STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675259	A. Building B. Wing	11/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cisco Nursing & Rehabilitation	1404 Front St Cisco, TX 76437

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37012 Based on interview and record review the facility failed to ensure the right to personal privacy for one of six residents (Resident #2) reviewed for their right to personal privacy. Former Nurse Aid B posted a video of Resident #2 on her personal Facebook page without the explicit permission of Resident #2. This failure puts residents at risk of having their privacy violated by the facility by making photos and videos public without the residents having an opportunity to review and give specific permission to post those photos and/or videos. Findings include: Record review of Resident #2's electronic face sheet undated revealed Resident #2 was a [AGE] year-old male, admitted to the facility on [DATE] and discharged on [DATE], Resident #2's diagnoses included: . Multiple Sclerosis, Bipolar Disorder, Cognitive Communication deficit, Trigeminal neuralgia, Anxiety Disorder, Mild Intellectual disabilities . Record review of Resident #2's most recent Discharge MDS dated [DATE] revealed in Section C that Resident #2 needed modified independence with daily decision-making cognitive skills with new situations only. Record review of Resident #2's care plan dated 12/19/2018 .[Resident #2] has behavioral outbursts (cussing and screaming) requiring frequent monitoring and redirection related to Diagnosis of Bipolar Disorder. He has an average of 7 episodes of behaviors weekly. Goal: [Resident #2] will have a decrease in behavioral episodes to less than 7 weekly, feel safe within facility/environment with dignity intact through next quarter . Approach: remove from excessive external stimuli, assess for needs like pain, hunger, boredom, anxiety, other concerns that can affect behaviors, maintain resident and other resident's safety as needed, remove from area if causing harm or disrupting environment, medications as ordered, monitor for side effects, redirect behavioral outbursts and episodes and document .Problem Start date: 05/02/16 .Category Cognitive Loss/Dementia .Cognitive loss/dementia or alteration in thought processes related to Multiple Sclerosis evidenced by impaired decision making and long term memory loss, BIMS score of 8 .Goal: will maintain current level of cognitive function as evidenced by ability to recall staff names and faces, and that he is in a nursing home through review dated .approach: .promote dignity, converse with resident and ensure privacy while providing care, allowing him to voice concerns . (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's signed admission agreement by the Business Office Manager and Responsible Party for Resident #2 dated 03/31/2016 revealed the following: .35. Resident information and Photographs: The Resident and Responsible Party authorize the Facility to take photographs of the Resident or portions thereof for activities, medical, identification purposes or general promotional material . In an interview on 11/2/21 at 1:18pm CNA B said that she recalled the incident with Resident #2 and a video being posted on former Nurse Aid B's personal Facebook page. CNA B said that she was caring for Resident #2 and during the course of his care they were in a jokingly manner discussing that he was elected Valentine King and CNA B said that Resident #2 voiced that he was upset about it and wanted former NURSE AID B to know he was upset so Resident #2 agreed to make a video to send to former Nurse Aid B from CNA B's personal cell phone. CNA B said that she made the video and sent it to former Nurse Aid B and the video showed that he was acting like he was upset about being voted Valentine King by the facility staff and then towards the end of the video it showed him laughing. CNA B said that when former Nurse Aid B received the video she edited out the part that showed him laughing and made it look like he was upset. CNA B said that Resident #2 had asked to send the video to former Nurse Aid B and she did. CNA B said that both her and Resident #2 were joking around and laughing with each other when the video was made and it was not done without his consent to send to former Nurse Aid B, however it was not known by Resident #2 that former Nurse Aid B was going to post it on her personal Facebook page. CNA B said that the Former Administrator counselled her and gave her a written write-up when the incident occurred. CNA B said that she was informed by the Former Administrator that even if a resident consents or requests to be videoed or a picture taken it was against facility policy. CNA B said that it was a bad judgement call and she understood the severity of it. CNA B said that she had no idea the former Nurse Aid B was going to edit the video and post it to her personal face book page. In an interview on 11/2/21 at 2:00pm, the Corporate Administrator said that she had no knowledge of a video being posted on a staff members personal Facebook page but that if it was, it was highly inappropriate and against their company policy. Employees are educated during orientation about patient privacy. In an interview with the Human Resource Coordinator, she said that she did recall disciplinary action being done by the Former Administrator for both