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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on interview and record review the facility failed to ensure the resident's right to be free from abuse for 12 of 15 residents (Resident #1-7, 12-16) reviewed for abuse: a. CNA B was alleged to get in the resident's face, yell and then aggressively remove the resident's hand from the wheelchair and CNA B was alleged to have pulled Resident #1 hair. b. CNA D was alleged to have turned off the Resident #2's call light without assisting the resident resulting in emotional distress for Resident #2. c. CNA B was alleged to have told Resident #3 to cut off her leg if it was causing her so much pain which resulted in emotional distress and depression to the resident. d. CNA A and CNA B were alleged to have been rough with Resident #4 when providing care. e. NA C was alleged to have been rough with care to Resident #5 and her roommate, Resident #16 which caused the resident to feel bad. f. NA C was alleged to have been rough with care to Resident #6 and shook her roommate, Resident #7 causing emotional distress. g. CNA A and CNA B were verbally and physically aggressive with Resident #13 in the shower room. An Immediate Jeopardy (IJ) was identified on 5/14/2021. While the IJ was removed on 5/20/2021, 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: Record review of a staffing schedule, dated 5/10/2021-5/16/2021 revealed: (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-CNA A and CNA B worked together on the 300-hallway from 6 am-2 p.m. on 5/10/2021, 5/11/2021 and 5/12/2021 and were scheduled to work together on the 300-hallway on 5/14/2021, 5/15/2021 and 5/16/2021. -CNA C and CNA D worked together on the 300-hallway from 2 p.m.-10 p.m. on 5/10/2021, 5/11/2021 and 5/12/201 and were scheduled to work together on the 300-hallway on 5/14/2021, 5/15/2021 and 5/16/2021. a. Record review of a face sheet for Resident #1, dated 5/13/2021 revealed the resident was a [AGE] year-old-male admitted to the facility on [DATE] with diagnoses that included congenital malformation syndromes predominantly involving limbs (birth defect primarily affecting the limbs), pseudobulbar effect (a neurological condition characterized by episodes of sudden uncontrollable and inappropriate laughing or crying), and intellectual disabilities. Record review of Resident #1's quarterly MDS, dated [DATE], revealed that the resident had a BIMS' score of 5 (maximum score 15) 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. Record review of Resident #1's Care Plan created on 5/22/2018 and last revised on 4/01/2020 revealed the resident had an impaired cognitive function or impaired thought process with impaired decision making and required staff to present just one thought, idea, question or command at a time. During an interview on 5/12/2021 at 5:25 p.m., with Resident #1 revealed the resident had childlike mannerisms and speech in which he repeated what was spoken to him. Resident #1 was unable to be 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 learned during change of report (unknown 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 responded with That's hard to prove, it could have been a joke. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/13/2021 at 2:27 p.m., the Speech Pathologist stated she was standing in the 300-hallway on 12/20/2020 near the therapy area when she heard a someone talking aggressively to Resident #1. The Speech Pathologist looked in the direction of the commotion and witnessed CNA B tell Resident #1 in an aggressive manner to go to his room. The resident stated to CNA B that he did not want to go to his room, so CNA B got in Resident #1's face, yelled at the resident and began moving the resident's wheelchair. She also witnessed CNA B aggressively remove Resident #1's hand from his wheelchair. CNA A was observing from 3 feet away and a MA (unknown) was also in the hallway. CNA B stopped what she was doing when she saw she was being observed. Approximately 10 minutes later CNA A was sitting at the nurse's station and said something to Resident #1. The resident responded with no. CNA A then responded with yes and kept going back and forth with the resident and wouldn't let it go. The Speech Pathologist stated she informed the Administrator when the incident occurred either 12/20/2020 or 12/21/2020 via text. The Administrator called her back within 30 minutes of the notification and stated, Yeah, we have been getting some complaints about CNA B. Thank you for letting me know. The Speech Pathologist stated this incident really shook her. She stated, I have seen and heard harsh voice before, but this was to the point of abuse. The Speech Pathologist stated she had not been interviewed, had not been asked to give a witness statement and had not been asked to give any other details to the witnessed event. 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 of any grievance from the Speech Pathologist in December or since that time period 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. During an interview on 5/14/2021 at 5:44 p.m. the DON stated she did not have any knowledge of complaints of abuse or mistreatment of Resident #1 except a report she received on Monday, 5/10/2021. On 5/10/2021, LVN G informed her Resident #1 stated CNA B pulled his hair . The DON stated she talked to Resident #1 and he said someone touched his hair. The DON stated you just have to know Resident # 1 . The DON confirmed she did not suspend CNA B or remove her from resident care during the investigation and did not interview other residents or additional staff. The DON stated other people would have reported it if they had a concern. The DON stated several residents had expressed concerns about CNA A and CNA B talking to them loud and the Administrator had spoken to the two CNA's in her office to talk to them about it. The DON indicated Resident #1 had behaviors and repeated things he heard. The DON stated she does not remember if she notified the Administrator. The DON stated she was trained to report abuse to the Administrator immediately. b. 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 diagnosis 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 (maximum score 15) 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. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #2's Care Plan created on 9/01/2020 revealed staff should discuss with the resident/family any concerns, fears, issues regarding health or other subjects. 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. During an interview on 5/12/2021 at 1:41 p.m., Resident #2 stated she moved from the 300 to the 200-hallway because she wanted to get away from CNA C and CNA D. She stated, They are real mean assholes to me. Resident #2 stated NA C and CNA D also didn't do what they were supposed to do for her. Resident #2 also stated that CNA B was bossy. She stated, she would rather not give any further details because she was afraid of what would happen. Resident #2 stated she had talked to the DON who stated she would take care of it but nothing improved. Resident #2 stated she had the Administrators cell phone number and tried to reach her without success, so she called her family member and informed them of what had occurred. 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). RN N stated he had a hard time believing it was true because he had been up and down the hallway and into the resident room and Resident #2 had never said anything to him about it prior. The Resident's family member was upset when he called and spoke to RN N about the concern. 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 the brother of NA C, who no longer worked at the facility. The DON stated she honored Resident #2's request to not work with the brother of NA C. 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). During an interview on 5/13/2021 at 4:13 p.m., the BOM confirmed Resident #2 complained on 5/06/2021 that staff (unknown) kept turning off her call light when she put the call light on without assisting her. The BOM stated the resident's family called and spoke to her and was very upset about the incident, The BOM stated immediately after finishing the conversation with Resident #2 she walked straight from the conversation to the Administrator's office and informed her of Resident #2's concern. The BOM stated the Administrator responded by stating, Resident #2 isn't happy about a lot of things. The BOM stated to the Administrator who was the Abuse Coordinator, I know, but I feel like we have to do something. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/14/2021 at 11:25 a.m., the DON confirmed she was aware of Resident #2's grievance. The DON stated she was clocking out and going home in the evening on 5/04/2021 and saw CNA D with a Hoyer lift outside of Resident #2's room. The DON stated she assumed Resident #2 had been changed and the situation was resolved. The DON stated she was not aware of a call light issue or complaint about staff turning off the call light without assisting the resident. The DON stated she doesn't investigate if she feels like she can resolve a problem. The DON stated she would investigate if a resident were to say I am being abused or someone hit me because that would be a completely different ball game and I wouldn't hesitate to tell my staff to hit the door. During an interview on 5/14/2021 at 1:18 p.m., the Administrator stated an example of abuse/neglect was staff not answering a call light or turning it off without attending to the resident leaving them soiled. The Administrator stated RN G called her at home and stated Resident #2 was not soiled (unknown date and unknown time). The Administrator confirmed she also spoke with Resident #2's family member (unknown date and unknown time) who was really upset about the resident being soiled and call lights turned off. The Administrator explained to the family member that staff would change Resident #2 immediately. The Administrator stated knowing that RN G had been in the resident room and the resident was just waiting for a CNA to finish with another resident she did not consider the grievance and complaint as neglect. The Administrator stated she felt like Resident #3 tended to exaggerate. The Administrator stated she wanted to see if what the resident reported was true and stated I do not want to call her a liar, but she sees things differently. I do not have staff here who would ignore a resident. The Administrator stated she had Resident #2 moved to a different hallway away from NA C and CNA D and Resident #2 was content on the new hallway. The Administrator stated Resident #2's behaviors were much better on the new hallway. When asked why she thought Resident #2's behaviors would improve on a new hallway away from NA C and CNA D? The Administrator stated that the new staff baby Resident #2 more. Their voices were not so stern. The Administrator confirmed she herself would not want to be spoken to in such a manner, with a stern voice. The Administrator stated she did not take written statements, or interview other staff who might have observed the incident or other residents because the resident didn't say she felt like she had any harm and the problem had been resolved as a grievance. c. Record review of a face sheet for Resident #3, dated 5/13/2021, revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affection left non-dominant side (weakness and paralysis on the left side of the body caused by damage to the brain from a stroke), major depression and anxiety disorder. Record review of Resident #3's quarterly MDS dated [DATE], revealed the resident had a BIMS' score of 10 (maximum score 15) which indicated a moderate cognitive impairment without the signs and symptoms of delirium, psychosis or other behaviors. Resident #3 required the assistance of 1-2 staff for care. Record review of Resident#3's Care Plan created on 1/02/2019 revealed the resident should be encouraged to express thoughts and feelings and encouraged to participate in decision making and tasks of daily living. