs so that [Resident #1] participates in the decision making process. Return at the agreed upon time. Interview on 09/25/24 at 9:58 AM with Resident #1's RP revealed she saw through the camera in the resident's room on 08/06/24 that CNA B had abused Resident #1. Resident #1's RP said when she got to the facility she went straight to the DON's office and showed both the DON and ADON A the video on 08/06/24. Resident #1's RP said the DON told her she could not watch anymore of the video but the ADON watched the rest. Resident #1's RP said she was told they were going to remove CNA B from the floor. Resident #1's RP said she was sent down to talk to the Administrator. Resident #1's RP said the Administrator watched a little bit of the videos and Resident #1's RP told her that it wasn't the worst part, but that the Administrator did not want to see anymore. Resident #1's RP said the Administrator told her that CNA B would not be allowed to work at the facility again and they would report the information back to the agency where he worked. Resident #1's RP said she asked them to have a nurse or someone to look at him for injuries because when she saw him he had a reddened area to his face. Resident #1's RP said she took a picture of the reddened area and showed the facility staff the picture from that day as well. Resident #1's RP said immediately after the incident, Resident #1 was very jumpy and acted scared when she or others got close to him which was unusual behavior for him. Observation and interview on 10/11/24 at 12:47 PM, Resident #1 was self-propelling his wheelchair on the unit. The resident was very pleasant and was able to answer simple basic questions when asked. Resident #1 was asked how he was being treated and he smiled and said oh good and continued to wheel off. There were no bruising or suspicious injuries noted at the time of the interaction. Observation of Video #1 provided by Resident #1's RP revealed the following occurred and was dated 08/06/24 at 10:27:21 AM through 10:29:06 AM: Resident #1 (who was a small and frail resident) was seen in bed, CNA B (who was a tall, heavy set man) walked into the frame of the camera and walked to the right side of the bed, opened up the cabinet and took a brief out and put it on the counter. CNA B moved the bedside table that was up against the wall so he could open the closet to get Resident #1's clothes out. CNA B set clothes on the bedside table. CNA B opened the cabinet again to get gloves out and set them on the bedside table. CNA B walked to a chair in the corner of Resident #1's room and sat down. CNA B said good morning and put the gloves on his hands. CNA B said We gotta get you up. Resident #1 said You can't get me up. You can't get me up. You can't get me up. The video ended. Observation of Video #3 provided by Resident #1's RP revealed the following occurred and was dated 08/06/24 at 10:30:02 AM through 10:35:25 AM: (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA B walked to the left side of the resident's bed and turned the lights on. CNA B said My name is [CNA B's name]. and he leaned towards the resident. CNA B picked up the bed remote and started to raise the bed and head of Resident #1's bed. Resident #1 said something unintelligible. CNA B said something unintelligible. CNA B then pulled the covers away from Resident #1 while Resident #1 pulled them back. CNA B grabbed Resident #1's arms and held them away from the covers and told Resident #1 Hold on a second, hold on. CNA B kept taking the covers off of Resident #1 and then grabbed both of his arms and pinned them above the resident's head and held them there while CNA B pulled his leg up to the bed and told Resident #1 I'm not playing with you. I'm not playing with you. I'm not playing with you. CNA B also said [something unintelligible] your friend. and then took the covers completely off of Resident #1 and laid them over the footboard of the bed. Resident #1 used his hands to grab at the sheet underneath him to try and cover himself and CNA B grabbed the sheet from the resident. CNA B pinned Resident #1's arms to the side of his head and held the resident there. Resident #1 said Get out the way. Get out the way. CNA B said I'm getting you up. Resident #1 said No. CNA B said Yes, I am. Resident #1 said something unintelligible. Resident #1 then turned to the side with the sheet in his hand where the aide was holding it and CNA B took his other hand and used it to check Resident #1's brief by pulling the back part of it out near his bottom area. CNA B took Resident #1's left hand and put it on his chest while CNA B put his knee on Resident #1's bed. CNA B then took his knee off the bed and turned the resident to the other side so he could use his other hand to remove the resident's brief from the right side. Resident #1's hands can be seen shaking in the video as he tried to reach down to stop CNA B. CNA B put his knee back on the bed while still holding the resident's hands down with his other hand. CNA B said [something unintelligible]. Do you want the sheet or do you want me to change you? What do you want to do? Pick one. You want the sheet or do you want me to change you? Do you want the sheet or do you want me to change you? Do you want the sheet or do you want me to change you? Resident #1 said No. CNA B said You want the sheet? You can have the sheet, I'm gonna change you. Resident #1 took his hands and tried pulling CNA B's hands away. CNA B took Resident #1's hands and tried pinning them above the residents head. Resident #1 said Hey! CNA B said I gotta change you. Resident #1 said No. CNA B said Yes. Resident #1 said No, you don't have to change me. CNA B said I do. CNA B crossed Resident #1's hands on his chest and held them there. Resident #1 tried to stop CNA B but he pushed his hands away. CNA B said Be careful now, be careful. CNA B took Resident #1's brief off and disappeared from the camera view with it then went to the right side of the bed to get Resident #1's pants and brief. CNA B walked to the left side of the bed, took the sheet from the bed and put it at the end of the bed. CNA B then opened up the brief. CNA B put the brief underneath Resident #1 and tried to turn him towards the aide but the resident started to try to pull the aide's hands off of him. CNA B then got on the bed again and forced Resident #1's hands and arms to his chest and told the resident Don't play with me repeatedly while holding the resident's hands and arms down. CNA B got on the resident's bed still holding onto the resident's upper arm. CNA B used his other hand to close the side of the resident's brief. The video ended. Observation of Video #4 provided by Resident #1's RP revealed the following and was dated 08/06/24 at 10:35:33 AM through 10:36:11 AM: CNA B was on the resident's bed putting his brief on him but the residents hands kept trying to stop him. CNA B pinned Resident #1's hands to his face and when the resident resisted, he used his full body weight to lean on Resident #1, holding his arms down and said Don't bite me. CNA B got off Resident #1 but was still on the bed holding the resident's arms away from him and down on the bed while he used his other hand to secure the side of the resident's brief. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation of Video #5 provided by Resident #1's RP revealed the following and was dated 08/06/24 at 10:36:10 AM through 10:38:11 AM: CNA B was closing the side of the residents brief while Resident #1 had reached for the aides hand to stop him. CNA B leaned on the resident again with his full body weight and pinned the resident to the side of the bed. CNA B then faced away from the resident and had his knee tucked under him and his leg kicked out hanging off the bed. Resident #1 was laying on his right side and said something unintelligible. CNA B had his left elbow holding the residents arms down so the aide could attach the brief on the side. Resident #1 said Get out of my room. CNA B leaned off of the resident and then put his knees down on the bed and used his body weight on the resident to hold his arms down. CNA B and Resident #1 begin to physically struggle and the resident is heard grunting. CNA B took Resident #1's hands and held his arms down at the bedside. CNA B leans back and has his phone in his hand and gets off the bed and puts the phone in the pocket on the front of his scrubs. CNA B took Resident #1's pants from the left side of the bed and walked out of the frame with them. A door is heard being closed in the background. Resident #1 was seen trying to use the pillow between his legs to cover himself by putting it on top of his legs. CNA B came back into the frame of the camera and walks to the right side of the resident's bed and said Turn to the other side. Turn to the other side. CNA B took his phone out of his pocket to look at it and then put it back in his pocket. CNA B said Turn to the other side. Turn to the other side. Resident #1 held his hand up and shook his head no. CNA B said I've got to get you up, the doctor told me to get you up. CNA B then took the pillow off of the resident. CNA B took the incontinent pad from under the resident and folded it towards the resident's body and said This ain't me, it's the doctor. Resident #1 was using his hands to stop the aide. CNA B said It's the doctor. Resident #1 held his hands up in the air while the aide touched the side of his brief. CNA B said Hey, listen to me. [unintelligible words]. while Resident #1 tried to push the aide away and CNA B held the resident's arms down. CNA B put his left knee on the bed and started to hold the resident's arms down. Resident #1 said No. CNA B said something unintelligible while holding the resident's arms down. CNA B said Stop. Stop that alright. Resident #1 said something unintelligible to the aide. CNA B said [something unintelligible] good sense, okay. Resident #1 said Get out of my room. CNA B took his leg off the bed while still holding the residents arms down. Resident #1 said something unintelligible. CNA B let go of Resident #1 and put his finger near his face and said Don't do it. Resident #1 said something unintelligible as CNA B adjusted the side of his brief. Resident #1 can be seen breathing very heavily and had a scared look on his face. CNA B finished securing the side of the resident's brief and said Turn to the other side. While pointing to the other side of the room. CNA B turned the resident's body to the other side of the bed while the resident reached towards him to stop. CNA B said Didn't I tell you don't play with me? Resident #1 said something unintelligible. CNA B leaned towards Resident #1 and said something unintelligible to him. CNA B then pulled back from the resident and pulled his legs towards the middle of the bed and Resident #1 tried using his hands to stop the aide. CNA B got back on the bed with both of his knees and used his body weight to hold Resident #1 down on the left side of the bed. Resident #1 can be heard grunting while CNA B used his body weight to hold the resident down. CNA B tried to get Resident #1's brief up on the side of him. Resident #1 can be heard moaning and CNA B said I'm almost done. The video ended. Observation of Video #7 provided by Resident #1's RP revealed the following and was dated 08/06/24 at 10:40:44 AM through 10:42:43 AM: (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA B was leaning on the resident and had the resident's pants on the bed and was trying to put them on the resident. Resident #1 can be seen struggling behind CNA B as the resident is pinned against the bed. CNA B used his elbow to hold the resident's arms down. CNA B said I told you not to do that. Resident #1 said No. and mumbled loudly. CNA B continued to put the resident's pants on his left leg and Resident #1 is still moaning. Resident #1 said something unintelligible as aide put his pants on his left leg. CNA B was still leaning on the resident pinning him against the side of the bed. Resident #1 said get out of my room. CNA B continued to put the pants on the resident and said Are you crazy? CNA B said something unintelligible twice. CNA B was holding onto the resident's grab bar on the left side of the resident's bed