STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675407	A. Building B. Wing	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 43150 Based on observation, interview, and record review the facility failed to ensure the resident had the right to be free from abuse for 8 of 10 residents (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident #10), reviewed for abuse. The facility failed to ensure a safe environment free from abuse for Resident #1 when can D was suspected to have used unnecessary force causing a spiral fracture to Resident #1 on night shift on 04/12/2023. The facility failed to ensure Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9, Resident #10 resided in a safe environment after making allegations of abuse toward CNA D and CNA D was continued to allow to work with all resident's even after prior allegations of abuse. This failure was determined to be an Immediate Jeopardy situation that was identified on 04/14/2023 at 5:51 p.m. While the IJ was removed on 04/17/2023 , the facility remained out of compliance at a severity level of actual harm and a scope of pattern due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could affect all residents by placing them at risk of abuse, physical harm, pain, mental anguish, emotion distress, serious harm, and death. Findings include: Resident #1: Record Review of Resident #1's face sheet documented he was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 was admitted with a diagnosis which includes: dementia without behavioral disturbance, muscle wasting and atrophy (loss or thinning of muscle tissue), difficulty in walking, Record review of Resident #1's admission Minimum Data Set (MDS) dated [DATE] documented that Resident #1's BIMS (Brief Interview for Mental Status) was a 3/15, meaning severe cognitive impairment. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Under Section B under Hearing, Speech, and Vision indicated that Resident #1, for ability to hear listed him at a 0, meaning no difficulty in normal conversation, social interaction, or watching tv. Under Section B in B0600 labeled Speech Clarity indicated listed at a 1 meaning that Resident #1 has unclear speech such as slurred or mumbled words. Under B0700 labeled Makes Self Understood Lists Resident #1 at a 1 meaning that Resident #1 is usually understood with difficulty communicating some words or finishing thoughts but is able if prompted or given time. Under B0800 labeled Ability to Understand documents that Resident #1 usually understands meaning misses some part/intent of message but comprehends most conversation. Under B0700 labeled Makes Self Understood is documented at a 1 meaning usually understands: difficulty communication some words or finishing thoughts but is able if prompted or given time. Under Section C for cognitive patterns for C0700 labeled short-term memory is left blank and not completed. Under C0700 labeled long-term memory is left blank and not completed. Under C0800 labeled Memory/Recall Ability is left blank and not completed. Under C01000 labeled Cognitive Skills for Daily Decision Making is left blank and not completed. Under C01300 for Delirium for the question, Is there evidence of an acute change in mental status, labeled as a) meaning no there is not a change in mental status, for inattention is listed as a 0 meaning no behavior is present, for disorganized thinking is listed as a 0 meaning there is no behavior present, for altered level of consciousness is listed as a 0 meaning behavior is not present. Under Section D for Resident Mood Interview under D0200 Resident #1 shows little interest or pleasure doing things displayed at a frequency of 7-11 days, feeling down, depressed, or hopeless at a frequency of 2-6 days, feeling tired or having little energy at a frequency of 2-6 days. Under Section E for E0200 under Behavioral Symptom-Presence and Frequency is documented at a 0 meaning Resident #1 did not exhibit behaviors for physical behavioral symptom directed towards others such as for example (hitting, scratching, pushing, kicking, grabbing, abusing others sexually) , verbal behavioral symptoms directed toward others such as, for example (threatening others, screaming at others, cursing at others), other behavioral symptoms not directed towards others such as, for example (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal such as screaming or disruptive sounds). Under B0300 under Overall Presence of Behavioral Symptoms listed at a 0 meaning Resident #1 did not exhibit these behaviors. Under B0500 under Impact on Resident for the questions: put the resident at significant risk for physical illness or injury, significantly interfere with resident care, significantly interfere with the resident's participation in activities or social interactions was blank and incomplete. Under (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	B0600 under Impact on Others for the questions: put others at significant risk for physical injury, significantly intrude on the privacy or activity of others, significantly disrupt care or living environment was left blank and incomplete. Under B0800 under rejection of care is listed as a 0 meaning that Resident #1 did not exhibit this behavior. Under Section E for Wandering labeled has the resident wandered list a 0 indicating that Resident #1 has not displayed this behavior. Under Section G for Functional Status for G0100 labeled a), bed mobility (how resident moves to and from lying positions, turns side to side, and positions body while in bed or alternate sleep furniture) is listed as a 1 meaning Resident #1 needs supervision (oversight, encouragement, or cueing) listed as a 2 person assist, b). transfer (how the resident moves between surfaces including to and from bed, wheelchair, and standing position) is listed as a 1 meaning Resident #1 needs supervision (oversight, encouragement, or cueing) with a 2 person assist, c). Walk in room is listed as a 1 meaning Resident #1 needs supervision (oversight, encouragement, or cueing) with a 1 person assist, e). Locomotion on unit (how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair) is listed as a 0 indicating Resident #1 does not need assistance. Under G0300 for Balance during Transitions and Walking for a). Moving from seated to standing position is listed as a 1 meaning (not steady, but able to stabilize without staff assistance), b). Walking is listed as a 1 meaning (not steady, but able to stabilize without staff assistance), e). Surface to Surface transfer (transfer between bed and wheelchair) is listed as a 1 meaning (not steady, but able to stabilize without staff assistance). Under G0400 labeled Functional Limitation of Range of Motion for a). Upper extremities is listed as a 0 meaning no impairment. Under G0600 labeled Mobility Devices indicates that Resident #1 uses a wheelchair. Under G0900 labeled Functional Rehabilitation Potential indicates for Direct care staff believe resident is capable of increased independence in at least some ADLs is listed as a 1 meaning yes, they do believe Resident #1 is capable of increased independence. Under Section J for Health Conditions for J0300 for Pain Assessment indicates that Resident #1 has not had any pain or hurting in the past 5 day. Under J1700 for, a). Did the resident have a fall any time in the last month prior to admission/entry or reentry, indicates that Resident #1 was listed as a 1 meaning that he did have a fall prior to admission in the past month, b). Did the resident have a fall any time in the past 2-6 months prior to admission/entry or reentry, is documented as a 1 indicating that Resident #1 has experienced a fall in the past 2-6 months prior to admission in the facility. C). Did the resident have any fracture related to a fall in the past 6 months prior to admission/entry or reentry is listed as a 0 meaning the resident has not experienced a fracture in the past 