CNA B and former Nurse Aid B after knowledge of a video being posted on former Nurse Aid B's personal Facebook page. The Human Resource Coordinator recalled that former Nurse Aid B was terminated by the Former Administrator for posting the video on her personal Facebook page and CNA B was given both a verbal counseling and a written write-up and placed on a 60-day probation period. Record review of Record of Employee Counseling dated 02/17/21 revealed the following: Employee Name [CNA B] Expectations/Outcome: [CNA B] will not record or video residents at anytime and will watch language. She understands abuse/neglect and dignity policy .Counselor's Signature: [Former Administrator] . Witness Signature: [Human Resource Coordinator] .Employee Signature: [CNA B] .dated 02/17/21. Record review of Termination Record dated 02/16/21 revealed the following: Name: [Former Nurse Aid B] Last day worked .02/15/21 .Termination Effective Date 02/16/21 .reason For Termination: .Other Misconduct explain .Posted on Facebook a resident having a tirade, HIPAA Violation .Signed [Former Administrator] 02/16/21 (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 11/03/21 at 9:21am, the responsible party for Resident #2 confirmed that Resident #2 was living with her now and was no longer a resident in the facility. The Responsible Party of Resident #2 was aware of the video but had not seen it and asked Resident #2 if he recalled the incident. Resident #2 told the Responsible Party during the telephone interview that he remembered CNA B making a video of him to send to former Nurse Aid B but that he did not know former Nurse Aid B was going to post it on her Facebook page. The Responsible Party for Resident #2 said that she knew about the video but had not seen it and requested for Resident #2 to not be asked any additional questions. In an interview with the Former Administrator on 11/2/21 at 9:45am, she said that she did not have any knowledge of a video being posted on a staff members personal Facebook page in February of 2021. In a follow up interview on 11/03/21 at 10:20am, the Former Administrator was able to recall the video that former Nurse Aid B posted on her personal Facebook page and indicated that she was terminated due to it violating facility policy and that CNA B had received a verbal and written counseling regarding the incident as well, she was placed on a 60 day probation period. The Former Administrator said she just forgot entirely about the incident until I refreshed her memory with reading the disciplinary actions back to her regarding the incident. Record review of the facility's employee handbook dated March 2017 revealed the following: page 28 Confidentiality of Information .In the course of performing their duties, employees may have access to or gain knowledge of confidential information concerning the Facility, its residents/clients, and other employees. Confidential information is defined as information to which the public does not have general access. This policy governs the use for further disclosure of such information .Unauthorized access to, and unauthorized release of, confidential information will violate this policy and may result in appropriate disciplinary action against the employee(s) involved, up to and potentially including termination of employment, depending upon the severity and/or repeat nature of the offense. Use of Mobile phones: The use of personal mobile phones at work is discouraged because it can interfere with work, resident care and be disruptive to others .page 35 . Resident Rights Resident entrust us with their physical an emotional well-being and their daily care. Obtain permission from residents or their legal representatives before releasing personal, financial , or medical information to anyone . Record review of the facility's policy entitled, Confidentiality of Information, dated December 2006, revealed the following: Policy Statement Our Facility shall treat all resident information confidentially .4. Release of resident information, including video, audio, or computer stored information, will be handled in a manner to protect resident rights . Record review of the facility's policy entitled, Resident Rights, dated August 2009, revealed the following: Policy Statement Employees shall treat all residents with kindness, respect and dignity. Policy Interpretation and Implementation .1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents right to: .d. Privacy and confidentiality; . 5. The unauthorized release, access, or disclosure of resident information is prohibited. All release, access, or disclosure of resident information must be in accordance with current laws governing privacy of information issues (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy entitled Videotaping, Photographing, and Other Imaging of Residents dated December 2006 revealed the following: Policy Statement: Residents will be protected from invasion of privacy that might occur from the use of resident photographs, videotapes, digital images and other visual recordings during resident care or other facility activities without the written consent of the resident. Policy Interpretation and Implementation .2. Written consent must be obtained from the resident or representative (sponsor) prior to photographing the resident for all purposes except abuse, neglect or emergencies and photography obtained for personal/family use .3. Unless otherwise required by federal or state law, photographs and other images may not be released without specific written authorization from the resident or representative (sponsor)

