STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2021
NAME OF PROVIDER OR SUPPLIER Bandera Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZI 222 Fm 1077 Bandera, TX 78003	P CODE
For information on the nursing home's	plan to correct this deficiency, please cont	tact 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	 and neglect by anybody. **NOTE- TERMS IN BRACKETS F Based on interview and record revi 12 of 15 residents (Resident #1-7, a. CNA B was alleged to get in the from the wheelchair and CNA B was b. CNA D was alleged to have turne emotional distress for Resident #2. c. CNA B was alleged to have told resulted in emotional distress and of d. CNA A and CNA B were alleged e. NA C was alleged to have been caused the resident to feel bad. f. NA C was alleged to have been r causing emotional distress. g. CNA A and CNA B were verbally An Immediate Jeopardy (IJ) was id remained out of compliance at a semonitoring the effectiveness of the These failures resulted in resident at the facility which caused emotional The findings were: 	resident's face, yell and then aggressi as alleged to have pulled Resident #1 h ed off the Resident #2's call light witho Resident #3 to cut off her leg if it was of depression to the resident. to have been rough with Resident #4 rough with care to Resident #5 and he rough with care to Resident #6 and sho y and physically aggressive with Reside entified on 5/14/2021. While the IJ was everity level of actual harm and a scope	ONFIDENTIALITY** 38511 dent's right to be free from abuse for vely remove the resident's hand nair. ut assisting the resident resulting in causing her so much pain which when providing care. r roommate, Resident #16 which bok her roommate, Resident #7 ent #13 in the shower room. s removed on 5/20/2021, the facility e of pattern due to the facility still delay in identifying abuse within ts.

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: 676233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2021	
NAME OF PROVIDER OR SUPPLIER Bandera Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 222 Fm 1077 Bandera, TX 78003		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC iden		ifying information)	
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	 5/12/2021 and were scheduled to the facilit syndromes predominantly involving neurological condition characterized crying), and intellectual disabilities. Record review of Resident #1's quare of 5 (maximum score 15) which ind recall words and phrases after minut staff members for care. Record review of Resident #1's Carresident had an impaired cognitive required staff to present just one the During an interview on 5/12/2021 and mannerisms and speech in which the interviewed due to his intellectual de During an interview on 5/12/2021 and source) that Resident #1 complained 	t 1:19 p.m. LVN G stated she learned o ed that a staff member pulled his hair o she reported it to the DON on 5/10/202	14/2021, 5/15/2021 and 5/16/2021. .m. on 5/10/2021, 5/11/2021 and 4/2021, 5/15/2021 and 5/16/2021. ed the resident was a [AGE] led congenital malformation he limbs), pseudobulbar effect (a e and inappropriate laughing or at the resident had a BIMS' score tively impaired and was unable to d required the assistance of 1-2 revised on 4/01/2020 revealed the rith impaired decision making and time. the resident had childlike tesident #1 was unable to be during change of report (unknown ver the weekend	

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	676233	B. Wing	05/20/2021
NAME OF PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZI	P CODE
Bandera Nursing & Rehabilitation		222 Fm 1077 Bandera, TX 78003	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	 300-hallway on 12/20/2020 near the Resident #1. The Speech Patholog Resident #1 in an aggressive manning of this room, so CNA B got in Rewheelchair. She also witnessed CN was observing from 3 feet away and doing when she saw she was being nurse's station and said something with yes and kept going back and for she informed the Administrator whee Administrator called her back within some complaints about CNA B. The really shook her. She stated, I have The Speech Pathologist stated she statement and had not been asked Record review of a text message da Administrator revealed a message moment, I'd like to talk to you abour Administrator via text. During an interview on 5/14/2021 a from the Speech Pathologist in Dec CNA B abusing or mistreating Resi no concerns about the way staff tal During an interview on 5/14/2021 a of abuse or mistreatment of Resident LVN G informed her Resident #1 st and he said someone touched his fromfirmed she did not suspend CN, interview other residents or additior concern. The DON stated several in them loud and the Administrator. The immediately. b. Record review of a face sheet for admitted to the facility on [DATE] and congestive heart failure, major deput. 	t 2:27 p.m., the Speech Pathologist state e therapy area when she heard a some ist looked in the direction of the commo- ler to go to his room. The resident state sident #1's face, yelled at the resident #1' d a MA (unknown) was also in the half g observed. Approximately 10 minutes 1 to Resident #1. The resident responde orth with the resident and wouldn't let it en the incident occurred either 12/20/20 a 30 minutes of the notification and stat ank you for letting me know. The Speed e seen and heard harsh voice before, b had not been interviewed, had not beer to give any other details to the witness ated Sunday, 12/20/2020 between the that read: Hi, Administrator! Sorry to bo t something I saw today at the facility. T t 1:15 p.m., the Administrator stated sh tember or since that time period or any dent #1 prior to surveyor intervention. Tk to Resident #1.	eone talking aggressively to botion and witnessed CNA B tell ad to CNA B that he did not want to and began moving the resident's is hand from his wheelchair. CNA A way. CNA B stopped what she was later CNA A was sitting at the d with no. CNA A then responded go. The Speech Pathologist stated D20 or 12/21/2020 via text. The ed, Yeah, we have been getting ch Pathologist stated this incident ut this was to the point of abuse. en asked to give a witness ed event. Speech Pathologist to the other you today, but if you have a There was no response from the the Administrator stated she had have any knowledge of complaints Monday, 5/10/2021. On 5/10/2021, stated she talked to Resident #1 show Resident # 1 . The DON uring the investigation and did not would have reported it if they had a ut CNA A and CNA B talking to a to talk to them about it. The DON DON stated she does not remember t abuse to the Administrator ed a [AGE] year-old-female s which included chronic systolic

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NAME OF PROVIDER OR SUPPLIER Bandera Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 222 Fm 1077 Bandera, TX 78003	
For information on the nursing home's	plan to correct this deficiency, please cont	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	(4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICI (Each deficiency must be preceded by f		on)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	 Record review of Resident #2's Carresident/family any concerns, fears Record review of a facility grievance said Resident #2 needed to be char (unknown staff) promised to change received on 5/04/2021. The docum her and yells at them to get out of h different hallway. During an interview on 5/12/2021 a 200-hallway because she wanted to assholes to me. Resident #2 stated Resident #2 also stated that CNA E because she was afraid of what wo she would take care of it but nothin number and tried to reach her with had occurred. During an interview on 5/12/2021 a changed in a 4-hour window and al a hard time believing it was true be and Resident #2 had never said an when he called and spoke to RN N telephone that Resident #2 had sair responded. During an interview on 5/12/2021 a of NA C, who no longer worked at t work with the brother of NA C. There Resident #2 has also complained a her. The DON stated she communiunknown time). During an interview on 5/13/2021 a that staff (unknown) kept turning of BOM stated the resident's family castated immediately after finishing th conversation to the Administrator's Administrator responded by stating 	re Plan created on 9/01/2020 revealed , issues regarding health or other subject e dated 5/4/2021 revealed a family menged since beginning of shift and state e but did not. The Administrator signed ent indicated Resident #2 was unhapp her room. The plan to resolve the grieva t 1:41 p.m., Resident #2 stated she modo o get away from CNA C and CNA D. S I NA C and CNA D also didn't do what 3 was bossy. She stated, she would rat uild happen. Resident #2 stated she has g improved. Resident #2 stated she has but success, so she called her family m t 5:31 p.m. RN N stated Resident #2 co so complained that CNA D was rude (of cause he had been up and down the h ything to him about it prior. The Reside about the concern. RN N stated he nord d staff was rude. He stated he didn't kr t 6:34 p.m., the DON stated Resident # he facility. The DON stated Resident # t 4:13 p.m., the BOM confirmed Resident # t 4:13 p.m., the p.t th	staff should discuss with the ects. mber of Resident #2 called and d CNA D just turns off light and the document and dated it as y when NA C and CNA D care for ance was to move Resident #2 to a oved from the 300 to the he stated, They are real mean they were supposed to do for her. her not give any further details ad talked to the DON who stated d the Administrators cell phone member and informed them of what complained about not being date unknown). RN N stated he ha allway and into the resident room ent's family member was upset tified the Administrator via now how the Administrator #2 first had issues with the brother ed Resident #2's request to not por rough (unknown date and time). nt either NA C or CNA D to care fo #2's concerns (unknown date and ent #2 complained on 5/06/2021 nt on without assisting her. The set about the incident, The BOM valked straight from the 's concern. The BOM stated the things. The BOM stated to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676233 NAME OF PROVIDER OR SUPPLIER Bandera Nursing & Rehabilitation		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. Building COMPLETED B. Wing 05/20/2021 STREET ADDRESS, CITY, STATE, ZIP CODE 222 Fm 1077 Bandera, TX 78003	
For information on the nursing home's p	plan to correct this deficiency, please cont	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by		CIENCIES r full regulatory or LSC identifying information)	
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/14/2021 a grievance. The DON stated she wa D with a Hoyer lift outside of Reside changed and the situation was resc about staff turning off the call light v she feels like she can resolve a pro am being abused or someone hit m hesitate to tell my staff to hit the do During an interview on 5/14/2021 a staff not answering a call light or tur Administrator stated RN G called he unknown time). The Administrator of date and unknown time) who was n Administrator stated knowing that F CNA to finish with another resident Administrator stated she felt like Res see if what the resident reported wa differently. I do not have staff here of #2 moved to a different hallway awa hallway. The Administrator stated for asked why she thought Resident #2 D? The Administrator stated she filt like asked why she thought Resident #2 D? The Administrator stated she did no observed the incident or other reside the problem had been resolved as a c. Record review of a face sheet for admitted to the facility on [DATE] an hemiparesis following cerebral infan- side of the body caused by damage Record review of Resident #3's qua (maximum score 15) which indicated delirium, psychosis or other behavior	t 11:25 a.m., the DON confirmed she w s clocking out and going home in the e ent #2's room. The DON stated she ass lyed. The DON stated she was not aw without assisting the resident. The DON blem. The DON stated she would inve- ie because that would be a completely or. t 1:18 p.m., the Administrator stated ar rning it off without attending to the resid er at home and stated Resident #2 was confirmed she also spoke with Residen eally upset about the resident being so y member that staff would change Res NG had been in the resident room an she did not consider the grievance and esident #3 tended to exaggerate. The Ad as true and stated I do not want to call who would ignore a resident. The Adm ay from NA C and CNA D and Residen the seident #2's behaviors were much bet 2's behaviors would improve on a new e new staff baby Resident #2 more. Th f would not want to be spoken to in suc ot take written statements, or interview lents because the resident didn't say sl	vas aware of Resident #2's vening on 5/04/2021 and saw CNA sumed Resident #2 had been are of a call light issue or complaint J stated she doesn't investigate if stigate if a resident were to say I different ball game and I wouldn't example of abuse/neglect was dent leaving them soiled. The s not soiled (unknown date and t #2's family member (unknown iled and call lights turned off. The sident #2 immediately. The d the resident was just waiting for a d complaint as neglect. The sdministrator stated she wanted to her a liar, but she sees things inistrator stated she had Resident t #2 was content on the new ter on the new hallway. When hallway away from NA C and CNA teir voices were not so stern. The sh a manner, with a stern voice. other staff who might have he felt like she had any harm and ed a [AGE] year-old female as which included hemiplegia and weakness and paralysis on the left ression and anxiety disorder. e resident had a BIMS' score of 10 hout the signs and symptoms of the of 1-2 staff for care.

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(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by		CIENCIES full regulatory or LSC identifying informati	on)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a facility grievance CNA B had made {an} ugly comme grievance was made and signed by DON signed off on the grievance at been rough with care since she ma A would not get me out of bed whe nobody comes, you know why. Res B because she had already caused with tears and added, I cannot do a and puts the blanket where I can't r air-conditioning). She takes my (foo finished (with the food) but I know t talked to CNA B, I get attitude from loud noise because I am scared it's pain. I want to ask for someone els and I will have to sit in my own was to the DON about them. During an interview on 5/12/2021 at 4/30/2021, CNA B told the resident contracture of the leg that was caus the DON on 4/30/2021 via telephor was just a joke. The DON gave LVI apologize. During an interview on 5/12/2021 at approximately 2 weeks ago, Reside told her to chop off her leg becauses she was going to cry when she told to straighten her contractured leg at #3 keeps talking about it. CNA B st she was going to report the inciden Administrator and added I am a sin During an interview on 5/12/2021 a upset about a comment CNA B ma you need to cut if off. The DON state on Monday (unknown date). The D situation. CNA B stated she was pl or remove her from resident care w not interview other staff or resident.	e, dated 5/01/2021 revealed Resident is int about her leg not working and that s y the DON who assigned the investigat s resolved on 5/03/2021. It 10:55 a.m. on the 300-hallway with R ide a complaint about CNA A's mother, n asked for assistance and stated, If yo sident #3 stated she did not want to talk d enough trouble by making the compla- anything to suit, CNA B. She constantly reach it. She says I am freezing out my bot tray away before I am done with my bot tray away before I am done with my cNA A. I feel terrorized. CNA B is alw s her. When asked if she felt safe, Resi e (to provide care) but I am afraid If I s ite. Resident #3 she had reported her of the cut off her leg because it was more sed by a stroke. LVN G stated Resident #3 to cut off her leg because it was more sed by a stroke. LVN G stated she repo- te. The DON responded by stating CNA N G instructions to go with CNA B into the aide about the incident. She further and even though it's been a couple of w ated she reported it to LVN G who was it. Restorative Aide MM stated the aide about the incident. She further and even though it's been a couple of w ated she reported it to LVN G who was it. Restorative Aide MM stated the Abus igle mom and I worry about my job. tt 5:44 p.m. the DON confirmed LVN G de about the resident's leg in which CN ted she talked to LVN G and CNA B. T have CNA B apologize to the resident. d she reported the incident to the Adm ON stated she investigated the situatio aying with the resident. The DON confi- thile she investigated, did not take any s because Resident #3 was fine with the ted she asked Resident #3 if she was con-	#3 voiced to nurse, LVN G that he should just chop it off. The ion to herself on 5/03/2021. The esident #3 who stated CNA A had CNA B. Resident #3 stated, CNA bu push the button (call light) and c about the complaint against CNA int. The resident became emotional takes the little blanket off my feet roommate (with the of cod. CNA B asked me if I am food anyway. Since they (unknown ays yelling. I jump when I hear any dent #3 stated, I know there will be ay anything I won't get changed concerns to LVN G and had talked informed her on 5/1/2021 that on of a bother than a help due to a orted the complaint immediately to A B didn't mean it seriously and it the Resident #3's and have CNA E d on an unknown date e rough with her and that CNA B M stated Resident #3 looked like er stated the resident tries very har eeks since the incident, Resident the Charge Nurse who responder se Coordinator was the had reported that Resident #3 was IA B stated This darn leg of yours, he DON stated after talking to both This occurred over the weekend inistrator during morning meeting n by talking to CNA B about the rmed she did not suspend CNA B written witness statements and did the kidding and did not follow up or
	(continued on next page)		

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(X4) ID PREFIX TAG			CIENCIES full regulatory or LSC identifying information)	
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	 had been informed that Resident # know who informed her or when sh #3, she reminded the resident that about her leg and the resident resp want to play like that. The Administ and the resident replied joking. She Administrator confirmed she did no perform an investigation because th Administrator stated Resident #3 m Administrator stated Resident #3 m Administrator stated based on her of During an interview on 5/13/2021 at complained about CNA A, CNA B at had complained about the resident. The Speech Pathologist stated she protect the resident. The Speech P the grievance to the Administrator I resident. The Speech Pathologist is needed to know because I need to papers. The Speech Pathologist stated she was not asked to write at Record review of a text message fr 4/19/2021 at 4:30 p.m., that read A During an interview on 5/14/2021 at from the Speech Pathologist or any #3 prior to surveyor intervention. Th Speech Pathologist. d. Record review of Resident #4's fut to the facility on [DATE] with diagnos to thrive, dementia with behavioral Record review of Resident #4's qua 15) which indicated a moderate cog for care. 	arterly MDS dated [DATE] revealed a B gnitive impairment. Resident #4 require re Plan created 5/03/2019 and last revi a reach and the resident should be enco d the resident needed prompt response Care Plan revealed that staff should ref	off her leg. She stated she did not are when she spoke to Resident r leg and plays around with talking hat day. It is not funny, and I do not ought CNA B was mean or joking ind the resident replied no. The her from resident care and did not ind understood it was a joke. The dicate she was harmed. The not feel like there was any abuse. Ited several residents had implained that CNA A and CNA B fucking bullshit, I am tired of this. he resident as anonymous to try to ame on the grievance and handed ator stated Thank you at the time stated she needed the name of the or responded with, Okay, I just residents fill out a lot of grievance additional information other than e resident. The Speech Pathologist terviewed. Speech Pathologist dated t a grievance. he was not aware of any grievance abusing or mistreating Resident received any grievances from the in [AGE] year-old female admitted e pulmonary disease, adult failure MINS' score of 9 (maximum score d the assistance of 1 staff member	