while using his elbow to keep the resident's arm from coming near him. CNA B was putting the resident's pants on. CNA B stopped and looked at the resident and then lifted off of him. Resident #1 put himself near the middle of the bed where his legs were and his pants were at his ankles. CNA B pulled the resident's legs towards him on the right side of the bed and the resident tried pulling his legs towards his chest and attempted to grab his legs from the aide. Resident #1 said Leave me alone. CNA B kept putting the resident's pants on his on his right leg while Resident #1 tried pulling the pants up on his leg to cover himself. Resident #1's hands were seen shaking. The video ended. Observation of Video #8 provided by Resident #1's RP revealed the following and was dated 08/06/24 at 10:42:51 AM through 10:43:26 AM: CNA B was putting Resident #1's pants over his knees. Resident #1 tried grabbing the aide and the aide grabbed the resident back. CNA B put his knee on the bed to lean over the resident and took Resident #1's arms to cross them over his chest. CNA B said I don't play with you. I already told you. I don't told you. I already told you. Do not play with me. as he was leaning over the resident holding his arms to his chest. The video ended. Observation of Video #10 provided by Resident #1's RP revealed the following and was dated 08/06/24 at 10:45:29 AM through 10:47:28 AM: CNA B was holding Resident #1's left arm down and said You're going to hurt yourself. CNA B used his right knee to hold the resident's left arm down by putting his knee on the resident's arm on the bed while he pulled the resident's left arm through the sleeve of the shirt. CNA B said Shit. CNA B got off the bed and said C'mon. while he pulled the residents arms to sit him up on the side of the bed. Resident #1 started punching the aide in his stomach area. CNA B took the resident's left arm and put it through the sleeve hole in the shirt. Resident #1 fell back to the bed and CNA B said I'm not playing with you. While he tried to get the resident's shirt on. Resident #1 said No. CNA B said something unintelligible twice. CNA B pulled the resident's shirt down and leaned back to stand in front of the resident and said You want your shoes on? Want your shoes on? Resident #1 nodded yes. CNA B walked out of the camera angle towards the wall in the room and Resident #1 was sitting on the side of the bed. CNA B sat next to the resident on the bed with his shoes in his hands. CNA B kicked his leg out to look at something, then put I back under him. CNA B took the Velcro straps off the resident's shoe and pulled the resident's leg up to put the shoe on. The video ended. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Telephone interview on 09/25/24 at 5:18 PM with CNA B revealed he was upset because the facility refused to allow him to write a statement about what happened. CNA B said he was working with an aggressive resident who bit him and hit him when he was working at the facility. CNA B said he restrained the resident while this was happening. CNA B said he did not receive any information on how to care for the resident before the start of his shift. CNA B said he guessed the resident was having PTSD since he was a veteran. CNA B said the residents at this facility were individuals who were aggressive on dementia wings. CNA B said he was told to get the resident ready and when he went into the room, the resident was ultra aggressive but once he calmed down everything was okay. CNA B said he walked into the resident's room and felt like he was blindsided. CNA B said he had been trained on caring for residents with dementia previously but he expected to be prepared to care for residents who fought and fought aggressively. CNA B said the resident struck him in the face and bit his arm while he was getting him prepared to sit in the chair to eat. CNA B said he had to restrain the resident to hold him back from hitting the aide. CNA B said he had been trained that if a resident was highly resistant to care to just back off and let them be but was in midst of caring for the resident before figuring out what happened. CNA B said he did not walk away from caring for the resident because he would pause in between incidents as if the episode was over and once the resident was dressed he stopped. CNA B said he did not feel he abused the resident by restraining him. When CNA B was asked about what he said to the resident in the video, he refused to answer. CNA B said he was not originally assigned to this resident but was asked to get him ready for the day so he did. Interview on 10/11/24 at 8:35 AM with the Administrator and the DON revealed they were never made aware of the full video and never got to see Resident #1 being restrained while CNA B was providing care. Both the Administrator and the DON further stated they were only able to view a very small portion of the video where the aide was taking the resident shirt off when he was changing him. They said it appeared the aide did require more training and believed he had worked in a psychiatric facility where they were allowed to restrain people. The Administrator and DON further stated at no time and under no circumstances, were staff allowed to restrain a resident during care. If a resident became combative the staff were to back away and ensure the resident was safe, try again later and report to the charge nurse. Record review of the facility's Abuse and Neglect-Clinical Protocol policy, revised March 2018, reflected: 1. 'Abuse' is defined at [symbol]483.5 as 'the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse facilitated or enabled through the use of technology.' .4. 'willful' as defined at [symbol]483.5 and as used in the definition of 'abuse,' means the 'individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.' Cause Identification, 1. The staff, with the physician's input as needed, will investigate alleged abuse and neglect to clarify what happened and identify possible causes .Treatment/Management, 1. The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect. 2. The management and staff, with physician support, will address situations of suspected or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations Monitoring and Follow-up .3. The physician will advise the facility and help review and address abuse and neglect issues as part of the quality assurance process. (continued on next page)

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	745019	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
James L West Center for Dementia Care	1111 Summit Ave Fort Worth, TX 76102

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	After Administrative review an Immediate Jeopardy was identified on 10/11/24. The Administrator and DON were notified of the Immediate Jeopardy on 10/11/24 at 8:30 AM. The IJ template was provided to the facility on [DATE] at 8:47 AM. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy. The facility's Plan of Removal for the Immediate Jeopardy was accepted on 10/11/24 at 11:11 AM and reflected the following: .Summary of Details which lead to outcomes: On 10/11/24, a surveyor provided an IJ Template notification that the Survey Agency has determined that conditions at the center constitute immediate jeopardy to resident health regarding an incident on 8/6/24. The notification of the alleged immediate jeopardy states as follows: F 604-Failure to Ensure that a resident had the right to be free from physical restraints: The facility failed to ensure a resident had the right to be free from physical restraints imposed for the purposes of discipline or convenience when CNA B (agency staff) physically restrained Resident #1 while providing the resident care after resident refusal. Corrective actions for those found to have been affected by the deficient practice: o All residents have the potential to be affected. Identified resident remained in facility with no adverse reactions. The facility census on 8/6/24 was 105. o The identified agency CNA was placed on a do not return to the facility and notification was made to the agency manager regarding the allegations of abuse to include physical restraining of the resident. o Adhoc QAPI meeting held 10/11/24 to review current abuse and neglect policy including the no restraint policy and added additional procedures to ensure resident safety with agency staff. o All staff to be in-serviced over abuse and neglect to include no restraining of residents during care. o All allegations of abuse by anyone will be investigated and reported in adherence to Provider letter 2024-14. o Limit the use of agency staffing. The training provided will be the following: o Abuse and neglect in-servicing will be done by DON and ADONs or designee. Training will be completed for our staff by 2:00pm 10/11/24. Staff that are on leave or not present for the in-service must be trained prior to working a shift on the floor. All Management staff will be retrained on abuse and neglect to include no restraining or residents during care. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Agency staff training before the start of their shift. Inservice packets will be left at each nursing station. Agency will review packet, signature of acknowledgement, and send signature page to staffing phone before starting shift. This training will now include no restraining of residents in any manner, including during care. o If any suspicion of negligent practice, will be reported to the agency manager, as well as any other reporting necessary to state providers. Abuse and neglect in-servicing including not using restraints will continue. o The administrator and [NAME] will be responsible for making sure the training is completed. Ongoing monitoring: o All components of this plan of correction will be submitted to the facility QAPI committee meeting and additional recommendations will be made until substantial compliance has been achieved. o An Emergency QAPI meeting was conducted on 10/11/24. The Medical director was notified and agrees with the plan. o Agency staff will be reviewed for compliance to ensure that regulatory guidelines have been met for them to work in the facility. Who is responsible for implementing of processes? The administrative nurses (ADON and DON) and Administrator Monitoring: Record review of in-service records, dated 10/11/24, reflected the staff had been trained on abuse to include never to restrain a resident for any purpose. If a resident refuses care they are to ensure the resident was safe, report to the charge nurse and reapproach later to assist with care. Interviews on 10/11/24 from 1:38 PM to 6:36 PM with the following staff from various shifts and days revealed if a resident became combative during care they were to step back make and ensure the resident was safe, report the incident to the charge nurse, and report to the charge nurse and try the care again later. Under no circumstances was a resident to be restrained during care. The staff included: CNA RR, CNA SS, CNA TT, LVN UU, LVN VV, LVN WW, CNA XX, CNA YY, CNA ZZ, CNA AAA, CNA K, CNA BBB, LVN CCC, CNA DDD, CNA EEE, CNA M, CNA N, LVN FFF, CNA GGG, LVN HHH, CNA III, RN JJJ, LVN U, CNA KKK, CNA BB, LVN LLL. Observation on 10/11/24 from 12:17 PM to 1:17 PM revealed there were no agency staff working in any of the houses and there was an inservice binder that included the restraint inservice where any agency staff had to be inserviced on the facility's policy regarding abuse and restraints. Observation on 10/11/24 from 12:17 PM to 1:17 PM revealed there were no concerns with the interactions between the staff and the residents in any of the houses. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 10/11/24 at 12:47 PM with three family members revealed they all had cameras in the resident rooms and they all stated they did not have any concerns regarding abuse or restraints. After administrative review an IJ was identified on 10/11/24. The IJ template was provided to the facility on [DATE] at 8:30 AM. While the IJ was removed on 10/11/24, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with a potential for more than minimal harm because all staff had not been trained on the Plan of Removal.