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F 0600 Level of Harm - Actual harm 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** 37012 Based on interview and record reviews, the facility failed to ensure residents have the right to be free from abuse for one (Resident #1) of six residents reviewed for abuse and neglect. The facility failed to: Failed to identify and Protect Resident #1 from physical and psychosocial abuse on 08/18/21, specifically feelings of humiliation, embarrassment, anger, physical bruising and pain to both her knees when the Former Administrator asked Resident #1 to reenact how Resident #1 was able to get up independently from a self-reported fall; during the reenactment the Former Administrator spoke in a derogatory and demeaning tone to Resident #1, instructed staff to wait before providing assistance to Resident #1 with help off the floor and onto her bed after a duration of approximately 20 minutes, the Former Administrator also gained knowledge prior to the reenactment that Resident #1 would be physically unable to independently get herself up from the floor without staff assistance. This failure could place residents at risk of abuse, physical harm, pain and mental anguish and emotional distress. Findings Include: Record review of Resident #1's electronic face sheet undated revealed Resident #1 was a [AGE] year old female, readmitted to the facility on [DATE] with an initial admitted [DATE] with diagnoses to include: .Type 2 Diabetes mellitus, Cerebral infarction due to embolism, Unspecified abnormalities of gait and mobility, Muscle Weakness, Morbid obesity, Major Depressive disorder, Pain, Hypertension . Record review of Resident #1's electronic physician orders, dated 11/03/21, unsigned, revealed the following orders were active: Acetaminophen tablet 325mg, Administer 2 tablets every four hours as needed for Mild Pain 1-3 .Document level of pain (0-10) and specify scale used to determine pain level . Start Date 02/05/21 End Date .Open Ended PRN Medications . Record review of Resident #1's most recent Quarterly MDS dated [DATE] revealed in Section C that Resident #1 had a BIMS score of 10, which indicated moderate cognitive impairment .Section C1310 indicated that Resident #1 displayed disorganized thinking but that it fluctuated,(comes and goes, changes in severity) .rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject) .Section D Mood revealed that Resident #1 indicated she had feelings of being down, depressed or hopeless for several days and felt tired and lethargic for more than 7-11 days during a 14 day look back. Section G revealed Resident #1 required supervision and setup help only to walk in room and required limited assistance by one staff member for toileting. Section J revealed that Resident #1 had not received any PRN pain medication or non-medication interventions for pain and Resident #1 reported occasional pain that limited her day to day activities. Section J indicated that Resident #1 had not had any falls since admission or reentry. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's care plan dated 08/13/20 .Resident is at risk for falls r/t requires assistance and unsteady gait; [Resident #1] has had 0 falls in the last 90 days .Goal Long Term Goal: 09/22/20 Resident will have fall risk assessment score of 16 maintain or decrease, will have 2 or fewer falls and be free from significant injury through next quarter .Approach .assistive devices as needed .walker .call bell in reach .document resident participation and staff assistance as per policy .Provide ADL assistance as needed to complete task Problem: Cognitive Loss/Dementia .Goal: Will maintain current level of cognitive function aeb: BIMS of 12 or higher through review date .Approach: promote dignity: Converse with resident and ensure privacy while providing care .observe, document, report to MD prn: Dementia s/sx decision making problem, memory problem, difficulty expressing self or understanding others . Record review of Resident #1's incident report dated 08/18/21 at 4:25pm, entered by RN A, revealed the following: Date and Time of Incident: 08/18/21 at 1:30pm . Description .Fall Describe injury .No injury .Type of Incident: Fall .incident Reported By .Former Nurse Aid A .Location of Occurrence: Resident Room .First Aide Provided, none needed .Other Notifications .Administrator and Physician A Record review of Resident #1's progress notes dated 8/18/21-8/24/21 revealed the following entries: .8/18/21 5:03pm .The nurse aide came to this nurse and reported that this resident stated to him that she fell in the bathroom floor when trying to exit the bathroom. This nurse asked resident about the incident and the resident stated that her roommate was trying to enter the room, quickly and that is when she fell in the bathroom. This nurse assessed resident. No injuries noted. All applicable parties have been notified. Neuro checks started . e-Signed by [RN A] .8/19/21 at 12:32am .Day 1 f/u fall with neuro checks WNL, No delayed injury noted .e-Signed by [RN B] .8/19/21 at 12:47pm .Resident c/o knee pain, upon assessment noted some swelling and discoloration to right knee [Physician A] here, received new order for right knee x-ray, ordered with [mobile x-ray company]. E-signed [LVN A] .8/19/21 at 10:08pm V/S WNL, Resident complains of pain on Bilateral knees. Some bruising noted to knees .e-Signed [LVN B] .8/21/21 at 10:25pm V/S WNL Resident continues to complain of pain on Bilateral Knees, bruising noted, dark purple in the center with edges fading yellow, noted to knees .e-Signed by [LVN B] .8/22/21 7:18am .Noted 2 small bruises to right lower knee, 1 small bruise to lower left knee, C/O Pain 4/10, APAP (acetaminophen) x 2 given at this time .e-Signed by [LVN C] . 