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a facility grievance, dated 5/01/2021 revealed Resident #3 voiced to nurse, LVN G that CNA B had made {an} ugly comment about her leg not working and that she should just chop it off. The grievance was made and signed by the DON who assigned the investigation to herself on 5/03/2021. The DON signed off on the grievance as resolved on 5/03/2021. During an interview on 5/12/2021 at 10:55 a.m. on the 300-hallway with Resident #3 who stated CNA A had been rough with care since she made a complaint about CNA A's mother, CNA B. Resident #3 stated, CNA A would not get me out of bed when asked for assistance and stated, If you push the button (call light) and nobody comes, you know why. Resident #3 stated she did not want to talk about the complaint against CNA B because she had already caused enough trouble by making the complaint. The resident became emotional with tears and added, I cannot do anything to suit, CNA B. She constantly takes the little blanket off my feet and puts the blanket where I can't reach it. She says I am freezing out my roommate (with the air-conditioning). She takes my (food) tray away before I am done with my food. CNA B asked me if I am finished (with the food) but I know better than to say no. She will take my food anyway. Since they (unknown) talked to CNA B, I get attitude from CNA A. I feel terrorized. CNA B is always yelling. I jump when I hear any loud noise because I am scared it's her. When asked if she felt safe, Resident #3 stated, I know there will be pain. I want to ask for someone else (to provide care) but I am afraid If I say anything I won't get changed and I will have to sit in my own waste. Resident #3 she had reported her concerns to LVN G and had talked to the DON about them. During an interview on 5/12/2021 at 1:19 p.m., LVN G stated Resident #3 informed her on 5/1/2021 that on 4/30/2021, CNA B told the resident to cut off her leg because it was more of a bother than a help due to a contracture of the leg that was caused by a stroke. LVN G stated she reported the complaint immediately to the DON on 4/30/2021 via telephone. The DON responded by stating CNA B didn't mean it seriously and it was just a joke. The DON gave LVN G instructions to go with CNA B into the Resident #3's and have CNA B apologize. During an interview on 5/12/2021 at 2:34 p.m., Restorative Aide MM stated on an unknown date approximately 2 weeks ago, Resident #3 told her CNA A and CNA B were rough with her and that CNA B told her to chop off her leg because it was contracted. Restorative Aide MM stated Resident #3 looked like she was going to cry when she told the aide about the incident. She further stated the resident tries very hard to straighten her contractured leg and even though it's been a couple of weeks since the incident, Resident #3 keeps talking about it. CNA B stated she reported it to LVN G who was the Charge Nurse who responded she was going to report the incident. Restorative Aide MM stated the Abuse Coordinator was the Administrator and added I am a single mom and I worry about my job. During an interview on 5/12/2021 at 5:44 p.m. the DON confirmed LVN G had reported that Resident #3 was upset about a comment CNA B made about the resident's leg in which CNA B stated This darn leg of yours, you need to cut if off. The DON stated she talked to LVN G and CNA B. The DON stated after talking to both LVN G and CNA B she decided to have CNA B apologize to the resident. This occurred over the weekend (unknown date) and the DON stated she reported the incident to the Administrator during morning meeting on Monday (unknown date). The DON stated she investigated the situation by talking to CNA B about the situation. CNA B stated she was playing with the resident. The DON confirmed she did not suspend CNA B or remove her from resident care while she investigated, did not take any written witness statements and did not interview other staff or residents because Resident #3 was fine with the kidding and did not follow up or monitor Resident #3. The DON stated she asked Resident #3 if she was okay with CNA B continuing her care and she said she was fine with it. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 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 when she spoke to Resident #3, she reminded the resident that she herself makes comments about her leg and plays around with talking about her leg and the resident responded with Yeah, but I wasn't playing that day. It 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 suspend CNA B from work or remove her from resident care and did not perform an investigation because the resident was fine with the incident and understood it was a joke. The Administrator stated Resident #3 never used the word abuse and didn't indicate she was harmed. The Administrator stated based on her conversation with Resident #3 she did not feel like there was any abuse. During an interview on 5/13/2021 at 2:27 p.m., the Speech Pathologist stated several residents had complained about CNA A, CNA B and NA C. Specifically, Resident #3 complained that CNA A and CNA B had complained about the residents bowel movements and stated, this is fucking bullshit, I am tired of this. The Speech Pathologist stated she filled out a grievance form and listed the resident as anonymous to try to protect the resident. The Speech Pathologist stated she signed her own name on the grievance and handed the grievance to the Administrator personally on 4/19/2021. The Administrator stated Thank you at the time she turned it in. The Administrator later called her back into the office and stated she needed the name of the resident. The Speech Pathologist identified Resident #3. The Administrator responded with, Okay, I just needed to know because I need to filter them because sometimes certain residents fill out a lot of grievance papers. The Speech Pathologist stated she was never asked to give any additional information other than what was written on the grievance and when she was asked to identify the resident. The Speech Pathologist stated she was not asked to write a written statement and had not been interviewed. Record review of a text message from the Rehabilitation Director and the Speech Pathologist dated 4/19/2021 at 4:30 p.m., that read Administrator wanted to talk to you about a grievance. During an interview on 5/14/2021 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 Resident #3 prior to surveyor intervention. The Administrator stated she had never received any grievances from the Speech Pathologist. d. Record review of Resident #4's face sheet, dated 5/15/2021 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease, adult failure to thrive, dementia with behavioral disturbance and colostomy status. Record review of Resident #4's quarterly MDS dated [DATE] revealed a BIMS' score of 9 (maximum score 15) which indicated a moderate cognitive impairment. Resident #4 required the assistance of 1 staff member for care. Record review of Resident #4's Care Plan created 5/03/2019 and last revised on 3/27/2020 revealed the resident's call light should be within reach and the resident should be encouraged to use the call light for assistance. The Care Plan indicated the resident needed prompt response to all requests for assistance to prevent falls. Further review of the Care Plan revealed that staff should refrain from making negative comments related to the odor from the ostomy site during care. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 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. During an interview on 5/12/2021 at 6:34 p.m., the DON stated Resident #4 made a complaint last week (unknown date) that CNA A and CNA B would not let her go to bed. The DON stated she asked Resident #4 to just humor the two CNA's and stay up for just 30 minutes. The DON confirmed she did not investigate the incident. The DON stated the two CNA's were Spanish aggressive and spoke aggressively as was part of her culture , but the DON did not consider it abuse. The DON gave an example, Go take a shower in a stern, 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 to the facility on [DATE] with diagnoses which included major depressive disorder recurrent, heart failure, and cerebral infarction. Record review of Resident #5's quarterly MDS dated [DATE] revealed a BIMS score of 8 (maximum score of 15) which indicated a moderate cognitive impairment with inattentiveness (difficulty focusing attention) without symptoms of psychosis or other behaviors. Resident #5 required the assistance of 1-2 staff members for care. Record review of Resident #5's Care Plan, dated 1/27/2021 revealed the resident had made statements that she was going to starve herself and refused to discuss the issues with psychological services. During an interview on 5/12/2021 at 10:34 a.m. on the 300-hallway Resident #5 stated she didn't like living at the nursing facility and didn't feel safe. She stated NA C was rough with me and he hurts my roommate, Resident #16 when providing care (unknown date and time). Resident #5 stated Resident #16 cried out like she was being hurt when NA C was taking care of her. She also stated staff (refused to give names) said she was fat when providing care and that makes her feel bad. Resident #5 stated she had talked to the DON at one time about the rough care but did not remember when this conversation occurred. She stated the DON stated because she was fat, the care may be rough which in turn made the resident feel bad. The resident stated she was afraid of getting in trouble for talking to this surveyor and turned her head to the side and refused to answer further questions. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/12/2021 at 5:44 p.m., the DON stated Resident #5 just wanted to stay in bed all the time. At one time, Resident #5 indicated she wanted to lose weight and prior to admission had planned on getting gastric surgery for weight loss. The DON stated she had talked with Resident #5 and told her she was beautiful and had a lot to live for. The DON stated she had exhausted her attempts to get Resident #5 out of bed. The DON stated the resident was refusing meals, only drinking sodas and loosing excess weight. The DON stated she suggested psych services to the resident, and she refused. The DON stated, Resident #5 had finally agreed to eat as long as she was allowed to stay in bed. The DON stated she told Resident #5 if you don't help yourself, we can't help you. The DON stated she was not aware of anyone calling the resident fat and that had not been disclosed to her by the resident. During an interview on 5/14/2021 at 2:34 p.m., the Administrator confirmed she did not thoroughly investigate Resident #5's concerns because when the interviewed Resident #5 the resident stated she felt safe now. The Administrator stated although Resident #5 indicated NA C was rough with her roommate, Resident #16, the Administrator did not feel like there was any abuse. The Administrator stated the resident gave her a blank stare and then eventually stated CNA A was rough with her roommate. Resident #5 stated the roommate said ow and no during care by CNA A. The Administrator confirmed the roommate was not interviewable due to cognitive status, but sometimes is able to answer simple questions. The Administrator stated she asked the roommate if she felt safe and she responded with oh yeah. The Administrator stated she told Resident #5 to come to her for any concerns. f. 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). Record review of Resident #6's admission MDS, dated [DATE] revealed a BIMS score of 15 (maximum score 15) which indicated the resident was completely cognitively intact. During an interview on 5/13/2021 at 2:27 p.m., the Speech Pathologist stated Resident #6 was in tears on Monday 5/3/2021. Resident #6 stated that the weekend had been terrible because staff had been ignoring call lights, when the staff would come, she would ask for assistance and the staff would never come back. Resident #6 stated she needed help in the bathroom and NA C came into her room. Resident #6 reported that she screamed at him to get out because she didn't want NA C to take care of her because he was male and because he shook her roommate Resident #7 right before Resident #7 had to go to the hospital. Resident #6 informed the Speech Pathologist she didn't tell anyone about the incident because she wasn't comfortable reporting it. The Speech Pathologist stated she had filled out a grievance which she had previously been instructed to do and on 5/03/2021 put it directly on top of the Administrator's desk. The Speech Pathologist stated the Administrator did not follow up with any questions. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/13/2021 at 4:43 p.m., Resident #6 stated NA C came into their room and shook her roommate Resident #7 with his hands because Resident #7 kept pressing the call light. Resident #6 stated the resident had been hurting and crying out. Resident #6 stated NA C was also rough with her. She had told him she didn't want a man taking care of her and didn't feel comfortable with a man touching her privately, so she had asked him to leave the room and get a woman. Resident #6 stated he left at that time but came back in later. Resident #6 stated she screamed at him and told him to get out and he pulled her depends up really hard and fast. Resident #6 became emotional and started crying and stated, there might be someone that can't stop him like I can. Resident #6 stated she didn't report the incident to anyone that she can remember because it was upsetting. Record review of Resident #7's face sheet, dated 5/15/2021, revealed an [AGE] year-old-female admitted on [DATE] and readmitted on [DATE] with diagnoses which included: cerebral aneurysm (weakness and bleeding from the wall of a vein inside of the brain), occlusion and stenosis of left carotid artery (blockage and narrowing of the main artery leading into the brain) and age-related physical debility (symptoms of aging resulting in limitations) . Record review of Resident #7's quarterly MDS, dated [DATE] revealed a BIMS score of 9 (maximum score 15) which indicated the resident had a moderate cognitive impairment. During an interview on 5/13/2021 at 5:11 p.m. Resident #7 stated NA C got upset with me because I asked for something trivial. I do not really know what I did, but he grabbed me by the shoulders, one hand on each side of her arms and shook me. Resident #7 stated NA C lost his cool really easily. Resident #7 stated she looked at her skin for days and never saw a bruise, so she decided to let it go. Resident #7 stated NA C and CNA D used threats and intimidation on her and indicated the threats were they wouldn't do something for the resident that she needed. Resident #7 stated, CNA D turned off her call light without doing what Resident #7 asked the CNA to do and then exited the room the room aggressively. CNA D also refused to fill the residents water jug. Resident #7 stated her roommate, Resident #6, had been upset about the situation and reported it to someone in therapy. Resident #7 stated she was worried about getting someone in trouble by reporting the incident. During an interview on 5/14/2021 at 1:15 p.m., the Administrator stated she was not aware an any grievance or concern from the Speech Pathologist or anyone else regarding Resident # 6 or Resident #7 prior to surveyor intervent [TRUNCATED]