6 months prior to admission into the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Under J1800 labeled Any falls since admission/entry or re-entry prior to assessment indicates a 1 meaning that Resident #1 has experienced a fall prior to admission into the facility. A). No Injuries is listed as a 1 meaning (no evidence of any injury on physical assessment by the nurse or primary care clinician, no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall). Record review of Resident #1s Care Plan dated 4/12/2023 revealed Resident #1 had a fracture of the left humerus with the interventions of: non weight bearing to LUE-nursing was to remove from sling 3 times a day to perform elbow extension only PROM. Nursing only to perform. In-service was given on 4/12/2023 to CN from PT on how to perform PROM correctly to prevent further injury. LPN, RN, DON, apply sling and encourage to leave it on assisting as needed for proper placement. Record review of Resident #1s Care Plan dated 04/14/2023 indicated Resident #1 had limited mobility r/t fx of left humerus that limits ADL self-performance. AEB unable to use left arm and requires a restorative nursing program to maintain current level of function with the interventions of: Nursing rehab/restorative: Passive ROM Program #1 extend lower arm flexing elbow 3 sets of 15 with 5 second pause. Record review of Resident #1s Care Plan dated on 02/28/2023 indicated Resident #1 is dependent on staff for meeting emotional, intellectual, physical, and social needs due to cognitive deficits with the interventions of: All staff to converse while providing care, establish and record level of activity and interests by talking with Resident, caregivers, and family on admission and as necessary, needs assistance/escort to activity function. Record review of Resident #1s Care Plan dated on 02/28/2023 indicated Resident #1 is deficit with dementia with the interventions with ADLs as follows: bed mobility: self-performance supervision, bed mobility: support provided with 2 person physical assist, transfer: self-performance supervision, support provided with 2 person physical assist, walk in room: self-performance supervision, support provided with one person assist, locomotion on unit: self-performance independent, support provided no setup or physical help from staff, nurse aides to document most dependent self-performance per shift. Monitor signs and symptoms of ADL decline and notify family, MD, identify causes and solutions. Record review of Resident #1s Care Plan dated on 02/28/2023 indicated Resident #1 is an elopement risk/wanderer with disoriented to place, wander risk is 9, with the interventions of distract from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, snacks, monitor location throughout shifts. Document wandering behavior and attempted diversional intervention in behavior log. Record review of Resident #1s Care Plan dated on 02/28/2023 indicated that Resident #1 had a cognitive impairment due to dementia with the interventions of ask yes/no questions in order to determine the resident's needs. Cue, reorient and supervise as needed. Need assistance with all decision making. Keep routine consistent and try to provide care givers as much as possible in order to decrease confusion. Present just one thought, idea, question or command at a time. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1s Care Plan dated on 02/28/2023 indicated that Resident #1 had a communication problem with difficulty making self-understood and difficulty understanding others with the interventions of monitor/document for physical/nonverbal indicators of discomfort or distress, and follow-up as needed. Monitor/document frustration level, wait 30 seconds before providing with a word. Speak on an adult level, speaking clearly and slower than normal. Validate message by repeating aloud. Record review of Resident #1s Care Plan dated on 02/28/2023 indicated that Resident #1 is at risk for falls with gait/balance problems with the interventions of: provide with a chair to sit in when wondering in halls, be sure my call light is within reach and remind to use it for assistance as needed. Record Review of Resident #1's Progress notes dated 04/12/2023 at 5:38 am, signed by LVN A revealed: Note Text: Resident #1 woke up and came to nursing station stating he fell asleep on hand, and it was hurting/tingling. Assessed and hand was red with minimal puffiness. Resident #1 walks off and was later found in another Resident's room asleep in an empty bed. Male Aide (CNA D) was notified, and he assisted Resident #1 and he assisted Resident #1 out of room and down hall to his assigned room. LVN A (Nurse) hears Resident #1 yelling really loud and complaining of shoulder pain. LVN A (Nurse) asked Nurse Aide (CNA D) what did he do and he replied nothing, I just lifted him up under his arms and took him to his room. Nurse (LVN A) and Aide went into room to see what was wrong and Resident #1 attempts to hit aide yelled, get away from me in anger. Assessed arm and noticed bruising to lower forearm but Resident #1 had on a long sleeve shirt that would only go up so far. Resident #1 lays down. A few minutes later LVN A hears Resident #1 still moaning in pain. By this time aide (CNA D) reports that he just vomited and needed to leave and go home because he wasn't feeling well. Nurse (LVN A) and only aide (CNA C) present, goes in to check on Resident #1. This time I (LVN A) attempted to take off Resident #1 shirt and he's yelling in pain. I (LVN A) was able to get it off and assessed shoulder. I (LVN A) noticed a crease in arm in-between shoulder and elbow. Softly palpating down arm, Resident #1 guards' arm and a knot is felt and arms appears to be disformed. I (LVN A) had the aide (CNA C) to ask Resident #1 what happened in the room in Spanish, and he replied, He hit me two times. BOM, MD, wife, and Regional Operations Director notified. 911 called and Resident #1 transferred to UMC. During an observation on 04/13/2023 at 12:01 p.m., Resident #1 was sleeping and did not awaken to name being called. Resident #1 had a sling on the left arm. Resident #1 did not appear to be in any distress at this time. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 04/15/2023 at 12:48 p.m., with Family member 13 stated that the morning that Resident #1 was sent out to the hospital she received a call from LVN A and told her that Resident #1 had a hurt arm and was being sent out to the hospital. Family member 13 stated that LVN A told her that Resident #1 had stated that CNA D had hurt his arm. Family member 13 stated that she immediately felt sick to her stomach because she had been told by Resident #1 on a couple of different occasions that CNA D was mean to him. Family member 13 stated that she had told the staff and Administrator about Resident #1 stating that CNA D was being mean. Family member 13 stated she didn't know if anything had been done about the other times that Resident #1 had complained because she never heard anything from the staff or Administrator about the situations. Family member 13 stated that she would hope that now that something would get done about CNA D hurting Resident #1. Family member 13 stated that it's bad enough that something like this had to happen before something would get done about CNA D hurting Resident #1. Family member 13 stated that BOM had called her later that morning after she had already talked to LVN A and BOM told her that CNA D was transferring Resident #1 to bed and accidentally hurt him. Family member 13 stated that on one of the other times that Resident #1 was saying he was being treated mean, Resident #1 had told her and her brother, He beat me, Resident #1 had told family member 13, That big guy was in a boxing match with me, he beat me. Family member 13 stated that she took her concerns to the Administrator and never heard anything else about it. *Resident #2: Record Review of Resident #2 face sheet documented he is a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 was admitted with a diagnosis which includes: stroke, seizures, difficulty swallowing, facial weakness, major depressive disorder, anxiety disorder, type 2 diabetes, muscle wasting, cognitive communication deficit, lack of coordination, hyperlipidemia (a condition which there are high levels of fat particles (lipids) in the blood). Record review of Resident #2's admission MDS dated [DATE] documented that Resident #2's BIMS was listed as 00 meaning zero points are assigned if the resident didn't repeat words correctly Under B0600 for Speech Clarity indicated that Resident #2 scored 1 meaning Unclear Speech-slurred or mumbled words. Under B0700 for Makes Self Understood indicated that Resident #2 scored 2 for ability to express ideas and wants. meaning sometimes understood ability is limited to making concrete requests. Under B0800 for Ability to Understand Others-understanding verbal content scoring a 2 meaning responds adequately to simple and direct communication only. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Under G0110 for Activities of Daily Living Assistance indicates: A). Bed Mobility (how the resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture) Resident #2 scored a 3 meaning extensive assistance (resident involved in activity, staff providing weight bearing support) with 2 persons assist. B). Transfer (how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position), Resident #2 scored a 4 indicating total dependence (full staff performance every time during entire 7-day period). G). Dressing how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas, Resident scored a 3 indicating extensive assistance (resident involved in activity, staff providing weight bearing support) with 2 persons assist). Resident #2 scored a 3 indicating extensive assistance (resident involved in activity, staff providing weight bearing support) with one person assist. Toilet Use: how resident uses the toilet room, commode, bedpan, or urinal Record review of Resident #2s Care Plan dated on 07/01/2022 indicated the following: Resident #2 has an ADL self-care performance deficit with interventions of: ADL self-performance fluctuates with confusion but usually requires assistance as follows: Bed mobility-self-performance (Total Dependence), Bed mobility: support provided with 2-person physical assist, Transfer: self-performance (total dependence), Transfer-support provided with 2 person physical assist, walk in room- self-performance (activity did not occur), walk in room- support provided ADL activity did not occur, Walk in corridor- self-performance (Activity did not occur), walk in corridor-support provided ADL activity itself did not occur, Locomotion on unit-self performance (total dependence), Locomotion on unit- support provided one person physical assist, Locomotion off unit- self-performance (total dependence), locomotion off unit- support provided with one person physical assist, Dressing: self-performance (Extensive assistance), Dressing: support provided with two person physical assist, Eating: self-performance (Supervision), Eating: support provided with one person physical assist, Toilet use: self-performance (Total dependence), Toilet use: support provided with two person physical assist, Personal hygiene: self-performance (Total dependence), Personal hygiene: support provided with two-person physical assist, Nurse aides to document Resident #2s most dependence self-performance per shift. Monitor for signs and symptoms of ADL decline and notify family, MD, identifying causes and solutions. Monitor/document/report to MD as needed any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. Record Review of Resident #2's Progress notes dated 04/15/2023 at 10:57 am, signed by Social Worker revealed: Social worker spoke with Family Member #12 to let her know about the new reporting guidelines for abuse and neglect. She (Family Member #12) asked that it be mailed. She (Family Member #12) may also pick it up today when she is here. The form is also placed in Resident #2's room. During an Observation on 04/13/2023 at 12:08 pm with Sampled Resident #2 revealed: Observed Resident #2 laying in his bed visiting with family member. Observed Resident #2 free from distress. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an Interview with Resident #2 on 04/13/2023 at 12:07 pm. Resident #2 was able to slowly reveal the complaint that he had against CNA D with the help of family member. Resident #2 stated that during care he went to grab side bars and CNA D pushed him hard and motioned to Surveyor where his head was hit on the side bars. Resident #2 stated, He hits me, hard. (CNA D). Resident #2 put his fingers on top of his head and stated, Devil. Surveyor stated who is the Devil, Resident #2 called CNA D by name. Observed Resident #2 began to show signs of anxiety just talking about it and began to tear up in his eyes. Family member #11 had to console Resident #2 to get him to calm down. During an interview on 04/13/2023 at 12:17 p.m., with Family member 12 via telephone for Resident #2, Family Member #11 used her own personal cell phone to reach out to Family member #12 and was happy to share some concerns. Family Member #12 stated that she does have some concerns with CNA D and that she did not have a lot of time because she had to get back to work but would like the opportunity to write down all the concerns and get back with Surveyor in a couple of days. Family Member #12 stated that she was told by Resident #2's old roommate (Resident #9) that he witnessed CNA D tell Resident #2 to stop using the call light so much or the next time he puts him in the Hoyer lift he (CNA D) will leave him there. Family Member #12 stated that the Administrator and BOM both knew that these things were going on and did nothing about it. Family Member #12 stated that she had stressed out so much from worrying about Resident #2 being in the facility when CNA D is working. Family Member #12 stated that she would like to make a written statement to provide to Surveyor about all the things that CNA D did to Resident #2. Record Review of a written Statement provided on 04/15/2023 at 8:00 am, from Family member #12, revealed: To Whom it May Concern: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	I (Family Member #12) just want to say thank you, my name is (Family Member #12), stated it is unfortunate that they are in the situation that they are in with the facility. Family Member #12 stated that she is willing to share Resident #2 journey at the facility in hopes that something or someone will finally do something to help these residents. Family Member #12 stated that everything had gone fine until the facility had hired CNA D (nights). Family Member #12 stated that she finally became concerned when CNA D had acted in a manner in front of another family member like he didn't like Resident #2 (talking rude to him). Family Member #12 stated that CNA D had a demeanor that he did not have a very caring personality and acted like he didn't want to be there most times. Family Member #12 stated that she had witnessed one of the times that CNA D had been rough with Resident #2 when she walked in when he was providing care and she told CNA D, Hey be easy with him. Family Member #12 stated that it seemed to upset CNA D when she told him because he got an upset look on his face. Family Member #12 stated that as time passed by it got to a point when Resident #2 didn't want family to leave him there alone when CNA D was working. Family Member #12 stated that she finally reported her concerns to the DON and Administrator at the time on October 2022 and she was told that the facility was investigating the situation but nothing ever changed. Family Member #12 stated that she asked weeks later and was still told that it was being