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(X4) ID PREFIX TAG	AG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		ion)	
F 0600 Level of Harm - Immediate jeopardy to resident health or safety	During an interview on 5/12/2021 at 10:50 a.m. on the 300-hallway, with Resident #4 stated two morning female staff members, identified as mother and daughter, CNA A and CNA B (also identified by description) were rough when they provided care (unknown dates and times). Resident #4 stated she had asked the two CNA's to slow down and be careful, but she received no verbal response to her request. Resident #4 stated she had not told anyone because she was afraid to say anything.			
Residents Affected - Some	During an interview on 5/12/2021 at 6:34 p.m., the DON stated Resident #4 made a complair (unknown date) that CNA A and CNA B would not let her go to bed. The DON stated she ask to just humor the two CNA's and stay up for just 30 minutes. The DON confirmed she did not incident. The DON stated the two CNA's were Spanish aggressive and spoke aggressively as her culture, but the DON did not consider it abuse. The DON gave an example, Go take a sh demanding tone of voice.			
	During an interview on 5/14/2021 at 2:34 p.m., the Administrator stated after receiving information from this surveyor that Resident #4 had stated CNA A and CNA B were rough with care, she interviewed Resident #4 The Administrator stated during the interview Resident #4 did not use the word rough. Resident #4 said the CNA's were fast. The Administrator stated, when she asked her if she felt safe, she said yes, CNA A and CNA B just need to slow down. The Administrator stated since the Resident did not use the word rough during the interview, she didn't think there was any abuse and did not investigate further. e. Record review of Resident #5's face sheet, dated 5/16/2021 revealed a [AGE] year-old-female admitted the facility on [DATE] with diagnoses which included major depressive disorder recurrent, heart failure, and cerebral infarction.			
	15) which indicated a moderate co	ord review of Resident #5's quarterly MDS dated [DATE] revealed a BIMS score of 8 (maximum score which indicated a moderate cognitive impairment with inattentiveness (difficulty focusing attention) but symptoms of psychosis or other behaviors. Resident #5 required the assistance of 1-2 staff membrare.		
		re Plan, dated 1/27/2021 revealed the d refused to discuss the issues with psy		
	During an interview on 5/12/2021 at 10:34 a.m. on the 300-hallway Resident #5 stated she didr the nursing facility and didn't feel safe. She stated NA C was rough with me and he hurts my ro Resident #16 when providing care (unknown date and time). Resident #5 stated Resident #16 of she was being hurt when NA C was taking care of her. She also stated staff (refused to give na was fat when providing care and that makes her feel bad. Resident #5 stated she had talked to one time about the rough care but did not remember when this conversation occurred. She state stated because she was fat, the care may be rough which in turn made the resident feel bad. T stated she was afraid of getting in trouble for talking to this surveyor and turned her head to the refused to answer further questions.			
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For information on the nursing home's p	plan to correct this deficiency, please cont	act the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by the second		IENCIES full regulatory or LSC identifying informati	on)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	 time. At one time, Resident #5 indic getting gastric surgery for weight low was beautiful and had a lot to live for out of bed. The DON stated the rest The DON stated she suggested psy #5 had finally agreed to eat as long if you don't help yourself, we can't heresident fat and that had not been of During an interview on 5/14/2021 at Resident #5's concerns because with the Administrator stated although F the Administrator did not feel like the blank stare and then eventually stated she asked the roommate said ow and no during calinterviewable due to cognitive statu stated she asked the roommate if s she told Resident #5 to come to held f. Record review of Resident #6's fat on [DATE] with diagnosis which incompacified fracture of the shaft of heamage). Record review of Resident #6's adm 15) which indicated the resident was During an interview on 5/13/2021 at Monday 5/3/2021. Resident #6 state call lights, when the staff would com Resident #6 stated she needed held that she screamed at him to get out and because he shook her roommate Resident #6 informed the Speech F comfortable reporting it. The Speece previously been instructed to do an and because he shook her roommate its of the short was provide the state of the speece previously been instructed to do an and because he shook her roommate Resident #6 informed the Speech F comfortable reporting it. The Speece previously been instructed to do an and because he shook her roommate its and the speece previously been instructed to do an and because he shook her roommate its and because he shook her roommate its and the speece previously been instructed to do an and because he shook her roommate its and the speece previously been instructed to do an and because he shook her roommate its and because he shook her roommate its and because he shook her roommate its and the speece previously been instructed to do an and because he shook her roommate its and the speece previously been instructed to do an and because he shook her roommate its and the speec	t 2:34 p.m., the Administrator confirment the interviewed Resident #5 the re- Resident #5 indicated NA C was rough ere was any abuse. The Administrator ted CNA A was rough with her roomma- are by CNA A. The Administrator confir s, but sometimes is able to answer sim- he felt safe and she responded with of r for any concerns. Are sheet, dated 5/15/2021, revealed a luded type 2 diabetes mellitus with dial numerus and polyneuropathy (fracture nission MDS, dated [DATE] revealed a	ior to admission had planned on h Resident #5 and told her she d her attempts to get Resident #5 g sodas and loosing excess weight. afused. The DON stated, Resident e DON stated she told Resident #5 aware of anyone calling the d she did not thoroughly investigate sident stated she felt safe now. with her roommate, Resident #16, stated the resident gave her a ate. Resident #5 stated the med the roommate was not hple questions. The Administrator n yeah. The Administrator stated n [AGE] year-old-female, admitted betic chronic kidney disease, of bone of the arm with nerve BIMS score of 15 (maximum score ted Resident #6 was in tears on because staff had been ignoring he staff would never come back. her room. Resident #6 reported care of her because he was male 7 had to go to the hospital. the incident because she wasn't a grievance which she had the Administrator's desk. The

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	676233	A. Building B. Wing	05/20/2021	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE	
Bandera Nursing & Rehabilitation		222 Fm 1077 Bandera, TX 78003		
For information on the nursing home's p	plan to correct this deficiency, please con	act the nursing home or the state survey a	agency.	
(X4) ID PREFIX TAG			CIENCIES / full regulatory or LSC identifying information)	
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	roommate Resident #7 with his han the resident had been hurting and of him she didn't want a man taking ca she had asked him to leave the roo back in later. Resident #6 stated she really hard and fast. Resident #6 be that can't stop him like I can. Reside remember because it was upsetting Record review of Resident #7's face [DATE] and readmitted on [DATE] to bleeding from the wall of a vein insi and narrowing of the main artery lea- resulting in limitations) . Record review of Resident #7's qua 15) which indicated the resident had During an interview on 5/13/2021 a for something trivial. I do not really side of her arms and shook me. Re looked at her skin for days and nev CNA D used threats and intimidatio the resident that she needed. Reside #7 asked the CNA to do and then er residents water jug. Resident #7 sta- reported it to someone in therapy. F reporting the incident.	e sheet, dated 5/15/2021, revealed an with diagnoses which included: cerebra de of the brain), occlusion and stenosis ading into the brain) and age-related pl nterly MDS, dated [DATE] revealed a E	the call light. Resident #6 stated is also rough with her. She had told ith a man touching her privately, so id he left at that time but came out and he pulled her depends up d stated, there might be someone ent to anyone that she can [AGE] year-old-female admitted on al aneurysm (weakness and s of left carotid artery (blockage hysical debility (symptoms of aging) BIMS score of 9 (maximum score bt upset with me because I asked the shoulders, one hand on each Ily easily. Resident #7 stated she t go. Resident #7 stated NA C and e they wouldn't do something for all light without doing what Resident CNA D also refused to fill the oveen upset about the situation and out getting someone in trouble by	

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NAME OF PROVIDER OR SUPPLIER Bandera Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZI 222 Fm 1077 Bandera, TX 78003	P CODE
For information on the nursing home's	plan to correct this deficiency, please cont	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	IENCIES full regulatory or LSC identifying informati	on)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	 **NOTE- TERMS IN BRACKETS H Based on interview and record revie prevent abuse for 7 of 15 (Resident The facility failed to ensure the Adm and procedures when: 1. The Administrator failed to condu- witnesses of the abuse allegations, alleged perpetrators during the inve- continued to work and have direct of 2. The Administrator failed to report no later than 2 hours after the incid- abuse allegations. An Immediate Jeopardy (IJ) was idde remained out of compliance at a se still monitoring the effectiveness of These failures resulted in a delay in psychosocial harm to the residents The findings were: Record review of the facility Reside suspected case of exploitation, neg Administrator, or his/her designee, reporting requirements of such incide surveying/licensing the community the Community Medical Director. 9. Administrator within 24 hours of the report of abuse, the designated Community 	t allegations of abuse to the State Survent and failed to notify the Attending Plentified on 5/14/2021. While the IJ was verity level of actual harm and a scope the Plan of Removal. In identifying abuse within the facility whand placed residents at risk for continuent Abuse Policy dated July 2018 reveal lect, injuries of unknown source or abuwill notify the following persons or aged dent .a). The State licensing/certification c) law enforcement officials d) the resident at the statements from witnesses, if e occurrence of such incident. 11. Upor mmunity Abuse Coordinator will request nitor the resident's emotions concerning	ONFIDENTIALITY** 38511 en policies and procedures to red for abuse; followed the facility's abuse policy tten witness statement, interview #3, #4, #5, #6, and #7 from the are of the allegations of abuse, sta rey Agency (HHS) immediately but hysician and Medical Director of the eremoved on 5/20/2021, the facility to of pattern due to the facility was the caused emotional and mental ued abuse.

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For information on the nursing home's	plan to correct this deficiency, please cont	tact the nursing home or the state survey a	agency.	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFIC		IENCIES full regulatory or LSC identifying information	on)	
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Further review of a facility policy, tit Investigations: All reports of resider state regulations) shall be promptly management-appointed individual of medical record to determine events c). interview any witnesses to the in team members who have had conta the resident's roommate, family me member provides care of services a reports will be reduced to writing. W such reports shall be attached to th requirements. 6. Team members of may be reassigned to non-resident have been reviewed by the Adminis 1a. Record review of a face sheet fi year-old-male admitted to the faciliti syndromes predominantly involving neurological condition characterized crying), and intellectual disabilities. Record review of Resident #1's qua of 5 which indicated the resident was phrases after minutes, had no docu care. During an interview on 5/12/2021 a mannerisms and speech in which h interviewed due to his intellectual d During an interview on 5/12/2021 a source) that Resident #1 complaine	led Resident Abuse Policy dated July 2 at abuse, neglect and injuries which har and thoroughly investigated by the Co conducting the investigation will, at a m leading up to the incident, b)interview incident d) interview the resident (as me act with the resident during the period of mbers and visitors g) interview other re- and h) review all events leading up to the /itnesses will be required to sign and di- e Provider Investigation Report) per cu is this community who have an allegation care duties or suspended from duty un- strator/designee. or Resident #1, dated 5/13/2021, revea- y on [DATE] with diagnoses that includd limbs (birth defect primarily affecting the d by episodes of sudden uncontrollable arterly MDS, dated [DATE], revealed the as severely cognitively impaired and war- imented behaviors and required the as- t 5:25 p.m., with Resident #1 revealed the repeated what was spoken to him. R isability and cognitive status. t 1:19 p.m. LVN G stated during chang ed that a staff member pulled his hair or she reported it to the DON on 5/10/202	2018 revealed: C. Abuse ve an unknown source (defined by mmunity Management. 2. The inimum a0 review the resident's the person(s) reporting the incident dically appropriate) e) interview of the alleged incident f). interview esidents to whom the accused team ne alleged incident 4. Witness ate such reports (Note: a copy of irrent state/federal reporting n against them of resident abuse ntil the results of the investigation aled the resident was a [AGE] led congenital malformation he limbs), pseudobulbar effect (a e and inappropriate laughing or at the resident had a BIMS' score as unable to recall words and sistance of 1-2 staff members for the resident had childlike tesident #1 was unable to be e of report she learned (unknown ver the weekend	

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(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by f		IENCIES full regulatory or LSC identifying informati	on)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	 300-hallway on 12/20/2020 near the Resident #1. The Speech Patholog Resident #1 in an aggressive mann room, so CNA B got in Resident #1 wheelchair. She also witnessed CN was observing from 3 feet away and doing when she saw she was being nurse's station and said something with yes and kept going back and fd she informed the Administrator whee Administrator called her back withir some complaints about CNA B. That Record review of a text message da Administrator revealed a message moment, I'd like to talk to you about Administrator via text. During an interview on 5/14/2021 a from the Speech Pathologist or any #1 prior to surveyor intervention an allegations The Administrator stated During an interview on 5/14/2021 a of abuse or mistreatment of Resident #1 st and he said someone touched his f confirmed she did not suspend CN/ interview other residents or additior concern. The DON stated several r them loudly and the Administrator f DON indicated Resident #1 had be remember if she notified the Admini Administrator immediately. b. Record review of a face sheet for admitted to the facility on [DATE] and congestive heart failure, major deput 	t 2:27 p.m., the Speech Pathologist state e therapy area when she heard a some ist looked in the direction of the commo- ter to go to his room. The resident state 's face, yelled at the resident and bega IA B aggressively remove Resident #1' d a MA (unknown) was also in the halk g observed. Approximately 10 minutes to Resident #1. The resident responde orth with the resident and wouldn't let it en the incident occurred either 12/20/20 a 30 minutes of the notification and stat ank you for letting me know. ated Sunday, 12/20/2020 between the that read: Hi, Administrator! Sorry to bo t something I saw today at the facility. The t 1:15 p.m., the Administrator stated sh one else regarding CNA A and CNA B d therefore had not reported to the Stat d she had no concerns about the way se t 5:44 p.m. the DON stated she did not nt #1 except a report she received on I ated CNA B pulled his hair. The DON shair. The DON stated other people esidents had expressed concerns about and spoken to the two CNA's in her offic haviors and repeated things he heard. istrator. The DON stated she was train in Resident #2, dated 5/13/2021, revealed the readmitted on [DATE] with diagnose ressive disorder and hypothyroidism. arterly MDS, dated [DATE], revealed the orgitive impairment without signs and se d the assistance of 1-2 staff members	eone talking aggressively to botion and witnessed CNA B tell ad he did not want to go to his in moving the resident's is hand from his wheelchair. CNA A way. CNA B stopped what she was later CNA A was sitting at the ad with no. CNA A then responded go. The Speech Pathologist stated 020 or 12/21/2020 via text. The red, Yeah, we have been getting Speech Pathologist to the other you today, but if you have a There was no response from the the was not aware an any grievance abusing or mistreating Resident te Reporting Agency the staff talk to Resident #1. thave any knowledge of complaints Monday, 5/10/2021. On 5/10/2021, stated she talked to Resident #1 know Resident # 1. The DON luring the investigation and did not would have reported it if they had a ut CNA A and CNA B talking to ce to talk to them about it. The The DON stated she does not ed to report abuse to the ed a [AGE] year-old-female as which included chronic systolic at the resident had a BIMS' score symptoms of delirium, psychosis or