8/24/21 at 11:41am .Social worker was asked to speak to the resident about a prior incident. Resident told Social Worker that she fell coming out of the bathroom and she got mad at her roommate and told her she shouldn't close the door like that. Resident said she crawled from the bathroom to bed and pulled herself up at the end of the bed to get in her chair. She wanted to report that she had hurt herself, so she went down to tell the [Former Administrator] but she said [Former Administrator] did not believe her. [Former Administrator] did not believe that the resident had crawled and gotten up on her own, so the resident said that [Former Administrator] took her to a room that looked like hers and made her get on the floor and crawl in the same directions as the way she had done it before, and told [Resident #1] that was the only thing that would convince her she was telling the truth. The resident told the social worker that she got on the floor and crawled some, but it really hurt her knees because she had already done it and they were sore, so she couldn't go as far as the bed. She said she stopped and collapsed and then [Former Administrator] got her in the bed and told [Resident #1] she had proved to her that it did not happen that way. [Resident #1] said she didn't tell anyone at first, but then [LVN A] told her two people had reported that she had been made to crawl. [LVN A gave her an 800# to call and said she had also called to report it .E-Signed by [Social Worker]. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's Medication Administration Record for August 2021 revealed the following: . Order: pain evaluation every shift. Document level of Pain (0-10) and specify scale to determine pain level . every shift .8/9/21 from 10:00 pm - 6:00am Resident #1 had a pain level of 4/10; on 8/13/21 from 2:00pm - 10:00pm, Resident #1 had a pain level of 3/10; from 8/14/21-8/18/21 Resident #1's pain evaluation was documented as a zero, indicating, no pain. On 8/18/21 from 6:00am-2:00pm Resident #1 reported pain 6/10, 8/19/21 during both the 6am-2pm and 2pm-10pm shift Resident #1 had a pain scale of 3/10 documented; 8/20/21 shifts 6am-2pm and 10pm-6am documented a 2/10 pain scale; 8/21/21 all shifts reported 4-5/10 on the pain scale; 8/22/21 all shifts reported 2-3/10; 8/23/21 all shifts reported 3/10 on the pain scale, 8/24/21 6am-2pm and 2pm-10pm reported 3-4/10 on the pain scale; 8/25/21 6am-2pm and 2pm-10pm reported 2/10 on the pain scale; From 8/26/21-8/31/21 Resident #1 did not have any documentation of pain. On 8/22/21 Resident #1 received Acetaminophen tablet; 325mg 2 tablets as needed for mild pain on two occasions. Record review of the PRN Medication Notes for Resident #1 revealed the following: .Date: 8/22/21 0915 . Reason: Bilateral knee pain .Result: effective .Date 8/22/21 2300 (11:00pm) .Reason: Bilateral Knee pain . Result: effective . Record review of Resident #1's Portable Service Requisition for a x-ray to right knee for Pain in right knee dated 08/19/21 at 1516 (3:16pm) revealed the following: .Date of Service: 8/19/21 .Referring Physician: Physician A .Procedure .Right Knee 1-2 views, Findings: See Impressions .Impressions: Examination Radiographs of the knee Indication: Pain .Findings: .There is no evidence of periprosthetic fracture or knee dislocation. Surrounding soft tissues are within normal limits. No evidence of osteomyelitis .Impression: Normal knee arthroplasty . In an observation and interview on 11/01/21 at 1:25pm, Resident #1 was calm, resting on her bed, smiling at times throughout the interview and was oriented to her name, place but she did not know the year or the name of the current president. Resident #1 said that she recalled the incident when the Former Administrator came into her room after Resident #1 had reported that while attempting to come out of her bathroom, her roommate was attempting to enter into the room, both the entry door and bathroom doors collided and Resident #1 reported that the bathroom door came back on her and made her lose her balance and fall to the floor. Resident #1 said that she reported to nursing staff (could not recall staff name) that she had fallen but was able to get herself up. Resident #1 said that shortly after she reported that she had fallen to the nursing staff, the Former Administrator came to her room with several staff members and that she was asked by the Administrator what happened. Resident #1 said that she did not realize what was going on and was assisted by staff back onto the floor; Resident #1 said she started to crawl like she did and after she went as far as I could, I told the Former Administrator My knees are killing me! I can't do it anymore, my knees hurt! Resident #1 said it hurt it hurt a lot. Resident #1 said the next day she could not go to therapy because her knees hurt and were very sore. Resident #1 recalled the former administrator telling me I was lying and that was her way of proving it. Resident #1 said that the Former Administrator did not believe that she had fallen and was able to get herself up. Resident #1 said that it made her feel ridiculous and embarrassed and she had pain, swelling and bruising for almost a week. Resident #1 said that the Administrator attempted to come to her room the next day but she refused to speak with her and was fearful of her. Resident #1 stated that after that day, she never saw the Former Administrator again and since she has not been in the building she felt safe now. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview on 11/1/21 at 1:40pm the Occupational Therapy Aid said that he recalled the incident with Resident #1. The Occupational Therapy Aid said that he recalled the Former Administrator coming into the therapy room after the incident with Resident #1 and was speaking to the Physical Therapist in a boastful manner and recalled the Former Administrator telling the Physical Therapist that she was proud of herself because she found out that Resident #1 was lying, and told staff that her roommate had pushed her on the floor. The Occupation Therapy Aid said that the Former Administrator then proceeded to tell the Physical Therapist that she didn't believe Resident #1 so RN A assisted Resident #1 to the floor and had her reenact how she got herself up, but was not able to get herself up, staff had to help her back up. Then, the Occupational Therapy Aid said that he recalled Resident #1 reporting to him that very same day that she did not want to participate in therapy because she was in pain from being left on the floor for about thirty minutes, the Occupational Therapy aid said that Resident #1 said she was asked to try and try to get up by the Former Administrator and couldn't do it. The Occupational Therapy Aid said that he discussed with his management team and it was already being discussed with other interdisciplinary team members that the Former Administrator was being reported to corporate. The Occupational Therapist Aid said that he was contracted by another company and followed their protocol as well to report the incident. In an interview on 11/1/21 at 2:50pm, the Social Worker said she did recall the incident with the Former Administrator and Resident #1. The Social Worker said that the Corporate Administrator called her and asked her to come and visit Resident #1 as soon as possible to discuss an incident that occurred between her and the Former Administrator. The Social Worker said that Resident #1 was able to recall the incident but on the day, she interviewed her (8/24/21) she did not appear particularly upset but understood she was when it first happened (8/18/21). The Social Worker said that Resident #1 was not sure and didn't understand why it happened. The Social Worker said that after she learned of the incident she did not feel that resident's should ever be treated that way, the Social Worker indicated that residents are often confused and will be wrong at how something happened many times and that the Former Administrator should not have tried to prove that Resident #1 was wrong by doing what she did, making her get on the floor; the Social Worker said it was both physically and emotionally abusive, [Resident #1] is an elderly person and if you make someone get on the floor it could hurt them even more, [Resident #1] indicated that she felt safe in the facility since the [Former Administrator] was no longer in the facility. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In a telephone interview on 11/2/21 at 8:34am, Nurse Aid A said that he recalled the incident with Resident #1 and the Former Administrator. Nurse Aid A said that he recalled the Former Administrator coming out in the hallway and asking him and another staff member to come to Resident #1's room. Nurse Aid A said that he and CNA A walked in and found Resident #1 on the floor in the bathroom, RN A was standing behind Resident #1 and the Former Administrator was standing over Resident #1 with her arms folded looking down at her. Nurse Aid A said that Resident #1 was visibly upset appeared angry and distraught. Nurse Aid A said the Former Administrator was talking down to Resident #1 in a harsh tone, Nurse Aid A said he did not recall exactly what she said but recalled she was telling her to show her how she got herself up. Nurse Aid A said that at this time he and CNA A attempted to get Resident #1 off the floor and was told to wait, not to pick her up, the former administrator wanted Resident #1 to show her how she got up. Nurse Aid A said that he recalled being in the room for at least 20 minutes, perhaps even more with Resident #1 being on the floor. Nurse Aid A said he felt that what was happening was not right but he wasn't sure what to do since the former Administrator was in the room, Nurse Aid A said he did not feel that he had a choice to intervene since the Former Administrator was in the room. Nurse Aid A said that after approximately twenty minutes, the Former Administrator asked us to assist Resident #1 from the floor and we placed her in bed . Nurse Aid A said that during his shift Resident #1 did not report any pain or injury to him. Nurse Aid A said after the incident Resident #1's demeanor really changed, at first she