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on interview and record review the facility failed to implement written policies and procedures to prevent abuse for 7 of 15 (Resident #1, #2, #3, #4, #5, #6, and #7) reviewed for abuse; The facility failed to ensure the Administrator thoroughly investigated and followed the facility's abuse policy and procedures when: 1. The Administrator failed to conduct a thorough investigation, obtain written witness statement, interview witnesses of the abuse allegations, and failed to protect Resident #1, #2, #3, #4, #5, #6, and #7 from the alleged perpetrators during the investigation. Although the facility was aware of the allegations of abuse, staff continued to work and have direct contact with the residents. 2. The Administrator failed to report allegations of abuse to the State Survey Agency (HHS) immediately but no later than 2 hours after the incident and failed to notify the Attending Physician and Medical Director of the abuse allegations. An Immediate Jeopardy (IJ) was identified on 5/14/2021. While the IJ was removed on 5/20/2021, the facility remained out of compliance at a severity level of actual harm and a scope of pattern due to the facility was still monitoring the effectiveness of the Plan of Removal. These failures resulted in a delay in identifying abuse within the facility which caused emotional and mental psychosocial harm to the residents and placed residents at risk for continued abuse. The findings were: Record review of the facility Resident Abuse Policy dated July 2018 revealed: A4. When an alleged or suspected case of exploitation, neglect, injuries of unknown source or abuse is reported, the Community Administrator, or his/her designee, will notify the following persons or agencies per the current state/federal reporting requirements of such incident .a). The State licensing/certification agency responsible fore surveying/licensing the community c) law enforcement officials d) the resident's attending physician and e) the Community Medical Director. 9. Written statements from witnesses, if any, shall be provided to the Administrator within 24 hours of the occurrence of such incident. 11. Upon receiving information concerning report of abuse, the designated Community Abuse Coordinator will request that a representative of the social services department/designees monitor the resident's emotions concerning the incident as well as the resident's reactions to his/her involvement in the investigation. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Further review of a facility policy, titled Resident Abuse Policy dated July 2018 revealed: C. Abuse Investigations: All reports of resident abuse, neglect and injuries which have an unknown source (defined by state regulations) shall be promptly and thoroughly investigated by the Community Management. 2. The management-appointed individual conducting the investigation will, at a minimum a0 review the resident's medical record to determine events leading up to the incident, b)interview the person(s) reporting the incident c). interview any witnesses to the incident d) interview the resident (as medically appropriate) e) interview team members who have had contact with the resident during the period of the alleged incident f). interview the resident's roommate, family members and visitors g) interview other residents to whom the accused team member provides care of services and h) review all events leading up to the alleged incident 4. Witness reports will be reduced to writing. Witnesses will be required to sign and date such reports (Note: a copy of such reports shall be attached to the Provider Investigation Report) per current state/federal reporting requirements. 6. Team members of this community who have an allegation against them of resident abuse may be reassigned to non-resident care duties or suspended from duty until the results of the investigation have been reviewed by the Administrator/designee. 1a. Record review of a face sheet for Resident #1, dated 5/13/2021, revealed the resident was a [AGE] year-old-male admitted to the facility on [DATE] with diagnoses that included congenital malformation syndromes predominantly involving limbs (birth defect primarily affecting the limbs), pseudobulbar effect (a neurological condition characterized by episodes of sudden uncontrollable and inappropriate laughing or crying), and intellectual disabilities. Record review of Resident #1's quarterly MDS, dated [DATE], revealed that the resident had a BIMS' score of 5 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 childlike mannerisms and speech in which he repeated what was spoken to him. Resident #1 was unable to be interviewed due to his intellectual disability and cognitive status. During an interview on 5/12/2021 at 1:19 p.m. LVN G stated during change of report she learned (unknown 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 responded with That's hard to prove, it could have been a joke. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/13/2021 at 2:27 p.m., the Speech Pathologist stated she was standing in the 300-hallway on 12/20/2020 near the therapy area when she heard a someone talking aggressively to Resident #1. The Speech Pathologist looked in the direction of the commotion and witnessed CNA B tell Resident #1 in an aggressive manner to go to his room. The resident stated he did not want to go to his room, so CNA B got in Resident #1's face, yelled at the resident and began moving the resident's wheelchair. She also witnessed CNA B aggressively remove Resident #1's hand from his wheelchair. CNA A was observing from 3 feet away and a MA (unknown) was also in the hallway. CNA B stopped what she was doing when she saw she was being observed. Approximately 10 minutes later CNA A was sitting at the nurse's station and said something to Resident #1. The resident responded with no. CNA A then responded with yes and kept going back and forth with the resident and wouldn't let it go. The Speech Pathologist stated she informed the Administrator when the incident occurred either 12/20/2020 or 12/21/2020 via text. The Administrator called her back within 30 minutes of the notification and stated, Yeah, we have been getting some complaints about CNA B. Thank you for letting me know. 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 grievance from the Speech Pathologist or anyone else regarding CNA A and CNA B abusing or mistreating Resident #1 prior to surveyor intervention and therefore had not reported to the State Reporting Agency the allegations The Administrator stated she had no concerns about the way staff talk to Resident #1. During an interview on 5/14/2021 at 5:44 p.m. the DON stated she did not have any knowledge of complaints of abuse or mistreatment of Resident #1 except a report she received on Monday, 5/10/2021. On 5/10/2021, LVN G informed her Resident #1 stated CNA B pulled his hair. The DON stated she talked to Resident #1 and he said someone touched his hair. The DON stated you just have to know Resident # 1. The DON confirmed she did not suspend CNA B or remove her from resident care during the investigation and did not interview other residents or additional staff. The DON stated other people would have reported it if they had a concern. The DON stated several residents had expressed concerns about CNA A and CNA B talking to them loudly and the Administrator had spoken to the two CNA's in her office to talk to them about it. The DON indicated Resident #1 had behaviors and repeated things he heard. The DON stated she does not remember if she notified the Administrator. The DON stated she was trained to report abuse to the Administrator immediately. b. 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. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 cared 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. During an interview on 5/12/2021 at 1:41 p.m., Resident #2 stated she moved from the 300 to the 200-hallway because she wanted to get away from CNA C and CNA D. She stated, They are real mean assholes to me. Resident #2 stated NA C and CNA D also didn't do what they were supposed to do for her. She stated, she would rather not give any further details because she was afraid of what would happen. Resident #2 stated she had the Administrators cell phone number and tried to reach her without success, so she called her family member and informed them of what had occurred. 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 complained that CNA D was rude (date unknown). RN N stated he had a hard time believing it was true because he had been up and down the hallway and into the resident room and Resident #1 had never said anything to me about it prior. The Resident's family member called RN N and was 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 family member 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). During an interview on 5/13/2021 at 9:28 p.m., Resident #2's family member stated Resident #2 had called upset and stated staff members NA C and CNA D were taking away the resident's call light from her and treating her bad. The family member stated he called the facility and spoke to RN G who assured him NA C and CNA D would be removed from caring for Resident #2. The next day, NA C and CNA D were again taking care of Resident #2. The family member stated he again called the facility and spoke to the BOM and requested that Resident #2 be moved off of the 300-hallway so that she would not be cared for by NA C and CNA D. The family member stated the Administrator did not return his calls until 5/12/2021. During an interview on 5/13/2021 at 4:13 p.m., the BOM confirmed Resident #2 complained on 5/06/2021 that staff (unknown) kept turning off her call light when she put them on without assisting her. The BOM stated the resident's family member called and spoke to her and was very upset about the incident and then came to the facility to see the resident. The BOM stated immediately after finishing the conversation with Resident #2, she walked straight from the conversation to the Administrator's office and informed her of Resident #2's concern. The BOM stated the Administrator responded by stating, Resident #2 isn't happy about a lot of things. The BOM stated to the Administrator, I know, but I feel like we have to do something. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/14/2021 at 11:25 a.m., the DON confirmed she was aware of Resident #2's grievance and complaints about not getting changed. The DON stated she was clocking out on 5/04/2021 (unknown time) and going home and saw CNA D with a Hoyer lift. The DON stated she assumed Resident #2 had been changed and the situation was resolved. The DON stated she was not aware of a call light issue of complaint about staff turning off the call light without assisting the resident. The DON stated she doesn't investigate if she feels like she can resolve a problem. If a resident were to say, I am being abused or someone hit me that would be a completely different ball game and I wouldn't hesitate to tell my staff to hit-the-door. During an interview on 5/14/2021 at 1:18 p.m., the Administrator stated an example of abuse/neglect was staff not answering a call light or turning it off without attending to the resident leaving them soiled. The Administrator stated RN G called her at home and stated Resident #2 was not soiled. The Administrator confirmed she also spoke with Resident #2's family member who was really upset. The Administrator explained to the family member that staff would change Resident #2 immediately. The Administrator stated knowing that RN G had been in the resident room and the resident was just waiting for a CNA to finish with another resident was not neglect. The Administrator stated she felt like Resident #2 tends to exaggerate. The Administrator stated she wanted to see if what the resident reported was true and stated I do not want to call her a liar, but she sees things differently. I do not have staff here who would ignore a resident. The Administrator stated she had Resident #2 moved to a different hallway away from NA C and CNA D and Resident #2 was content on the new hallway. The Administrator stated Resident #2's behaviors were much better on the new hallway. When asked why she thought Resident #2's behaviors would improve on a new hallway away from NA C and CNA D? The Administrator stated that the new staff baby Resident #2 more. Their voices were not so stern. The Administrator confirmed she herself would not want to be spoken to in such a manner with a stern voice. The Administrator stated she did not report the incident to the State Survey Agency (HHS) because the resident didn't say she felt like she had any harm. During an interview on 5/14/2021 at 1:18 p.m., the Administrator stated an example of abuse/neglect was staff not answering a call light or turning it off without attending to the resident leaving them soiled. The Administrator stated RN G called her at home and stated Resident #2 was not soiled. The Administrator confirmed she also spoke with Resident #3's family member who was really upset about the resident being soiled and call lights turned off. The Administrator explained to the family member that staff would change Resident #3 immediately. The Administrator stated knowing that RN G had been in the resident room and the resident was just waiting for a CNA to finish with another resident was not neglect. The Administrator stated she felt like Resident #3 tends to exaggerate. The Administrator stated she wanted to see if what the resident reported was true and stated I do not want to call her a liar, but she sees things differently. I do not have staff here who would ignore a resident. The Administrator stated she had Resident #2 moved to a different hallway away from NA C and CNA D and Resident #2 was content on the new hallway. The Administrator stated Resident #2's behaviors were much better on the new hallway. When asked why she thought Resident #2's behaviors would improve on a new hallway away from NA C and CNA D? The Administrator stated that the new staff baby Resident #2 more. Their voices were not so stern. The Administrator confirmed she herself would not want to be spoken to in such a manner with a stern voice. The Administrator stated she did not take written statements, or interview other staff who might have observed the incident or other residents because the resident didn't say she felt like she had any harm and the problem had been resolved as a grievance. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	c. Record review of a face sheet for Resident #3, dated 5/13/2021, revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affection left non-dominant side (weakness and paralysis on the left side of the body caused by damage to the brain from a stroke), major depression and anxiety disorder. Record review of Resident #3's quarterly MDS dated [DATE], revealed the resident had a BIMS' score of 10 which indicated a moderate cognitive impairment without the signs and symptoms of delirium, psychosis or other behaviors. Resident #3 required the assistance of 1-2 staff for care. Record review of a facility grievance, dated 5/01/2021, revealed Resident #3 voiced to nurse, LVN G that CNA B had made {an} ugly comment about her leg not working and that she should just chop it off. The grievance was made and signed by the DON who assigned the investigation to herself on 5/03/2021. The DON signed off on the grievance as resolved on 5/03/2021. During an interview on 5/12/2021 at 10:55 a.m. on the 300-hallway with Resident #3 who stated CNA A had been rough with care since she made a complaint about CNA B. Resident #3 stated, CNA A would not get me out of bed when asked for assistance and stated, If you push the button (call light) and nobody comes, you know why. Resident #3 stated she did not want to talk about the complaint against CNA B because she had already caused enough trouble by making the complaint. The resident became emotional with tears and added, I cannot do anything to suit, CNA B. She constantly takes the little blanket off my feet and puts the blanket where I can't reach it. She says I am freezing out my roommate (with the air-conditioning). She takes my (food) tray away before I am done with my food. CNA B asked me if I am finished (with the food) but I know better than to say no. She will take my food anyway. Since they (unknown) talked to CNA B, I get attitude from CNA A. I feel terrorized. CNA B is always yelling. I jump when I hear any loud noise because I am scared it's her. When asked if she felt safe, Resident #3 stated, I know there will be pain. I want to ask for someone else (to provide care) but I am afraid If I say anything I won't get changed and I will have to sit in my own waste. Resident #3 she had reported her concerns to LVN G and had talked to the DON about them. During an interview on 5/12/2021 at 1:19 p.m., LVN G stated Resident #3 informed her on 5/1/2021 that on 4/30/2021, CNA B told the resident to cut off her leg because it was more of a bother than a help due to a contracture of the leg that was caused by a stroke. LVN G stated she reported the complaint immediately to the DON on 4/30/2021 via telephone. The DON responded by stating CNA B didn't mean it seriously and it was just a joke. The DON gave LVN G instructions to go with CNA B into the Resident #3's and have CNA B apologize. During an interview on 5/12/2021 at 2:34 p.m., Restorative Aide MM stated on an unknown date approximately 2 weeks ago, Resident #3 told her CNA A and CNA B were rough with her and that CNA B told her to chop off her leg because it was contracted. Restorative Aide MM stated Resident #3 looked like she was going to cry when she told the aide about the incident. She further stated the resident tries very hard to straighten her contractured leg and even though it's been a couple of weeks since the incident, Resident #3 keeps talking about it. CNA B stated she reported it to LVN G who was the Charge Nurse who responded she was going to report the incident. Restorative Aide MM stated the Abuse Coordinator was the Administrator and added I am a single mom and I worry about my job. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/12/2021 at 5:44 p.m. the DON confirmed LVN G had reported that Resident #3 was upset about a comment CNA B made about the resident's leg in which CNA B stated This darn leg of yours, you need to cut if off. The DON stated she talked to LVN G and CNA B. The DON stated after talking to both LVN G and CNA B she decided to have CNA B apologize to the resident. This occurred over the weekend (unknown date) and the DON stated she reported the incident to the Administrator during morning meeting on Monday (unknown date). The DON stated she investigated the situation by talking to CNA B about the situation. CNA B stated she was playing with the resident. The DON confirmed she did not suspend CNA B or remove her from resident care while she investigated, did not take any written witness statements and did not interview other staff or residents because Resident #3 was fine with the kidding. The DON stated she asked Resident #3 if she was okay with CNA B continuing her care and she said she was fine with it. 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. It 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 suspend CNA B from work or remove her from resident care and did not perform an investigation 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. During an interview on 5/13/2021 at 2:27 p.m., the Speech Pathologist stated several residents had complained about CNA A, CNA B and NA C. Specifically, Resident #3 complained that CNA A and CNA B had complained about the residents bowel movements and stated, this is fucking bullshit, I am tired of this. The Speech Pathologist stated she filled out a grievance form and listed the resident as anonymous to try to protect the resident. The Speech Pathologist stated she signed her own name on the grievance and handed the grievance to the Administrator personally on 4/19/2021. The Administrator stated Thank you at the time she turned it in. The Administrator later called her back into the office and stated she needed the name of the resident. The Speech Pathologist identified Resident #3. The Administrator responded with, Okay, I just needed to know because I need to filter them because sometimes certain residents fill out a lot of grievance papers. The Speech Pathologist stated she was never asked to give any additional information other than what was written on the grievance and when she was asked to identify the resident. The Speech Pathologist stated she was not asked to write a written statement and had not been interviewed. Record review of a text message from the Rehabilitation Director and the Speech Pathologist dated 4/19/2021 at 4:30 p.m., that read Administrator wanted to talk to you about a grievance. During an interview on 5/14/2021 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 Resident #3 prior to surveyor intervention. The Administrator stated she had never received any grievances from the Speech Pathologist. d. Record review of Resident #4's face sheet, dated 5/15/2021 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease, adult failure to thrive, dementia with behavioral disturbance and colostomy status. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #4's quarterly MDS dated [DATE] revealed a BIMS' score which indicated a moderate cognitive impairment. Resident #4 required the assistance of 1 staff member for care. 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 daughter and mother, 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. 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 #2 did not use the word rough, she said they were fast. Administrator said, when I asked her if she felt safe, she said yes, CNA A and CNA B just need to slow down. The Administrator stated since Resident #4 did not use the word rough during the interview, she didn't think there was any abuse. During an interview on 5/12/2021 at 6:34 p.m., the DON stated Resident #4 made a complaint last week (unknown date) that CNA A and CNA B would not let her go to bed. The DON stated she asked Resident #4 to just humor the two CNA's and stay up for just 30 minutes. The DON confirmed she did not investigate the incident. The DON stated the two CNA's were Spanish aggressive and spoke aggressively as part of their culture, but the DON did not consider it abuse. The DON gave an example, Go take a shower in a stern, 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 #2 did not use the word rough. She said they were fast. When I 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 to the facility on [DATE] with diagnoses which included major depressive disorder recurrent, heart failure, and cerebral infarction. Record review of Resident #5's quarterly MDS dated [DATE] revealed a BIMS' score which indicated a moderate cognitive impairment with inattentiveness (difficulty focusing attention) without symptoms of psychosis or other behaviors. Resident #5 required the assistance of 1-2 staff members for care. During an interview on 5/12/2021 at 10:34 a.m., on the 300-hallway with Resident #5 who stated she didn't like living at the nursing facility and didn't feel safe. Resident #5 stated CNA A was rough with me and he hurts my roommate when providing care (unknown date and time). Resident #5 stated Resident #16 cried out that she was being hurt when CNA A was taking care of her. She also stated staff (refused to give names) said she was fat when providing care and that makes her feel bad. Resident #5 stated she had talked to the DON at one time about the rough care but did not remember when this conversation occurred. She stated, the DON stated because she was fat, the care may be rough which in turn made the resident feel bad. Resident #5 stated she was afraid of getting in trouble for talking to this surveyor and turned her head to the side and refused to answer further questions. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/14/2021 at 2:34 p.m., the Administrator confirmed she did not thoroughly investigate rough care or abuse because she interviewed Resident #5 after receiving information from this surveyor that CNA A was rough with care and did not feel like there was any abuse. The Administrator stated the resident gave her a blank stare and then eventually stated CNA A was rough with her roommate. Resident #5 stated the roommate said ow and no during care by CNA A. The Administrator confirmed the roommate was not interviewable due to cognitive status, but sometimes is able to answer simple questions. The Administrator stated she asked the roommate if she felt safe and she responded with oh yeah. The Administrator stated she told Resident #5 to come to her for any concerns. f. 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. Record review of Resident #6's admission MDS, dated [DATE] revealed a BIMS' score which indicated the resident was completely cognitively intact. During an interview on 5/13/2021 at 2:27 p.m., the Speech Pathologist stated Resident #6 was in tears on Monday 5/3/2021. Resident #6 stated that the weekend had been terrible because staff had been ignoring call lights, when the staff would come, she would ask for assistance and the staff would never come back. Resident #6 stated she needed help in the bathroom and NA C came into her room. Resident #6 reported that she screamed at him to get out because she didn't want NA C to take care of her because he was male and because he shook her roommate Resident #7 right before Resident #7 had to go to the hospital. Resident #6 informed the Speech Pathologist she didn't tell anyone about the incident because she wasn't comfortable reporting it. The Speech Pathologist stated she had filled out a grievance which she had previously been instructed to do and on 5/03/2021 put it directly on top of the Administrator's desk. The Speech Pathologist stated the Administrator did not follow up with any questions. During an interview on 5/13/2021 at 4:43 p.m., Resident #6 stated NA C came into their room and shook her roommate Resident #7 with his hands because Resident #7 kept pressing the call light. Resident #6 stated the resident had been hurting and crying out. Resident #6 stated NA C was also rough with her. She had told him she didn't want a man taking care of her and didn't feel comfortable with a man touching her privately, so she had asked him to leave the room and get a woman. Resident #6 stated he left at that time but came back in later. Resident #6 stated she screamed at him and told him to get out and he pulled her depends up really hard and fast. Resident #6 became emotional and started crying and stated, there might be someone that can't stop him like I can. Resident #6 stated she didn't report the incident to anyone that she can remember because it was upsetting. Record review of Resident #7's face sheet, dated 5/15/2021, revealed an [AGE] year-old-female admitted on [DATE] and readmitted on [DATE] with diagnoses which included: cerebral aneurysm (weakness and bleeding from the wall of a vein inside of the brain), occlusion and stenosis of left carotid artery (blockage and narrowing of the main artery leading into the brain) and age-related physical debility (symptoms of aging resulting in limitations) . Record review of Resident #7's quarterly MDS, dated [DATE] revealed a BIMS score of 9 (maximum score 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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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on interview and record review, the facility failed to ensure that all allegations involving abuse and neglect, were reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials including the State Survey agency (HHS), in accordance with State law through established procedures for 7 of 7 residents (Resident # 1, #2, #3, #4, #5, #6 and #7) reviewed for abuse, in that; 1. The facility failed to report to the State Survey Agency (HHS) within two hours an allegation of abuse to Resident #1 when LVN G reported to the DON that Resident #1 indicated CNA B pulled his hair and when a Speech Pathologist reported to the Administrator that she had witnessed CNA B get in Resident #1's face, yell and then aggressively remove Resident #1's hands from his wheelchair. 