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For information on the nursing home's	plan to correct this deficiency, please con	l tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICI (Each deficiency must be preceded by fi		CIENCIES full regulatory or LSC identifying informati	on)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	said Resident #2 needed to be cha (unknown staff) promised to chang received on 5/04/2021. The docum her and yells at them to get out of h different hallway. During an interview on 5/12/2021 a	e dated 5/4/2021 revealed a family me nged since beginning of shift and state e but did not. The Administrator signed ent indicated Resident #2 was unhapp ner room. The plan to resolve the grieva t 1:41 p.m., Resident #2 stated she mo o get away from CNA C and CNA D. Si	d CNA D just turns off light and the document and dated it as y when NA C and CNA D cared for ance was to move Resident #2 to a byted from the 300 to the
	assholes to me. Resident #2 stated She stated, she would rather not gi Resident #2 stated she had the Ad she called her family member and i	they were supposed to do for her. s afraid of what would happen.	
	During an interview on 5/12/2021 a changed in a 4-hour window and co hard time believing it was true beca and Resident #1 had never said an and was upset. RN N stated he not rude. He stated he didn't know how	unknown). RN N stated he had a lway and into the resident room nt's family member called RN N	
	member who no longer works at the with him. Then Resident #2 complained about care from CNA I	t 6:34 p.m., the DON stated Resident # e facility. The DON stated she honored ined NA C was too rough (unknown da 0 and doesn't want either NA C or CNA strator Resident #2's concerns (unknow	I Resident #2's request to not work ate and time). Resident #2 has als to to care for her. The DON stated
	upset and stated staff members NA treating her bad. The family member and CNA D would be removed from taking care of Resident #2. The fam requested that Resident #2 be mov	t 9:28 p.m., Resident #2's family memb a C and CNA D were taking away the re- er stated he called the facility and spok n caring for Resident #2. The next day, nily member stated he again called the red off of the 300-hallway so that she w the Administrator did not return his call	esident's call light from her and e to RN G who assured him NA C NA C and CNA D were again facility and spoke to the BOM and yould not be cared for by NA C and
	that staff (unknown) kept turning of stated the resident's family membe came to the facility to see the resid Resident #2, she walked straight fm Resident #2's concern. The BOM s	t 4:13 p.m., the BOM confirmed Reside f her call light when she put them on wi r called and spoke to her and was very ent. The BOM stated immediately after om the conversation to the Administrative tated the Administrator responded by se ed to the Administrator, I know, but I fe	ithout assisting her. The BOM upset about the incident and ther finishing the conversation with or's office and informed her of stating, Resident #2 isn't happy
	(continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Bandera Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZI 222 Fm 1077	P CODE
		Bandera, TX 78003	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	IENCIES full regulatory or LSC identifying informati	on)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	grievance and complaints about no (unknown time) and going home an #2 had been changed and the situal issue of complaint about staff turnin doesn't investigate if she feels like s or someone hit me that would be a hit-the-door. During an interview on 5/14/2021 a staff not answering a call light or tur Administrator stated RN G called he confirmed she also spoke with Res explained to the family member tha knowing that RN G had been in the another resident was not neglect. T Administrator stated she wanted to her a liar, but she sees things differ Administrator stated she had Resid Resident #2 was content on the new better on the new hallway. When as hallway away from NA C and CNA Their voices were not so stern. The such a manner with a stern voice. T Survey Agency (HHS) because the During an interview on 5/14/2021 a staff not answering a call light or tur Administrator stated RN G called he confirmed she also spoke with Resi soiled and call lights turned off. The Resident #3 immediately. The Adm the resident was just waiting for a C stated she felt like Resident #3 teno resident reported was true and stat have staff here who would ignore a different hallway away from NA C a Administrator stated Resident #2 is thought Resident #2's behaviors wo Administrator stated that the new si Administrator confirmed she hersel Administrator stated she did not tak	t 11:25 a.m., the DON confirmed she w t getting changed. The DON stated shu d saw CNA D with a Hoyer lift. The DO tion was resolved. The DON stated sh go ff the call light without assisting the she can resolve a problem. If a residen completely different ball game and I w t 1:18 p.m., the Administrator stated ar ming it off without attending to the resident at the and stated Resident #2 was ident #2's family member who was real t staff would change Resident #2 imme resident room and the resident was ju he Administrator stated she felt like Re- see if what the resident reported was t ently. I do not have staff here who wou ent #2 moved to a different hallway aw w hallway. The Administrator stated Re- sked why she thought Resident #2's be D? The Administrator stated that the n a Administrator confirmed she herself w The Administrator stated she did not re resident didn't say she felt like she han t 1:18 p.m., the Administrator stated ar ming it off without attending to the resis er at home and stated Resident #2 was ident #3's family member who was real a Administrator explained to the family inistrator stated knowing that RN G ha CNA to finish with another resident was Is to exaggerate. The Administrator stated she ind CNA D and Resident #2 was conte behaviors were much better on the new build improve on a new hallway away fr taff baby Resident #2 more. Their voice f would not want to be spoken to in suc- ise written statements, or interview othe use the resident didn't say she felt like ievance.	e was clocking out on 5/04/2021 DN stated she assumed Resident ie was not aware of a call light resident. The DON stated she it were to say, I am being abused ouldn't hesitate to tell my staff to in example of abuse/neglect was dent leaving them soiled. The is not soiled. The Administrator ediately. The Administrator stated ist waiting for a CNA to finish with esident #2 tends to exaggerate. The true and stated I do not want to ca- uld ignore a resident. The <i>vay</i> from NA C and CNA D and esident #2's behaviors were much ehaviors would improve on a new ew staff baby Resident #2 more. <i>vould not want to be spoken to in port the incident to the State d any harm.</i> In example of abuse/neglect was dent leaving them soiled. The is not soiled. The Administrator Ily upset about the resident being member that staff would change d been in the resident room and is not neglect. The Administrator ated she wanted to see if what the he sees things differently. I do not a had Resident #2 moved to a int on the new hallway. The w hallway. When asked why she om NA C and CNA D? The es were not so stern. The ch a manner with a stern voice. The r staff who might have observed

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(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by f		CIENCIES full regulatory or LSC identifying informati	on)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	 c. Record review of a face sheet for admitted to the facility on [DATE] at hemiparesis following cerebral infatiside of the body caused by damage. Record review of Resident #3's quat which indicated a moderate cognition other behaviors. Resident #3 require Record review of a facility grievance CNA B had made {an} ugly commergrievance was made and signed by DON signed off on the grievance at During an interview on 5/12/2021 at been rough with care since she marme out of bed when asked for assis you know why. Resident #3 stated had already caused enough trouble added, I cannot do anything to suit, blanket where I can't reach it. She sim (food) tray away before I am do know better than to say no. She will attitude from CNA A. I feel terrorize am scared it's her. When asked if s someone else (to provide care) but my own waste. Resident #3 she hat During an interview on 5/12/2021 a 4/30/2021, CNA B told the resident contracture of the leg that was cause the DON on 4/30/2021 via telephor was just a joke. The DON gave LVI apologize. During an interview on 5/12/2021 a approximately 2 weeks ago, Reside told her to chop off her leg because she was going to cry when she told to straighten her contractured leg a #3 keeps talking about it. CNA B still still a some stome still a some still a some stom still a	r Resident #3, dated 5/13/2021, reveal nd readmitted on [DATE] with diagnost rection affection left non-dominant side (a to the brain from a stroke), major dep arterly MDS dated [DATE], revealed the ve impairment without the signs and sy red the assistance of 1-2 staff for care. e, dated 5/01/2021, revealed Resident nt about her leg not working and that sy the DON who assigned the investigat s resolved on 5/03/2021. t 10:55 a.m. on the 300-hallway with R de a complaint about CNA B. Residen stance and stated, If you push the butto she did not want to talk about the comp a by making the complaint. The resider CNA B. She constantly takes the little says I am freezing out my roommate (w ne with my food anyway. Since they (un d. CNA B is always yelling. I jump whe he felt safe, Resident #3 stated, I know I am afraid If I say anything I won't get d reported her concerns to LVN G and t 1:19 p.m., LVN G stated Resident #3 to cut off her leg because it was more sed by a stroke. LVN G stated Resident #3 to cut off her leg because it was more sed by a stroke. LVN G stated Resident #3 to cut off her leg because it was more sed by a stroke. LVN G stated Resident #3 to cut off her leg because it was more sed by a stroke. LVN G stated Resident #3 to cut off her leg because it was more sed by a stroke. LVN G stated Resident #3 to cut off her leg because it was more sed by a stroke. LVN G stated She reporte t 2:34 p.m., Restorative Aide MM state ent #3 told her CNA A and CNA B were a it was contracted. Restorative Aide MM the aide about the incident. She further nd even though it's been a couple of w ated she reported it to LVN G who was t. Restorative Aide MM stated the Abu	ed a [AGE] year-old female es which included hemiplegia and weakness and paralysis on the le ression and anxiety disorder. e resident had a BIMS' score of 10 mptoms of delirium, psychosis or #3 voiced to nurse, LVN G that he should just chop it off. The ion to herself on 5/03/2021. The esident #3 who stated CNA A had t #3 stated, CNA A would not get on (call light) and nobody comes, olaint against CNA B because she t became emotional with tears an blanket off my feet and puts the vith the air-conditioning). She take am finished (with the food) but I known) talked to CNA B, I get in I hear any loud noise because I v there will be pain. I want to ask f changed and I will have to sit in had talked to the DON about ther informed her on 5/1/2021 that on of a bother than a help due to a orted the complaint immediately to A B didn't mean it seriously and it the Resident #3's and have CNA I d on an unknown date e rough with her and that CNA B M stated Resident #3 looked like er stated the resident tries very ha reeks since the incident, Resident is the Charge Nurse who responde

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(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by f		TENCIES full regulatory or LSC identifying information	on)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	 upset about a comment CNA B mayou need to cut if off. The DON state LVN G and CNA B she decided to (unknown date) and the DON state on Monday (unknown date). The D situation. CNA B stated she was ploor remove her from resident care w not interview other staff or resident asked Resident #3 if she was okay During an interview on 5/12/2021 a had been informed that Resident # know who informed her or when sh plays around with talking about her is not funny, and I do not want to pl CNA B was mean or joking and the resident care and did not perform a understands it was a joke. The Administration complained about CNA A, CNA B a had complained about the resident. The Speech Pathologist stated she protect the resident. The Speech Pathologist stated she was written on the grievance to the Administrator I resident. The Speech Pathologist stated she was written on the grievance as tated she was not asked to write a Record review of a text message fr 4/19/2021 at 4:30 p.m., that read A During an interview on 5/14/2021 a from the Speech Pathologist. d. Record review of Resident #4's fit and the speech approace. 	at 5:44 p.m. the DON confirmed LVN G de about the resident's leg in which CN ted she talked to LVN G and CNA B. Th have CNA B apologize to the resident. d she reported the incident to the Admi ON stated she investigated the situatio aying with the resident. The DON confir hile she investigated, did not take any 's because Resident #3 was fine with th with CNA B continuing her care and sh t 2:29 p.m., the Administrator confirmer 3 was upset that CNA B told her to cut e was informed. The Administrator stat leg and the resident responded with Y ay like that. The Administrator asked Re- resident replied joking. She asked Res tor confirmed she did not suspend CN/ in investigation because the resident win inistrator stated she did not feel like it t 2:27 p.m., the Speech Pathologist sta and NA C. Specifically, Resident #3 cor s bowel movements and stated, this is ' filled out a grievance form and listed th athologist stated she signed her own in bersonally on 4/19/2021. The Administrator filter them because sometimes certain ater called her back into the office and dentified Resident #3. The Administrator filter them because sometimes certain and when she was asked to identify the and when she was asked to identif	A B stated This darn leg of yours, he DON stated after talking to both This occurred over the weekend inistrator during morning meeting n by talking to CNA B about the rmed she did not suspend CNA B written witness statements and did he kidding. The DON stated she he said she was fine with it. d she was previously aware and off her leg. She stated she did not ted reminded Resident #3 that she eah, but I wasn't playing that day. It tesident #3 again if she thought sident #3 if she felt unsafe and the A B from work or remove her from as fine with the incident and was abuse. ted several residents had mplained that CNA A and CNA B fucking bullshit, I am tired of this. he resident as anonymous to try to ame on the grievance and handed rator stated Thank you at the time stated she needed the name of the or responded with, Okay, I just residents fill out a lot of grievance additional information other than a resident. The Speech Pathologist terviewed. Speech Pathologist dated tt a grievance. he was not aware of any grievance abusing or mistreating Resident received any grievances from the n [AGE] year-old female admitted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2021
NAME OF PROVIDER OR SUPPLIER Bandera Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 222 Fm 1077	
		Bandera, TX 78003	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
 (Each deficiency must be preceded by F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Residents Affected - Some During an interview on 5/12/2021 a female staff members, identified as description), were rough when they asked the two CNA's to slow down Resident #4 stated she had not tol During an interview on 5/14/2021 a surveyor that Resident #4 had stat The Administrator stated during the fast. Administrator stated during the fast. Administrator stated during the fast. Administrator stated during the fast. Administrator stated the two CNA's and sti incident. The DON stated the two CNA's and sti incident. The DON stated the two culture, but the DON did not consid demanding tone of voice. During an interview on 5/14/2021 a surveyor that Resident #4 had stat The Administrator stated during the fast. When I asked her if she felt stated administrator stated during the fast. When I asked her if she felt stated administrator stated during the fast. When I asked her if she felt stated administrator stated during the fast. When I asked her if she felt stated administrator stated during the fast. When I asked her if she felt stated administrator stated during the fast. When I asked her if she felt stated administrator stated during the fast. When I asked her if she felt stated administrator stated during the fast. When I asked her if she felt stated administrator stated during the fast. When I asked her if she felt stated administrator stated during the fast. When I asked her if she felt stated administrator stated during the fast. When I asked her if she felt stated administrator stated during the fast. When I asked her if she felt stated administrator stated during the fast. When I asked her if she felt stated administrator stated during the fast. When I asked her if she felt stated. 		acce sheet, dated 5/16/2021 revealed a es which included major depressive dis arterly MDS dated [DATE] revealed a E in inattentiveness (difficulty focusing att dent #5 required the assistance of 1-2 t 10:34 a.m., on the 300-hallway with F didn't feel safe. Resident #5 stated CN g care (unknown date and time). Reside	staff member for care. esident #4 stated two morning and CNA B (also identified by nes). Resident #4 stated she had rbal response to her request. y anything. ter receiving information from this care, she interviewed Resident #4 word rough, she said they were VA A and CNA B just need to slow ugh during the interview, she didn' #4 made a complaint last week DON stated she asked Resident #4 nfirmed she did not investigate the oke aggressively as part of their e, Go take a shower in a stern, ter receiving information from this care, she interviewed Resident #4 word rough. She said they were st need to slow down. The the interview, she didn't think [AGE] year-old-female admitted to order recurrent, heart failure, and BIMS' score which indicated a ention) without symptoms of staff members for care. Resident #5 who stated she didn't IA A was rough with me and he ent #5 stated Resident #16 cried
	moderate cognitive impairment with psychosis or other behaviors. Reside During an interview on 5/12/2021 a like living at the nursing facility and hurts my roommate when providing out that she was being hurt when C names) said she was fat when providal talked to the DON at one time about She stated, the DON stated because	n inattentiveness (difficulty focusing attent dent #5 required the assistance of 1-2 t 10:34 a.m., on the 300-hallway with F didn't feel safe. Resident #5 stated CN g care (unknown date and time). Reside CNA A was taking care of her. She also viding care and that makes her feel bac ti the rough care but did not remember se she was fat, the care may be rough as afraid of getting in trouble for talking	ention) without sympton staff members for care. Resident #5 who stated IA A was rough with me ent #5 stated Resident stated staff (refused to I. Resident #5 stated sl when this conversation which in turn made the

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For information on the nursing home's	plan to correct this deficiency, please con	I tact the nursing home or the state survey :	agency.
(X4) ID PREFIX TAG	(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by f		on)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/14/2021 a rough care or abuse because she i CNA A was rough with care and did gave her a blank stare and then event the roommate said ow and no durin interviewable due to cognitive status stated she asked the roommate if s she told Resident #5 to come to he f. Record review of Resident #6's far on [DATE] with diagnosis which incourspecified fracture of the shaft of Record review of Resident #6's addr resident was completely cognitively During an interview on 5/13/2021 a Monday 5/3/2021. Resident #6 stat call lights, when the staff would cor Resident #6 stated she needed hel that she screamed at him to get ou and because he shook her roomma Resident #6 informed the Speech F comfortable reporting it. The Speece previously been instructed to do an Speech Pathologist stated the Adm During an interview on 5/13/2021 a roommate Resident #7 with his har the resident had been hurting and of him she didn't want a man taking ca she had asked him to leave the root back in later. Resident #6 stated sh really hard and fast. Resident #6 be that can't stop him like I can. Resid remember because it was upsetting Record review of Resident #7's fac [DATE] and readmitted on [DATE] of bleeding from the wall of a vein insi and narrowing of the main artery le resulting in limitations).	t 2:34 p.m., the Administrator confirme interviewed Resident #5 after receiving d not feel like there was any abuse. The entually stated CNA A was rough with 1 ing care by CNA A. The Administrator co is, but sometimes is able to answer sim the felt safe and she responded with of r for any concerns. ace sheet, dated 5/15/2021, revealed a cluded type 2 diabetes mellitus with diath humerus and polyneuropathy. mission MDS, dated [DATE] revealed a v intact. t 2:27 p.m., the Speech Pathologist state d that the weekend had been terrible me, she would ask for assistance and th p in the bathroom and NA C came into t because she didn't want NA C to take ate Resident #7 right before Resident # Pathologist stated she had filled out d on 5/03/2021 put it directly on top of inistrator did not follow up with any que t 4:43 p.m., Resident #6 stated NA C was are of her and didn't feel comfortable w of and get a woman. Resident #6 stated the screamed at him and told him to get exame emotional and started crying an ent #6 stated she didn't report the incide t #6 stated she didn't report the incide t #6 stated she didn't report the incide the screamed at him and told him to get are of her and didn't report the incide the stated she didn't report the incide	d she did not thoroughly investigate information from this surveyor that e Administrator stated the resident her roommate. Resident #5 stated onfirmed the roommate was not hele questions. The Administrator in yeah. The Administrator stated in [AGE] year-old-female, admitted betic chronic kidney disease, BIMS' score which indicated the ted Resident #6 was in tears on because staff had been ignoring he staff would never come back. her room. Resident #6 reported care of her because he was male 7 had to go to the hospital. the incident because she wasn't a grievance which she had the Administrator's desk. The estions. ame into their room and shook her the call light. Resident #6 stated as also rough with her. She had told ith a man touching her privately, so ed he left at that time but came out and he pulled her depends up d stated, there might be someone lent to anyone that she can [AGE] year-old-female admitted on al aneurysm (weakness and s of left carotid artery (blockage hysical debility (symptoms of aging
	15) which indicated the resident had a moderate cognitive impairment. During an interview on 5/13/2021 at 5:11 p.m. Resident # [TRUNCATED]		