seemed ashamed and embarrassed about the incident then she seemed angrier; lasted for a few weeks. Nurse Aid A said that Resident #1 normally did not participate in activities and pretty much stayed in her room. In a telephone interview on 11/2/21 at 9:15am, Physician A recalled being notified while in the facility of Resident #1 having Right Knee Pain and ordered an x-ray for her; was not aware that the Former Administrator asked Resident #1 to reenact a fall by having Resident #1 get back on the floor and show the Former Administrator she could get up herself. Physician A said that it was not necessary to have a resident reenact a fall unless it would be something the physical therapy was trying to assess for therapy purposes, Physician A said that there certainly should have been questions to have asked after a reported fall from a resident. Physician A said that he was not contacted to his knowledge by any Regional Staff from the facility regarding the possibility of an abuse investigation. Physician A said that it would not have been comfortable for Resident #1 to have been asked to reenact and certainly would have been mentally stressful for her to reenact. (continued on next page)

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	675259	A. Building B. Wing	11/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cisco Nursing & Rehabilitation	1404 Front St Cisco, TX 76437

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In a telephone interview on 11/2/21 at 9:45am, the Former Administrator said she recalled the incident with Resident #1. The Former Administrator said that she was notified by RN A that Resident #1 reported that she fell and got herself up on her own. The Former Administrator said she went to the nurse's station and asked RN A to come to Resident #1's room to discuss her fall. The Former Administrator said she was in the room talking with Resident #1 and asked her how that happened. The Former Administrator said that Resident #1 got up out of the bed, walked to the bathroom and told her that [Resident #1's] roommate just plowed into the door and knocked her down. The Former Administrator said that when I asked her if she could tell me how she fell Resident #1 replied In order to do that I would have to show you The former Administrator said she asked Resident #1 if she minded showing us and Resident #1 said no and at that time RN A lowered Resident #1 to the floor; the Former Administrator said Resident #1 then explained and tried to grab the over the toilet seat and the Former Administrator said at that time RN A and myself tried to tell Resident #1 we would help her up but Resident #1 told her No, I can do it and after a few minutes she was helped from the floor. The Former Administrator said that two CNAs assisted Resident #1 up off the floor. Former Nurse Aid A and CNA A were the two staff members that assisted Resident #1 up from floor and back to her bed. The Former Administrator then stated that she asked Resident #1 if she was hurting anywhere and she denied pain. The Former Administrator stated that Resident #1 was in the floor for approximately 2-3 minutes and that she was consistently asking her to get up but Resident #1 kept replying No, I can do it, No, I can do it. The Former administrator said that she tried to get up in front of the toilet. The Former Administrator could not recall where she was in the floor when she was assisted up by staff. The Former Administrator said that it was not a normal process that she was aware of for a resident to be asked to get in the floor to show staff how they got themselves up after a fall. The Former Administrator said that therapy has at times asked residents to reenact a fall. The Former Administrator said she was pretty sure therapy was not present in Resident #1's room. The Former Administrator said the purpose of Resident #1 reenacting how she was able to get herself up after she reported she fell was that the Former Administrator wanted to make sure that if she was falling she was actually getting up and stated I just needed a picture in my head. The Former Administrator said that Resident #1 displayed attention seeking behaviors and did not like having a roommate. The Former Administrator denied telling Resident #1 to remain on the floor after Nurse Aid A and CNA A attempted to get her up. The Former Administrator said that looking back at it now she should not have allowed Resident #1 to have gotten in the floor to show her how she got herself up because it was upsetting for her. The Former Administrator said that it was a normal process to be notified when someone falls to ensure there was no injury or if there were any resident to resident issues that needed to be investigated and reported. The Former Administrator said that she had never had any other residents reenact how they fell or got themselves up, normally just take an interview and document what the resident reports. The Former Administrator said the purpose of Resident #1 getting on the floor was to know if it was actually happening, needed to see if she needed any interventions or if she could reach her call light. The Former Administrator said it was necessary for her [resident #1] to reenact how she was getting up in order to provide education for her, make sure she had shoes on when she goes to the bathroom, and to make sure the facility provided a safe environment