investigated and still nothing changed. Family Member #12 stated that she got so frustrated because the facility is supposed to protect the resident's and did nothing to protect. Family Member #12 stated that about the second week of November 2022 she was approached by the DON and stated that the DON told her that there was an incident that the CNA D had Resident #2 up in the Hoyer and CNA D told Resident #2 that if he didn't stop, bitching, and pushing the call light that he (CNA D) would leave him up there. Family Member #12 stated that she was told by DON at the time that CNA D had left Resident #2 in midair in his brief that was soiled and wet for a good period of time. Family member #12 stated that she was told that the situation is being investigated, and again nothing happened. Family Member #12 stated that she went to the DON after days of hearing nothing and asked what was going to be done and DON stated that other residents had to be questioned. Family Member #12 stated that she asked at this time for CNA D not to be allowed to go into the room or care for Resident #2. Family Member #12 stated that she was told by the administrator that the facility could not do that and that is when she knew that there was going to be a problem with this place. Family Member #12 stated that it got to a point that family members would try to go as much as possible in hopes that the situation would stop. Family Member #12 stated that most times she was there that Resident #2 would show anxiety anytime CNA D would work. Family Member #12 stated that another incident happened in December 2022 with CNA D and Resident #2. Family Member #12 stated she was there at the facility with Resident #2, and she pushed the call light because Resident #2 was soaking wet and had, poop in his brief. Family Member #12 stated that Resident #2 started getting really anxious and scared. Family Member #12 stated that CNA D came in the room and told Family Member #12 that she had to leave the room for the privacy of Resident #2. Family Member #12 told CNA D that she would not leave the room. Family Member #12 stated that CNA D then told her that he would not change Resident #2 then. Family Member #12 stated that she told CNA D that she was going to report him to the administrator. Family Member #12 stated when she threatened to report CNA D, he then changed Resident #2, but CNA D was very rough and when he pushed Resident #2 to the side CNA D pushed him so hard that Resident #2 hit his head on the side pull bars. Family Member #12 stated that Resident #2 would cry sometimes and say that he was scared to go to sleep because of CNA D. Family member #12 stated that she did report this to the administrator and again, nothing, just investigating. Family Member #12 stated that she finally got to the point with the administrator that she said, What is it going to take, CNA D seriously hurting someone or killing them? Family Member #12 stated that she was scared daily, and this stressed her out because she was constantly worried about Resident #2. Family member #12 stated that things got worse with CNA D and Resident #2 began telling her that CNA D would twist his arm really hard and yell at him. Family Member #12 stated that she had went to the facility on [DATE]th, 2023, and already had Resident #2 up and in the wheelchair. Family Member #12 stated that Resident #2 was crying and very scared with his fists clenched. Family Member #12 stated, What's wrong, what happened, to Resident #2. Family Member #12 stated that Resident #2 had told her that CNA D was pulling and hitting him in his bad arm and leg. Family Member #12 stated that she had never been so scared before for Resident #2 because it was getting worse. Family Member #12 stated that she would have to go out of town that day due

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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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 - Some	Resident #3: Record Review of Resident #3's face sheet documented she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 was admitted with diagnoses which included: stroke, anorexia, muscle wasting and atrophy (decrease in size of a body part), dementia, lack of coordination, atherosclerotic heart disease (buildup of fats, cholesterol, and other substances on the artery walls), unsteadiness on feet, schizoaffective disorder, depression, anxiety, seizures, insomnia, high blood pressure, abnormalities of gait and mobility. Record review of Resident #3 admission MDS dated [DATE] documented that Resident #2's BIMS was listed as 12 meaning cognitively moderately impaired. Under B0200-Hearing: Resident #3 was listed as 0 meaning: Adequate- no difficulty in normal conversation, social interaction, listening to tv. Under B0600-Speech Clarity: Resident #3 was listed as 0 meaning: distinct intelligible words. Under B0700-Makes Self Understood: Resident #3 was listed as 1 meaning: Usually Understood-difficulty communicating some words or finishing thoughts but is able if prompted or given time. Under B0800-Understands Verbal Content however able: Resident #3 is listed as a 1 meaning: Usually understands-misses some part/intent of message but comprehends most conversation. Under C1310-Delirium- Resident #3 was listed as a 0 meaning there is no delirium. Under G0110-Functional Status: Bed mobility-Resident #3 was listed as extensive assistance with 2 person assist, Transfer-Resident #3 is listed as total dependence with 2 person assist, walk in room- Resident #3 was listed as activity did not occur, Walk in corridor- Resident #3 was listed as activity occurred only once or twice with 1 person assist, Locomotion on Unit- Resident #3 was listed as extensive assistance with one person assist, Locomotion off Unit- Resident #3 was listed as extensive assistance with one person assist, Dressing- Resident #3 is listed as extensive assistance with 2 person assist, Eating- Resident #3 was listed as supervision with one person assist, Toilet use- Resident #3 was listed as total dependent with 2 person assist, Personal hygiene- Resident #3 is listed as extensive assistance with one person assist. Under G0120-Bathing: Resident #3 was listed as total dependent. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #3s Care Plan dated on 12/11/2018 revealed: Resident #3 had an ADL self-care deficit due with dementia with interventions of: Bed mobility-extensive assistance with 2-person physical assist, Transfer-self-performance extensive assistance with 2 persons physical assist, walk in room-self-performance activity did not occur, Walk in corridor-self-performance activity did not occur, locomotion on unit- self-performance extensive assistance with one person physical assistance, locomotion off unit: self-performance extensive assistance with one person physical assist, dressing- self-performance extensive assistance with 2 person physical assist, eating: self-performance supervision with support provided setup help only, toilet use: self-performance total dependence with 2 person physical assist, personal hygiene: self-performance extensive assistance with 2 persons physical assistance, Refer to Physical therapy/occupational therapy/ speech therapy or restorative in ADL self-performance, Nurse aides to document her most dependent self-performance per shift. Monitor for signs and symptoms ADL decline and notify family, and MD, identifying causes and solutions. Monitor/ document/ report to MD as needed any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. Allow her sufficient [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** 43150 Based on observation, interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 24 hours after the allegation was made, to the administrator of the facility and to other officials (which included to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 1 residents (Resident #1) reviewed