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NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Bandera Nursing & Rehabilitation		222 Fm 1077 Bandera, TX 78003	
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(X4) ID PREFIX TAG		IENCIES full regulatory or LSC identifying informati	on)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Timely report suspected abuse, negled authorities. **NOTE- TERMS IN BRACKETS HAVE Based on interview and record review neglect, were reported immediately, because the allegation involve abuse, or involve abuse and do not result in serie including the State Survey agency (Hof 7 residents (Resident #1, #2, #3, # 1. The facility failed to report to the St Resident #1 when LVN G reported to Speech Pathologist reported to the Advell and then aggressively remove Resident #2 when Administrator that CNA D had turned emotional abuse to Resident #2 3. The facility failed to report to the St worbal and emotional abuse when Re her leg if it was causing her so much she would know why after she reported away the residents food before she w to report within two hours when these 4. The facility failed to report to the St Resident #4 stated CNA A and CNA B		glect, or theft and report the results of the advectory of the facility failed to ensure that all at the point of the the advectory of the adv	ONFIDENTIALITY** 38511 allegations involving abuse and egation is made, if the events that is that cause the allegation do not or of the facility and to other officials rough established procedures for 7 e, in that; b hours an allegation of abuse to CNA B pulled his hair and when a CNA B pulled his hair and when a CNA B get in Resident #1's face, air. b hours an allegation of neglect and and the BOM reported to the ssisting the resident resulting in b hours an allegation of physical, ON that CNA B told her to cut off if no one answered her call light CNA A and CNA B would take of abuse. The facility again failed ministrator by a State Surveyor. b hours an allegation of abuse wher ported to the Administrator by a
	6. The facility failed to report to the State Survey Agency (HHS) within two hours an allegation of abuse when Resident #6 reported to PTA OO that she had witnessed NA shake her roommate, Resident #7 after becoming frustrated.		
	An Immediate Jeopardy (IJ) was id While the IJ was removed on 5/20/ harm and a scope of pattern due to		liance at a severity level of actual
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2021
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		ion)
F 0609 Level of Harm - Immediate	These failures affected residents who made outcries of abuse and placed them at risk for continued and unrecognized abuse and emotional distress.		
jeopardy to resident health or safety	The findings include:		
Residents Affected - Some	1. Record review of a face sheet for Resident #1, dated 5/13/2021, revealed the resident w year-old-male admitted to the facility on [DATE] with diagnoses that included congenital masyndromes predominantly involving limbs, pseudobulbar effect (a neurological condition chepisodes of sudden uncontrollable and inappropriate laughing or crying), and intellectual di		
	Record review of Resident #1's quarterly MDS, dated [DATE], revealed that the resident had a BIMS' score which indicated the resident was severely cognitively impaired and was unable to recall words and phrases after minutes, had no documented behaviors and required the assistance of 1-2 staff members for care.		
	 During an interview on 5/12/2021 at 5:25 p.m., with Resident #1 revealed the resident had child mannerisms and speech in which he repeated what was spoken to him. Resident #1 was unable interviewed due to his intellectual disability and cognitive status. During an interview on 5/12/2021 at 1:19 p.m. LVN G stated she heard during change of report source) that Resident #1 complained that a staff member pulled his hair over the weekend (5/8/2021-5/9/2021). LVN G stated she reported it to the DON on 5/10/2021. The DON respond That's hard to prove, it could have been a joke. During an interview on 5/14/2021 at 5:44 p.m. the DON did not have any knowledge of complain or mistreatment of Resident #1 except a report she received on Monday, 5/10/2021. On 5/10/2021 informed her Resident #1 stated CNA B pulled his hair. The DON talked to Resident #1 and he someone touched his hair. The DON stated does not remember if she notified the Administrator stated she was trained to report abuse to the Administrator immediately. 		
	300-hallway on 12/20/2020 near th Resident #1. The Speech Patholog Resident #1 in an aggressive man B got in Resident #1's face, yelled witnessed CNA B aggressively rem 3 feet away and a MA (unknown) w saw she was being observed. Appr said something to Resident #1. The going back and forth with the reside Administrator when the incident occ	at 2:27 p.m., the Speech Pathologist state e therapy area when she heard a some pist looked in the direction of the common ner to go to his room. The resident did r at the resident and began moving the r love Resident #1's hand from his whee vas also in the hallway. CNA B stopped roximately 10 minutes later CNA A was e resident responded with no. CNA A the ent and wouldn't let it go. The Speech F curred either 12/20/2020 or 12/21/2020 otification and stated, Yeah, we have b now.	eone talking aggressively to otion and witnessed CNA B tell not want to go to his room, so CNA resident's wheelchair. She also elchair. CNA A was observing from I what she was doing when she is sitting at the nurse's station and hen responded with yes and kept Pathologist stated she informed the D via text. The Administrator called
	(continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Bandera Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZI 222 Fm 1077 Bandera, TX 78003	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICI (Each deficiency must be preceded by fi		CIENCIES full regulatory or LSC identifying informati	on)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a text message dated Sunday, 12/20/2020 between the Speech Pathologist to the Administrator revealed a message that read: Hi, Administrator! Sorry to bother you today, but if you have a moment, I'd like to talk to you about something I saw today at the facility. There was no response from the Administrator via text. During an interview on 5/14/2021 at 1:15 p.m., the Administrator stated she was not aware an any grievand from the Speech Pathologist or anyone else regarding CNA A and CNA B abusing or mistreating Resident		
	 #1 prior to surveyor intervention. The Administrator stated she had no concerns about the way staff talk to Resident #1. 2. Record review of a face sheet for Resident #2, dated 5/13/2021, revealed a [AGE] year-old-female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic systolic congestive heart failure, major depressive disorder and hypothyroidism. 		
	Record review of Resident #2's quarterly MDS, dated [DATE], revealed that the resident had a BIMS' score of 12 which indicated a moderate cognitive impairment without signs and symptoms of delirium, psychosis or other behaviors. Resident #2 required the assistance of 1-2 staff members for care.		
	Record review of a facility grievance dated 5/4/2021 revealed a family member of Resident #2 called and said Resident #2 needed to be changed since beginning of shift and stated CNA D just turns off light and (unknown staff) promised to change but did not. The Administrator signed the document and dated it as received on 5/04/2021. The document indicated Resident #2 was unhappy when NA C and CNA D care for her and yells at them to get out of her room. The plan to resolve the grievance was to move Resident #2 to a different hallway.		
	200-hallway because she wanted to assholes to me. Resident #2 stated She stated, she would rather not gi Resident #2 stated she had the Ad	t 1:41 p.m., Resident #2 stated she mo o get away from CNA C and CNA D. S I NA C and CNA D also didn't do what ve any further details because she was ministrators cell phone number and trie nformed them of what had occurred.	he stated, They are real mean they were supposed to do for her. s afraid of what would happen.
	During an interview on 5/12/2021 at 5:31 p.m. RN N stated Resident #2 complained about not being changed in a 4-hour window and also complained that CNA D was rude (date unknown). The Resident's family member also called upset. RN N stated he notified the Administrator via telephone that Resident #2 had said staff was rude. He stated he didn't know how the Administrator responded.		
	During an interview on 5/12/2021 at 6:34 p.m., the DON stated Resident #2 first had issues with NA C brother who no longer works at the facility. The DON stated she honored Resident #2's request to not work with him. Then Resident #2 complained NA C was too rough (unknown date and time). Resident #2 has also complained about care from CNA D and doesn't want either NA C or CNA D to care for her. The DON stated she communicated with the Administrator Resident #2's concerns (unknown date and unknown time).		
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NAME OF PROVIDER OR SUPPLIE		B. Wing	05/20/2021
NAME OF PROVIDER OR SUPPLIER Bandera Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZI 222 Fm 1077 Bandera, TX 78003	P CODE
For information on the nursing home's p	plan to correct this deficiency, please cont	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by f		IENCIES full regulatory or LSC identifying informati	on)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	upset and stated a mother and son light from her and treating her bad. assured him NA C and CNA D wou D were again taking care of Reside spoke to the BOM and requested th cared for by NA C and CNA D. The 5/12/2021. During an interview on 5/13/2021 a that staff (unknown) kept turning off stated the resident's called and spo facility to see the resident. The BOI she walked straight from the conve concern. The BOM stated the Admit things. The BOM stated to the Admit things an interview on 5/14/2021 a staff not answering a call light or tur Administrator stated RN G called her confirmed she also spoke with Resi	t 9:28 p.m., Resident #2's family memb staff members (NA C and CNA D) wer The family member stated he called th Id be removed from caring for Residen nt #2. The family member stated he ca hat Resident #2 be moved off of the 30 family member stated the Administrate t 4:13 p.m., the BOM confirmed Reside f her call light when she put them on w ke to her and was very upset about the VI stated immediately after finishing the resation to the Administrator's office and nistrator responded by stating, Reside inistrator, I know, but I feel like we hav t 1:18 p.m., the Administrator stated ar rning it off without attending to the reside er at home and stated Resident #2 was ident #3's family member who was rea	re taking away the resident's call the facility and spoke to RN G who it #2. The next day, NA C and CN/ illed again called the facility and 0-hallway so that she would not be or did not return his calls until ent #2 complained on 5/06/2021 ithout assisting her. The BOM e incident and then came to the e conversation with Resident #3, d informed her of Resident #3's nt #3 isn't happy about a lot of e to do something. In example of abuse/neglect was dent leaving them soiled. The s not soiled. The Administrator Ily upset. The Administrator
	knowing that RN G had been in the another resident was not neglect. T The Administrator stated she wante call her a liar, but she sees things of Administrator stated she had Resid Resident #2 was content on the new better on the new hallway. When as hallway away from NA C and CNA Their voices were not so stern. The such a manner with a stern voice. T Survey Agency (HHS) because the 3. Record review of a face sheet for	t staff would change Resident #3 imme resident room and the resident was ju he Administrator stated she felt like Re ed to see if what the resident reported y lifferently. I do not have staff here who ent #2 moved to a different hallway aw w hallway. The Administrator stated Re sked why she thought Resident #2's be D? The Administrator stated that the n Administrator confirmed she herself w The Administrator stated she did not re resident didn't say she felt like she hav r Resident #3, dated 5/13/2021, reveal	st waiting for a CNA to finish with esident #3 tended to exaggerate. was true and stated I do not want i would ignore a resident. The ray from NA C and CNA D and esident #2's behaviors were much ehaviors would improve on a new ew staff baby Resident #2 more. rould not want to be spoken to in port the incident to the State d any harm. ed a [AGE] year-old female
	hemiparesis following cerebral infai side of the body caused by damage	nd readmitted on [DATE] with diagnose rction affection left non-dominant side (e to the brain from a stroke), major dep arterly MDS dated [DATE], revealed the	weakness and paralysis on the learnession and anxiety disorder.
	which indicated a moderate cognitiv	reinpairment without the signs and sy ed the assistance of 1-2 staff for care.	mptoms of delirium, psychosis or

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NAME OF PROVIDER OR SUPPLIER Bandera Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZI 222 Fm 1077 Bandera, TX 78003	P CODE
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(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by the second		CIENCIES full regulatory or LSC identifying information)	
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	 CNA B had made {an} ugly comme grievance was made and signed by signed off on the grievance as resc. During an interview on 5/12/2021 a been rough with care since she ma A would not get me out of bed whe nobody comes, you know why. Resc B because she was already caused emotional with tears and added, I c off my feet and puts the blanket wh air-conditioning). She takes my (foo finished (with the food) but I know t talked to CNA B, I get attitude from loud noise because I am scared it's pain. I want to ask for someone els and I will have to sit in my own was to the DON about them. During an interview on 5/12/2021 a approximately 2 weeks ago, Reside told her to chop off her leg becauses she was going to cry when she told to straighten her contractured leg a #3 keeps talking about it. CNA B st she was going to report the incident Administrator and added I am a sin During an interview on 5/12/2021 a 4/30/2021, CNA B told the resident contracture of the leg that was caus the DON on 4/30/2021 via telephor was just a joke. The DON gave LVI apologize. During an interview on 5/12/2021 a upset about a comment CNA B ma you need to cut if off. The DON sta LVN G and CNA B she decided to 	t 10:55 a.m. on the 300-hallway with R de a complaint about CNA A's mother, n asked for assistance and stated, If yo sident #3 stated she did not want to talk d enough trouble by making the compla annot do anything to suit, CNA B. She ere I can't reach it. She says I am freez od) tray away before I am done with my better than to say no. She will take my f CNA A. I feel terrorized. CNA B is alwa e her. When asked if she felt safe, Resid e (to provide care) but I am afraid If I sa te. Resident #3 she had reported her c t 2:34 p.m., Restorative Aide MM state e it was contracted. Restorative Aide MI I the aide about the incident. She further nd even though it's been a couple of w ated she reported it to LVN G who was t. Restorative Aide MM stated the Abus	he should just chop it off. The to herself on 5/03/2021. The DON esident #3 who stated CNA A had CNA B. Resident #3 stated, CNA on push the button (call light) and c about the complaint against CNA int. The resident became constantly takes the little blanket zing out my roommate (with the of food. CNA B asked me if I am food anyway. Since they (unknown) ays yelling. I jump when I hear any dent #3 stated, I know there will be ay anything I won't get changed concerns to LVN G and had talked d on an unknown date e rough with her and that CNA B M stated Resident #3 looked like er stated the resident tries very hard eeks since the incident, Resident the Charge Nurse who responded se Coordinator was the informed her on 5/1/2021 that on of a bother than a help due to a orted the complaint immediately to A B didn't mean it seriously and it the Resident #3's and have CNA B had reported that Resident #3 was IA B stated This darn leg of yours, he DON stated after talking to both This occurred over the weekend