for her. The Former Administrator said that she did not know if Resident #1 could have just been asked to describe the incident verses getting on the floor to show her because Resident #1 tells different stories to different people. The Former Administrator said she didn't know when Resident #1 said she fell but that it was not something the Former Administrator was trying to prove Resident #1 was lying about. The Former Administrator said that the next day LVN A reported that Resident #1 was upset over the incident that had happened and I went in to talk to Resident #1 with LVN A present, Resident #1 did not want to talk to me. By that time, Regional Staff were involved due to staff reporting the incident to the Regional Nurse and I was suspended pending the outcome of the investigation, I asked staff to write statements of the incident. The Former Administrator said that she typed Nurse Aid A's statement because his handwriting was horrible, and that Nurse Aid A signed it and did not indicate it was incorrect. The Former Administrator said that the Corporate Administrator became involved because they felt it was reportable and were going to conduct an investigation. The Former Administrator said that she had no knowledge of Resident #1 being upset after the incident until the next day, she reported to LVN A and I took a grievance form in her room but she was upset about how I talked to her when she reported falling. The

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview on 11/02/21 at 10:47am, RN A said that she was asked to go to Resident #1's room with the Former Administrator on 08/18/21 to discuss Resident #1's fall that she had reported. RN A said that her and the Former Administrator went in to talk to Resident #1 and the Former Administrator seemed adamant about having Resident #1 show her what happened when she [Resident #1] fell . RN A said that Resident #1 walked the Former Administrator through how she fell by getting up from her bed and going into the bathroom, at this time RN A said that the Former Administrator asked Resident #1 how she got up from the floor and Resident #1 said she needed to get on the floor to show her and proceeded to get down into the floor. RN A said that she told Resident #1 she did not have to get in the floor to show the Former Administrator but by this time Resident #1 was insistent about showing the Former Administrator. RN A said that she did assist Resident #1 onto the floor and kept telling her she didn't have to do this. RN A said the Former Administrator was standing over Resident #1 and seemed herself very adamant about having Resident #1 demonstrate how she was able to get herself up from the floor. The whole thing just didn't seem right RN A said. RN A said that Resident #1 was unable to pull herself up in the bathroom and then proceeded to pull herself across the room towards her bed, RN A said that the Former Administrator called two CNAs into the room and asked both of them CNA A and former Nurse Aid A if they had answered Resident #1's call light earlier, at that time. RN A said that she did not recall if the Former Administrator instructed the aides to not assist Resident #1 up, but do recall Resident #1 seemed angered and kept trying to prove to the Former Administrator how she got up and after a period of time, RN A could not recall how long but it seemed like a while Resident #1 was assisted up by CNA A and Former Nurse Aid A to her bed. RN A recalled the Former Administrator asking Resident #1 How could you possibly have gotten up on your own? .she kept repetitively insinuating she couldn't so it. RN A said Resident #1 was upset during the incident and felt that Resident #1 wanted to prove the Former Administrator wrong. RN A said that she didn't agree with what Resident #1 was doing and offered several times to Resident #1 that she didn't have to do this. RN A said looking back now, she should have intervened and told the Former Administrator to stop and not have allowed Resident #1 to get on the floor but at the time RN A said she felt that if she didn't help Resident #1 she would try and do it again without staff being present just to prove she could do it. RN A said she did not recall Resident #1 suffering any injuries after the incident and did evaluate her when she reported that she fell and there were no injuries. RN A said she was suspended the next day following an investigation regarding the incident, was asked to write a statement and that was all she recalled after the incident. RN A said it was not a normal process for the Former Administrator to go into residents' rooms and ask them to reenact falls or how they got up from a fall. RN A said that having Resident #1 get on the floor did not change any interventions for her safety. In an interview on 11/2/21 at 11:45am, Resident #1's responsible party recalled being notified of the incident and stated that Resident #1 seemed angry about what the Former Administrator had made her do and recalled her having bruising to her knees. The Responsible Party of Resident #1 said she visited weekly and did not feel that Resident #1 suffered long term effects from the incident but knew she was pretty upset when it happened. In an interview on 11/02/21 at 1:15pm, Resident #1 said that she normally did not participate in activities too much other than attending church services occasionally; Resident #1 said that