2. The facility failed to report to the State Survey Agency (HHS) within two hours an allegation of neglect and emotional abuse to Resident #2 when Resident #2, a family member, RN and the BOM reported to the Administrator that CNA D had turned off Resident #2's call light without assisting the resident resulting in emotional distress to the Resident #2. 3. The facility failed to report to the State Survey Agency (HHS) within two hours an allegation of physical, verbal and emotional abuse when Resident #3 reported to LVN and the DON that CNA B told her to cut off her leg if it was causing her so much pain. When CNA A told Resident #3 if no one answered her call light she would know why after she reported the abuse from CNA B and when CNA A and CNA B would take away the residents food before she was finished in response to the report of abuse. The facility again failed to report within two hours when these allegations were reported to the Administrator by a State Surveyor. 4. The facility failed to report to the State Survey Agency (HHS) within two hours an allegation of abuse when Resident #4 stated CNA A and CNA B were rough with care which was reported to the Administrator by a State Surveyor on 5/12/2021. 5. The facility failed to report to the State Survey Agency (HHS) within two hours an allegation of abuse when Resident #5 reported CNA C was rough with care to herself and to her roommate, Resident #16 which was reported to the Administrator by a State Surveyor. 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 identified and the Administrator was notified on 5/14/2021 at 4:06 p.m. While the IJ was removed on 5/20/2021, the facility remained out of compliance at a severity level of actual harm and a scope of pattern due to the facility was still monitoring the effectiveness of the Plan of Removal. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	These failures affected residents who made outcries of abuse and placed them at risk for continued and/or unrecognized abuse and emotional distress. The findings include: 1. Record review of a face sheet for Resident #1, dated 5/13/2021, revealed the resident was a [AGE] year-old-male admitted to the facility on [DATE] with diagnoses that included congenital malformation syndromes predominantly involving limbs, pseudobulbar effect (a neurological condition characterized by episodes of sudden uncontrollable and inappropriate laughing or crying), and intellectual disabilities. 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 like mannerisms and speech in which he repeated what was spoken to him. Resident #1 was unable to be 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 (unknown 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 responded with 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 complaints of abuse or mistreatment of Resident #1 except a report she received on Monday, 5/10/2021. On 5/10/2021, LVN G informed her Resident #1 stated CNA B pulled his hair. The DON talked to Resident #1 and he said someone touched his hair. The DON stated does not remember if she notified the Administrator. The DON stated she was trained to report abuse to the Administrator immediately. During an interview on 5/13/2021 at 2:27 p.m., the Speech Pathologist stated she was standing in the 300-hallway on 12/20/2020 near the therapy area when she heard a someone talking aggressively to Resident #1. The Speech Pathologist looked in the direction of the commotion and witnessed CNA B tell Resident #1 in an aggressive manner to go to his room. The resident did not want to go to his room, so CNA B got in Resident #1's face, yelled at the resident and began moving the resident's wheelchair. She also witnessed CNA B aggressively remove Resident #1's hand from his wheelchair. CNA A was observing from 3 feet away and a MA (unknown) was also in the hallway. CNA B stopped what she was doing when she saw she was being observed. Approximately 10 minutes later CNA A was sitting at the nurse's station and said something to Resident #1. The resident responded with no. CNA A then responded with yes and kept going back and forth with the resident and wouldn't let it go. The Speech Pathologist stated she informed the Administrator when the incident occurred either 12/20/2020 or 12/21/2020 via text. The Administrator called her back within 30 minutes of the notification and stated, Yeah, we have been getting some complaints about CNA B. Thank you for letting me know. (continued on next page)

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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 grievance 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. During an interview on 5/12/2021 at 1:41 p.m., Resident #2 stated she moved from the 300 to the 200-hallway because she wanted to get away from CNA C and CNA D. She stated, They are real mean assholes to me. Resident #2 stated NA C and CNA D also didn't do what they were supposed to do for her. She stated, she would rather not give any further details because she was afraid of what would happen. Resident #2 stated she had the Administrators cell phone number and tried to reach her without success, so she called her family member and informed them of what had occurred. 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). (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/13/2021 at 9:28 p.m., Resident #2's family member stated Resident #2 had called upset and stated a mother and son staff members (NA C and CNA D) were taking away the resident's call light from her and treating her bad. The family member stated he called the facility and spoke to RN G who assured him NA C and CNA D would be removed from caring for Resident #2. The next day, NA C and CNA D were again taking care of Resident #2. The family member stated he called again called the facility and spoke to the BOM and requested that Resident #2 be moved off of the 300-hallway so that she would not be cared for by NA C and CNA D. The family member stated the Administrator did not return his calls until 5/12/2021. During an interview on 5/13/2021 at 4:13 p.m., the BOM confirmed Resident #2 complained on 5/06/2021 that staff (unknown) kept turning off her call light when she put them on without assisting her. The BOM stated the resident's called and spoke to her and was very upset about the incident and then came to the facility to see the resident. The BOM stated immediately after finishing the conversation with Resident #3, she walked straight from the conversation to the Administrator's office and informed her of Resident #3's concern. The BOM stated the Administrator responded by stating, Resident #3 isn't happy about a lot of things. The BOM stated to the Administrator, I know, but I feel like we have to do something. During an interview on 5/14/2021 at 1:18 p.m., the Administrator stated an example of abuse/neglect was staff not answering a call light or turning it off without attending to the resident leaving them soiled. The Administrator stated RN G called her at home and stated Resident #2 was not soiled. The Administrator confirmed she also spoke with Resident #3's family member who was really upset. The Administrator explained to the family member that staff would change Resident #3 immediately. The Administrator stated knowing that RN G had been in the resident room and the resident was just waiting for a CNA to finish with another resident was not neglect. The Administrator stated she felt like Resident #3 tended to exaggerate. The Administrator stated she wanted to see if what the resident reported was true and stated I do not want to call her a liar, but she sees things differently. I do not have staff here who would ignore a resident. The Administrator stated she had Resident #2 moved to a different hallway away from NA C and CNA D and Resident #2 was content on the new hallway. The Administrator stated Resident #2's behaviors were much better on the new hallway. When asked why she thought Resident #2's behaviors would improve on a new hallway away from NA C and CNA D? The Administrator stated that the new staff baby Resident #2 more. Their voices were not so stern. The Administrator confirmed she herself would not want to be spoken to in such a manner with a stern voice. The Administrator stated she did not report the incident to the State Survey Agency (HHS) because the resident didn't say she felt like she had any harm. 3. Record review of a face sheet for Resident #3, dated 5/13/2021, revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affection left non-dominant side (weakness and paralysis on the left side of the body caused by damage to the brain from a stroke), major depression and anxiety disorder. Record review of Resident #3's quarterly MDS dated [DATE], revealed the resident had a BIMS' score of 10 which indicated a moderate cognitive impairment without the signs and symptoms of delirium, psychosis or other behaviors. Resident #3 required the assistance of 1-2 staff for care. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a facility grievance, dated 5/01/2021, revealed Resident #3 voiced to nurse, LVN G that CNA B had made {an} ugly comment about her leg not working and that she should just chop it off. The grievance was made and signed by the DON who assign the investigation to herself on 5/03/2021. The DON signed off on the grievance as resolved on 5/03/2021. During an interview on 5/12/2021 at 10:55 a.m. on the 300-hallway with Resident #3 who stated CNA A had been rough with care since she made a complaint about CNA A's mother, CNA B. Resident #3 stated, CNA A would not get me out of bed when asked for assistance and stated, If you push the button (call light) and nobody comes, you know why. Resident #3 stated she did not want to talk about the complaint against CNA B because she was already caused enough trouble by making the complaint. The resident became emotional with tears and added, I cannot do anything to suit, CNA B. She constantly takes the little blanket off my feet and puts the blanket where I can't reach it. She says I am freezing out my roommate (with the air-conditioning). She takes my (food) tray away before I am done with my food. CNA B asked me if I am finished (with the food) but I know better than to say no. She will take my food anyway. Since they (unknown) talked to CNA B, I get attitude from CNA A. I feel terrorized. CNA B is always yelling. I jump when I hear any loud noise because I am scared it's her. When asked if she felt safe, Resident #3 stated, I know there will be pain. I want to ask for someone else (to provide care) but I am afraid If I say anything I won't get changed and I will have to sit in my own waste. Resident #3 she had reported her concerns to LVN G and had talked to the DON about them. During an interview on 5/12/2021 at 2:34 p.m., Restorative Aide MM stated on an unknown date approximately 2 weeks ago, Resident #3 told her CNA A and CNA B were rough with her and that CNA B told her to chop off her leg because it was contracted. Restorative Aide MM stated Resident #3 looked like she was going to cry when she told the aide about the incident. She further stated the resident tries very hard to straighten her contractured leg and even though it's been a couple of weeks since the incident, Resident #3 keeps talking about it. CNA B stated she reported it to LVN G who was the Charge Nurse who responded she was going to report the incident. Restorative Aide MM stated the Abuse Coordinator was the Administrator and added I am a single mom and I worry about my job. During an interview on 5/12/2021 at 1:19 p.m., LVN G stated Resident #3 informed her on 5/1/2021 that on 4/30/2021, CNA B told the resident to cut off her leg because it was more of a bother than a help due to a contracture of the leg that was caused by a stroke. LVN G stated she reported the complaint immediately to the DON on 4/30/2021 via telephone. The DON responded by stating CNA B didn't mean it seriously and it was just a joke. The DON gave LVN G instructions to go with CNA B into the Resident #3's and have CNA B apologize. During an interview on 5/12/2021 at 5:44 p.m. the DON confirmed LVN G had reported that Resident #3 was upset about a comment CNA B made about the resident's leg in which CNA B stated This darn leg of yours, you need to cut if off. The DON stated she talked to LVN G and CNA B. The DON stated after talking to both LVN G and CNA B she decided to have CNA B apologize to the resident. This occurred over the weekend (unknown date) and the DON stated she reported the incident to the Administrator during morning meeting on Monday (unknown date). (continued on next page)