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	676233	B. Wing	05/20/2021
NAME OF PROVIDER OR SUPPLIE	NAME OF PROVIDER OR SUPPLIER		P CODE
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For information on the nursing home's	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)		on)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/12/2021 at 2:29 p.m., the Administrator confirmed she was previously aware and had been informed that Resident #3 was upset that CNA B told her to cut off her leg. She stated she did not know who informed her or when she was informed. The Administrator stated reminded Resident #3 that she plays around with talking about her leg and the resident responded with Yeah, but I wasn't playing that day. is not funny, and I do not want to play like that. The Administrator asked Resident #3 again if she thought CNA B was mean or joking and the resident replied joking. She asked Resident #3 if she felt unsafe and the resident replied no. The Administrator confirmed she did not report this incident to the State Reporting Agency (HHS) because the resident was fine with the incident and understands it was a joke. The Administrator stated she did not feel like it was abuse.		
	complained about CNA A, CNA B a had complained about the resident. The Speech Pathologist stated she protect the resident. The Speech P the grievance to the Administrator p she turned it in. The Administrator l resident. The Speech Pathologist id	Ind NA C. Specifically Resident #3 con s bowel movements and stated, this is filled out a grievance form and listed th athologist stated she signed her own n bersonally on 4/19/2021. The Administr ater called her back into the office and Jentified Resident #3. The Administrato filter them because sometimes certain	nplained that CNA A and CNA B fucking bullshit, I am tired of this. he resident as anonymous to try to ame on the grievance and handed rator stated Thank you at the time stated she needed the name of the pr responded with, Okay, I just
		om the Rehabilitation Director and the dministrator wanted to talk to you abou	
	complaint from the Speech Therap	t 1:15 p.m., the Administrator stated sh st regarding Resident #3 or any other i complaints were abuse and therefore irveyor intervention.	resident. The Administrator stated
		ace sheet, dated 5/15/2021 revealed a oses which included chronic obstructive disturbance and colostomy status.	
		arterly MDS dated [DATE] revealed a B sident #4 required the assistance of 1	
	female staff members, identified as description), were rough when they asked the two CNA's to slow down	t 10:50 a.m. on the 300-hallway with R mother daughter and mother, CNA A provided care (unknown dates and tim and be careful, but she received no ve d anyone because she was afraid to sa	and CNA B (also identified by nes). Resident #4 stated she had rbal response to her request.
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2021
NAME OF PROVIDER OR SUPPLIER Bandera Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZI 222 Fm 1077 Bandera, TX 78003	P CODE
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			agency.
(X4) ID PREFIX TAG	AG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/14/2021 a surveyor that Resident #4 had state The Administrator stated during the fast. Administrator stated sinu think there was any abuse and ther surveyor intervention. 5. Record review of Resident #5's fit the facility on [DATE] with diagnose cerebral infarction. Record review of Resident #5's qua moderate cognitive impairment with psychosis or other behaviors. Reside During an interview on 5/12/2021 a like living at the nursing facility and hurts my roommate when providing out that she was being hurt when C names) said she was fat when prov talked to the DON at one time abou She stated, the DON stated becaus feel bad. Resident #5 stated she wa head to the side and refused to ans During an interview on 5/14/2021 a abuse to the State Survey Agency uf from this surveyor that CNA A was stare and then eventually stated CN said ow and no during care by CNA to cognitive status, but sometimes i the roommate if she felt safe and sh to come to her for any concerns. 6. Record review of Resident #6's for on [DATE] with diagnosis which inc unspecified fracture of the shaft of 1 Record review of Resident #6's adr resident was completely cognitively Record review of Resident #6's adr	t 2:34 p.m., the Administrator stated aff ad CNA A and CNA B were rough with interview Resident #2 did not use the ed her if she felt safe, she said yes, CM ce Resident #4 did not use the word ro efore did not report the allegations to the ace sheet, dated 5/16/2021 revealed a as which included major depressive dis- arterly MDS dated [DATE] revealed a B in inattentiveness (difficulty focusing atted bent #5 required the assistance of 1-2 st t 10:34 a.m., on the 300-hallway with F didn't feel safe. Resident #5 stated CN care (unknown date and time). Reside NA A was taking care of her. She also iding care and that makes her feel bad t the rough care but did not remember se she was fat, the care may be rough v as afraid of getting in trouble for talking wer further questions. t 2:34 p.m., the Administrator confirmed (HHS) because she interviewed Reside to answer simple questions. The A was rough with her roommate. Re A. The Administrator confirmed the ro s able to answer simple questions. The ne responded with oh yeah. The Admini ace sheet, dated 5/15/2021, revealed a luded type 2 diabetes mellitus with dial numerus and polyneuropathy. nission MDS, dated [DATE] revealed a with diagnoses which included: cerebra	ter receiving information from this care, she interviewed Resident #4. word rough, she said they were VA A and CNA B just need to slow ugh during the interview, she didn't he State Reporting Agency until [AGE] year-old-female admitted to order recurrent, heart failure, and IMS' score which indicated a ention) without symptoms of staff members for care. Resident #5 who stated she didn't IA A was rough with me and he ent #5 stated Resident #16 cried stated staff (refused to give I. Resident #5 stated she had when this conversation occurred. which in turn made the resident to this surveyor and turned her ent #5 after receiving information ted the resident gave her a blank seident #5 stated the roommate ommate was not interviewable due a Administrator stated she asked nistrator stated she told Resident #5 an [AGE] year-old-female, admitted betic chronic kidney disease, BIMS' score which indicated the [AGE] year-old-female admitted on al aneurysm, occlusion and
	resident had a moderate cognitive i (continued on next page)	mpairment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIE Bandera Nursing & Rehabilitation	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing STREET ADDRESS, CITY, STATE, ZI 222 Fm 1077 Bandera, TX 78003	(X3) DATE SURVEY COMPLETED 05/20/2021 P CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	 Monday 5/3/2021. Resident #6 statt call lights, when the staff would con Resident #6 stated she needed hell that she screamed at him to get out and because he shook her roomma Resident #6 informed the Speech F comfortable reporting it. The Speec previously been instructed to do an Speech Pathologist stated the Adm During an interview on 5/14/2021 at or concern from the Speech Pathologist stated the Adm. During an interview on 5/12/201 at CNA A, CNA B, NA C and CNA D. with the Administrator. The DON fur abuse. She stated she was trained DON stated, she communicated free During an interview on 5/12/2021 at of abuse including abuse to Reside Administrator denied knowledge of We see so much from Resident #7 -Resident #3 has behavior problem culture here is different -CNA A and CNA B are my best wor being seen by psych for behaviors. Record review of TULIP on 5/13/20 allegations of abuse concerning Re 	t 2:27 p.m., the Speech Pathologist state of that the weekend had been terrible ne, she would ask for assistance and the p in the bathroom and NA C came into the because she didn't want NA C to take the Resident #7 right before Resident # Pathologist she didn't tell anyone about h Pathologist stated she had filled out d on 5/03/2021 put it directly on top of inistrator did not follow up with any que t 1:15 p.m., the Administrator stated she ogist or anyone else regarding Resider of reported the incident prior to surveyu 6:34 p.m. the DON stated she had record The DON stated these complaints were rither stated she did not feel like any of to report any suspicion of abuse imme quently throughout the day with the Add t 7:00 p.m. the Administrator was notifi nt #1, #2, #3, #4, and #5 by CNA A, CI all allegations of abuse. The Administr 1. He makes false allegations. s. I think she is prejudice. She is one of wants to lie in her bed and not eat. I se I'm sorry but I don't think her complain 21 at 11:00 a.m. revealed the facility h sident #1, #2. #3, #4, #5, #6, or #7 whi reported to the Administrator by reside	because staff had been ignoring he staff would never come back. her room. Resident #6 reported care of her because he was male 7 had to go to the hospital. the incident because she wasn't a grievance which she had the Administrator's desk. The estions. He was not aware an any grievance of the or Resident #7 prior to or intervention. eived multiple complaints about e discussed in morning meetings the resident complaints were diately to the Administrator. The lministrator. ed of multiple resident allegations NA B, NA C and CNA D. The ator stated: f the 'City Name Locals'. The ts. They don't baby the residents. e her several times a day. She is t has any teeth. ad not self-reported any of the ch were reported to the

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, Bandera Nursing & Rehabilitation 222 Fm 1077 Bandera, TX 78003	CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC iden	ntifying information)
 F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some During an interview on 5/13/2021 at 12:42 p.m., the Admin 5/12/2021 affer being informed of the allegations of abuse 300-hallways. As a result, she was going to split up CNA A have them work in separate hallways instead of together or reminded staff and resident that she is the Abuse Coordin reminded staff and resident that she is the Abuse Coordin reminded staff and resident that she is the Abuse Coordin reminded staff and resident that she is the Abuse Coordin reminded staff and resident that she is the Abuse Coordin reminded staff and resident that she is the Abuse Coordin reminded staff and resident that she is the Abuse Coordin reminded staff and resident that she is the Abuse Coordin reminded staff and resident that she is the Abuse Coordin reminded staff and resident that she is the Abuse Coordin reminded staff and resident that she is the Abuse Coordin they wanted to that about. The ADON stated she theought 1 miscommunication between staff and residents, and she to witnessed abuse or had abuse reported to her. During an interview on 5/14/2021 at 11:35 a.m., the DON facility abuse policy. She stated she had been trained to resident was asafe, initiating the investigation of the comple and then the Administrator stated was monitored the ADON direct supervisor, but this monitoring was not despately for monitoring the nursing team. The DON or resident swas not acceptable. The rounds were not being performed. During an interview on 5/14/2021 at 12:40 p.m. the Admin and stated a grievance is something that can be fixed and that caused harm or is not right. An incident that needs to Neglect is interview on sing that can be fixed and that caused harm or is not right. An incident that heeds is the did not have proof the allegations were truthful. The A with Corporate who agreed not to report. (continued on next page) 	histrator stated she stayed at the facility last on and interview residents who were awake on the and CNA B and split up NA C and CNA D and in the same hallway. The Administrator also ator and gave an in-service called soft touch onfirmed she did not report to the State Survey her on 5/12/2021 because she did not believe the confirmed she had not performed Guardian Angel the didn't think she would be able to provide a Rounds had been performed for the month of m. The ADON stated the Guardian Angel Rounds as and see if they had any concerns or anything he IJ the current resident complaints were a ased on opinion of the fact that she had never stated she had read and was familiar with the aspond to a abuse complaint by ensuring the int, reporting to the Administrator any complaint isions about reporting to State Agencies. The DON confused about why the IJ situation had occurred. Is and it was concerning that staff and residents by her niece, the ADON and confirmed she was bocumented. The DON stated it was ultimately her onfirmed the Guardian Angel Monitoring of stated not performing Angel rounds and checking e DON confirmed she was the Abuse Coordinator did not cause harm. An allegation is something be reported is intentional. Abuse is intentional. Is the facility abuse policy. When she received an or reports the allegation to the State Survey Agency ow the report to the State Survey Agency because

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building	(X3) DATE SURVEY COMPLETED
	676233	B. Wing	05/20/2021
NAME OF PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZI	P CODE
Bandera Nursing & Rehabilitation		222 Fm 1077 Bandera, TX 78003	
For information on the nursing home's	plan to correct this deficiency, please cont	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	assigning and reviewing Guardian A with the DON. The Administrator co completed on a daily basis by her m The Administrator stated, Guardian team was assigned 5 resident room the resident in their room and check environmental concerns. The Admin week, but was unsure which staff m told them it had to be done. She mo confirmed it was her responsibility t completed, The Administrator state During an interview on 5/14/2021 a or way to document allegations of a	t 12:55 p.m. the Administrator stated sl Angel Rounds, by working on the floor onfirmed she was aware that Guardian nanagement team but did not reveal ho Angel Rounds was a program in which is in which to check in with each day. T k to see if the resident had any concerr nistrator stated she had re-assigned th ionitored the 300-hallway. The Adminis onitors the monitoring notes for any cor o monitor staff and ensure the Guardia d, I know my employees pretty well and t 1:09 p.m. the Administrator confirmed abuse or completed investigations to giv of allegations of abuse she replied, all a D]	with staff and by communicating Angel Rounds were not being by long it had not been completed. In a member of the management The Angel was supposed to contact is and see if there were any e Guardian Angel Assignments this strator stated she talked to staff and incerns. The Administrator in Angel Rounds were getting d did not have any concerns.

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NAME OF PROVIDER OR SUPPLIERSTREET ADDRESS, CITY, STATE, ZIP CODEBandera Nursing & Rehabilitation222 Fm 1077 Bandera, TX 78003		P CODE	
For information on the nursing home's p	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG		JMMARY STATEMENT OF DEFICIENCIES ach deficiency must be preceded by full regulatory or LSC identifying information)	
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	 Respond appropriately to all alleger **NOTE- TERMS IN BRACKETS H Based on interview and record review were thoroughly investigated, failed residents (Resident #1, #2, #3, #4, The Administrator, who is the Abus potential abuse and mistreatment b them to have direct contact with the 1. The Speech Pathologist reported face, yell and then aggressively rem 2. Resident #2, a family member, R off Resident #2's call light without a 3. Resident #3 reported CNA B told emotional distress and depression for the fact of the	d violations. AVE BEEN EDITED TO PROTECT Co ew, the facility failed to ensure that all a I to take corrective action and prevent if #5, #6 and #7) reviewed for abuse: e Coordinator, failed to thoroughly inver- y allowing the alleged perpetrators to re- residents while the investigation proce- I to the Administrator that she had with nove the resident's hand from the when the resident's hand from the when the resident resulting in emotion I her to cut off her leg if it was causing to the resident. of abuse when she reported CNA A and of abuse when she reported NA C was of physical abuse when she reported the nal distress to Resident #6. entified and the Administrator was notifieremained out of compliance at a severi I monitoring the effectiveness of the PI ho made outcries of abuse and placed	ONFIDENTIALITY** 38511 alleged violations involving abuse further potential abuse for 7 of 7 estigate and prevent further remain in the facility and allowed ess was occurring when: essed CNA B get in Resident #1's elchair. hinistrator that CNA D had turned on distress to Resident #2. her so much pain which resulted in d CAN B were rough with care. erough with care for herself and her hat CNA C shook her roommate out fied on 5/14/2021. While the IJ was ty level of actual harm and a scope an of Removal. them at risk for continued and/or

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	 which indicated the resident was seafter minutes, had no documented a fitter minutes, had no documented a Record review of Resident #1's Carresident had an impaired cognitive required staff to present just one the During an interview on 5/12/2021 a source) that Resident #1 complaine (5/8/2021-5/9/2021). LVN G stated That's hard to prove, it could have the During an interview on 5/12/2021 a mannerisms and speech in which h interviewed due to his intellectual d During an interview on 5/14/2021 a of abuse or mistreatment of Residee LVN G informed her Resident #1 st and he said someone touched his h confirmed she did not suspend CN/ interview other residents or additior concern. The DON stated several rethem loud and the Administrator ha indicated Resident #1 had behavior if she notified the Administrator. The immediately. During an interview on 5/13/2021 a 300-hallway on 12/20/2020 near the Resident #1. The Speech Patholog Resident #1 in an aggressive manner B got in Resident #1's face, yell at twitnessed CNA B aggressively rem 3 feet away and a MA (unknown) w saw she was being observed. Appr said something to Resident #1. The going back and forth with the reside Administrator when the incident occher back within 30 minutes of the nr CNA B. Thank you for letting me km 	t 5:25 p.m., with Resident #1 revealed re repeated what was spoken to him. R	nable to recall words and phrases of 1-2 staff members for care. revised on 4/01/2020 revealed the <i>i</i> th impaired decision making and a time. during change of report (unknown ver the weekend 21. The DON responded with the resident had childlike Resident #1 was unable to be t have any knowledge of complaint Monday, 5/10/2021. On 5/10/2021 stated she talked to Resident #1 show Resident # 1 . The DON during the investigation and did not would have reported it if they had ut CNA A and CNA B talking to e to talk to them about it. The DON DON stated she does not remember t abuse to the Administrator ated she was standing in the eone talking aggressively to obtion and witnessed CNA B tell not want to go to his room, so CNA ident's wheelchair. She also elchair. CNA A was observing from I what she was doing when she is sitting at the nurse's station and hen responded with yes and kept Pathologist stated she informed the 0 via text. The Administrator called been getting some complaints about e had never been asked to write a

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	DEFICIENCIES ded by full regulatory or LSC identifying information)	
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administrator revealed a message moment, I'd like to talk to you abou Administrator via text. During an interview on 5/14/2021 a	ated Sunday, 12/20/2020 between the that read: Hi, Administrator! Sorry to be t something I saw today at the facility.	other you today, but if you have a There was no response from the ne was not aware an any grievance
	#1 prior to surveyor intervention, so	rone else regarding CNA A and CNA B o she had not investigated or removed she had no concerns about the way sta	any staff from contact with the
	of abuse or mistreatment of Reside LVN G informed her Resident #1 st and he said someone touched his h indicated Resident #1 had behavior an investigation or remove any staf	t 5:44 p.m. the DON stated she did not nt #1 except a report she received on ated CNA B pulled his hair . The DON hair. The DON stated you just have to H is and repeated things he heard. The E f from contact with the Resident. The E e DON stated she was trained to repor	Monday, 5/10/2021. On 5/10/2021 stated she talked to Resident #1 know Resident # 1. The DON DON confirmed she did not perform DON stated she does not remember
	admitted to the facility on [DATE] a	r Resident #2, dated 5/13/2021, reveal nd readmitted on [DATE] with diagnosi ressive disorder and hypothyroidism.	
	which indicated a moderate cognitiv	arterly MDS, dated [DATE], revealed th ve impairment without signs and symple assistance of 1-2 staff members for c	toms of delirium, psychosis or othe
	200-hallway because she wanted to assholes to me. Resident #2 stated She stated, she would rather not gi Resident #2 stated she had the Adu	t 1:41 p.m., Resident #2 stated she mo o get away from CNA C and CNA D. S I NA C and CNA D also didn't do what ve any further details because she was ministrators cell phone number and trie nformed them of what had occurred.	he stated, They are real mean they were supposed to do for her. s afraid of what would happen.
	changed for a 4-hour window and a had a hard time believing it was tru room and Resident #1 had never sa stated he notified the Administrator didn't know how the Administrator r	t 5:31 p.m. RN N stated Resident #1 cd also complained that CNA D was rude of e because he had been up and down t aid anything to me about it prior. The R via telephone that Resident #2 had sa responded. RN G confirmed he had con ity computerized training program. He to the Administrator.	(date unknown). RN N stated he he hallway and into the resident tesident's son called upset. RN N id staff was rude. He stated he mpleted abuse training upon hire
	(continued on next page)		