for abuse. The facility failed to report a reasonable suspicion of Abuse for Resident #1 after allegations were made by staff members to Administrator and Resident #1 suffered a spiral fracture to his upper left arm. This failure could place all residents at risk of further potential injuries or Abuse. Findings included: Resident #1: Record Review of Resident #1's face sheet documented he was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 was admitted with a diagnosis which includes: dementia without behavioral disturbance, muscle wasting and atrophy (loss or thinning of muscle tissue), difficulty in walking, Record review of Resident #1's admission Minimum Data Set (MDS) dated [DATE] documented that Resident #1's BIMS (Brief Interview for Mental Status) listed as 3, meaning severe cognitive impairment. Under Section B under Hearing, Speech, and Vision indicated that Resident #1, for ability to hear listed him at a 0, meaning no difficulty in normal conversation, social interaction, or watching tv. Under Section B in B0600 labeled Speech Clarity indicated listed at a 1 meaning that Resident #1 has unclear speech such as slurred or mumbled words. Under B0700 labeled Makes Self Understood Lists Resident #1 at a 1 meaning that Resident #1 is usually understood with difficulty communicating some words or finishing thoughts but is able if prompted or given time. Under B0800 labeled Ability to Understand documents that Resident #1 usually understands meaning misses some part/intent of message but comprehends most conversation. Under B0700 labeled Makes Self Understood is documented at a 1 meaning usually understands: difficulty communication some words or finishing thoughts but is able if prompted or given time. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Under Section C for cognitive patterns for C0700 labeled short-term memory is left blank and not completed. Under C0700 labeled long-term memory is left blank and not completed. Under C0800 labeled Memory/Recall Ability is left blank and not completed. Under C01000 labeled Cognitive Skills for Daily Decision Making is left blank and not completed. Under C01300 for Delirium for the question, Is there evidence of an acute change in mental status, labeled as a) meaning no there is not a change in mental status, for inattention is listed as a 0 meaning no behavior is present, for disorganized thinking is listed as a 0 meaning there is no behavior present, for altered level of consciousness is listed as a 0 meaning behavior is not present. Under Section D for Resident Mood Interview under D0200 Resident #1 shows little interest or pleasure doing things displayed at a frequency of 7-11 days, feeling down, depressed, or hopeless at a frequency of 2-6 days, feeling tired or having little energy at a frequency of 2-6 days. Under Section E for E0200 under Behavioral Symptom-Presence and Frequency is documented at a 0 meaning Resident #1 did not exhibit behaviors for physical behavioral symptom directed towards others such as for example (hitting, scratching, pushing, kicking, grabbing, abusing others sexually) , verbal behavioral symptoms directed toward others such as, for example (threatening others, screaming at others, cursing at others), other behavioral symptoms not directed towards others such as, for example (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal such as screaming or disruptive sounds). Under B0300 under Overall Presence of Behavioral Symptoms listed at a 0 meaning Resident #1 did not exhibit these behaviors. Under B0500 under Impact on Resident for the questions: put the resident at significant risk for physical illness or injury, significantly interfere with resident care, significantly interfere with the resident's participation in activities or social interactions was blank and incomplete. Under B0600 under Impact on Others for the questions: put others at significant risk for physical injury, significantly intrude on the privacy or activity of others, significantly disrupt care or living environment was left blank and incomplete. Under B0800 under rejection of care is listed as a 0 meaning that Resident #1 did not exhibit this behavior. Under Section E for Wandering labeled has the resident wandered list a 0 indicating that Resident #1 has not displayed this behavior. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Under Section G for Functional Status for G0100 labeled a), bed mobility (how resident moves to and from lying positions, turns side to side, and positions body while in bed or alternate sleep furniture) is listed as a 1 meaning Resident #1 needs supervision (oversight, encouragement, or cueing) listed as a 2 person assist, b). transfer (how the resident moves between surfaces including to and from bed, wheelchair, and standing position) is listed as a 1 meaning Resident #1 needs supervision (oversight, encouragement, or cueing) with a 2 person assist, c). Walk in room is listed as a 1 meaning Resident #1 needs supervision (oversight, encouragement, or cueing) with a 1 person assist, e). Locomotion on unit (how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair) is listed as a 0 indicating Resident #1 does not need assistance. Under G0300 for Balance during Transitions and Walking for a). Moving from seated to standing position is listed as a 1 meaning (not steady, but able to stabilize without staff assistance), b). Walking is listed as a 1 meaning (not steady, but able to stabilize without staff assistance), e). Surface to Surface transfer (transfer between bed and wheelchair) is listed as a 1 meaning (not steady, but able to stabilize without staff assistance). Under G0400 labeled Functional Limitation of Range of Motion for a). Upper extremities is listed as a 0 meaning no impairment. Under G0600 labeled Mobility Devices indicates that Resident #1 uses a wheelchair. Under G0900 labeled Functional Rehabilitation Potential indicates for Direct care staff believe resident is capable of increased independence in at least some ADLs is listed as a 1 meaning yes, they do believe Resident #1 is capable of increased independence. Under Section J for Health Conditions for J0300 for Pain Assessment indicates that Resident #1 has not had any pain or hurting in the past 5 day. Under J1700 for, a). Did the resident have a fall any time in the last month prior to admission/entry or reentry, indicates that Resident #1 was listed as a 1 meaning that he did have a fall prior to admission in the past month, b). Did the resident have a fall any time in the past 2-6 months prior to admission/entry or reentry, is documented as a 1 indicating that Resident #1 has experienced a fall in the past 2-6 months prior to admission in the facility. C). Did the resident have any fracture related to a fall in the past 6 months prior to admission/entry or reentry is listed as a 0 meaning the resident has not experienced a fracture in the past 6 months prior to admission into the facility. Under J1800 labeled Any falls since admission/entry or re-entry prior to assessment indicates a 1 meaning that Resident #1 has experienced a fall prior to admission into the facility. A). No Injuries is listed as a 1 meaning (no evidence of any injury on physical assessment by the nurse or primary care clinician, no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall). (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 #1s Care Plan dated 4/12/2023 revealed Resident #1 had a fracture of the left humerus with the interventions of: non weight bearing to LUE-nursing was to remove from sling 3 times a day to perform elbow extension only PROM. Nursing only to perform. In-service was given on 4/12/2023 to CN from PT on how to perform PROM correctly to prevent further injury. LPN, RN, DON, apply sling and encourage to leave it on assisting as needed for proper placement. Record review of Resident #1s Care Plan dated 04/14/2023 indicated Resident #1 had limited mobility r/t fx of left humerus that limits ADL self-performance. AEB unable to use left arm and requires a restorative nursing program to maintain current level of function with the interventions of: Nursing rehab/restorative: Passive ROM Program #1 extend lower arm flexing elbow 3 sets of 15 with 5 second pause. Record review of Resident #1s Care Plan dated on 02/28/2023 indicated Resident #1 is dependent on staff for meeting emotional, intellectual, physical, and social needs due to cognitive deficits with the interventions of: All staff to converse while providing care, establish and record level of activity and interests by talking with Resident, caregivers, and family on admission and as necessary, needs assistance/escort to activity function. Record review of Resident #1s Care Plan dated on 02/28/2023 indicated Resident #1 is deficit with dementia with the interventions with ADLs as follows: bed mobility: self-performance supervision, bed mobility: support provided with 2 person physical assist, transfer: self-performance supervision, support provided with 2 person physical assist, walk in room: self-performance supervision, support provided with one person assist, locomotion on unit: self-performance independent, support provided no setup or physical help from staff, nurse aides to document most dependent self-performance per shift. Monitor signs and symptoms of ADL decline and notify family, MD, identify causes and solutions. Record review of Resident #1s Care Plan dated on 02/28/2023 indicated Resident #1 is an elopement risk/wanderer with disoriented to place, wander risk is 9, with the interventions of distract from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, snacks, monitor location throughout shifts. Document wandering behavior and attempted diversional intervention in behavior log. Record review of Resident #1s Care Plan dated on 02/28/2023 indicated that Resident #1 had a cognitive impairment due to dementia with the interventions of ask yes/no questions in order to determine the resident's needs. Cue, reorient and supervise as needed. Need assistance with all decision making. Keep routine consistent and try to provide care givers as much as possible in order to decrease confusion. Present just one thought, idea, question or command at a time. Record review of Resident #1s Care Plan dated on 02/28/2023 indicated that Resident #1 had a communication problem with difficulty making self-understood and difficulty understanding others with the interventions of monitor/document for physical/nonverbal indicators of discomfort or distress, and follow-up as needed. Monitor/document frustration level, wait 30 seconds before providing with a word. Speak on an adult level, speaking clearly and slower than normal. Validate message by repeating aloud. (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 #1s Care Plan dated on 02/28/2023 indicated that Resident #1 is at risk for falls with gait/balance problems with the interventions of: provide with a chair to sit in when wondering in halls, be sure my call light is within reach and remind to use it for assistance as needed. Record Review of Resident #1's Progress notes dated 04/12/2023 at 5:38 am, signed by LVN A revealed: Note Text: Resident #1 woke up and came to nursing station stating he fell asleep on hand, and it was hurting/tingling. Assessed and hand was red with minimal puffiness. Resident #1 walks off and was later found in another Resident's room asleep in an empty bed. Male Aide (CNA D) was notified, and he assisted Resident #1 and he assisted Resident #1 out of room and down hall to his assigned room. LVN A (Nurse) hears Resident #1 yelling really loud and complaining of shoulder pain. LVN A (Nurse) asked Nurse Aide (CNA D) what did he do and he replied nothing, I just lifted him up under his arms and took him to his room. Nurse (LVN A) and Aide went into room to see what was wrong and Resident #1 attempts to hit aide yelled, get away from me in anger. Assessed arm and noticed bruising to lower forearm but Resident #1 had on a long sleeve shirt that would only go up so far. Resident #1 lays down. A few minutes later LVN A hears Resident #1 still moaning in pain. By this time aide (CNA D) reports that he just vomited and needed to leave and go home because he wasn't feeling well. Nurse (LVN A) and only aide (CNA C) present, goes in to check on Resident #1. This time I (LVN A) attempted to take off Resident #1 shirt and he's yelling in pain. I (LVN A) was able to get it off and assessed shoulder. I (LVN A) noticed a crease in arm in-between shoulder and elbow. Softly palpating down arm, Resident #1 guards' arm and a knot is felt and arms appears to be disformed. I (LVN A) had the aide (CNA C) to ask Resident #1 what happened in the room in Spanish, and he replied, He hit me two times. BOM, MD, wife, and Regional Operations Director notified. 911 called and Resident #1 transferred to UMC. During an observation on 04/13/2023 at 12:01 p.m., Resident #1 was sleeping and did not awaken to name being called. Resident #1 had a sling on the left arm. Resident #1 did not appear to be in any distress at this time. During an interview on 04/15/2023 at 12:48 p.m., with Family member 13 stated that the morning that Resident #1 was sent out to the hospital she received a call from LVN A and told her that Resident #1 had a hurt arm and was being sent out to the hospital. Family member 13 stated that LVN A told her that Resident #1 had stated that CNA D had hurt his arm. Family member 13 stated that she immediately felt sick to her stomach because she had been told by Resident #1 on a couple of different occasions that CNA D was mean to him. Family member 13 stated that she had told the staff and Administrator about Resident #1 stating that CNA D was being mean. Family member 13 stated she didn't know if anything had been done about the other times that Resident #1 had complained because she never heard anything from the staff or Administrator about the situations. Family member 13 stated that she would hope that now that something would get done about CNA D hurting Resident #1. Family member 13 stated that it's bad enough that something like this had to happen before something would get done about CNA D hurting Resident #1. Family member 13 stated that BOM had called her later that morning after she had already talked to LVN A and BOM told her that CNA D was transferring Resident #1 to bed and accidentally hurt him. Family member 13 stated that on one of the other times that Resident #1 was saying he was being treated mean, Resident #1 had told her and her brother, He beat me, Resident #1 had told family member 13, That big guy was in a boxing match with me, he beat me. Family member 13 stated that she took her concerns to the Administrator and never heard anything else about it. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an Interview on 04/13/2023 at 1:16 pm with CNA D, stated that he has worked in the facility for approximately six months. CNA D stated that he had just barely had to meet with the police to give a statement. CNA D stated that he did not know before this that there was a problem. CNA D stated that the facility had not called him to let him know that there was an issue. CNA D stated that when the police called to question him and now being interviewed by State let him know that there was a problem. CNA D stated that he had three interactions with Resident #1 that night that he worked. CNA D stated that the first two interactions with Resident #1 was just to redirect him back to his room. CNA D stated that the last interaction that he had with Resident #1 is when Resident #1 was found by the Monitor Tech in another resident room in an empty bed. CNA D stated that the Monitor Tech L stated that she needed help to transfer Resident #1. CNA D stated that he offered to help. CNA D stated that he tapped Resident #1 on the shoulder a few times to wake him up. CNA D stated that immediately Resident #1 was aggravated when he was awakened. CNA D stated that Resident #1 was telling him to leave him alone. CNA D stated that he walked out of the room for approximately 10 minutes to allow Resident #1 to calm down. CNA D stated that he returned into the room and tapped on the shoulder of Resident #1 again. CNA D stated that Resident #1 was having a hard time standing up so CNA D stated that he grabbed Resident #1 in both of the arm pit areas to pick him up with his (CNA D) thumbs on the outside of the armpits. CNA D stated that Resident #1 began to punch him several times in the CNA D stomach. CNA D stated that it did not bother him that Resident #1 was hitting him because he is not a big guy. CNA D stated, I am a big guy, and I can handle it. CNA D stated that he escorted Resident #1 to his room with no problems. CNA D stated that he escorted Resident #1 by getting behind Resident #1 and grabbing his arms and directing him to go towards his room. CNA D stated that when he was redirecting Resident #1 that he kept trying to pull away from him (CNA D), so CNA D stated he had to grab firmly to keep Resident #1 from trying to pull away while CNA D redirected him. CNA D gave a witness statement that Resident #1 does not like him (CNA D) and he does not know why. CNA D stated that the incident happened on 04/11/2023 on his night shift. CNA D stated, Now as of 04/13/2023, I am probably being suspended since State is in the building). CNA D stated that the administrator didn't tell him anything about the incident or question him yet still until State came in the building. CNA D stated that the Administrator told him that when he is done giving a statement to State then she needed to question him. CNA D stated that he did have another complaint with another resident and had been written up for that one before. CNA D stated that the resident that made that complaint didn't like him either and tried to make accusations that CNA D was rough with him (Resident #2). CNA D stated that is all he is going to say unless he has an attorney. Surveyor ended Interview and thanked CNA D for taking the time to interview. CNA D stated to Surveyor, I'm sure I will have 3 days to be pissed off about all this, I'm sure that's what I am going to do. I can't afford to get suspended again. Record Review of the Disciplinary Action for CNA D, provided on 04/13/2023, labeled, Counseling Notice, dated on 03/13/2023, revealed: CNA D had been suspended for three days and a 30-day probation period for a previous accusation of being too rough with a different resident which was used as a sample resident for this investigation. Suspension: 3 days Reason for Counseling Notice: Complaint from Resident #2 family, See Report on back. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Report on Back: 03/13/2023, HR counseled with CNA D, discussed his approach to patient care. He apologized and stated he didn't realize he was being too rough. He has been suspended for 3 days. After counseling CNA D agreed to a 30-day probation period and would not be allowed any reports from family or residents. CNA D stated he loved his job and would be agreeable to the 30-probation period, and then would review. Supervisor Statement: I have discussed the counseling notice with the employee CNA D. Signatures included Administrator, CNA D, and BOM Record Review of the Disciplinary Action for CNA D, provided on 04/14/2023, labeled, Counseling Notice, dated on 04/14/2023 at 12:30 pm revealed: CNA 4 had been terminated on 04/14/2023 via phone with no signature from employee provided. Termination-Effective Date: 04/14/2023 at 12:30 pm Reason for Counseling Notice: Termination due to employee allegations of Abuse and Neglect. Signed by: Administrator, BOM, No Employee signature provided. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/13/2023 at 4:20 p.m. with CNA C, stated that she worked with CNA D on the shift of 04/11/2023 going into 04/12/2023 from 7p.m. top 7 a.m. night shift. CNA C stated that she thought the incident was on 04/10/2023 going into 04/11/2023 but could check camera to make sure. CNA C stated that at about 2:30 a.m. the monitoring tech asked her and CNA D if they could help to get Resident #1 out of another room because she had found him asleep in an empty bed that was not his. CNA C stated that she was busy with another resident at the time that the monitoring tech had asked so CNA D stated that he would go help. CNA C stated that the monitoring tech was fully capable of doing it herself and she is unsure why the monitoring tech needed help to walk Resident #1 back to his bed, but she still wanted assistance. CNA C stated that when she was done tending to her resident, she overheard LVN A ask CNA D, What did you do to Resident #1?, CNA C stated that she also heard LVN A ask CNA D, Why is Resident #1 yelling in pain right when you walk out of his room? CNA C stated that she then heard CNA D tell LVN A that he had just grabbed Resident #1 under both of his arms and pulled him up out of the bed to transfer him. CNA C stated that she then witnessed CNA D say that he was all of a sudden feeling sick and she saw him go outside. CNA C stated that when CNA D came back inside the facility he asked if anyone cared if he went home because he did not feel good. CNA C stated that she was surprised because up to that point CNA D had not acted as though he was sick, she stated, He was fine all night. CNA C stated to CNA D that she did not care if he went home and that she could handle the workload, and then he left. CNA C stated that LVN A asked her if she would go with her to Resident #1 room to ask him what happened because he was crying out in pain since CNA D had left his room. CNA C stated that she would go with LVN A to Resident #1s room to find out what happened. CNA C stated that she asked Resident #1 in Spanish what happened and why is he in pain and CNA C stated that Resident #1 stated, He hit me, TWICE (DOS). CNA C stated that she told Resident #1, Why do you say that? CNA C stated that Resident #1 stated, He wanted to fight me. CNA C stated that she observed Resident #1 in a lot of pain. CNA C stated that Resident #1 was crying and moaning in pain. CNA C stated that she showed Resident #1 with her hand and opened her hand and stated, Did he hit you with open hand like this? CNA C stated that she then made a fist and showed Resident #1 and then asked Resident #1, Or did he hit you with a fist? CNA C stated that Resident #1 then made a fist and stated, He hit me like this. CNA C stated that she observed LVN A assess Resident #1 for injuries and they both saw a big red mark on his upper left arm. CNA C stated that LVN A was slightly feeling Resident #1's arm and stated there is a big lump and a space. CNA C stated that LVN A then stated that she needed to call the administrator and get Resident #1 sent out to the hospital. CNA C stated she did know that CNA D is not allowed to go into some of the residents' rooms alone because of being rough with some of the residents. CNA C stated that she did not know if Resident #1 was one of those residents or not, but she does know that he is not allowed in some of the other resident's rooms alone. CNA C stated that she had been told that by the nursing staff when she first started working there. CNA C stated that she was told that sometimes she may have to help him with certain residents and when she asked why that is what she was told. CNA C stated that she has noticed that CNA D would avoid taking care of Resident #1 and he has stated before that he did not like Resident #1. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675407	A. Building B. Wing	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/13/2023 at 5:26 p.m. with Administrator revealed she was aware of the incident that occurred with Resident #1 and CNA D on 04/12/2023. Administrator stated BOM called her at approximately 3:30 a.m. on 04/12/2023 and told Administrator that LVN A called BOM to report that Resident #1 was punched in the face and there was blood everywhere. Administrator stated that she called the facility and spoke to LVN A and was told that Resident #1 was in pain to the point of moaning and was being sent out to the hospital. Administrator stated that LVN A told her that CNA D was involved, and she did assess the resident for injuries. Administrator stated, In my thinking that since Resident #1 was already being sent out to the hospital, that everything was taken care of. I was thinking that since CNA D had gone home sick and Resident #1 was sent out to the hospital, that everything was calm and taken care of. Administrator stated that LVN A stated that CNA D was involved with the incident with Resident #1, but she was thinking now that CNA D went home not feeling well and the resident was sent to the hospital everything is okay for now. Administrator stated that her next plan of action was to make sure the family was notified and that everyone was okay. Administrator stated that she was told by the BOM that she had contacted the Medical Director after the incident happened. Administrator stated that when she came into work that morning around 8 am or 8:30 am, she notified the police, and the police made a report. (Surveyor contacted chief police and informed that in the investigation process and report is not ready to view at this point on 04/14/2023). Administrator stated that she had not interviewed CNA D yet until after surveyor had interviewed him on 04/13/2023 sometime after 2:00 p.m. Administrator stated that when she asked CNA D what happened on 04/13/2023 sometime after 2:00 p.m., he stated that he had transferred Resident #1 to the room and that it. Administrator stated that CNA D had already been written up for a different incident for allegations of abuse, with Resident #2 and now he will be written up for Resident #1. Administrator stated that CNA D is not supposed to be in the room with Resident #2 due to the allegations that was made against him by family member and Resident #2. Administrator stated that he is supposed to have a partner to make sure that nothing happens. Administrator stated that she has had to partner CNA D up with a partner with certain residents due to allegations being made but she does not have the staff to just exclude him from working with certain residents because of the allegations. Administrator stated that her way of monitoring CNA D to make sure that he was using a partner to enter certain residents' rooms was that she wouldn't get any more complaints and that is how she would know. Administrator stated that she had not suspended CNA D at this time but that she is going to suspend him. Administrator stated that CNA D went home because he felt sick during his shift on 04/12/2023 and was not scheduled to work on 04/13/2023 but Administrator stated that she was going to suspend him when he came in to work next. Administrator stated that she does have CNA D phone number and could contact him that way but has not done that. Administrator stated she was just going to suspend him when he came in. Administrator stated that she does know what the policy says about reporting abuse and neglect. Administrator stated that she was not sure how to fill out the provider investigation report but did report but not until the next day when she came to work. Surveyor pulled out the facility provided policy for abuse and showed the Administrator the protocols for reporting allegations of abuse when there is an injury. Administrator stated that she is aware that she was supposed to report within the 2-hour timeframe but was tired and it was the middle of the morning so she was just going to report when she came into work and did not think that would be a problem. Administrator stated that the incident occurred around 3:00-3:30 a. m. and the incident was reported on 04/12/2023 after Administrator got to work sometime after 8:00 or 8:30 a. m. Administrator stated that her staff has been trained in abuse and neglect. Administrator stated that right now the facility does not have a DON or an ADON and she stated that usually the DON and ADON is responsible for making sure that training is completed. Administrator stated that the negative potential outcome for not preventing abuse is that other residents may get hurt. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/16/2023 at 9:57 a.m. Administrator brought in a disciplinary form to Surveyor and had stated that she had herself written up for failing to report in the 2-hour timeframe and failure to report on the online portal for Abuse and Neglect. Surveyor reviewed disciplinary document and noticed it was dated as of 04/12/2023 but was provided on 04/16/2023. It shows the document is a written warning. Signed by Administrator, BOM, and an unidentified signature. During an Interview on 04/13/2023 at 6:11 p.m. with LVN A, stated that she worked the night shift and that the night of the incident on 04/11/2023-04/12/2023 Resident #1 came to the nurse station and stated, I fell asleep on my hand. LVN A stated that Resident#1 had been asleep since 10 or 11 p.m. and had come to the nurse station approximately around 12:30 a.m. LVN A stated that she told Resident #1 that it would be fine just to give it a couple of minutes and his hand would wake back up. LVN A stated that Resident #1 then walked away, and she did not see what direction he had went. LVN A stated that she just figured that Resident #1 went to the day room to watch tv because he would do that sometimes. LVN A stated that when the Monitor Tech L went to make rounds, she noticed that Resident #1 was not in his bed and came to ask her if LVN A had seen Resident #1. LVN A stated that she told the Monitor Tech L that she had not seen him since he said his hand fell asleep. LVN A stated that she noticed that Monitor Tech L was going room to room to find Resident #1 and had found Resident #1 in Resident #10s room in the vacant bed, asleep. LVN A stated that a couple of minutes go by and LVN A stated that she hears Monitor Tech L and CNA D talking. LVN A stated that she had heard the Monitor Tech L tell CNA D that Resident #1 was in the vacant bed in Resident #10s room by the door. LVN A stated that she heard CNA D state, I will take care of it. LVN A stated that when she saw CNA D next, he had Resident #1 from behind, grabbing his upper arms to direct Resident #1. LVN A stated that she felt that CNA D was being a little aggressive with his direction and she kind of said, Hey, (calling CNA D by his name), aren't you handling him (Resident #1) a little rough? LVN A stated that CNA D did not say anything and continued to take Resident #1 to his room. LVN A stated that CNA D was in Resident #1s room for a little while and when she saw CNA D come out of Resident #1s room, she heard Resident #1 moaning as though he was in pain. LVN A stated that she then asked CNA D, What did you do? Why is he in moaning like that? LVN A stated that CNA D stated to her, Nothing, I had to pick Resident #1 up under both of his arms to pick him up. LVN A stated that she went in Resident #1s room, and he was holding his upper arm and moaning. LVN A stated that she looked at Resident #1s upper arm where he was holding it and saw a big red mark on his upper arm. LVN A stated that she asked Resident #1 what was wrong, and he was just crying. LVN A stated that she went to get Resident #1 some Tylenol and gave it to him. LVN 1 stated that when she came out of Resident #1s room from giving him Tylenol, that CNA D stated that he was leaving and had already contacted BOM to let her know he was leaving because he did not feel well. LVN A stated that CNA D quickly left after that. LVN A stated that she could still hear Resident #1 [TRUNCATED]