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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. It 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. During an interview on 5/13/2021 at 2:27 p.m., the Speech Pathologist stated several residents had complained about CNA A, CNA B and NA C. Specifically Resident #3 complained that CNA A and CNA B had complained about the residents bowel movements and stated, this is fucking bullshit, I am tired of this. The Speech Pathologist stated she filled out a grievance form and listed the resident as anonymous to try to protect the resident. The Speech Pathologist stated she signed her own name on the grievance and handed the grievance to the Administrator personally on 4/19/2021. The Administrator stated Thank you at the time she turned it in. The Administrator later called her back into the office and stated she needed the name of the resident. The Speech Pathologist identified Resident #3. The Administrator responded with, Okay, I just needed to know because I need to filter them because sometimes certain residents fill out a lot of grievance papers. Record review of a text message from the Rehabilitation Director and the Speech Pathologist dated 4/19/2021 at 4:30 p.m., that read Administrator wanted to talk to you about a grievance. During an interview on 5/14/2021 at 1:15 p.m., the Administrator stated she never received a grievance or complaint from the Speech Therapist regarding Resident #3 or any other resident. The Administrator stated she did not feel like Resident's #3's complaints were abuse and therefore had not reported the allegations to the State Reporting Agency until surveyor intervention. 4. Record review of Resident #4's face sheet, dated 5/15/2021 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease, adult failure to thrive, dementia with behavioral disturbance and colostomy status. Record review of Resident #4's quarterly MDS dated [DATE] revealed a BIMS' score which indicated a moderate cognitive impairment. Resident #4 required the assistance of 1 staff member for care. 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 daughter and mother, 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. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 #2 did not use the word rough, she said they were fast. Administrator said, when I asked her if she felt safe, she said yes, CNA A and CNA B just need to slow down. The Administrator stated since Resident #4 did not use the word rough during the interview, she didn't think there was any abuse and therefore did not report the allegations to the State Reporting Agency until surveyor intervention. 5. Record review of Resident #5's face sheet, dated 5/16/2021 revealed a [AGE] year-old-female admitted to the facility on [DATE] with diagnoses which included major depressive disorder recurrent, heart failure, and cerebral infarction. Record review of Resident #5's quarterly MDS dated [DATE] revealed a BIMS' score which indicated a moderate cognitive impairment with inattentiveness (difficulty focusing attention) without symptoms of psychosis or other behaviors. Resident #5 required the assistance of 1-2 staff members for care. During an interview on 5/12/2021 at 10:34 a.m., on the 300-hallway with Resident #5 who stated she didn't like living at the nursing facility and didn't feel safe. Resident #5 stated CNA A was rough with me and he hurts my roommate when providing care (unknown date and time). Resident #5 stated Resident #16 cried out that she was being hurt when CNA A was taking care of her. She also stated staff (refused to give names) said she was fat when providing care and that makes her feel bad. Resident #5 stated she had talked to the DON at one time about the rough care but did not remember when this conversation occurred. She stated, the DON stated because she was fat, the care may be rough which in turn made the resident feel bad. Resident #5 stated she was afraid of getting in trouble for talking to this surveyor and turned her head to the side and refused to answer further questions. During an interview on 5/14/2021 at 2:34 p.m., the Administrator confirmed she did not report rough care or abuse to the State Survey Agency (HHS) because she interviewed Resident #5 after receiving information from this surveyor that CNA A was rough with care. The Administrator stated the resident gave her a blank stare and then eventually stated CNA A was rough with her roommate. Resident #5 stated the roommate said ow and no during care by CNA A. The Administrator confirmed the roommate was not interviewable due to cognitive status, but sometimes is able to answer simple questions. The Administrator stated she asked the roommate if she felt safe and she responded with oh yeah. The Administrator stated she told Resident #5 to come to her for any concerns. 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. Record review of Resident #6's admission MDS, dated [DATE] revealed a BIMS' score which indicated the resident was completely cognitively intact. Record review of Resident #7's face sheet, dated 5/15/2021, revealed an [AGE] year-old-female admitted on [DATE] and readmitted on [DATE] with diagnoses which included: cerebral aneurysm, occlusion and stenosis of left carotid artery and age-related physical debility. Record review of Resident #7's quarterly MDS, dated [DATE] revealed a BIMS' score which indicated the resident had a moderate cognitive impairment. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/13/2021 at 2:27 p.m., the Speech Pathologist stated Resident #6 was in tears on Monday 5/3/2021. Resident #6 stated that the weekend had been terrible because staff had been ignoring call lights, when the staff would come, she would ask for assistance and the staff would never come back. Resident #6 stated she needed help in the bathroom and NA C came into her room. Resident #6 reported that she screamed at him to get out because she didn't want NA C to take care of her because he was male and because he shook her roommate Resident #7 right before Resident #7 had to go to the hospital. Resident #6 informed the Speech Pathologist she didn't tell anyone about the incident because she wasn't comfortable reporting it. The Speech Pathologist stated she had filled out a grievance which she had previously been instructed to do and on 5/03/2021 put it directly on top of the Administrator's desk. The Speech Pathologist stated the Administrator did not follow up with any questions. During an interview on 5/14/2021 at 1:15 p.m., the Administrator stated she was not aware an any grievance or concern from the Speech Pathologist or anyone else regarding Resident # 6 or Resident #7 prior to surveyor intervention, so she had not reported the incident prior to surveyor intervention. During an interview on 5/12/201 at 6:34 p.m. the DON stated she had received multiple complaints about CNA A, CNA B, NA C and CNA D. The DON stated these complaints were discussed in morning meetings with the Administrator. The DON further stated she did not feel like any of the resident complaints were abuse. She stated she was trained to report any suspicion of abuse immediately to the Administrator. The DON stated, she communicated frequently throughout the day with the Administrator. During an interview on 5/12/2021 at 7:00 p.m. the Administrator was notified of multiple resident allegations of abuse including abuse to Resident #1, #2, #3, #4, and #5 by CNA A, CNA B, NA C and CNA D. The Administrator denied knowledge of all allegations of abuse. The Administrator stated: - We see so much from Resident #1. He makes false allegations. -Resident #3 has behavior problems. I think she is prejudice. She is one of the 'City Name Locals'. The culture here is different -CNA A and CNA B are my best workers. They are firmer with the residents. They don't baby the residents. -Resident #5 is a [NAME] She just wants to lie in her bed and not eat. I see her several times a day. She is being seen by psych for behaviors. I'm sorry but I don't think her complaint has any teeth. Record review of TULIP on 5/13/2021 at 11:00 a.m. revealed the facility had not self-reported any of the allegations of abuse concerning Resident #1, #2. #3, #4, #5, #6, or #7 which were reported to the Administrator on 5/12/2021 or were reported to the Administrator by residents, family members, BOM or staff. (continued on next page)

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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 Administrator stated she stayed at the facility last on 5/12/2021 after being informed of the allegations of abuse and interview residents who were awake on the 300-hallway. As a result, she was going to split up CNA A and CNA B and split up NA C and CNA D and have them work in separate hallways instead of together on the same hallway. The Administrator also reminded staff and resident that she is the Abuse Coordinator and gave an in-service called soft touch reminding staff to be gentle with care. The Administrator confirmed she did not report to the State Survey Agency any of the allegations which had been reported to her on 5/12/2021 because she did not believe the allegations were abuse. During an interview on 5/13/2021 at 3:56 p.m., the ADON confirmed she had not performed Guardian Angel Rounds this week on the 300-hallway. The ADON stated she didn't think she would be able to provide documentation on the monitoring form that Guardian Angel Rounds had been performed for the month of May. She stated, I want to be honest. I don't think I did them. The ADON stated the Guardian Angel Rounds were an opportunity to check on the residents in their rooms and see if they had any concerns or anything they wanted to talk about. The ADON stated she thought the IJ the current resident complaints were a miscommunication between staff and residents, and she based on opinion of the fact that she had never witnessed abuse or had abuse reported to her. During an interview on 5/14/2021 at 11:35 a.m., the DON stated she had read and was familiar with the facility abuse policy. She stated she had been trained to respond to a abuse complaint by ensuring the resident was safe, initiating the investigation of the complaint, reporting to the Administrator any complaint and then the Administrator would take over and make decisions about reporting to State Agencies. The DON stated she felt like she had let her residents down and felt confused about why the IJ situation had occurred. The DON stated she felt there was a communication issues and it was concerning that staff and residents felt afraid to talk. The DON stated that staff was monitored by her niece, the ADON and confirmed she was the ADON direct supervisor, but this monitoring was not documented. The DON stated it was ultimately her responsibility for monitoring the nursing team. The DON confirmed the Guardian Angel Monitoring of residents was not actively performed every day. The DON stated not performing Angel rounds and checking on resident issues and complaints was not acceptable. The DON confirmed the ADON did not tell her the rounds were not being performed. During an interview on 5/14/2021 at 12:40 p.m. the Administrator confirmed she was the Abuse Coordinator and stated a grievance is something that can be fixed and did not cause harm. An allegation is something that caused harm or is not right. An incident that needs to be reported is intentional. Abuse is intentional. Neglect is intentional. The Administrator stated she follows the facility abuse policy. When she received an allegation of abuse/neglect or exploitation she immediately reports the allegation to the State Survey Agency and to Corporate. The Administrator stated she did not follow the report to the State Survey Agency because she did not have proof the allegations were truthful. The Administrator stated she did review the allegations with Corporate who agreed not to report. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/14/2021 at 12:55 p.m. the Administrator stated she monitored the facility by assigning and reviewing Guardian Angel Rounds, by working on the floor with staff and by communicating with the DON. The Administrator confirmed she was aware that Guardian Angel Rounds were not being completed on a daily basis by her management team but did not reveal how long it had not been completed. The Administrator stated, Guardian Angel Rounds was a program in which a member of the management team was assigned 5 resident rooms in which to check in with each day. The Angel was supposed to contact the resident in their room and check to see if the resident had any concerns and see if there were any environmental concerns. The Administrator stated she had re-assigned the Guardian Angel Assignments this week, but was unsure which staff monitored the 300-hallway. The Administrator stated she talked to staff and told them it had to be done. She monitors the monitoring notes for any concerns. The Administrator confirmed it was her responsibility to monitor staff and ensure the Guardian Angel Rounds were getting completed, The Administrator stated, I know my employees pretty well and did not have any concerns. During an interview on 5/14/2021 at 1:09 p.m. the Administrator confirmed she did not have a written method or way to document allegations of abuse or completed investigations to give this surveyor as requested. When asked how she keeps track of allegations of abuse she replied, all allegations are reported immediately and then [TRUNCATED]