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observation, interview and record review, the facility failed to develop and implement written policies and procedures that prohibit and prevent the neglect of residents for 1 of 7 residents (Resident #1) reviewed for abuse. The facility failed to implement the facility's written policies and procedures to prohibit and prevent abuse of Resident #1 when CNA B pinned Resident #1's hands and arms to the bed, used his body weight on Resident #1 to force him to comply with receiving care, and told Resident #1 not to play with him on 08/06/24. The facility failed to ensure CNA B (an agency CNA) had been trained on how to care for Resident #1, a resident who refused care, and also had dementia training prior to beginning the shift. An IJ was identified on 09/25/24. The IJ template was provided to the facility on [DATE] at 5:17 PM. While the IJ was removed on 09/26/24, the facility remained out of compliance at a scope of isolated and a severity level of a potential for more than minimal harm because all staff had not been trained on the plan of removal. This failure placed residents at risk for abuse. Findings included: Record review of the facility's Abuse and Neglect-Clinical Protocol policy, revised March 2018, reflected: 1. 'Abuse' is defined at [symbol]483.5 as 'the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse facilitated or enabled through the use of technology.' .4. 'willful' as defined at [symbol]483.5 and as used in the definition of 'abuse,' means the 'individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.' Cause Identification, 1. The staff, with the physician's input as needed, will investigate alleged abuse and neglect to clarify what happened and identify possible causes .Treatment/Management, 1. The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect. 2. The management and staff, with physician support, will address situations of suspected or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations Monitoring and Follow-up .3. The physician will advise the facility and help review and address abuse and neglect issues as part of the quality assurance process. Interview on 09/26/24 at 6:00 PM with the Administrator revealed the facility did not have a policy that addressed preventing abuse. The Administrator explained that the facility followed the provider letter 2024-14 as the facility's policy. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's face sheet, dated 09/26/24, reflected the resident was an [AGE] year-old male who admitted to the facility on [DATE]. Record review of Resident #1's Quarterly MDS Assessment, dated 07/22/24, reflected he had a BIMS score of 4 indicating severe cognitive impairment. Under the behavior section, there were no behaviors exhibited towards others nor were there any refusals or rejection of care. Under the functional abilities and goals section, it was noted that Resident #1 required partial/moderate assistance for upper and lower body dressing. Resident #1 had diagnoses of non-Alzheimer's Disease (any form of dementia other than Alzheimer's disease), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and muscle weakness (generalized). Record review of Resident #1's care plan reflected the following: - Focus: [Resident #1] has an ADL self-care performance deficit r/t dementia .Goal: [Resident #1] will be encouraged to perform self care as his ability allows and will receive adequate assistance from staff to complete self-care tasks that he is not able to do on his own throughout this review period .Interventions: DRESSING: Allow sufficient time for dressing and undressing. - Focus: [Resident #1] has a behavior problem r/t Dementia (Sometimes resistant to assistance with person care/ bathing. Strikes out and yells at staff) .Goal: [Resident #1] will have fewer behavior episodes by the review date .Interventions: Explain all procedures to [Resident #1] before starting and allow him time to adjust to changes. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Utilize dementia-specific care techniques to help alleviate [Resident #1's] fear and frustration during care. Use Positive Approach to Care, Validation techniques, Compassionate Tough, distraction, and redirection. - Focus: [Resident #1] is resistive to care on occasions r/t Dementia .Goal: [Resident #1] will cooperate with care through the review date .Interventions: If [Resident #1] resists with ADLs, reassure him, leave and return 5-10 minutes later and try again. If possible, negotiate a time for ADLs so that [Resident #1] participates in the decision making process. Return at the agreed upon time. Interview on 09/25/24 at 9:58 AM with Resident #1's RP revealed she saw through the camera in the resident's room on 08/06/24 that CNA B had abused Resident #1. Resident #1's RP said when she got to the facility she went straight to the DON's office and showed both the DON and ADON A the video. Resident #1's RP said the DON told her she couldn't watch anymore of the video but the ADON watched the rest. Resident #1's RP said she was told they were going to remove CNA B from the floor. Resident #1's RP said she was sent down to talk to the Administrator. Resident #1's RP said the Administrator watched a little bit of the videos and Resident #1's RP told her that it wasn't the worst part, but that the Administrator did not want to see anymore. Resident #1's RP said the Administrator told her that CNA B would not be allowed to work at the facility again and they would report the information back to the agency where he worked. Resident #1's RP said she had asked them to have a nurse or someone to look at him for injuries because when she saw him he had a reddened area to his face. Resident #1's RP said she took a picture of the reddened area and showed the facility staff the picture from that day as well. Resident #1's RP said immediately after the incident, Resident #1 was very jumpy and acted scared when she or others got close to him which was unusual behavior for him. Observation of Video #1 provided by Resident #1's RP revealed the following occurred and was dated 08/06/24 at 10:27:21 AM through 10:29:06 AM: (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1 was seen in bed, CNA B walked into the frame of the camera and walked to the right side of the bed, opened up the cabinet and took a brief out and put it on the counter. CNA B moved the bedside table that was up against the wall so he could open the closet to get Resident #1's clothes out. CNA B set clothes on the bedside table. CNA B opened the cabinet again to get gloves out and set them on the bedside table. CNA B walked to a chair in the corner of Resident #1's room and sat down. CNA B said good morning and put the gloves on his hands. CNA B said We gotta get you up. Resident #1 said You can't get me up. You can't get me up. You can't get me up. The video ended. Observation of Video #2 provided by Resident #1's RP revealed the following occurred and was dated 08/06/24 at 10:29:32 AM through 10:29:57 AM: CNA B is still sitting in the chair in the corner of the room putting gloves on and said You don't think I can pick you up? We'll see. CNA B stood up. The video ended. Observation of Video #3 provided by Resident #1's RP revealed the following occurred and was dated 08/06/24 at 10:30:02 AM through 10:35:25 AM: (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA B walked to the left side of the resident's bed and turned the lights on. CNA B said My name is [CNA B's name]. and he leaned towards the resident. CNA B picked up the bed remote and started to raise the bed and head of Resident #1's bed. Resident #1 said something unintelligible. CNA B said something unintelligible. CNA B then pulled the covers away from Resident #1 while Resident #1 pulled them back. CNA B grabbed Resident #1's arms and held them away from the covers and told Resident #1 Hold on a second, hold on. CNA B kept taking the covers off of Resident #1 and then grabbed both of his arms and put them above the resident's head to hold them there while CNA B pulled his leg up to the bed and told Resident #1 I'm not playing with you. I'm not playing with you. I'm not playing with you. CNA B also said [something unintelligible] your friend. and then took the covers completely off of Resident #1 and laid them over the footboard of the bed. Resident #1 used his hands to grab at the sheet underneath him to try and cover himself and CNA B grabbed the sheet from the resident. CNA B pinned Resident #1's arms to the side of his head and held the resident there. Resident #1 said Get out the way. Get out the way. CNA B said I'm getting you up. Resident #1 said No. CNA B said Yes, I am. Resident #1 said something unintelligible. Resident #1 then turned to the side with the sheet in his hand where the aide was holding it and CNA B took his other hand and used it to check Resident #1's brief by pulling the back part of it out near his bottom area. CNA B took Resident #1's left hand and put it on his chest while CNA B put his knee on Resident #1's bed. CNA B then took his knee off the bed and turned the resident to the other side so he could use his other hand to remove the resident's brief from the right side. Resident #1's hands can be seen shaking in the video as he tried to reach down to stop CNA B. CNA B put his knee back on the bed while still holding the resident's hands down with his other hand. CNA B said [something unintelligible]. Do you want the sheet or do you want me to change you? What do you want to do? Pick one. You want the sheet or do you want me to change you? Do you want the sheet or do you want me to change you? Do you want the sheet or do you want me to change you? Resident #1 said No. CNA B said You want the sheet? You can have the sheet, I'm gonna change you. Resident #1 took his hands and tried pulling CNA B's hands away. CNA B took Resident #1's hands and tried pinning them above the residents head. Resident #1 said Hey! CNA B said I gotta change you. Resident #1 said No. CNA B said Yes. Resident #1 said No, you don't have to change me. CNA B said I do. CNA B crossed Resident #1's hands on his chest and held them there. Resident #1 tried to stop CNA B but he pushed his hands away. CNA B said Be careful now, be careful. CNA B took Resident #1's brief off and disappeared from the camera view with it then went to the right side of the bed to get Resident #1's pants and brief. CNA B walked to the left side of the bed, took the sheet from the bed and put it at the end of the bed. CNA B then opened up the brief. CNA B put the brief underneath Resident #1 and tried to turn him towards the aide but the resident started to try to pull the aide's hands off of him. CNA B then got on the bed again and forced Resident #1's hands and arms to his chest and told the resident Don't play with me repeatedly while holding the resident's hands and arms down. CNA B got on the resident's bed still holding onto the resident's upper arm. CNA B used his other hand to close the side of the resident's brief. The video ended. Observation of Video #4 provided by Resident #1's RP revealed the following and was dated 08/06/24 at 10:35:33 AM through 10:36:11 AM: CNA B was on the resident's bed putting his brief on him but the residents hands kept trying to stop him. CNA B pinned Resident #1's hands to his face and when the resident resisted, he used his full body weight to lean on Resident #1, holding his arms down and said Don't bite me. CNA B got off Resident #1 but was still on the bed holding the resident's arms away from him and down on the bed while he used his other hand to secure the side of the resident's brief. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation of Video #5 provided by Resident #1's RP revealed the following and was dated 08/06/24 at 10:36:10 AM through 10:38:11 AM: CNA B was closing the side of the residents brief while Resident #1 had reached for the aides hand to stop him. CNA B leaned on the resident again with his full body weight and pinned the resident to the side of the bed. CNA B then faced away from the resident and had his knee tucked under him and his leg kicked out hanging off the bed. Resident #1 was laying on his right side and said something unintelligible. CNA B had his left elbow holding the residents arms down so the aide could attach the brief on the side. Resident #1 said Get out of my room. CNA B leaned off of the resident and then put his knees down on the bed and used his body weight on the resident to hold his arms down. CNA B and Resident #1 begin to physically struggle and the resident is heard grunting. CNA B took Resident #1's hands and held his arms down at the bedside. CNA B leans back and has his phone in his hand and gets off the bed and puts the phone in the pocket on the front of his scrubs. CNA B took Resident #1's pants from the left side of the bed and walked out of the frame with them. A door is heard being closed in the background. Resident #1 was seen trying to use the pillow between his legs to cover himself by putting it on top of his legs. CNA B came back into the frame of the camera and walks to the right side of the resident's bed and said Turn to the other side. Turn to the other side. CNA B took his phone out of his pocket to look at it and then put it back in his pocket. CNA B said Turn to the other side. Turn to the other side. Resident #1 held his hand up and shook his head no. CNA B said I've got to get you up, the doctor told me to get you up. CNA B then took the pillow off of the resident. Observation of Video #6 provided by Resident #1's RP revealed the following and was dated 08/06/24 at 10:38:15 AM through 10:40:17 AM: CNA B took the incontinent pad from under the resident and folded it towards the resident's body and said This ain't me, it's the doctor. Resident #1 was using his hands to stop the aide. CNA B said It's the doctor. Resident #1 held his hands up in the air while the aide touched the side of his brief. CNA B said Hey, listen to me. [unintelligible words]. while Resident #1 tried to push the aide away and CNA B held the resident's arms down. CNA B put his left knee on the bed and started to hold the resident's arms down. Resident #1 said No. CNA B said something unintelligible while holding the resident's arms down. CNA B said Stop. Stop that alright. Resident #1 said something unintelligible to the aide. CNA B said [something unintelligible] good sense, okay. Resident #1 said Get out of my room. CNA B took his leg off the bed while still holding the residents arms down. Resident #1 said something unintelligible. CNA B let go of Resident #1 and put his finger near his face and said Don't do it. Resident #1 said something unintelligible as CNA B adjusted the side of his brief. Resident #1 can be seen breathing very heavily and had a scared look on his face. CNA B finished securing the side of the resident's brief and said Turn to the other side. While pointing to the other side of the room. CNA B turned the resident's body to the other side of the bed while the resident reached towards him to stop. CNA B said Didn't I tell you don't play with me? Resident #1 said something unintelligible. CNA B leaned towards Resident #1 and said something unintelligible to him. CNA B then pulled back from the resident and pulled his legs towards the middle of the bed and Resident #1 tried using his hands to stop the aide. CNA B got back on the bed with both of his knees and used his body weight to hold Resident #1 down on the left side of the bed. Resident #1 can be heard grunting while CNA B used his body weight to hold the resident down. CNA B tried to get Resident #1's brief up on the side of him. Resident #1 can be heard moaning and CNA B said I'm almost done. The video ended. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation of Video #7 provided by Resident #1's RP revealed the following and was dated 08/06/24 at 10:40:44 AM through 10:42:43 AM: CNA B was leaning on the resident and had the resident's pants on the bed and was trying to put them on the resident. Resident #1 can be seen struggling behind CNA B as the resident is pinned against the bed. CNA B used his elbow to hold the resident's arms down. CNA B said I told you not to do that. Resident #1 said No. and mumbled loudly. CNA B continued to put the resident's pants on his left leg and Resident #1 is still moaning. Resident #1 said something unintelligible as aide put his pants on his left leg. CNA B was still leaning on the resident pinning him against the side of the bed. Resident #1 said get out of my room. CNA B continued to put the pants on the resident and said Are you crazy? CNA B said something unintelligible twice. CNA B was holding onto the resident's grab bar on the left side of the resident's bed while using his elbow to keep the resident's arm from coming near him. CNA B was putting the resident's pants on. CNA B stopped and looked at the resident and then lifted off of him. Resident #1 put himself near the middle of the bed where his legs were and his pants were at his ankles. CNA B pulled the resident's legs towards him on the right side of the bed and the resident tried pulling his legs towards his chest and attempted to grab his legs from the aide. Resident #1 said Leave me alone. CNA B kept putting the resident's pants on his on his right leg while Resident #1 tried pulling the pants up on his leg to cover himself. Resident #1's hands were seen shaking. The video ended. Observation of Video #8 provided by Resident #1's RP revealed the following and was dated 08/06/24 at 10:42:51 AM through 10:43:26 AM: CNA B was putting Resident #1's pants over his knees. Resident #1 tried grabbing the aide and the aide grabbed the resident back. CNA B put his knee on the bed to lean over the resident and took Resident #1's arms to cross them over his chest. CNA B said I don't play with you. I already told you. I don't told you. I already told you. Do not play with me. as he was leaning over the resident holding his arms to his chest. The video ended. Observation of Video #9 provided by Resident #1's RP revealed the following and was dated 08/06/24 at 10:43:26 AM through 10:45:24 AM: (continued on next page)

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	745019	A. Building B. Wing	10/11/2024

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James L West Center for Dementia Care	1111 Summit Ave Fort Worth, TX 76102

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA B eventually let go of the resident's arms that were crossed on his chest. CNA B got off the bed and started pulling the resident's pants up. CNA B walked to the other side of the bed to pull his pants up from the left side of the bed and pulled the residents legs towards him to lift the resident up under to pull the pants up on the backside. Resident #1's hands were shaking and he said something unintelligible. CNA B turned the resident away from him so Resident #1 was facing the right side of the bed and pulled the resident's pants up on the backside of him. Resident #1 turned his upper body towards CNA B. CNA B turned the residents legs towards him on the left side of the bed to pull his pants up on that side. CNA B let the resident's legs fall to the bed and walked around to the right side of the bed. Resident #1 can be seen heavily breathing and had a scared look on his face. CNA B took the shirt that was taken from the closet earlier from the bedside table and told the resident You're wearing something different. and put the shirt back in the closet. CNA B said I'm going to put you in something blue. and grabbed a blue shirt from the closet. CNA B walked around to the left side of the bed with the blue shirt. CNA B put the blue shirt on the footboard of the bed and said C'mon. Put your shirt on. and started to pull the resident's legs towards the left side of the bed towards the aide. CNA B then pulled the resident's arms to lift him to a more seated position on the side of the bed. CNA B said I got you. and started to pull the resident's shirt off of him. CNA B started to pull the shirt over his head and Resident #1 started to shake and breathe loudly. CNA B said I got you. and pulled the shirt off of Resident #1. The resident fell back onto the bed. CNA B rolled up the shirt and tossed it to the side of the room out of camera view. The video ended. Observation of Video #10 provided by Resident #1's RP revealed the following and was dated 08/06/24 at 10:45:29 AM through 10:47:28 AM: CNA B was holding Resident #1's left arm down and said You're going to hurt yourself. CNA B used his right knee to hold the resident's left arm down by putting his knee on the resident's arm on the bed while he pulled the resident's left arm through the sleeve of the shirt. CNA B said Shit. CNA B got off the bed and said C'mon. while he pulled the residents arms to sit him up on the side of the bed. Resident #1 started punching the aide in his stomach area. CNA B took the resident's left arm and put it through the sleeve hole in the shirt. Resident #1 fell back to the bed and CNA B said I'm not playing with you. While he tried to get the resident's shirt on. Resident #1 said No. CNA B said something unintelligible twice. CNA B pulled the resident's shirt down and leaned back to stand in front of the resident and said You want your shoes on? Want your shoes on? Resident #1 nodded yes. CNA B walked out of the camera angle towards the wall in the room and Resident #1 was sitting on the side of the bed. CNA B sat next to the resident on the bed with his shoes in his hands. CNA B kicked his leg out to look at something, then put I back under him. CNA B took the Velcro straps off the resident's shoe and pulled the resident's leg up to put the shoe on. The video ended. Observation and interview on 09/25/24 at 10:40 AM with Resident #1 revealed he was laying in his bed in his room. Resident #1 said he was doing okay and was not in any pain. Resident #1 did not have any bruises or marks to his face. Resident #1 said someone was mean to him and hurt him, but could not specify who it was. Resident #1 said that he had seen the person who hurt him recently but was not able to say when he last saw them. Resident #1 appeared tired and stopped answering questions so the surveyor left the room. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 09/25/24 at 12:00 PM with LVN G revealed she cared for Resident #1. LVN G said Resident #1 had a behavior of refusing care and fighting staff when trying to care for him. LVN G said she never forced Resident #1 to receive care and instead would make sure he was safe and try again at a later time to provide him care if he refused. LVN G said she knew that physically forcing a resident to receive care was considered abuse. Interview on 09/25/24 at 12:20 PM with RA C revealed he cared for Resident #1. RA C said Resident #1 did refuse care at times, so he would leave him alone and come back at a later time to try to provide care again. RA C said he would never force Resident #1 to receive care because that was a right the resident had to refuse. Interview on 09/25/24 at 12:33 PM with CNA D revealed she cared for Resident #1. CNA D said Resident #1 sometimes refused care. CNA D said she would make sure Resident #1 was safe and would not force him to receive care. CNA D explained that she would try to provide care at a later time to Resident #1 and would not force him to receive care. Interview on 09/25/24 at 12:44 PM with CNA E revealed he cared for Resident #1. CNA E said Resident #1 refused care sometimes. CNA E said he would not force Resident #1 to receive care and instead would make sure he was safe and try again at a later time to give care to him. Interview on 09/25/24 at 12:53 PM with LVN F revealed she cared for Resident #1. LVN F said Resident #1 did refuse care at times. LVN F said she never forced Resident #1 to receive care and instead would make sure he was safe and would try again at a later time to provide the care to him. LVN F explained that physically forcing a resident to receive care was considered a form of abuse. Interview on 09/25/24 at 1:44 PM with ADON A revealed she was familiar with Resident #1. ADON A said Resident #1 refused care but staff had been trained to come back at a different time if a resident refused care. ADON A said Resident #1's RP came to the facility on e day and told her and the DON that she wanted to show them something. ADON A said Resident #1's RP showed a video of the aide attempting to provide care to Resident #1 but she could not recall the details of the video. ADON A said Resident #1's RP told them that she did not like the way the aide handled Resident #1 and did not want the aide to continue caring for the resident. ADON A said Resident #1's RP also showed them the picture of his face where there was redness to his face but she did not ask the RP how he got the redness. ADON A said Resident #1's RP expressed the redness was from the way the aide handled the resident. ADON A said she saw Resident #1 later that day and he did not have any redness noted to his face. ADON A said since she did not see the redness noted to Resident #1's face like in the picture she could not say that was how it happened or what caused it. ADON A said after she watched the videos, she went upstairs to take CNA B off the floor. ADON A said when she spoke with CNA B, he explained that Resident #1 was refusing care and being combative and he was trained to continue providing care when that happened. ADON A said after she talked with CNA B, he left the facility. ADON A said her impression of the video was that the aide was from an agency and that was not how the facility trained their own staff to handle resident refusals. ADON A said agency aides did not get any trainings from the facility when they pick up shifts for the facility. ADON A said their staff had been trained by the facility to make sure a resident was safe and then stop trying to provide care when they refused. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 09/25/24 at 2:11 PM with the DON revealed Resident #1 refused care at times and staff were supposed to give him a break and come back to reapproach or swap out with someone else to continue and provide care to him. The DON said one day Resident #1's RP came to her office and wanted to share a video with her. The DON said she asked Resident #1's RP to send the video to her but Resident #1's RP did not know how to do that. The DON said Resident #1's RP pulled up a video and the DON saw in the video Resident #1 put his hand up to say stop and that was enough for her to see. The DON said she told Resident #1's RP that if she wanted to share more about the situation, the best thing to do was to get the Administrator involved. The DON said Resident #1's RP also showed her the picture of Resident #1 that showed the redness on his face. The DON said when she went to see Resident #1 later that day she did not see any redness to his face, so whatever it was, it had resolved by the time she saw him. The DON said when she spoke with CNA B he said Resident #1 was fighting him during care and she explained to him that any time a resident refused care CNA B should stop. The DON said CNA B explained that he had been trained to continue providing care for a resident even if they had refused. The DON said there was no training provided to agency staff and she did not check their training before they picked up a shift at the facility. The DON said the facility used agency staff about one to three times per month, but it depended on staffing. The DON said it was appropriate for CNA B to continue providing care to Resident #1 even if he refused if that was how he had been trained even though it was not how the facility trained their staff. The DON said it was considered abuse if a staff member pinned a residents hands to the side of their head, above their head, and to their chest. The DON said another form of abuse could be a staff putting their body weight against a resident and using that to force the resident to comply while the staff ripped off the resident's brief and sheets. Interview on 09/25/24 at 2:41 PM with the Administrator revealed Resident #1 refused care. The Administrator said facility staff had been trained to redirect a resident or give them a minute to try to get the resident focused on something else instead. The Administrator said Resident #1's RP came to her office to show her the videos and said that the ADON and DON had already seen them. The Administrator said she saw there was a large male and he went into the room and provided care to Resident #1. The Administrator said she did not see anything on the video that was abusive. The Administrator said she asked Resident #1's RP if there was something worse on the video and was told no but it was not how the facility's staff would have handled the situation. The Administrator said Resident #1's RP brought up something about Resident #1's face and the DON told her that they did not see anything on his face. The Administrator said she never saw any other video but said the video she did see concerned her. The Administrator said agency staff were not given any training from the facility. The Administrator said the facility used agency staff about four to six times per month, but they tried to use their own staff as much as possible. The Administrator said if she thought anything CNA B did at that time was abusive, she would have reported it and completed an investigation. The Administrator began to watch the first part of video #3 that was provided by Resident #1's RP to the surveyor. The Administrator did not want to watch the whole video and only watched the first part of it where Resident #1 and CNA B were physically struggling with the covers. The Administrator said based on what she saw and what the surveyor told her had happened, that was considered abuse. The Administrator revealed she was the abuse coordinator for the facility and would be responsible for investigation and reporting any allegation of abuse. The Administrator said all staff were responsible for ensuring that residents were free from abuse. The Administrator said she expected all staff to follow the facility's abuse policy and not following it put residents at risk of injuries and psychological issues. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Telephone interview on 09/25/24 at 5:18 PM with CNA B revealed he was upset because the facility refused to allow him to write a statement about what happened. CNA B said he was working with an aggressive resident who bit him and hit him when he was working at the facility. CNA B said he restrained the resident while this was happening. CNA B said he did not receive any information on how to care for the resident before the start of his shift. CNA B said he guessed the resident was having PTSD since he was a veteran. CNA B said the residents at this facility were individuals who were aggressive on dementia wings. CNA B said he was told to get the resident ready and when he went into the room, the resident was ultra aggressive but once he calmed down everything was okay. CNA B said he walked into the resident's room and felt like he was blindsided. CNA B said he had been trained on caring for residents with dementia previously but he expected to be prepared to care for residents who fought and fought aggressively. CNA B said the resident struck in him in the face and bit his arm while he was getting him prepared to sit in the chair to eat. CNA B said he had to restrain the resident to hold him back from hitting the aide. CNA B said he had been trained that if a resident was highly resistant to care to just back off and let them be but was in midst of caring for the resident before figuring out what happened. CNA B said he did not walk away from caring for the resident because he would pause in between incidents as if the episode was over and once the resident was dressed he stopped. CNA B said he did not feel he abused the resident by restraining him. When CNA B was asked about what he said to the resident in the video, he refused to answer. CNA B said he was not originally assigned to [NAME][TRUNCATED]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observation , interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment were reported immediately to the State survey Agency in accordance with State law through(established procedures for 1 of 7 residents (Resident #1) reviewed for abuse and neglect. The facility failed to report an abuse allegation made by Resident #1's RP's on 08/06/24 when it was alleged CNA B was rough and continued providing care to Resident #1 even though he refused leaving red marks to Resident #1's face. This failure could place residents at risk for abuse and/or neglect . Findings included: Record review of the facility's Abuse and Neglect- Clinical Protocol policy, revised March 2018, reflected: 1. 'Abuse' is defined at [symbol]483.5 as 'the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse facilitated or enabled through the use of technology.' .4. 'willful' as defined at [symbol]483.5 and as used in the definition of 'abuse,' means the 'individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.' Cause Identification, 1. The staff, with the physician's input as needed, will investigate alleged abuse and neglect to clarify what happened and identify possible causes .Treatment/Management, 1. The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect. 2. The management and staff, with physician support, will address situations of suspected or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations Monitoring and Follow-up .3. The physician will advise the facility and help review and address abuse and neglect issues as part of the quality assurance process. Interview on 09/26/24 at 6:00 PM with the Administrator revealed the facility did not have a policy that addressed preventing abuse. The Administrator explained that the facility followed the provider letter 2024-14 as the facility's policy. Record review of PL 2024-14, dated 08/29/24, and titled Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Other Incidents that a Nursing Facility (NF) Must Report to the Health and Human Services Commission (HHSC) reflected: 2.0 Policy Details & Provider Responsibilities, 2.1 Incidents that a NF Must Report to HHSC, A NF must report to CII the following types of incidents, in accordance with applicable state and federal requirements: Abuse .Suspicious injuries of unknown source . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's face sheet, dated 09/26/24, reflected the resident was an [AGE] year-old male who admitted to the facility on [DATE]. Record review of Resident #1's Quarterly MDS Assessment, dated 07/22/24, reflected he had a BIMS of 4 indicating severe cognitive impairment. Under the behavior section, there were no behaviors exhibited towards others nor were there any refusals or rejection of care. Under the functional abilities and goals section, it was noted that Resident #1 required partial/moderate assistance for upper and lower body dressing. Resident #1 had diagnoses of non-Alzheimer's Disease (any form of dementia other than Alzheimer's disease), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and muscle weakness (generalized). Record review of Resident #1's care plan reflected the following: - Focus: [Resident #1] has an ADL self-care performance deficit r/t dementia .Goal: [Resident #1] will be encouraged to perform self care as his ability allows and will receive adequate assistance from staff to complete self-care tasks that he is not able to do on his own throughout this review period .Interventions: DRESSING: Allow sufficient time for dressing and undressing. - Focus: [Resident #1] has a behavior problem r/t Dementia (Sometimes resistant to assistance with person care/ bathing. Strikes out and yells at staff) .Goal: [Resident #1] will have fewer behavior episodes by the review date .Interventions: Explain all procedures to [Resident #1] before starting and allow him time to adjust to changes. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Utilize dementia-specific care techniques to help alleviate [Resident #1's] fear and frustration during care. Use Positive Approach to Care, Validation techniques, Compassionate Tough, distraction, and redirection. - Focus: [Resident #1] is resistive to care on occasions r/t Dementia .Goal: [Resident #1] will cooperate with care through the review date .Interventions: If [Resident #1] resists with ADLs, reassure him, leave and return 5-10 minutes later and try again. If possible, negotiate a time for ADLs so that [Resident #1] participates in the decision making process. Return at the agreed upon time. Interview on 09/25/24 at 9:58 AM with Resident #1's RP revealed she saw through the camera in the resident's room on 08/06/24 that CNA B had abused Resident #1. Resident #1's RP said when she got to the facility she went straight to the DON's office and showed both the DON and ADON A the video. Resident #1's RP said the DON told her she couldn't watch anymore of the video but the ADON watched the rest. Resident #1's RP said she was told they were going to remove CNA B from the floor. Resident #1's RP said she was sent down to talk to the Administrator. Resident #1's RP said the Administrator watched a little bit of the videos and Resident #1's RP told her that it wasn't the worst part, but that the Administrator did not want to see anymore. Resident #1's RP said the Administrator told her that CNA B would not be allowed to work at the facility again and they would report the information back to the agency where he worked. Resident #1's RP said she had asked them to have a nurse or someone to look at him for injuries because when she saw him he had a reddened area to his face. Resident #1's RP said she took a picture of the reddened area and showed the facility staff the picture from that day as well. Resident #1's RP said immediately after the incident, Resident #1 was very jumpy and acted scared when she or others got close to him which was unusual behavior for him. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 09/25/24 at 10:40 AM with Resident #1 revealed he was laying in his bed in his room. Resident #1 said he was doing okay and was not in any pain. Resident #1 did not have any bruises or marks to his face. Resident #1 said someone was mean to him and hurt him, but could not specify who it was. Resident #1 said that he had seen the person who hurt him recently but was not able to say when he last saw them. Resident #1 appeared tired and stopped answering questions so the surveyor left the room. Interview on 09/25/24 at 1:44 PM with ADON A revealed she was familiar with Resident #1. ADON A said Resident #1 refused care but staff had been trained to come back at a different time if a resident refused care. ADON A said Resident #1's RP came to the facility on e day and told her and the DON that she wanted to show them something. ADON A said Resident #1's RP showed a video of the aide attempting to provide care to Resident #1 but she could not recall the details of the video. ADON A said Resident #1's RP told them that she did not like the way the aide handled Resident #1 and did not want the aide to continue caring for the resident. ADON A said Resident #1's RP also showed them the picture of his face where there was redness to his face but she did not ask the RP how he got the redness. ADON A said Resident #1's RP expressed the redness was from the way the aide handled the resident. ADON A said she saw Resident #1 later that day and he did not have any redness noted to his face. ADON A said since she did not see the redness noted to Resident #1's face like in the picture she could not say that was how it happened or what caused it. ADON A said after she watched the videos, she went upstairs to take CNA B off the floor. ADON A said when she spoke with CNA B, he explained that Resident #1 was refusing care and being combative and he was trained to continue providing care when that happened. ADON A said after she talked with CNA B, he left the facility. ADON A said her impression of the video was that the aide was from an agency and that was not how the facility trained their own staff to handle resident refusals. ADON A said agency aides did not get any trainings from the facility when they pick up shifts for the facility. ADON A said their staff had been trained by the facility to make sure a resident was safe and then stop trying to provide care when they refused. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/25/24 at 2:11 PM with the DON revealed Resident #1 refused care at times and staff were supposed to give him a break and come back to reapproach or swap out with someone else to continue and provide care to him. The DON said one day Resident #1's RP came to her office and wanted to share a video with her. The DON said she asked Resident #1's RP to send the video to her but Resident #1's RP did not know how to do that. The DON said Resident #1's RP pulled up a video and the DON saw in the video Resident #1 put his hand up to say stop and that was enough for her to see. The DON said she told Resident #1's RP that if she wanted to share more about the situation, the best thing to do was to get the Administrator involved. The DON said Resident #1's RP also showed her the picture of Resident #1 that showed the redness on his face. The DON said when she went to see Resident #1 later that day she did not see any redness to his face, so whatever it was, it had resolved by the time she saw him. The DON said when she spoke with CNA B he said Resident #1 was fighting him during care and she explained to him that any time a resident refused care CNA B should stop. The DON said CNA B explained that he had been trained to continue providing care for a resident even if they had refused. The DON said there was no training provided to agency staff and she did not check their training before they picked up a shift at the facility. The DON said the facility used agency staff about one to three times per month, but it depended on staffing. The DON said it was appropriate for CNA B to continue providing care to Resident #1 even if he refused if that was how he had been trained even though it was not how the facility trained their staff. The DON said it was considered abuse if a staff member pinned a residents hands to the side of their head, above their head, and to their chest. The DON said another form of abuse could be a staff putting their body weight against a resident and using that to force the resident to comply while the staff ripped off the resident's brief and sheets. Interview on 09/25/24 at 2:41 PM with the Administrator revealed Resident #1 refused care. The Administrator said facility staff had been trained to redirect a resident or give them a minute to try to get the resident focused on something else instead. The Administrator said Resident #1's RP came to her office to show her the videos and said that the ADON and DON had already seen them. The Administrator said she saw there was a large male and he went into the room and provided care to Resident #1. The Administrator said she did not see anything on the video that was abusive. The Administrator said she asked Resident #1's RP if there was something worse on the video and was told no but it was not how the facility's staff would have handled the situation. The Administrator said Resident #1's RP brought up something about Resident #1's face and the DON told her that they did not see anything on his face. The Administrator said she was not sure if the red marks seen on Resident #1's face in the picture provided by Resident #1's RP were from the situation with CNA B or not. The Administrator said it could have been from Resident #1 leaning on something or his pillow being creased but she did not do any follow up to see what caused it. The Administrator said she did not consider it abuse at the time. The Administrator said she never saw any other video but said the video she did see concerned her. The Administrator said agency staff were not given any training from the facility. The Administrator said the facility used agency staff about four to six times per month, but they tried to use their own staff as much as possible. The Administrator said if she thought anything CNA B did at that time was abusive, she would have reported it and completed an investigation. The Administrator began to watch the first part of video #3 that was provided by Resident #1's RP to the surveyor. The Administrator did not want to watch the whole video and only watched the first part of it where Resident #1 and CNA B were physically struggling with the covers. The Administrator said based on what she saw and what the surveyor told her had happened, that was considered abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a follow-up interview on 09/25/24 at 5:05 PM, the Administrator revealed she was the abuse coordinator for the facility. The Administrator explained she was responsible for reporting and investigating allegations of abuse. The Administrator said all staff were responsible for ensuring residents were free from abuse and she expected all staff to follow the facility's abuse and neglect policy. The Administrator said if the facility's abuse policy was not followed that put residents at risk of injuries and psychological issues. The Administrator said since Resident #1's RP did not say what CNA B did in the videos was abusive, she did not think it needed to be reported or investigated further. Telephone interview on 09/25/24 at 5:18 PM with CNA B revealed he was upset because the facility refused to allow him to write a statement about what happened. CNA B said he was working with an aggressive resident who bit him and hit him when he was working at the facility. CNA B said he restrained the resident while this was happening. CNA B said he did not receive any information on how to care for the resident before the start of his shift. CNA B said he guessed the resident was having PTSD since he was a veteran. CNA B said the residents at this facility were individuals who were aggressive on dementia wings. CNA B said he was told to get the resident ready and when he went into the room, the resident was ultra aggressive but once he calmed down everything was okay. CNA B said he walked into the resident's room and felt like he was blindsided. CNA B said he had been trained on caring for residents with dementia previously but he expected to be prepared to care for residents who fought and fought aggressively. CNA B said the resident struck in him in the face and bit his arm while he was getting him prepared to sit in the chair to eat. CNA B said he had to restrain the resident to hold him back from hitting the aide. CNA B said he had been trained that if a resident was highly resistant to care to just back off and let them be but was in midst of caring for the resident before figuring out what happened. CNA B said he did not walk away from caring for the resident because he would pause in between incidents as if the episode was over and once the resident was dressed he stopped. CNA B said he did not feel he abused the resident by restraining him. When CNA B was asked about what he said to the resident in the video, he refused to answer. CNA B said he was not originally assigned to this resident but was asked to get him ready for the day so he did.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observation, interview and record review, the facility failed to have evidence that all alleged violations were thoroughly investigated and prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress for 1 of 7 residents (Resident #1) reviewed for abuse. The facility failed to implement their abuse policy and investigate alleged or suspected physical abuse when Resident #1's RP told them CNA B continued to provide care after the resident had refused and told them CNA B was rough during care leaving red marks to Resident #1's face. An IJ was identified on 09/25/24. The IJ template was provided to the facility on [DATE] at 5:17 PM. While the IJ was removed on 09/26/24, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because all staff had not been trained on the plan of removal. This failure could place all residents at risk for abuse and psychosocial harm. Findings included: Record review of the facility's Abuse and Neglect- Clinical Protocol policy, revised March 2018, reflected: 1. 'Abuse' is defined at [symbol]483.5 as 'the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse facilitated or enabled through the use of technology.' .4. 'willful' as defined at [symbol]483.5 and as used in the definition of 'abuse,' means the 'individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.' Interview on 09/26/24 at 6:00 PM with the Administrator revealed the facility did not have a policy that addressed preventing abuse. The Administrator explained that the facility followed the provider letter 2024-14 as the facility's policy. Record review of Resident #1's face sheet, dated 09/26/24, reflected the resident was an [AGE] year-old male who admitted to the facility on [DATE]. Record review of Resident #1's Quarterly MDS Assessment, dated 07/22/24, reflected he had a BIMS score of 4 indicating severe cognitive impairment. Under the behavior section, there were no behaviors exhibited towards others nor were there any refusals or rejection of care. Under the functional abilities and goals section, it was noted that Resident #1 required partial/moderate assistance for upper and lower body dressing. Resident #1 had diagnoses of non-Alzheimer's Disease (any form of dementia other than Alzheimer's disease), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and muscle weakness (generalized). (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's care plan reflected the following: - Focus: [Resident #1] has an ADL self-care performance deficit r/t dementia .Goal: [Resident #1] will be encouraged to perform self care as his ability allows and will receive adequate assistance from staff to complete self-care tasks that he is not able to do on his own throughout this review period .Interventions: DRESSING: Allow sufficient time for dressing and undressing. -Focus: [Resident #1] has a behavior problem r/t Dementia (Sometimes resistant to assistance with person care/ bathing. Strikes out and yells at staff) .Goal: [Resident #1] will have fewer behavior episodes by the review date .Interventions: Explain all procedures to [Resident #1] before starting and allow him time to adjust to changes. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Utilize dementia-specific care techniques to help alleviate [Resident #1's] fear and frustration during care. Use Positive Approach to Care, Validation techniques, Compassionate Tough, distraction, and redirection. - Focus: [Resident #1] is resistive to care on occasions r/t Dementia .Goal: [Resident #1] will cooperate with care through the review date .Interventions: If [Resident #1] resists with ADLs, reassure him, leave and return 5-10 minutes later and try again. If possible, negotiate a time for ADLs so that [Resident #1] participates in the decision making process. Return at the agreed upon time. Interview on 09/25/24 at 9:58 AM with Resident #1's RP revealed she saw through the camera in the resident's room on 08/06/24 that CNA B had abused Resident #1. Resident #1's RP said when she got to the facility she went straight to the DON's office and showed both the DON and ADON A the video. Resident #1's RP said the DON told her she couldn't watch anymore of the video but the ADON watched the rest. Resident #1's RP said she was told they were going to remove CNA B from the floor. Resident #1's RP said she was sent down to talk to the Administrator. Resident #1's RP said the Administrator watched a little bit of the videos and Resident #1's RP told her that it wasn't the worst part, but that the Administrator did not want to see anymore. Resident #1's RP said the Administrator told her that CNA B would not be allowed to work at the facility again and they would report the information back to the agency where he worked. Resident #1's RP said she had asked them to have a nurse or someone to look at him for injuries because when she saw him he had a reddened area to his face. Resident #1's RP said she took a picture of the reddened area and showed the facility staff the picture from that day as well. Resident #1's RP said immediately after the incident, Resident #1 was very jumpy and acted scared when she or others got close to him which was unusual behavior for him. Observation of Video #1 provided by Resident #1's RP revealed the following occurred and was dated 08/06/24 at 10:27:21 AM through 10:29:06 AM: Resident #1 was seen in bed, CNA B walked into the frame of the camera and walked to the right side of the bed, opened up the cabinet and took a brief out and put it on the counter. CNA B moved the bedside table that was up against the wall so he could open the closet to get Resident #1's clothes out. CNA B set clothes on the bedside table. CNA B opened the cabinet again to get gloves out and set them on the bedside table. CNA B walked to a chair in the corner of Resident #1's room and sat down. CNA B said good morning and put the gloves on his hands. CNA B said We gotta get you up. Resident #1 said You can't get me up. You can't get me up. You can't get me up. The video ended. Observation of Video #2 provided by Resident #1's RP revealed the following occurred and was dated 08/06/24 at 10:29:32 AM through 10:29:57 AM: (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA B is still sitting in the chair in the corner of the room putting gloves on and said You don't think I can pick you up? We'll see. CNA B stood up. The video ended. Observation of Video #3 provided by Resident #1's RP revealed the following occurred and was dated 08/06/24 at 10:30:02 AM through 10:35:25 AM: CNA B walked to the left side of the resident's bed and turned the lights on. CNA B said My name is [CNA B's name]. and he leaned towards the resident. CNA B picked up the bed remote and started to raise the bed and head of Resident #1's bed. Resident #1 said something unintelligible. CNA B said something unintelligible. CNA B then pulled the covers away from Resident #1 while Resident #1 pulled them back. CNA B grabbed Resident #1's arms and held them away from the covers and told Resident #1 Hold on a second, hold on. CNA B kept taking the covers off of Resident #1 and then grabbed both of his arms and put them above the resident's head to hold them there while CNA B pulled his leg up to the bed and told Resident #1 I'm not playing with you. I'm not playing with you. I'm not playing with you. CNA B also said [something unintelligible] your friend. and then took the covers completely off of Resident #1 and laid them over the footboard of the bed. Resident #1 used his hands to grab at the sheet underneath him to try and cover himself and CNA B grabbed the sheet from the resident. CNA B pinned Resident #1's arms to the side of his head and held the resident there. Resident #1 said Get out the way. Get out the way. CNA B said I'm getting you up. Resident #1 said No. CNA B said Yes, I am. Resident #1 said something unintelligible. Resident #1 then turned to the side with the sheet in his hand where the aide was holding it and CNA B took his other hand and used it to check Resident #1's brief by pulling the back part of it out near his bottom area. CNA B took Resident #1's left hand and put it on his chest while CNA B put his knee on Resident #1's bed. CNA B then took his knee off the bed and turned the resident to the other side so he could use his other hand to remove the resident's brief from the right side. Resident #1's hands can be seen shaking in the video as he tried to reach down to stop CNA B. CNA B put his knee back on the bed while still holding the resident's hands down with his other hand. CNA B said [something unintelligible]. Do you want the sheet or do you want me to change you? What do you want to do? Pick one. You want the sheet or do you want me to change you? Do you want the sheet or do you want me to change you? Do you want the sheet or do you want me to change you? Resident #1 said No. CNA B said You want the sheet? You can have the sheet, I'm gonna change you. Resident #1 took his hands and tried pulling CNA B's hands away. CNA B took Resident #1's hands and tried pinning them above the residents head. Resident #1 said Hey! CNA B said I gotta change you. Resident #1 said No. CNA B said Yes. Resident #1 said No, you don't have to change me. CNA B said I do. CNA B crossed Resident #1's hands on his chest and held them there. Resident #1 tried to stop CNA B but he pushed his hands away. CNA B said Be careful now, be careful. CNA B took Resident #1's brief off and disappeared from the camera view with it then went to the right side of the bed to get Resident #1's pants and brief. CNA B walked to the left side of the bed, took the sheet from the bed and put it at the end of the bed. CNA B then opened up the brief. CNA B put the brief underneath Resident #1 and tried to turn him towards the aide but the resident started to try to pull the aide's hands off of him. CNA B then got on the bed again and forced Resident #1's hands and arms to his chest and told the resident Don't play with me repeatedly while holding the resident's hands and arms down. CNA B got on the resident's bed still holding onto the resident's upper arm. CNA B used his other hand to close the side of the resident's brief. The video ended. Observation of Video #4 provided by Resident #1's RP revealed the following and was dated 08/06/24 at 10:35:33 AM through 10:36:11 AM: (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA B was on the resident's bed putting his brief on him but the residents hands kept trying to stop him. CNA B pinned Resident #1's hands to his face and when the resident resisted, he used his full body weight to lean on Resident #1, holding his arms down and said Don't bite me. CNA B got off Resident #1 but was still on the bed holding the resident's arms away from him and down on the bed while he used his other hand to secure the side of the resident's brief. Observation of Video #5 provided by Resident #1's RP revealed the following and was dated 08/06/24 at 10:36:10 AM through 10:38:11 AM: CNA B was closing the side of the residents brief while Resident #1 had reached for the aides hand to stop him. CNA B leaned on the resident again with his full body weight and pinned the resident to the side of the bed. CNA B then faced away from the resident and had his knee tucked under him and his leg kicked out hanging off the bed. Resident #1 was laying on his right side and said something unintelligible. CNA B had his left elbow holding the residents arms down so the aide could attach the brief on the side. Resident #1 said Get out of my room. CNA B leaned off of the resident and then put his knees down on the bed and used his body weight on the resident to hold his arms down. CNA B and Resident #1 begin to physically struggle and the resident is heard grunting. CNA B took Resident #1's hands and held his arms down at the bedside. CNA B leans back and has his phone in his hand and gets off the bed and puts the phone in the pocket on the front of his scrubs. CNA B took Resident #1's pants from the left side of the bed and walked out of the frame with them. A door is heard being closed in the background. Resident #1 was seen trying to use the pillow between his legs to cover himself by putting it on top of his legs. CNA B came back into the frame of the camera and walks to the right side of the resident's bed and said Turn to the other side. Turn to the other side. CNA B took his phone out of his pocket to look at it and then put it back in his pocket. CNA B said Turn to the other side. Turn to the other side. Resident #1 held his hand up and shook his head no. CNA B said I've got to get you up, the doctor told me to get you up. CNA B then took the pillow off of the resident. Observation of Video #6 provided by Resident #1's RP revealed the following and was dated 08/06/24 at 10:38:15 AM through 10:40:17 AM: (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA B took the incontinent pad from under the resident and folded it towards the resident's body and said This ain't me, it's the doctor. Resident #1 was using his hands to stop the aide. CNA B said It's the doctor. Resident #1 held his hands up in the air while the aide touched the side of his brief. CNA B said Hey, listen to me. [unintelligible words]. while Resident #1 tried to push the aide away and CNA B held the resident's arms down. CNA B put his left knee on the bed and started to hold the resident's arms down. Resident #1 said No. CNA B said something unintelligible while holding the resident's arms down. CNA B said Stop. Stop that alright. Resident #1 said something unintelligible to the aide. CNA B said [something unintelligible] good sense, okay. Resident #1 said Get out of my room. CNA B took his leg off the bed while still holding the residents arms down. Resident #1 said something unintelligible. CNA B let go of Resident #1 and put his finger near his face and said Don't do it. Resident #1 said something unintelligible as CNA B adjusted the side of his brief. Resident #1 can be seen breathing very heavily and had a scared look on his face. CNA B finished securing the side of the resident's brief and said Turn to the other side. While pointing to the other side of the room. CNA B turned the resident's body to the other side of the bed while the resident reached towards him to stop. CNA B said Didn't I tell you don't play with me? Resident #1 said something unintelligible. CNA B leaned towards Resident #1 and said something unintelligible to him. CNA B then pulled back from the resident and pulled his legs towards the middle of the bed and Resident #1 tried using his hands to stop the aide. CNA B got back on the bed with both of his knees and used his body weight to hold Resident #1 down on the left side of the bed. Resident #1 can be heard grunting while CNA B used his body weight to hold the resident down. CNA B tried to get Resident #1's brief up on the side of him. Resident #1 can be heard moaning and CNA B said I'm almost done. The video ended. Observation of Video #7 provided by Resident #1's RP revealed the following and was dated 08/06/24 at 10:40:44 AM through 10:42:43 AM: CNA B was leaning on the resident and had the resident's pants on the bed and was trying to put them on