after the incident she was asked by staff if she wanted the police to be contacted and she told them no. Resident #1 said that she did not feel that she needed psychiatric services after the incident either. Resident #1 reported that since the facility terminated the Administrator she felt safe in the facility and has not had any problems with staff or treatment since the incident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview on 11/02/21 at 1:18pm, CNA B said she recalled the day of the incident between Resident #1 and the Former Administrator, however the only participation she had was prior to the incident, Resident #1 had reported to her that Resident #1's roommate slammed the door into the bathroom door as Resident #1 was coming out of the bathroom and that she did not report a fall but wanted someone to talk to her roommate about opening the doors abruptly. CNA B said it was at the end of her shift and she reported to former Nurse Aid A as he was coming on shift about Resident #1's concern and he agreed he would talk to Resident #1's roommate. CNA B said about 5:00pm that same day after she was already home she received a phone call from the Former Administrator asking her if Resident #1 had reported a fall and I told them no. The following day I came to work at 6:00am and was told by a staff member from the therapy department (unable to recall the name) that Resident #1 wanted to talk to me. CNA B said that Resident #1 confided to her that the Former Administrator had put her on the floor and made her reenact the fall CNA B said Resident #1 at this time reported pain to her knees so CNA B said she went immediately and reported to the nurse what Resident #1 had reported. CNA B said that again later that day after she was off she received a phone call from the Former Administrator telling her that Resident #1 had wanted to get back on the ground to show her how [Resident #1] got herself up off the floor. CNA B said that the nurse that she reported Resident #1's pain and incident to no longer worked at the facility. CNA B said that after the incident Resident #1 told her the incident upset her and embarrassed her when they made her get on the floor like that and CNA B said Resident #1 seemed angry, she stayed in her room more right after the incident and would tell therapy she had a headache but after about a week, she seemed to be herself again. CNA B said that she did have bruising to her knees and increased pain after the incident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview on 11/2/21 at 2:00pm, the Corporate Administrator said that she recalled the incident between Resident #1 and the Former Administrator. The Corporate Administrator said that both her and the Regional Nurse became aware of the situation by facility staff on 08/19/21 and immediately started an investigation and suspended the Former Administrator and RN A. The Former Administrator had already begun an investigation after multiple staff from the facility had contacted both the Regional Nurse and herself. The Corporate Administrator requested written statements from staff due to becoming apprised of Resident #1 reporting she was upset with the Former Administrator. The Corporate Administrator said that after the investigation was conducted she felt that the Former Administrator had lied about what transpired between her and Resident #1 and that she felt the Former Administrator had lied about the incident, specifically that Resident #1 was agreeable to get in the floor and reenact how she got herself up after reporting she fell . The Corporate Administrator said she spoke with RN A and that RN A felt that the Former Administrator had been very inappropriate with Resident #1. The Corporate Administrator said that it was learned that Resident #1 did agree to get on the floor but did not anticipate having to remain in the floor for approximately 20-30 minutes. The Corporate Administrator felt that the Former Administrator had caused both physical and psychosocial harm to Resident #1 as evidenced by Resident #1 having bruising and pain to her knees following the incident and reporting being emotionally upset by the way the Former Administrator had made her feel and the way she talked to her during the incident. Resident #1 was fearful of the Former Administrator after the incident and it was immediately determined that she was terminated on 08/20/21 and the incident was self-reported immediately to the state agency. The Corporate Administrator said that the Social Worker was asked to come and evaluate Resident #1 and safe surveys were conducted with other alert and oriented residents. The Regional Nurse conducted an abuse/neglect in-service on 08/20/21 for all staff after the incident and that Resident #1 did report feeling safe in the facility after knowing that the Former Administrator would no longer be working there. The Corporate Administrator said that Resident #1 did not want to contact the police. The Corporate Administrator said that several staff members were reporting to the corporate nurse and herself during the investigation that the Former Administrator was heard bragging about what she had made Resident #1 do and the fact that she proved her wrong and caught her in a lie. The Corporate Administrator said something like this should never have happened and that if the Former Administrator wanted to prove someth [TRUNCATED]