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse were thoroughly investigated, failed to take corrective action and prevent further potential abuse for 7 of 7 residents (Resident #1, #2, #3, #4, #5, #6 and #7) reviewed for abuse: The Administrator, who is the Abuse Coordinator, failed to thoroughly investigate and prevent further potential abuse and mistreatment by allowing the alleged perpetrators to remain in the facility and allowed them to have direct contact with the residents while the investigation process was occurring when: 1. The Speech Pathologist reported to the Administrator that she had witnessed CNA B get in Resident #1's face, yell and then aggressively remove the resident's hand from the wheelchair. 2. Resident #2, a family member, RN G and the BOM reported to the Administrator that CNA D had turned off Resident #2's call light without assisting the resident resulting in emotion distress to Resident #2. 3. Resident #3 reported CNA B told her to cut off her leg if it was causing her so much pain which resulted in emotional distress and depression to the resident. 4. Resident #4 made an allegation of abuse when she reported CNA A and CAN B were rough with care. 5. Resident #5 made an allegation of abuse when she reported NA C was rough with care for herself and her roommate, Resident #16. 6. Resident #6 made an allegation of physical abuse when she reported that CNA C shook her roommate out of frustration which caused emotional distress to Resident #6. An Immediate Jeopardy (IJ) was identified and the Administrator was notified on 5/14/2021. While the IJ was removed on 5/20/2021, the facility remained out of compliance at a severity level of actual harm and a scope of pattern due to the facility was still monitoring the effectiveness of the Plan of Removal. These failures affected residents who made outcries of abuse and placed them at risk for continued and/or unrecognized abuse and emotional distress. The findings include: 1. Record review of a face sheet for Resident #1, dated 5/13/2021 revealed the resident was a [AGE] year-old-male admitted to the facility on [DATE] with diagnoses that included congenital malformation syndromes predominantly involving limbs, pseudobulbar effect (a neurological condition characterized by episodes of sudden uncontrollable and inappropriate laughing or crying), and intellectual disabilities. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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. Record review of Resident #1's Care Plan created on 5/22/2018 and last revised on 4/01/2020 revealed the resident had an impaired cognitive function or impaired thought process with impaired decision making and required staff to present just one thought, idea, question or command at a time. During an interview on 5/12/2021 at 1:19 p.m. LVN G stated she learned during change of report (unknown 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 responded with That's hard to prove, it could have been a joke. During an interview on 5/12/2021 at 5:25 p.m., with Resident #1 revealed the resident had childlike mannerisms and speech in which he repeated what was spoken to him. Resident #1 was unable to be interviewed due to his intellectual disability and cognitive status. During an interview on 5/14/2021 at 5:44 p.m. the DON stated she did not have any knowledge of complaints of abuse or mistreatment of Resident #1 except a report she received on Monday, 5/10/2021. On 5/10/2021, LVN G informed her Resident #1 stated CNA B pulled his hair . The DON stated she talked to Resident #1 and he said someone touched his hair. The DON stated you just have to know Resident # 1 . The DON confirmed she did not suspend CNA B or remove her from resident care during the investigation and did not interview other residents or additional staff. The DON stated other people would have reported it if they had a concern. The DON stated several residents had expressed concerns about CNA A and CNA B talking to them loud and the Administrator had spoken to the two CNA's in her office to talk to them about it. The DON indicated Resident #1 had behaviors and repeated things he heard. The DON stated she does not remember if she notified the Administrator. The DON stated she was trained to report abuse to the Administrator immediately. During an interview on 5/13/2021 at 2:27 p.m., the Speech Pathologist stated she was standing in the 300-hallway on 12/20/2020 near the therapy area when she heard a someone talking aggressively to Resident #1. The Speech Pathologist looked in the direction of the commotion and witnessed CNA B tell Resident #1 in an aggressive manner to go to his room. The resident did not want to go to his room, so CNA B got in Resident #1's face, yell at the resident and began moving the resident's wheelchair. She also witnessed CNA B aggressively remove Resident #1's hand from his wheelchair. CNA A was observing from 3 feet away and a MA (unknown) was also in the hallway. CNA B stopped what she was doing when she saw she was being observed. Approximately 10 minutes later CNA A was sitting at the nurse's station and said something to Resident #1. The resident responded with no. CNA A then responded with yes and kept going back and forth with the resident and wouldn't let it go. The Speech Pathologist stated she informed the Administrator when the incident occurred either 12/20/2020 or 12/21/2020 via text. The Administrator called her back within 30 minutes of the notification and stated, Yeah, we have been getting some complaints about CNA B. Thank you for letting me know. The Speech Pathologist stated she had never been asked to write a written statement and had not been asked for details of the event she had witnessed. (continued on next page)

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F 0610 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 grievance from the Speech Pathologist or anyone else regarding CNA A and CNA B abusing or mistreating Resident #1 prior to surveyor intervention, so she had not investigated or removed any staff from contact with the resident. The Administrator stated she had no concerns about the way staff talk to Resident #1. During an interview on 5/14/2021 at 5:44 p.m. the DON stated she did not have any knowledge of complaints of abuse or mistreatment of Resident #1 except a report she received on Monday, 5/10/2021. On 5/10/2021, LVN G informed her Resident #1 stated CNA B pulled his hair . The DON stated she talked to Resident #1 and he said someone touched his hair. The DON stated you just have to know Resident # 1. The DON indicated Resident #1 had behaviors and repeated things he heard. The DON confirmed she did not perform an investigation or remove any staff from contact with the Resident. The DON stated she does not remember if she notified the Administrator. The DON stated she was trained to report abuse to the Administrator immediately. 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 diagnosis 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 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. During an interview on 5/12/2021 at 1:41 p.m., Resident #2 stated she moved from the 300 to the 200-hallway because she wanted to get away from CNA C and CNA D. She stated, They are real mean assholes to me. Resident #2 stated NA C and CNA D also didn't do what they were supposed to do for her. She stated, she would rather not give any further details because she was afraid of what would happen. Resident #2 stated she had the Administrators cell phone number and tried to reach her without success, so she called her family member and informed them of what had occurred. During an interview on 5/12/2021 at 5:31 p.m. RN N stated Resident #1 complained about not being changed for a 4-hour window and also complained that CNA D was rude (date unknown). RN N stated he had a hard time believing it was true because he had been up and down the hallway and into the resident room and Resident #1 had never said anything to me about it prior. The Resident's son 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. RN G confirmed he had completed abuse training upon hire and as ongoing training on the facility computerized training program. He further stated he was trained to report abuse/neglect immediately to the Administrator. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bandera Nursing & Rehabilitation	222 Fm 1077 Bandera, TX 78003

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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 at 6:34 p.m., the DON stated Resident #2 first had issues with NA C family member 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 confirmed she did not perform an investigation. The DON stated she communicated with the Administrator Resident #2's concerns (unknown date and unknown time). During an interview on 5/13/2021 at 9:28 p.m., Resident #2's family member stated Resident #2 had called upset and stated (NA C and CNA D were taking away the resident's call light from her and treating her bad. The family member stated he called the facility and spoke to RN G who assured him NA C and CNA D would be removed from caring for Resident #2. The next day, NA C and CNA D were again taking care of Resident #2. The family member stated he called again called the facility and spoke to the BOM and requested that Resident #2 be moved off of the 300-hallway so that she would not be cared for by NA C and CNA D. The family member stated the Administrator did not return his calls until 5/12/2021. During an interview on 5/13/2021 at 4:13 p.m., the BOM confirmed Resident #2 complained on 5/06/2021 that staff (unknown) kept turning off her call light when she put them on without assisting her. The BOM stated the resident's called and spoke to her and was very upset about the incident and then came to the facility to see the resident. The BOM stated immediately after finishing the conversation with Resident #3, she walked straight from the conversation to the Administrator's office and informed her of Resident #3's concern. The BOM stated the Administrator responded by stating, Resident #3 isn't happy about a lot of things. The BOM stated to the Administrator, I know, but I feel like we have to do something. During an interview on 5/14/2021 at 11:25 a.m., the DON confirmed she was aware of Resident #2's grievance. The DON stated she was clocking out and going home and saw CNA D with a Hoyer lift. The DON stated she assumed Resident #2 had been changed and the situation was resolved. The DON stated she was not aware of a call light issue of complaint about staff turning off the call light without assisting the resident. The DON stated she doesn't investigate if she feels like she can resolve a problem. If a resident were to say I am being abused or someone hit me that would be a completely different ball game and I wouldn't hesitate to tell my staff to hit the door. (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 5/14/2021 at 1:18 p.m., the Administrator stated an example of abuse/neglect was staff not answering a call light or turning it off without attending to the resident leaving them soiled. The Administrator stated RN G called her at home and stated Resident #2 was not soiled. The Administrator confirmed she also spoke with Resident #2's family member who was really upset about the resident being soiled and call lights turned off. The Administrator explained to the family member that staff would change Resident #2 immediately. The Administrator stated knowing that RN G had been in the resident room and the resident was just waiting for a CNA to finish with another resident was not neglect. The Administrator stated she felt like Resident #2 tends to exaggerate. The Administrator stated she wanted to see if what the resident reported was true and stated I do not want to call her a liar, but she sees things differently. I do not have staff here who would ignore a resident. The Administrator stated she had Resident #2 moved to a different hallway away from NA C and CNA D and Resident #2 was content on the new hallway. The Administrator stated Resident #2's behaviors were much better on the new hallway. When asked why she thought Resident #2's behaviors would improve on a new hallway away from NA C and CNA D? The Administrator stated that the new staff baby Resident #2 more. Their voices were not so stern. The Administrator confirmed she herself would not want to be spoken to in such a manner with a stern voice. The Administrator stated she did not take written statements, suspend any staff from contact with the resident, interview other staff who might have observed the incident or other residents because the resident didn't say she felt like she had any harm and the problem had been resolved as a grievance. 3. Record review of a face sheet for Resident #3, dated 5/13/2021, revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affection left non-dominant side (weakness and paralysis on the left side of the body caused by damage to the brain from a stroke), major depression and anxiety disorder. Record review of Resident #3's quarterly MDS dated [DATE], revealed the resident had a BIMS' score which indicated a moderate cognitive impairment without the signs and symptoms of delirium, psychosis or other behaviors. Resident #3 required the assistance of 1-2 staff for care. Record review of a facility grievance, dated 5/01/2021 revealed Resident #3 voiced to nurse, LVN G that CNA B had made {an} ugly comment about her leg not working and that she should just chop it off. The grievance was made and signed by the DON who assign the investigation to herself on 5/03/2021. The DON signed off on the grievance as resolved on 5/03/2021. (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 5/12/2021 at 10:55 a.m. on the 300-hallway with Resident #3 who stated CNA A had been rough with care since she made a complaint about CNA A's mother, CNA B. Resident #3 stated, CNA A would not get me out of bed when asked for assistance and stated, If you push the button (call light) and nobody comes, you know why. Resident #3 stated she did not want to talk about the complaint against CNA B because she was already caused enough trouble by making the complaint. The resident added, I cannot do anything to suit, CNA B. She constantly takes the little blanket off my feet and puts the blanket where I can't reach it. She says I am freezing out my roommate (with the air-conditioning). She takes my (food) tray away before I am done with my food. CNA B asked me if I am finished (with the food) but I know better than to say no. She will take my food anyway. Since they (unknown) talked to CNA B, I get attitude from CNA A. I feel terrorized. CNA B is always yelling. I jump when I hear any loud noise because I am scared it's her. When asked if she felt safe, Resident #3 stated, I know there will be pain. I want to ask for someone else (to provide care) but I am afraid If I say anything I won't get changed and I will have to sit in my own waste. Resident #3 she had reported her concerns to LVN G and had talked to the DON about them. During an interview on 5/12/2021 at 2:34 p.m., Restorative Aide MM stated on an unknown date approximately 2 weeks ago, Resident #3 told her CNA A and CNA B were rough with her and that CNA B told her to chop off her leg because it was contracted. Restorative Aide MM stated Resident #3 looked like she was going to cry when she told the aide about the incident. She further stated the resident tries very hard to straighten her contractured leg and even though it's been a couple of weeks since the incident, Resident #3 keeps talking about it. CNA B stated she reported it to LVN G who was the Charge Nurse who responded she was going to report the incident. Restorative Aide MM stated the Abuse Coordinator was the Administrator and