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	676233	B. Wing	05/20/2021
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	ENCIES ull regulatory or LSC identifying information)	
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	member who no longer works at the with him. Then Resident #2 complained complained about care from CNA E confirmed she did not perform an in Resident #2's concerns (unknown of During an interview on 5/13/2021 a upset and stated (NA C and CNA E The family member stated he called be removed from caring for Residen #2. The family member stated he ca Resident #2 be moved off of the 30 family member stated the Administr During an interview on 5/13/2021 a that staff (unknown) kept turning off stated the resident's called and spo facility to see the resident. The BOI she walked straight from the conver concern. The BOM stated the Administr hings. The BOM stated to the Administr During an interview on 5/14/2021 a grievance. The DON stated she wa DON stated she assumed Resident she was not aware of a call light iss resident. The DON stated she does	t 9:28 p.m., Resident #2's family member were taking away the resident's call light the facility and spoke to RN G who as and #2. The next day, NA C and CNA D alled again called the facility and spoke 0-hallway so that she would not be car rator did not return his calls until 5/12/2 t 4:13 p.m., the BOM confirmed Reside ther call light when she put them on wi ke to her and was very upset about the 4 stated immediately after finishing the resation to the Administrator's office and nistrator responded by stating, Resider inistrator, I know, but I feel like we have t 11:25 a.m., the DON confirmed she w s clocking out and going home and saw #2 had been changed and the situation us of complaint about staff turning off to n't investigate if she feels like she can omeone hit me that would be a completion.	Resident #2's request to not work ate and time). Resident #2 has also D to care for her. The DON municated with the Administrator oper stated Resident #2 had called ght from her and treating her bad. ssured him NA C and CNA D would were again taking care of Resident to the BOM and requested that ed for by NA C and CNA D. The 021. ent #2 complained on 5/06/2021 tithout assisting her. The BOM e incident and then came to the conversation with Resident #3, d informed her of Resident #3's in t #3 isn't happy about a lot of e to do something. was aware of Resident #2's w CNA D with a Hoyer lift. The on was resolved. The DON stated the call light without assisting the resolve a problem. If a resident

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	staff not answering a call light or tur Administrator stated RN G called he confirmed she also spoke with Res soiled and call lights turned off. The Resident #2 immediately. The Adm the resident was just waiting for a C stated she felt like Resident #2 tend resident reported was true and stat have staff here who would ignore a different hallway away from NA C a Administrator stated Resident #2's thought Resident #2's behaviors wo Administrator stated that the new si Administrator stated she did not tak interview other staff who might have she felt like she had any harm and 3. Record review of a face sheet for admitted to the facility on [DATE] an hemiparesis following cerebral infan side of the body caused by damage Record review of Resident #3's qua indicated a moderate cognitive imp behaviors. Resident #3 required the Record review of a facility grievanc CNA B had made {an} ugly comme	e, dated 5/01/2021 revealed Resident and nt about her leg not working and that s the DON who assign the investigation	dent leaving them soiled. The s not soiled. The Administrator Ily upset about the resident being member that staff would change d been in the resident room and not neglect. The Administrator ated she wanted to see if what the ne sees things differently. I do not had Resident #2 moved to a nt on the new hallway. The w hallway. When asked why she om NA C and CNA D? The se were not so stern. The th a manner with a stern voice. The ff from contact with the resident, its because the resident didn't say ievance. ed a [AGE] year-old female se which included hemiplegia and weakness and paralysis on the left ression and anxiety disorder. e resident had a BIMS' score which hs of delirium, psychosis or other #3 voiced to nurse, LVN G that he should just chop it off. The

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	676233	B. Wing	05/20/2021	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	STREET ADDRESS, CITY, STATE, ZIP CODE	
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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	 been rough with care since she ma A would not get me out of bed when nobody comes, you know why. Res B because she was already caused do anything to suit, CNA B. She coi- can't reach it. She says I am freezir away before I am done with my foo to say no. She will take my food an feel terrorized. CNA B is always yel When asked if she felt safe, Reside provide care) but I am afraid If I say Resident #3 she had reported her of During an interview on 5/12/2021 a approximately 2 weeks ago, Reside told her to chop off her leg because she was going to cry when she told to straighten her contractured leg a #3 keeps talking about it. CNA B st she was going to report the inciden Administrator and added I am a sin During an interview on 5/12/2021 a 4/30/2021, CNA B told the resident contracture of the leg that was caus the DON on 4/30/2021 via telephor was just a joke. The DON gave LVI apologize. During an interview on 5/12/2021 a upset about a comment CNA B ma you need to cut if off. The DON state on Monday (unknown date). The Di- situation. CNA B stated she was pla or remove her from resident care w not interview other staff or resident. 	t 10:55 a.m. on the 300-hallway with R de a complaint about CNA A's mother, n asked for assistance and stated, If yo ident #3 stated she did not want to talk a enough trouble by making the complain istantly takes the little blanket off my fe ng out my roommate (with the air-condid d. CNA B asked me if I am finished (wi yway. Since they (unknown) talked to C ling. I jump when I hear any loud noise on #3 stated, I know there will be pain. <i>y</i> anything I won't get changed and I will concerns to LVN G and had talked to the t 2:34 p.m., Restorative Aide MM state ent #3 told her CNA A and CNA B were e it was contracted. Restorative Aide MI the aide about the incident. She further nd even though it's been a couple of w ated she reported it to LVN G who was t. Restorative Aide MM stated the Abus gle mom and I worry about my job. t 1:19 p.m., LVN G stated Resident #3 to cut off her leg because it was more seed by a stroke. LVN G stated she repor- te. The DON responded by stating CN/ N G instructions to go with CNA B into the t 5:44 p.m. the DON confirmed LVN G de about the resident's leg in which CN ted she talked to LVN G and CNA B. The nave CNA B apologize to the resident. d she reported the incident to the Admi ON stated she investigated the situation aying with the resident. The DON confir hile she investigated, did not take any s because Resident #3 was fine with th with CNA B continuing her care and sh	CNA B. Resident #3 stated, CNA by push the button (call light) and c about the complaint against CNA int. The resident added, I cannot bet and puts the blanket where I itioning). She takes my (food) tray th the food) but I know better than CNA B, I get attitude from CNA A. I because I am scared it's her. I want to ask for someone else (to II have to sit in my own waste. In e DON about them. d on an unknown date e rough with her and that CNA B M stated Resident #3 looked like er stated the resident tries very hard eeks since the incident, Resident is the Charge Nurse who responded se Coordinator was the informed her on 5/1/2021 that on of a bother than a help due to a orted the complaint immediately to A B didn't mean it seriously and it the Resident #3's and have CNA B had reported that Resident #3 was IA B stated This darn leg of yours, he DON stated after talking to both This occurred over the weekend inistrator during morning meeting n by talking to CNA B about the rmed she did not suspend CNA B written witness statements and did the kidding. The DON stated she	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2021
NAME OF PROVIDER OR SUPPLIER Bandera Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZI 222 Fm 1077 Bandera, TX 78003	P CODE
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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/12/2021 a had been informed that Resident # know who informed her or when sh plays around with talking about her is not funny, and I do not want to pl CNA B was mean or joking and the resident replied no. The Administra resident care and did not perform a understands it was a joke. The Adr During an interview on 5/13/2021 a complained about CNA A, CNA B a had complained about the resident. The Speech Pathologist stated she protect the resident. The Speech P the grievance to the Administrator I resident. The Speech Pathologist in needed to know because I need to papers. Record review of a text message fr at 4:30 p.m., that read Administrator During an interview on 5/14/2021 a from the Speech Pathologist or any #3 prior to surveyor intervention. Th Speech Pathologist. 4. Record review of Resident #4's ft to the facility on [DATE] with diagno to thrive, dementia with behavioral Record review of Resident #4's qua moderate cognitive impairment. Re During an interview on 5/12/2021 a female staff members, identified as description), were rough when they asked the two CNA's to slow down	t 2:29 p.m., the Administrator confirmer 3 was upset that CNA B told her to cut e was informed. The Administrator stat leg and the resident responded with Y ay like that. The Administrator asked Re- resident replied joking. She asked Re- tor confirmed she did not suspend CN/ in investigation because the resident w ninistrator stated she did not feel like it t 2:27 p.m., the Speech Pathologist sta and NA C. Specifically Resident #3 com s bowel movements and stated, this is filled out a grievance form and listed th athologist stated she signed her own n personally on 4/19/2021. The Administra- ter called her back into the office and dentified Resident #3. The Administrator filter them because sometimes certain om the Rehabilitation Director to the Sp or wanted to talk to you about a grievan t 1:15 p.m., the Administrator stated sh one else regarding CNA A and CNA B he Administrator stated she had never in face sheet, dated 5/15/2021 revealed a pses which included chronic obstructive	d she was previously aware and off her leg. She stated she did not ted reminded Resident #3 that she eah, but I wasn't playing that day. It Resident #3 again if she thought sident #3 if she felt unsafe and the A B from work or remove her from as fine with the incident and was abuse. ted several residents had hplained that CNA A and CNA B fucking bullshit, I am tired of this. he resident as anonymous to try to ame on the grievance and handed rator stated Thank you at the time stated she needed the name of the or responded with, Okay, I just residents fill out a lot of grievance abusing or mistreating Resident received any grievances from the in [AGE] year-old female admitted a pulmonary disease, adult failure with S' score which indicated a staff member for care. Resident #4 stated two morning and CNA B (also identified by hes). Resident #4 stated she had rbal response to her request.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	(unknown date) that CNA A and CN to just humor the two CNA's and sta incident or suspend any staff from o	t 6:34 p.m., the DON stated Resident # NA B would not let her go to bed. The D ay up for just 30 minutes. The DON con contact with the resident. The DON star as was part of her was part of their cu	OON stated she asked Resident #4 nfirmed she did not investigate the ted the two CNA's were Spanish
	surveyor that Resident #4 had state The Administrator stated during the fast. When I asked her if she felt sa Administrator stated since the Resi	t 2:34 p.m., the Administrator stated af ed CNA A and CAN B were rough with e interview Resident #2 did not use the ife, she said yes, CNA A and CNA B ju dent did not use the word rough during vestigate further or suspend any staff f	care, she interviewed Resident #4 word rough. She said they were st need to slow down. The the interview, she didn't think
		ace sheet, dated 5/16/2021 revealed a es which included major depressive dis	
	Record review of Resident #5's quarterly MDS dated [DATE] revealed a BIMS moderate cognitive impairment with inattentiveness (difficulty focusing attention psychosis or other behaviors. Resident #5 required the assistance of 1-2 staft		ention) without symptoms of
		re Plan revealed the resident had made ss the issues with psychological service	
	like living at the nursing facility and roommate, Resident #16 when pro- cried out like she was being hurt wi names) said she was fat when pro- talked to the DON at one time about She stated the DON stated becaus	t 10:34 a.m., on the 300-hallway with F didn't feel safe. She stated NA C was viding care (unknown date and time). F nen NA C was taking care of her. She a viding care and that makes her feel bac ut the rough care but did not remember e she was fat, the care may be rough v fraid of getting in trouble for talking to t urther questions.	rough with me and he hurts my tesident #5 stated Resident #16 also stated staff (refused to give I. Resident #5 stated she had when this conversation occurred. which in turn made the resident fea
	rough care or abuse and did not relinterviewed Resident #5 after receidid not feel like there was any abus eventually stated CNA A was rough during care by CNA A. The Administratus, but sometimes is able to an	t 2:34 p.m., the Administrator confirme move or suspend any staff from contact ving information from this surveyor that se. The Administrator stated the residen with her roommate. Resident #5 state strator confirmed the roommate was no swer simple questions. The Administrator with oh yeah. The Administrator stated	t with Resident #5 because she CNA A was rough with care and the gave her a blank stare and ther d the roommate said ow and no to interviewable due to cognitive tor stated she asked the roommate
	(continued on next page)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	ion)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety	6. Record review of Resident #6's face sheet, dated 5/15/2021, revealed an [AGE] year-old-female, admitted on [DATE] with diagnosis which included type 2 diabetes mellitus with diabetic chronic kidney disease, unspecified fracture of the shaft of humerus and polyneuropathy (fracture of bone of the arm with nerve damage).		
Residents Affected - Some	Record review of Resident #6's add resident was completely cognitively	mission MDS, dated [DATE] revealed a / intact.	a BIMS' score which indicated the
	Monday 5/3/2021. Resident #6 stat call lights, when the staff would cor Resident #6 stated she needed hel that she screamed at him to get ou and because he shook her roomma Resident #6 informed the Speech F comfortable reporting it. The Speec previously been instructed to do an	It 2:27 p.m., the Speech Pathologist sta ted that the weekend had been terrible ne, she would ask for assistance and t p in the bathroom and NA C came into t because she didn't want NA C to take ate Resident #7 right before Resident # Pathologist she didn't tell anyone about ch Pathologist stated she had filled out id on 5/03/2021 put it directly on top of ininistrator did not follow up with any que	because staff had been ignoring he staff would never come back. her room. Resident #6 reported care of her because he was male 7 had to go to the hospital. t the incident because she wasn't a grievance which she had the Administrator's desk. The
	roommate Resident #7 with his har the resident had been hurting and o him she didn't want a man taking c she had asked him to leave the roo back in later. Resident #6 stated sh really hard and fast. Resident #6 bo	t 4:43 p.m., Resident #6 stated NA C on hots because Resident #7 kept pressing crying out. Resident #6 stated NA C wa are of her and didn't feel comfortable w om and get a woman. Resident #6 state he screamed at him and told him to get ecame emotional and started crying an ent #6 stated she didn't report the incio g.	g the call light. Resident #6 stated as also rough with her. She had tol vith a man touching her privately, s ed he left at that time but came out and he pulled her depends up d stated, there might be someone
	[DATE] and readmitted on [DATE] bleeding from the wall of a vein ins	e sheet, dated 5/15/2021, revealed an with diagnoses which included: cerebra ide of the brain), occlusion and stenosi ading into the brain) and age-related p	al aneurysm (weakness and is of left carotid artery (blockage
	· ·	arterly MDS, dated [DATE] revealed a l d a moderate cognitive impairment.	BIMS score of 9 (maximum score
	(continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/13/2021 a for something trivial. I do not really side of her arms and shook me. Re looked at her skin for days and new CNA D used threats and intimidatic the resident that she needed. CNA and slammed out of the room. CNA roommate, Resident #6 had been u #7 stated she was worried about ge During an interview on 5/14/2021 a or concern from the Speech Pathol surveyor intervention, so she had new with the residents. During an interview on 5/12/201 at CNA A, CNA B, NA C and CNA D. with the Administrator. The DON fu abuse. She stated she was trained DON stated, she communicated free During an interview on 5/12/2021 a of abuse including abuse to Reside Administrator denied knowledge of - We see so much from Resident # -Resident #3 has behavior problem culture here is different -CNA A and CNA B are my best wo -Resident #5 is a [NAME] She just being seen by psych for behaviors. Record review of TULIP on 5/13/2021 a members and did not investigate an	t 5:11 p.m. Resident #7 stated NA C grown what I did, but he grabbed my by esident #7 stated NA C lost his cool rearer saw a bruise, so she decided to let i on on her and indicated the threats were. D turned off my call light without doing A D would also refuse to fill the resident upset about the situation and reported in estimation someone in trouble by reporting to the situation and responsible to investigated and had not suspended for the resident to report any suspicion of abuse imme equently throughout the day with the Administrator was notifient #1, #2, #3, #4, and #5 by CNA A, CI all allegations of abuse. The Administrator was notifient #1, #2, #3, #4, and #5 by CNA A, CI all allegations of abuse.	 by upset with me because I asked the shoulders, one hand on each lly easily. Resident #7 stated NA C and e they wouldn't do something for what Resident #7 called her to do s water jug. Resident #7 stated her to someone in therapy. Resident he incident. be was not aware an any grievance at # 6 or Resident #7 prior to d or removed any staff from contact be discussed in morning meetings the resident complaints about e discussed in morning meetings the resident complaints were diately to the Administrator. The lministrator. ed of multiple resident allegations NA B, NA C and CNA D. The ator stated: f the 'City Name Locals'. The ts. They don't baby the residents. e her several times a day. She is t has any teeth. ad not self-reported any of the ch were reported to the ents, family members, BOM or