the resident. Resident #1 can be seen struggling behind CNA B as the resident is pinned against the bed. CNA B used his elbow to hold the resident's arms down. CNA B said I told you not to do that. Resident #1 said No. and mumbled loudly. CNA B continued to put the resident's pants on his left leg and Resident #1 is still moaning. Resident #1 said something unintelligible as aide put his pants on his left leg. CNA B was still leaning on the resident pinning him against the side of the bed. Resident #1 said get out of my room. CNA B continued to put the pants on the resident and said Are you crazy? CNA B said something unintelligible twice. CNA B was holding onto the resident's grab bar on the left side of the resident's bed while using his elbow to keep the resident's arm from coming near him. CNA B was putting the resident's pants on. CNA B stopped and looked at the resident and then lifted off of him. Resident #1 put himself near the middle of the bed where his legs were and his pants were at his ankles. CNA B pulled the resident's legs towards him on the right side of the bed and the resident tried pulling his legs towards his chest and attempted to grab his legs from the aide. Resident #1 said Leave me alone. CNA B kept putting the resident's pants on his on his right leg while Resident #1 tried pulling the pants up on his leg to cover himself. Resident #1's hands were seen shaking. The video ended. Observation of Video #8 provided by Resident #1's RP revealed the following and was dated 08/06/24 at 10:42:51 AM through 10:43:26 AM: (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA B was putting Resident #1's pants over his knees. Resident #1 tried grabbing the aide and the aide grabbed the resident back. CNA B put his knee on the bed to lean over the resident and took Resident #1's arms to cross them over his chest. CNA B said I don't play with you. I already told you. I don't told you. I already told you. Do not play with me. as he was leaning over the resident holding his arms to his chest. The video ended. Observation of Video #9 provided by Resident #1's RP revealed the following and was dated 08/06/24 at 10:43:26 AM through 10:45:24 AM: CNA B eventually let go of the resident's arms that were crossed on his chest. CNA B got off the bed and started pulling the resident's pants up. CNA B walked to the other side of the bed to pull his pants up from the left side of the bed and pulled the residents legs towards him to lift the resident up under to pull the pants up on the backside. Resident #1's hands were shaking and he said something unintelligible. CNA B turned the resident away from him so Resident #1 was facing the right side of the bed and pulled the resident's pants up on the backside of him. Resident #1 turned his upper body towards CNA B. CNA B turned the residents legs towards him on the left side of the bed to pull his pants up on that side. CNA B let the resident's legs fall to the bed and walked around to the right side of the bed. Resident #1 can be seen heavily breathing and had a scared look on his face. CNA B took the shirt that was taken from the closet earlier from the bedside table and told the resident You're wearing something different. and put the shirt back in the closet. CNA B said I'm going to put you in something blue. and grabbed a blue shirt from the closet. CNA B walked around to the left side of the bed with the blue shirt. CNA B put the blue shirt on the footboard of the bed and said C'mon. Put your shirt on. and started to pull the resident's legs towards the left side of the bed towards the aide. CNA B then pulled the resident's arms to lift him to a more seated position on the side of the bed. CNA B said I got you. and started to pull the resident's shirt off of him. CNA B started to pull the shirt over his head and Resident #1 started to shake and breathe loudly. CNA B said I got you. and pulled the shirt off of Resident #1. The resident fell back onto the bed. CNA B rolled up the shirt and tossed it to the side of the room out of camera view. The video ended. Observation of Video #10 provided by Resident #1's RP revealed the following and was dated 08/06/24 at 10:45:29 AM through 10:47:28 AM: CNA B was holding Resident #1's left arm down and said You're going to hurt yourself. CNA B used his right knee to hold the resident's left arm down by putting his knee on the resident's arm on the bed while he pulled the resident's left arm through the sleeve of the shirt. CNA B said Shit. CNA B got off the bed and said C'mon. while he pulled the residents arms to sit him up on the side of the bed. Resident #1 started punching the aide in his stomach area. CNA B took the resident's left arm and put it through the sleeve hole in the shirt. Resident #1 fell back to the bed and CNA B said I'm not playing with you. While he tried to get the resident's shirt on. Resident #1 said No. CNA B said something unintelligible twice. CNA B pulled the resident's shirt down and leaned back to stand in front of the resident and said You want your shoes on? Want your shoes on? Resident #1 nodded yes. CNA B walked out of the camera angle towards the wall in the room and Resident #1 was sitting on the side of the bed. CNA B sat next to the resident on the bed with his shoes in his hands. CNA B kicked his leg out to look at something, then put I back under him. CNA B took the Velcro straps off the resident's shoe and pulled the resident's leg up to put the shoe on. The video ended. (continued on next page)

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	745019	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
James L West Center for Dementia Care	1111 Summit Ave Fort Worth, TX 76102

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation and interview on 09/25/24 at 10:40 AM with Resident #1 revealed he was laying in his bed in his room. Resident #1 said he was doing okay and was not in any pain. Resident #1 did not have any bruises or marks to his face. Resident #1 said someone was mean to him and hurt him, but could not specify who it was. Resident #1 said that he had seen the person who hurt him recently but was not able to say when he last saw them. Resident #1 appeared tired and stopped answering questions so the surveyor left the room. Interview on 09/25/24 at 1:44 PM with ADON A revealed she was familiar with Resident #1. ADON A said Resident #1 refused care but staff had been trained to come back at a different time if a resident refused care. ADON A said Resident #1's RP came to the facility on e day and told her and the DON that she wanted to show them something. ADON A said Resident #1's RP showed a video of the aide attempting to provide care to Resident #1 but she could not recall the details of the video. ADON A said Resident #1's RP told them that she did not like the way the aide handled Resident #1 and did not want the aide to continue caring for the resident. ADON A said Resident #1's RP also showed them the picture of his face where there was redness to his face but she did not ask the RP how he got the redness. ADON A said Resident #1's RP expressed the redness was from the way the aide handled the resident. ADON A said she saw Resident #1 later that day and he did not have any redness noted to his face. ADON A said since she did not see the redness noted to Resident #1's face like in the picture she could not say that was how it happened or what caused it. ADON A said after she watched the videos, she went upstairs to take CNA B off the floor. ADON A said when she spoke with CNA B, he explained that Resident #1 was refusing care and being combative and he was trained to continue providing care when that happened. ADON A said after she talked with CNA B, he left the facility. ADON A said her impression of the video was that the aide was from an agency and that was not how the facility trained their own staff to handle resident refusals. ADON A said agency aides did not get any trainings from the facility when they pick up shifts for the facility. ADON A said their staff had been trained by the facility to make sure a resident was safe and then stop trying to provide care when they refused. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 09/25/24 at 2:11 PM with the DON revealed Resident #1 refused care at times and staff were supposed to give him a break and come back to reapproach or swap out with someone else to continue and provide care to him. The DON said one day Resident #1's RP came to her office and wanted to share a video with her. The DON said she asked Resident #1's RP to send the video to her but Resident #1's RP did not know how to do that. The DON said Resident #1's RP pulled up a video and the DON saw in the video Resident #1 put his hand up to say stop and that was enough for her to see. The DON said she told Resident #1's RP that if she wanted to share more about the situation, the best thing to do was to get the Administrator involved. The DON said Resident #1's RP also showed her the picture of Resident #1 that showed the redness on his face. The DON said when she went to see Resident #1 later that day she did not see any redness to his face, so whatever it was, it had resolved by the time she saw him. The DON said when she spoke with CNA B he said Resident #1 was fighting him during care and she explained to him that any time a resident refused care CNA B should stop. The DON said CNA B explained that he had been trained to continue providing care for a resident even if they had refused. The DON said there was no training provided to agency staff and she did not check their training before they picked up a shift at the facility. The DON said the facility used agency staff about one to three times per month, but it depended on staffing. The DON said it was appropriate for CNA B to continue providing care to Resident #1 even if he refused if that was how he had been trained even though it was not how the facility trained their staff. The DON said it was considered abuse if a staff member pinned a residents hands to the side of their head, above their head, and to their chest. The DON said another form of abuse could be a staff putting their body weight against a resident and using that to force the resident to comply while the staff ripped off the resident's brief and sheets. Interview on 09/25/24 at 2:41 PM with the Administrator revealed Resident #1 refused care. The Administrator said facility staff had been trained to redirect a resident or give them a minute to try to get the resident focused on something else instead. The Administrator said Resident #1's RP came to her office to show her the videos and said that the ADON and DON had already seen them. The Administrator said she saw there was a large male and he went into the room and provided care to Resident #1. The Administrator said she did not see anything on the video that was abusive. The Administrator said she asked Resident #1's RP if there was something worse on the video and was told no but it was not how the facility's staff would have handled the situation. The Administrator said Resident #1's RP brought up something about Resident #1's face and the DON told her that they did not see anything on his face. The Administrator said she was not sure if the red marks seen on Resident #1's face in the picture provided by Resident #1's RP were from the situation with CNA B or not. The Administrator said it could have been from Resident #1 leaning on something or his pillow being creased but she did not do any follow up to see what caused it. The Administrator said she did not consider it abuse at the time. The Administrator said she never saw any other video but said the video she did see concerned her. The Administrator said agency staff were not given any training from the facility. The Administrator said the facility used agency staff about four to six times per month, but they tried to use their own staff as much as possible. The Administrator said if she thought anything CNA B did at that time was abusive, she would have reported it and completed an investigation. The Administrator began to watch the first part of video #3 that was provided by Resident #1's RP to the surveyor. The Administrator did not want to watch the whole video and only watched the first part of it where Resident #1 and CNA B were physically struggling with the covers. The Administrator said based on what she saw and what the surveyor told her had happened, that was considered abuse. (continued on next page)

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