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0835	Administer the facility in a manner t	that enables it to use its resources effe	ctively and efficiently.
Level of Harm - Immediate jeopardy to resident health or	**NOTE- TERMS IN BRACKETS H	IAVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 38511
Residents Affected - Some	its resources effectively and efficier	Based on interview and record review, the facility failed to be administered in a manner that enablists resources effectively and efficiently to attain or maintain the highest practicable physical, ment psychosocial well-being of each resident for 7 of 15 residents (Residents ##1, #2, #3, #4, #5, #6, reviewed for abuse:	
	The Administrator, who was the fac and procedures when:	ility Abuse Coordinator, failed to incorp	porate the facility's abuse policies
	1. The Administrator failed to identify abuse for Resident's #1, #2, #3, #4, #5, #6, and #7.		
	2. The Administrator failed to Investigate allegations of abuse and failed to protect Resident's #1, #2, #3, #4, #5, #6, and #7 from abuse when she failed to remove the alleged perpetrators from continued access to the residents.		
	An Immediate Jeopardy (IJ) was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of actual harm and a scope of pattern due to the facility still monitoring the effectiveness of the Plan of Removal.		
	These failures resulted in resident abuse, a fear of reporting abuse and a delay in identifying abuse within the facility which caused emotional and psychosocial harm to the residents. The findings were:		
	year-old-male admitted to the facilit syndromes predominantly involving	or Resident #1, dated [DATE] revealed ty on [DATE] with diagnoses that includ I limbs (birth defect primarily affecting t d by episodes of sudden uncontrollable	ded congenital malformation he limbs), pseudobulbar effect (a
	source) that Resident #1 complained	:19 p.m. LVN G stated she learned dur ad that a staff member pulled his hair o DON on [DATE]. The DON responded	ver the weekend ([DATE]-[DATE])
	abuse or mistreatment of Resident informed her Resident #1 stated CI said someone touched his hair. The and CNA B talking to them loudly a	44 p.m. the DON stated she did not ha #1 except a report she received on Mo NA B pulled his hair. The DON stated s e DON stated several residents had ex nd the Administrator had spoken to the Resident #1 had behaviors and repeate	onday, [DATE]. On [DATE], LVN G the talked to Resident #1 and he pressed concerns about CNA A two CNA's in her office to talk to
	(continued on next page)		

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	676233	A. Building B. Wing	05/20/2021
NAME OF PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZI	P CODE
Bandera Nursing & Rehabilitation		222 Fm 1077 Bandera, TX 78003	
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(X4) ID PREFIX TAG	(X4) ID PREFIX TAG (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	 300-hallway on [DATE] near the the #1. The Speech Pathologist looked in an aggressive manner to go to hir oom, so CNA B got in Resident #1 wheelchair. She also witnessed CN was observing from 3 feet away an doing when she saw she was being nurse's station and said something with yes and kept going back and for she informed the Administrator whee Administrator called her back withir some complaints about CNA B. The really shook her. She stated, I have The Speech Pathologist stated she statement and had not been asked Record review of a Provider Investi #1 had confirmed allegations of about CDATE] at 1 unconfirmed instead of confirmed a confirmed she had not interviewed because she didn't feel like it was h Speech Pathologists manager shout Pathologist was required to report a confirm the allegations of abuse be 1b. Record review of a face sheet f to the facility on [DATE] and readm heart failure, major depressive diso Record review of a face sheet f to the facility on [DATE] and readm heart failure, major depressive diso Record review of a facility grievanc Resident #2 needed to be changed (unknown staff) promised to changer received on [DATE]. The document and yells at them to get out of her r different hallway. During an interview on [DATE] at 1 because she wanted to get away fr Resident #2 stated NA C and CNA stated that CNA B was bossy. She afraid of what would happen. Resident #2 needed to be changed of it, but nothing improved. Resident #2 stated NA C and CNA 	49 the Administrator stated she should and indicated confirmed had been mark the Speech Pathologist about her griev ar responsibility. The Speech Patholog ald be the one to interview her. The Ad abuse to the Administrator. The Admini cause there were no other witnesses to or Resident #2, dated [DATE], revealed itted on [DATE] with diagnosis which ir	e talking aggressively to Resident witnessed CNA B tell Resident #1 that he did not want to go to his in moving the resident's is hand from his wheelchair. CNA A way. CNA B stopped what she was later CNA A was sitting at the d with no. CNA A then responded igo. The Speech Pathologist stated or [DATE] via text. The ed, Yeah, we have been getting ch Pathologist stated this incident ut this was to the point of abuse. en asked to give a witness ed event. eyor intervention revealed Resident thave marked the report as ed in error. The Administrator vances and witnessed abuse gist was a contract worker and the ministrator stated the Speech strator stated she was unable to bo confirm. d a [AGE] year-old-female admitted fictuded chronic systolic congestive ber of Resident #2 called and said IA D just turns off light and the document and dated it as then NA C and CNA D care for her a was to move Resident #2 to a d from the 300 to the 200-hallway ey are real mean assholes to me. sed to do for her. Resident #2 also urther details because she was DN who stated she would take care cell phone number and tried to

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	676233	B. Wing	05/20/2021
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Bandera Nursing & Rehabilitation		222 Fm 1077 Bandera, TX 78003	
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(X4) ID PREFIX TAG	ID PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by		on)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	a 4-hour window and also complain time believing it was true because h Resident #2 had never said anythin called and spoke to RN N about the Resident #2 had said staff was rude During an interview on [DATE] at 4: (unknown) kept turning off her call I the resident's family called and spo immediately after finishing the conv the Administrator's office and inform responded by stating, Resident #2 i was the Abuse Coordinator, I know During an interview on [DATE] at 1: not answering a call light or turning Administrator stated RN G called he unknown time). The Administrator of date and unknown time) who was re Administrator stated knowing that Fi CNA to finish with another resident Administrator stated knowing that Fi CNA to finish with another resident Administrator stated she felt like Re see if what the resident reported was differently. I do not have staff here of #2 moved to a different hallway awa hallway. The Administrator stated Fi asked why she thought Resident #2 D? The Administrator stated she herseli The Administrator stated she herseli The Administrator stated she here and asked why she thought Resident #2 D? The Administrator stated she felt like Re asked why she thought Resident #2 D? The Administrator stated she felt file the problem had been resolved as a 1c. Record review of a face sheet for to the facility on [DATE] and readministrators following cerebral infar	31 p.m. RN N stated Resident #2 com ed that CNA D was rude (date unknow he had been up and down the hallway a g to him about it prior. The Resident's concern. RN N stated he notified the <i>A</i> a. He stated he didn't know how the Ad 13 p.m., the BOM confirmed Resident ight when she put the call light on withow ke to her and was very upset about the ersation with Resident #2 she walked s ead her of Resident #2's concern. The isn't happy about a lot of things. The BG , but I feel like we have to do somethin 18 p.m., the Administrator stated an ex- it off without attending to the resident I er at home and stated Resident #2 was confirmed she also spoke with Residen eally upset about the resident being so y member that staff would change Res tN G had been in the resident being so y member that staff would change Res tas true and stated I do not want to call who would ignore a resident. The Admi ay from NA C and CNA D and Residen tesident #2's behaviors were much bet 2's behaviors would improve on a new f enew staff baby Resident #2 more. The f would not want to be spoken to in such to take written statements, or interview lents because the resident didn't say sh a grievance. or Resident #3, dated [DATE], revealed itted on [DATE] with diagnoses which i rction affection left non-dominant side (a to the brain from a stroke), major dep	 m). RN N stated he had a hard and into the resident room and family member was upset when he Administrator via telephone that iministrator responded. #2 complained on [DATE] that staff bout assisting her. The BOM stated a incident, The BOM stated straight from the conversation to BOM stated the Administrator Who g. kample of abuse/neglect was staff eaving them soiled. The s not soiled (unknown date and t #2's family member (unknown iled and call lights turned off. The ident #2 immediately. The d the resident was just waiting for a d complaint as neglect. The dministrator stated she had Resident t #2 was content on the new ter on the new hallway. When hallway away from NA C and CNA heir voices were not so stern. The ch a manner, with a stern voice. Other staff who might have the felt like she had any harm and the a [AGE] year-old female admitted included hemiplegia and weakness and paralysis on the left

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For information on the nursing home's	plan to correct this deficiency, please con	l tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by		CIENCIES full regulatory or LSC identifying information	on)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	 been rough with care since she mad A would not get me out of bed when nobody comes, you know why. Rest B because she had already caused with tears and added, I cannot do a and puts the blanket where I can't r air-conditioning). She takes my (foo finished (with the food) but I know H talked to CNA B, I get attitude from loud noise because I am scared it's pain. I want to ask for someone els and I will have to sit in my own was to the DON about them. During an interview on [DATE] at 2 been informed that Resident #3 wa who informed her or when she was reminded the resident trasponded to play like that. The Administrator the resident replied joking. She ask Administrator stated Resident #3 n Administrator stated based on her of During an interview on [DATE] at 2 about CNA A, CNA B and NA C. Sp complained about the residents boo Speech Pathologist stated she filler protect the resident. The Speech P the grievance to the Administrator p thre scident. The Speech P the grievance to the Administrator p turned it in. The Administrator p turned it in. The Speech Pathologist is needed to know because I need to papers. The Speech Pathologist stated she filler protect the resident on the grievance stated she was not asked to write a Record review of a text message fr 	0:55 a.m. on the 300-hallway with Resi ide a complaint about CNA A's mother, n asked for assistance and stated, If yo sident #3 stated she did not want to talk d enough trouble by making the compla anything to suit, CNA B. She constantly reach it. She says I am freezing out my od) tray away before I am done with my better than to say no. She will take my f CNA A. I feel terrorized. CNA B is alwa sher. When asked if she felt safe, Reside (to provide care) but I am afraid If I sa ste. Resident #3 she had reported her c :29 p.m., the Administrator confirmed s is upset that CNA B told her to cut off h self makes comments about her leg and with Yeah, but I wasn't playing that da asked Resident #3 again if she thought tead Resident #3 if she felt unsafe and th t suspend CNA B from work or remove he resident was fine with the incident an ever used the word abuse and didn't inc conversation with Resident #3 she did n :27 p.m., the Speech Pathologist stated pecifically, Resident #3 complained tha wel movements and stated, this is fucki d out a grievance form and listed the re athologist stated she signed her own n bersonally on [DATE]. The Administrator called her back into the office and stated dentified Resident #3. The Administrator filter them because sometimes certain ated she was never asked to give any a and when she was asked to identify the a written statement and had not been in om the Rehabilitation Director and the for wanted to talk to you about a grievan	CNA B. Resident #3 stated, CNA by push the button (call light) and about the complaint against CNA int. The resident became emotional takes the little blanket off my feet roommate (with the food. CNA B asked me if I am food anyway. Since they (unknown) ays yelling. I jump when I hear any dent #3 stated, I know there will be ay anything I won't get changed oncerns to LVN G and had talked he was previously aware and had er leg. She stated she did not know en she spoke to Resident #3, she d plays around with talking about y. It is not funny, and I do not want c CNA B was mean or joking and he resident replied no. The her from resident care and did not nd understood it was a joke. The dicate she was harmed. The not feel like there was any abuse. A several residents had complained t CNA A and CNA B had ng bullshit, I am tired of this. The sident as anonymous to try to ame on the grievance and handed or stated Thank you at the time she ed she needed the name of the or responded with, Okay, I just residents fill out a lot of grievance additional information other than a resident. The Speech Pathologist terviewed. Speech Pathologist dated [DATE]

F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some During an interview of a Provid revealed the Administrato During an interview of a Provid revealed the Administrato During an interview with th commented to her the cord depressed, thinks about th make a judgement for Res unconfirmed abuse. The A use the word abuse and it Record review of a facility had made {an} ugly comm was made and signed by on the grievance as resolv 1d. Record review of Resi the facility on [DATE] with thrive, dementia with beha During an interview on [D) staff members, identified a rough when they provided CNA's to slow down and b she had not told anyone b During an interview on [D) surveyor that Resident #4 The Administrator stated o CNA's were fast. The Adm CNA B just need to slow of during the interview of a Provided CNA's were fast. The Adm		
Bandera Nursing & Rehabilitation For information on the nursing home's plan to correct this deficiency, p. (X4) ID PREFIX TAG SUMMARY STATEMENT Of (Each deficiency must be pre- leaded to the speech Pathologist) F 0835 During an interview on [D/ from the Speech Pathologist] Residents Affected - Some Record review of a Provider revealed the Administrato During an interview with the completed a grievance at commented to her the correlation of the speech o		ISTRUCTION (X3) DATE SURVEY COMPLETED 05/20/2021
Bandera Nursing & Rehabilitation For information on the nursing home's plan to correct this deficiency, p. (X4) ID PREFIX TAG SUMMARY STATEMENT Of (Each deficiency must be pre- leaded to the speech Pathologist) F 0835 During an interview on [D/ from the Speech Pathologist] Residents Affected - Some Record review of a Provider revealed the Administrato During an interview with the completed a grievance at commented to her the correlation of the speech o	STREET ADDRESS. (CITY, STATE, ZIP CODE
(X4) ID PREFIX TAG SUMMARY STATEMENT ((Each deficiency must be pre- (Each deficiency must be pre- from the Speech Pathologi #3 prior to surveyor intervices Speech Pathologist. Residents Affected - Some During an interview of a Provide revealed the Administrato During an interview of a grievance at commented to her the cor depressed, thinks about th make a judgement for Resi unconfirmed abuse. The A use the word abuse and it Record review of a facility had made {an} ugly commit was made and signed by: on the grievance as resolv. 1d. Record review of Resi the facility on [DATE] with thrive, dementia with behad During an interview on [D/ staff members, identified a rough when they provided CNA's to slow down and b she had not told anyone b During an interview of a provid revealed: Investigative su Administrator had not inclu-		
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some During an interview of a Provid revealed the Administrato During an interview with th commented to her the cor depressed, thinks about th make a judgement for Res unconfirmed abuse. The A use the word abuse and it Record review of a facility had made {an} ugly comm was made and signed by on the grievance as resolv 1d. Record review of Resi the facility on [DATE] with thrive, dementia with beha During an interview on [D) staff members, identified a rough when they provided CNA's to slow down and the she had not told anyone b During an interview on [D) surveyor that Resident #4 The Administrator stated of CNA's were fast. The Adm CNA's byust need to slow of <t< td=""><td>lease contact the nursing home or f</td><td>the state survey agency.</td></t<>	lease contact the nursing home or f	the state survey agency.
Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some During an interview with the completed a grievance at commented to her the cor depressed, thinks about the make a judgement for Resi unconfirmed abuse. The A use the word abuse and it Record review of a facility had made {an} ugly commit was made and signed by on the grievance as resolvant the facility on [DATE] with thrive, dementia with behavior During an interview on [D/ staff members, identified a rough when they provided CNA's to slow down and to she had not told anyone b During an interview on [D/ surveyor that Resident #4 The Administrator stated of CNA's were fast. The Adm CNA B just need to slow of during the interview, she of Record review of a Provid revealed: Investigative sur Administrator had not inclu-	OF DEFICIENCIES eceded by full regulatory or LSC iden	ntifying information)
Residents Affected - Some revealed the Administrato During an interview with the completed a grievance at commented to her the word abuse. The <i>A</i> use the word abuse and it make a judgement for Resident and the facility on [DATE] with thrive, dementia with behad During an interview on [DATE] with thrive, dementia with behad During an interview on [DATE] with thrive, dementia with behad completed and to danyone b During an interview on [DATE] with thrive, dementia with behad not told anyone b During an interview on [DATE] with thrive, dementia with behad not told anyone b During an interview on [DATE] with thrive, dementia with behad not told anyone b During an interview on [DATE] with three doministrator stated of CNA's were fast. The Adm CNA B just need to slow of during the interview, she completed and the interview of a Provide revealed: Investigative sure Administrator had not inclusion.	During an interview on [DATE] at 1:15 p.m., the Administrator stated she was not aware of any grievance from the Speech Pathologist or anyone else regarding CNA A and CNA B abusing or mistreating Reside #3 prior to surveyor intervention. The Administrator stated she had never received any grievances from Speech Pathologist. Record review of a Provider Investigative Report dated [DATE] after surveyor intervention for Resident	
 completed a grievance at commented to her the cordepressed, thinks about the make a judgement for Resunconfirmed abuse. The Ause the word abuse and it Record review of a facility had made {an} ugly commwas made and signed by on the grievance as resolved. 1d. Record review of Resist the facility on [DATE] with thrive, dementia with behat During an interview on [D/staff members, identified a rough when they provided CNA's to slow down and b she had not told anyone b During an interview on [D/surveyor that Resident #4 The Administrator stated of CNA's were fast. The Administrator stated of CNA's were fast. The Administrator stated of CNA's used to slow of during the interview, she of the interview of a Provided conditional condi	der Investigative Report dated [D. r had unconfirmed the allegation	
1d. Record review of Resi the facility on [DATE] with thrive, dementia with beha During an interview on [D/ staff members, identified a rough when they provided CNA's to slow down and b she had not told anyone b During an interview on [D/ surveyor that Resident #4 The Administrator stated of CNA's were fast. The Adm CNA B just need to slow of during the interview, she of Record review of a Provid revealed: Investigative sur Administrator had not inclu-	the time it occurred, but LVN G b mment hurt her feelings. The Adn he comment and then gets depre sident #3, but the resident stated Administrator confirmed the facilit t could absolutely still be abuse. grievance, dated [DATE] revealed nent about her leg not working an the DON who assigned the invest	54 p.m. the Administrator stated the DON had brought it back up because Resident #3 ninistrator stated the resident had moods and gets essed again. The Administrator stated she couldn't she didn't feel abused and that is why she ty abuse policy indicated someone didn't have to ed Resident #3 voiced to nurse, LVN G that CNA E ad that she should just chop it off. The grievance stigation to herself on [DATE]. The DON signed off
staff members, identified a rough when they provided CNA's to slow down and to she had not told anyone b During an interview on [D/ surveyor that Resident #4 The Administrator stated of CNA's were fast. The Adm CNA B just need to slow of during the interview, she of Record review of a Provid revealed: Investigative sur Administrator had not inclu-	ident #4's face sheet, dated [DAT	[E] revealed an [AGE] year-old female admitted to ic obstructive pulmonary disease, adult failure to y status.
surveyor that Resident #4 The Administrator stated of CNA's were fast. The Adm CNA B just need to slow of during the interview, she of Record review of a Provid revealed: Investigative sur Administrator had not inclu	as mother and daughter, CNA A a	allway, with Resident #4 stated two morning female and CNA B (also identified by description), were). Resident #4 stated she had asked the two erbal response to her request. Resident #4 stated lything.
revealed: Investigative sur Administrator had not incl	had stated CNA A and CNA B w during the interview Resident #4 ninistrator stated, when she aske	ator stated after receiving information from this vere rough with care, she interviewed Resident #4. did not use the word rough. Resident #4 said the ed her if she felt safe, she said yes, CNA A and ince the Resident did not use the word rough and did not investigate further.
	mmary unconfirmed. A Review of	ATE] after surveyor intervention for Resident #4 f the supporting documents revealed the facility egative from any of the residents or staff members
evidence of abuse to Resi stated staff were rough an	ident #4. The Administrator confi	01 p.m. the Administrator stated there was no rmed none of the interviews with residents who stigative packet. The Administrator stated those gation
(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2021
NAME OF PROVIDER OR SUPPLIE Bandera Nursing & Rehabilitation	ĒR	STREET ADDRESS, CITY, STATE, ZI 222 Fm 1077 Bandera, TX 78003	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	IENCIES full regulatory or LSC identifying informati	on)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	 the facility on [DATE] with diagnose cerebral infarction. During an interview on [DATE] at 11 the nursing facility and didn't feel sa Resident #16 when providing care as she was being hurt when NA C was was fat when providing care and th one time about the rough care but of stated because she was fat, the car stated she was afraid of getting in t refused to answer further questions. During an interview on [DATE] at 2 Resident #5's concerns because with the Administrator stated although I the Administrator stated although I the Administrator did not feel like the blank stare and then eventually star roommate said ow and no during car interviewable due to cognitive statu stated she asked the roommate if s she told Resident #5 to come to he Record review of a Provider Investif #5 had confirmed allegations of abut During an interview on [DATE] at 1 unconfirmed instead of confirmed a stated she was unable to confirm the abuse. 1f. Record review of Resident #6's on [DATE] with diagnosis which incompare if the staff would come, s Resident #6 stated she needed hel that she screamed at him to get our and because he shook her roommar Resident #6 informed the Speech F comfortable reporting it. The Speece previously been instructed to do an 	34 p.m., the Administrator confirmed s hen she interviewed Resident #5 the re Resident #5 indicated NA C was rough here was any abuse. The Administrator ted CNA A was rough with her roomma are by CNA A. The Administrator confir s, but sometimes is able to answer sim he felt safe and she responded with of r for any concerns. gative Report dated [DATE] after surve	45 stated she didn't like living at le and he hurts my roommate, stated Resident #16 cried out like aff (refused to give names) said she ted she had talked to the DON at on occurred. She stated the DON e resident feel bad. The resident urned her head to the side and he did not thoroughly investigate esident stated she felt safe now. with her roommate, Resident #16, stated the resident gave her a ate. Resident #5 stated the med the roommate was not uple questions. The Administrator in yeah. The Administrator stated eyor intervention revealed Resident thave marked the report as ted in error. The Administrator were no witnesses to confirm [AGE] year-old-female, admitted betic chronic kidney disease, of bone of the arm with nerve d Resident #6 was in tears on ecause staff had been ignoring call taff would never come back. her room. Resident #6 reported care of her because he was male 7 had to go to the hospital. the incident because she wasn't a grievance which she had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIE Bandera Nursing & Rehabilitation For information on the nursing home's		A (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. Building 05/20/2021 B. Wing 05/20/2021 STREET ADDRESS, CITY, STATE, ZIP CODE 222 Fm 1077 Bandera, TX 78003		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)				
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	roommate Resident #7 with his har the resident had been hurting and o him she didn't want a man taking ca she had asked him to leave the roo back in later. Resident #6 stated sh really hard and fast. Resident #6 be that can't stop him like I can. Resid remember because it was upsetting Record review of Resident #7's fac [DATE] and readmitted on [DATE] o bleeding from the wall of a vein insi and narrowing of the main artery le resulting in limitations).	e sheet, dated [DATE], revealed an [A0 with diagnoses which included: cerebra ide of the brain), occlusion and stenosis ading into the brain) and age-related pl	the call light. Resident #6 stated as also rough with her. She had told ith a man touching her privately, so ad he left at that time but came out and he pulled her depends up d stated, there might be someone lent to anyone that she can GE] year-old-female admitted on al aneurysm (weakness and s of left carotid artery (blockage hysical debility (symptoms of aging	
	something trivial. I do not really kno of her arms and shook me. Residen at her skin for days and never saw used threats and intimidation on he resident that she needed. Resident asked the CNA to do and then exite residents water jug. Resident #7 sta	11 p.m. Resident #7 stated NA C got u ow what I did, but he grabbed me by the nt #7 stated NA C lost his cool really ea a bruise, so she decided to let it go. Re r and indicated the threats were they w #7 stated, CNA D turned off her call lig ed the room the room aggressively. CN ated her roommate, Resident #6, had b Resident #7 stated she was worried about	e shoulders, one hand on each side asily. Resident #7 stated she looked esident #7 stated NA C and CNA D youldn't do something for the ght without doing what Resident #7 IA D also refused to fill the been upset about the situation and	
	concern from the Speech Patholog intervention.	:15 p.m., the Administrator stated she v ist or anyone else regarding Resident #	# 6 or Resident #7 prior to surveyor	
	 #7 had confirmed allegations of about the provided state of the provided state	gative Report dated [DATE] after surve use. :49 the Administrator stated she should and indicated confirmed had been mark he allegations of abuse because there w e created after surveyor intervention ar ealed there was a facility complaint Re ed [Staff] need more training on custom //tone of voice/compassionate care. Th hd ask the Ombudsman for culture sen ck monitor. 1 on 1 education for CNA A CNA A, CNA B and NA C providing car	d have marked the report as ted in error. The Administrator were no witnesses to confirm and dated [DATE] after and resolved sidents down the 300-hall. The er service and take more time with e Administrator and DON will sitivity {training} for residents. and NA C. Resident's #3, #4 and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676233	A. Building B. Wing	05/20/2021
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	
Bandera Nursing & Rehabilitation		222 Fm 1077 Bandera, TX 78003	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	 CNA Å, CNA B, NA C and CNA D i had witnessed CNA C get frustratewas a gentle person but became frond does not change the residents where shout and they make the residents and CNA B not to be so mean to peresidents stupid, especially Resider B team up and pick on Resident #1 because his wife had just died and they are mad because of the tone of which he/she was able to understar anonymous resident stated many refrom CNA A and CNA B. Some of the three different nurses (unknown na DON any longer because she says staffing shortage. I told the Administ Resident stated, Sometimes I just of Resident stated it was very importation. During an interview on [DATE] at 6 A, CNA B, NA C and CNA D (unknown in morning meetings with the Administ complaints were abuse. She stated Administrator. The DON stated, she During an interview on [DATE] at 7 abuse including abuse to Resident #3 has behavior problem culture here is different -CNA A and CNA B are my best wo -Resident #5 is a [NAME] She just of the state of the set o	2:45 p.m. an anonymous resident state In the facility who yell and say nasty thind d and lose his cool and lift a resident (u ustrated when his mother CNA D made In they needed changing. CNA A and C jump when they are working. The Resi- exple. CNA B said something bad back In the they took all their frustrations our and say mean and ugly things to him. accidentally soiled himself. CNA A and for- forice they use when they talk, and the nd. They jerk residents around and are esidents complain about the treatment he residents are afraid to shower. The mes) and nobody had done anything to everything is fine and makes excuses strator in [DATE], she talked to CNA D, ry, It feels hopeless. These people sho int for this surveyor to keep his/her ider 134 p.m. the DON stated she had received bown dates and times). The DON stated instrator. The DON further stated she d is he was trained to report any suspicion a communicated frequently throughout 100 p.m. the Administrator was notified #1, #2, #3, #4, and #5 by CNA A, CNA all allegations of abuse. The Administrator 1. He makes false allegations. s. I think she is prejudice. She is one o borkers. They are firmer with the resident wants to lie in her bed and not eat. I se I'm sorry but I don't think her complain	ngs. The Resident stated he/she unknown) too hard. Normally NA A a him do most of the work. CNA D CNA are mean and rough. They dent stated he/she had told CNA A . CNA A and CNA B called the t on Resident #4. CNA A and CNA One time, Resident #15 was crying I CNA B got mad at him. I can tell ley say bad words in Spanish not very discreet about it. The they receive in the shower room Resident stated he/she had told o help. I don't bother talking to the and says it's because of the but things are still the same. The puldn't be treated like this. The trify anonymous because they were wed multiple complaints about CNA these complaints were discussed id not feel like any of the resident us of abuse immediately to the the day with the Administrator. of multiple resident allegations of . B, NA C and CNA D. The ator stated: f the 'City Name Locals'. The ts. They don't baby the residents. e her several times a day. She is

R	STREET ADDRESS, CITY, STATE, ZI	I
NAME OF PROVIDER OR SUPPLIER Bandera Nursing & Rehabilitation		P CODE
plan to correct this deficiency, please con	l tact the nursing home or the state survey a	agency.
		on)
During an interview on [DATE] at 1 CNA B, NA C and CNA D, The DO of the complaints and does not kee she received a report about other s and via text daily throughout the da discuss issues and concerns. During an interview on [DATE] at 12 and stated a grievance is somethin that caused harm or is not right. An Neglect is intentional. The Administ allegation of abuse/neglect or explo stated if the investigation is very cle the results and she documents eve 2a. During an interview on [DATE] at 300-hallway on [DATE] near the the #1. The Speech Pathologist looked in an aggressive manner to go to hi room, so CNA B got in Resident #1 wheelchair. She also witnessed CN was observing from 3 feet away an doing when she saw she was being nurse's station and said something with yes and kept going back and fi she informed the Administrator whe Administrator called her back withir some complaints about CNA B. Tha really shook her. She stated, I have The Speech Pathologist stated she statement and had not been asked Record review of a text message da Administrator revealed a message	1:25 a.m., the DON stated she had rec N stated she doesn't remember who m p a log. She stated never was the word taff. The DON stated she communicate y. The DON stated she communicate g that can be fixed and did not cause h incident that needs to be reported is in trator stated she follows the facility abu- bitation she immediately performs an in ear and there are witnesses and everyt rything. The Administrator stated none at 2:27 p.m., the Speech Pathologist st erapy area when she heard a someone in the direction of the commotion and is room. The resident stated to CNA B 's face, yelled at the resident and bega IA B aggressively remove Resident #1' d a MA (unknown) was also in the halk g observed. Approximately 10 minutes to Resident #1. The resident responde orth with the resident and wouldn't let if an the incident occurred either [DATE] on 30 minutes of the notification and state ank you for letting me know. The Speet e seen and heard harsh voice before, b had not been interviewed, had not beet to give any other details to the witness ated Sunday, [DATE] between the Speet that read: Hi, Administrator! Sorry to bo	eived complaints about CNA A, ade the complaints or the specifics I abuse or disrespect used when ad with the Administrator verbally istrator everything and they she was the Abuse Coordinator arm. An allegation is something itentional. Abuse is intentional. se policy. When she received an vestigation of the allegation. She hing matches up then it shows her of these allegations were abuse. ated she was standing in the talking aggressively to Resident witnessed CNA B tell Resident #1 that he did not want to go to his n moving the resident's s hand from his wheelchair. CNA / vay. CNA B stopped what she was ater CNA A was sitting at the d with no. CNA A then responded go. The Speech Pathologist state or [DATE] via text. The ed, Yeah, we have been getting ch Pathologist stated this incident ut this was to the point of abuse. en asked to give a witness ed event. ech Pathologist to the other you today, but if you have a
	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by During an interview on [DATE] at 1 CNA B, NA C and CNA D, The DO of the complaints and does not kee she received a report about other s and via text daily throughout the da discuss issues and concerns. During an interview on [DATE] at 1 and stated a grievance is somethin that caused harm or is not right. An Neglect is intentional. The Administ allegation of abuse/neglect or explos stated if the investigation is very cle the results and she documents ever 2a. During an interview on [DATE] 300-hallway on [DATE] near the thu #1. The Speech Pathologist looked in an aggressive manner to go to h room, so CNA B got in Resident #1 wheelchair. She also witnessed CN was observing from 3 feet away an doing when she saw she was being nurse's station and said something with yes and kept going back and fi she informed the Administrator whe Administrator called her back withir some complaints about CNA B. Thir really shook her. She stated, I have The Speech Pathologist stated she statement and had not been asked Record review of a text message d Administrator revealed a message	Jan to correct this deficiency, please contact the nursing home or the state survey a SUMMARY STATEMENT OF DEFICIENCIES [Each deficiency must be preceded by full regulatory or LSC identifying informatie CNA B, NA C and CNA D, The DON stated she doesn't remember who m of the complaints and does not keep a log. She stated never was the word she received a report about other staff. The DON stated she tells the Admin discuss issues and concerns. During an interview on [DATE] at 12:40 p.m. the Administrator confirmed s and stated a grievance is something that can be fixed and did not cause h that caused harm or is not right. An incident that needs to be reported is in Neglect is intentional. The Administrator stated she follows the facility abu allegation of abuse/neglect or exploitation she immediately performs an in stated if the investigation is very clear and there are witnesses and every the results and she documents everything. The Administrator stated none 2a. During an interview on [DATE] at 2:27 p.m., the Speech Pathologist st 300-hallway on [DATE] near the therapy area when she heard a someone #1. The Speech Pathologist looked in the direction of the commotion and in an aggressive manner to go to his room. The resident and bega wheelchair. She also witnessed CNA B aggressively remove Resident #1' was observing from 3 feet away and a MA (unknown) was also in the hall doing when she saw she was being observed. Approximately 10 minutes is the informed the Administrator when the incident occurred either [DATE] at some complaints about CNA B. Thank you for letting me know. The Speech Pathologist stated on the she stated, in Administrator called her back within 30 minutes of the notification and state some complaints about CNA B. Thank you for letting me know. The Speech really shock her. She stated, i have seen and heard hard vice before, be The Speech Pathologist stated she had not been interviewed, had not beer really shock her. She stated, i have seen and heard harsh vice before, be The Spee