added I am a single mom and I worry about my job. During an interview on 5/12/2021 at 1:19 p.m., LVN G stated Resident #3 informed her on 5/1/2021 that on 4/30/2021, CNA B told the resident to cut off her leg because it was more of a bother than a help due to a contracture of the leg that was caused by a stroke. LVN G stated she reported the complaint immediately to the DON on 4/30/2021 via telephone. The DON responded by stating CNA B didn't mean it seriously and it was just a joke. The DON gave LVN G instructions to go with CNA B into the Resident #3's and have CNA B apologize. During an interview on 5/12/2021 at 5:44 p.m. the DON confirmed LVN G had reported that Resident #3 was upset about a comment CNA B made about the resident's leg in which CNA B stated This darn leg of yours, you need to cut if off. The DON stated she talked to LVN G and CNA B. The DON stated after talking to both LVN G and CNA B she decided to have CNA B apologize to the resident. This occurred over the weekend (unknown date) and the DON stated she reported the incident to the Administrator during morning meeting on Monday (unknown date). The DON stated she investigated the situation by talking to CNA B about the situation. CNA B stated she was playing with the resident. The DON confirmed she did not suspend CNA B or remove her from resident care while she investigated, did not take any written witness statements and did not interview other staff or residents because Resident #3 was fine with the kidding. The DON stated she asked Resident #3 if she was okay with CNA B continuing her care and she said she was fine with it. (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 5/12/2021 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. It 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 suspend CNA B from work or remove her from resident care and did not perform an investigation 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. During an interview on 5/13/2021 at 2:27 p.m., the Speech Pathologist stated several residents had complained about CNA A, CNA B and NA C. Specifically Resident #3 complained that CNA A and CNA B had complained about the residents bowel movements and stated, this is fucking bullshit, I am tired of this. The Speech Pathologist stated she filled out a grievance form and listed the resident as anonymous to try to protect the resident. The Speech Pathologist stated she signed her own name on the grievance and handed the grievance to the Administrator personally on 4/19/2021. The Administrator stated Thank you at the time she turned it in. The Administrator later called her back into the office and stated she needed the name of the resident. The Speech Pathologist identified Resident #3. The Administrator responded with, Okay, I just needed to know because I need to filter them because sometimes certain residents fill out a lot of grievance papers. Record review of a text message from the Rehabilitation Director to the Speech Pathologist dated 4/19/2021 at 4:30 p.m., that read Administrator wanted to talk to you about a grievance. During an interview on 5/14/2021 at 1:15 p.m., the Administrator stated she was not aware an any grievance from the Speech Pathologist or anyone else regarding CNA A and CNA B abusing or mistreating Resident #3 prior to surveyor intervention. The Administrator stated she had never received any grievances from the Speech Pathologist. 4. Record review of Resident #4's face sheet, dated 5/15/2021 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease, adult failure to thrive, dementia with behavioral disturbance and colostomy status. Record review of Resident #4's quarterly MDS dated [DATE] revealed a BIMS' score which indicated a moderate cognitive impairment. Resident #4 required the assistance of 1 staff member for care. 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 daughter and mother, 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. (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 5/12/2021 at 6:34 p.m., the DON stated Resident #4 made a complaint last week (unknown date) that CNA A and CNA B would not let her go to bed. The DON stated she asked Resident #4 to just humor the two CNA's and stay up for just 30 minutes. The DON confirmed she did not investigate the incident or suspend any staff from contact with the resident. The DON stated the two CNA's were Spanish aggressive and spoke aggressively as was part of her was part of their culture, but the DON did not consider it abuse. 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 CAN B were rough with care, she interviewed Resident #4. The Administrator stated during the interview Resident #2 did not use the word rough. She said they were fast. When I 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 or suspend any staff from contact with the resident. 5. Record review of Resident #5's face sheet, dated 5/16/2021 revealed a [AGE] year-old-female admitted to the facility on [DATE] with diagnoses which included major depressive disorder recurrent, heart failure, and cerebral infarction. Record review of Resident #5's quarterly MDS dated [DATE] revealed a BIMS' score which indicated a moderate cognitive impairment with inattentiveness (difficulty focusing attention) without symptoms of psychosis or other behaviors. Resident #5 required the assistance of 1-2 staff members for care. Record review of Resident #5's Care Plan revealed the resident had made statements that she was going to starve herself and refused to discuss the issues with psychological services. During an interview on 5/12/2021 at 10:34 a.m., on the 300-hallway with Resident #5 who stated she didn't like living at the nursing facility and didn't feel safe. She stated NA C was rough with me and he hurts my roommate, Resident #16 when providing care (unknown date and time). Resident #5 stated Resident #16 cried out like she was being hurt when NA C was taking care of her. She also stated staff (refused to give names) said she was fat when providing care and that makes her feel bad. Resident #5 stated she had talked to the DON at one time about the rough care but did not remember when this conversation occurred. She stated the DON stated because she was fat, the care may be rough which in turn made the resident feel bad. The resident stated she was afraid of getting in trouble for talking to this surveyor and turned her head to the side and refused to answer further questions. During an interview on 5/14/2021 at 2:34 p.m., the Administrator confirmed she did not thoroughly investigate rough care or abuse and did not remove or suspend any staff from contact with Resident #5 because she interviewed Resident #5 after receiving information from this surveyor that CNA A was rough with care and did not feel like there was any abuse. The Administrator stated the resident gave her a blank stare and then eventually stated CNA A was rough with her roommate. Resident #5 stated the roommate said ow and no during care by CNA A. The Administrator confirmed the roommate was not interviewable due to cognitive status, but sometimes is able to answer simple questions. The Administrator stated she asked the roommate if she felt safe and she responded with oh yeah. The Administrator stated she told Resident #5 to come to her for any concerns. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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). Record review of Resident #6's admission MDS, dated [DATE] revealed a BIMS' score which indicated the resident was completely cognitively intact. During an interview on 5/13/2021 at 2:27 p.m., the Speech Pathologist stated Resident #6 was in tears on Monday 5/3/2021. Resident #6 stated that the weekend had been terrible because staff had been ignoring call lights, when the staff would come, she would ask for assistance and the staff would never come back. Resident #6 stated she needed help in the bathroom and NA C came into her room. Resident #6 reported that she screamed at him to get out because she didn't want NA C to take care of her because he was male and because he shook her roommate Resident #7 right before Resident #7 had to go to the hospital. Resident #6 informed the Speech Pathologist she didn't tell anyone about the incident because she wasn't comfortable reporting it. The Speech Pathologist stated she had filled out a grievance which she had previously been instructed to do and on 5/03/2021 put it directly on top of the Administrator's desk. The Speech Pathologist stated the Administrator did not follow up with any questions. During an interview on 5/13/2021 at 4:43 p.m., Resident #6 stated NA C came into their room and shook her roommate Resident #7 with his hands because Resident #7 kept pressing the call light. Resident #6 stated the resident had been hurting and crying out. Resident #6 stated NA C was also rough with her. She had told him she didn't want a man taking care of her and didn't feel comfortable with a man touching her privately, so she had asked him to leave the room and get a woman. Resident #6 stated he left at that time but came back in later. Resident #6 stated she screamed at him and told him to get out and he pulled her depends up really hard and fast. Resident #6 became emotional and started crying and stated, there might be someone that can't stop him like I can. Resident #6 stated she didn't report the incident to anyone that she can remember because it was upsetting. Record review of Resident #7's face sheet, dated 5/15/2021, revealed an [AGE] year-old-female admitted on [DATE] and readmitted on [DATE] with diagnoses which included: cerebral aneurysm (weakness and bleeding from the wall of a vein inside of the brain), occlusion and stenosis of left carotid artery (blockage and narrowing of the main artery leading into the brain) and age-related physical debility (symptoms of aging resulting in limitations) . Record review of Resident #7's quarterly MDS, dated [DATE] revealed a BIMS score of 9 (maximum score 15) which indicated the resident had a moderate cognitive impairment. (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 at 5:11 p.m. Resident #7 stated NA C got upset with me because I asked for something trivial. I do not really know what I did, but he grabbed my by the shoulders, one hand on each side of her arms and shook me. Resident #7 stated NA C lost his cool really easily. Resident #7 stated she looked at her skin for days and never saw a bruise, so she decided to let it go. Resident #7 stated NA C and CNA D used threats and intimidation on her and indicated the threats were they wouldn't do something for the resident that she needed. CNA D turned off my call light without doing what Resident #7 called her to do and slammed out of the room. CNA D would also refuse to fill the residents water jug. Resident #7 stated her roommate, Resident #6 had been upset about the situation and reported it to someone in therapy. Resident #7 stated she was worried about getting someone in trouble by reporting the incident. During an interview on 5/14/2021 at 1:15 p.m., the Administrator stated she was not aware an any grievance or concern from the Speech Pathologist or anyone else regarding Resident # 6 or Resident #7 prior to surveyor intervention, so she had not investigated and had not suspended or removed any staff from contact with the residents. During an interview on 5/12/201 at 6:34 p.m. the DON stated she had received multiple complaints about CNA A, CNA B, NA C and CNA D. The DON stated these complaints were discussed in morning meetings with the Administrator. The DON further stated she did not feel like any of the resident complaints were abuse. She stated she was trained to report any suspicion of abuse immediately to the Administrator. The DON stated, she communicated frequently throughout the day with the Administrator. During an interview on 5/12/2021 at 7:00 p.m. the Administrator was notified of multiple resident allegations of abuse including abuse to Resident #1, #2, #3, #4, and #5 by CNA A, CNA B, NA C and CNA D. The Administrator denied knowledge of all allegations of abuse. The Administrator stated: - We see so much from Resident #1. He makes false allegations. -Resident #3 has behavior problems. I think she is prejudice. She is one of the 'City Name Locals'. The culture here is different -CNA A and CNA B are my best workers. They are firmer with the residents. They don't baby the residents. -Resident #5 is a [NAME] She just wants to lie in her bed and not eat. I see her several times a day. She is being seen by psych for behaviors. I'm sorry but I don't think her complaint has any teeth. Record review of TULIP on 5/13/2021 at 11:00 a.m. revealed the facility had not self-reported any of the allegations of abuse concerning Resident #1, #2. #3, #4, #5, #6, or #7 which were reported to the Administrator on 5/12/2021 or were reported to the Administrator by residents, family members, BOM or staff. During an interview on 5/13/2021 at 12:42 p.m., the Administrator confirmed she did not suspend any staff members and did not investigate any of these allegations of abuse because she they were reported to her as concerns and not abuse. After interviewing multiple residents on the 300-hallway last night, 5/12/2021 she had identified [TRUNCATED]

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on interview and record review, the facility failed to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 7 of 15 residents (Residents ##1, #2, #3, #4, #5, #6, and #7) reviewed for abuse: The Administrator, who was the facility Abuse Coordinator, failed to incorporate the facility's abuse policies and procedures when: 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: 1a. Record review of a face sheet for Resident #1, dated [DATE] revealed the resident was a [AGE] year-old-male admitted to the facility on [DATE] with diagnoses that included congenital malformation syndromes predominantly involving limbs (birth defect primarily affecting the limbs), pseudobulbar effect (a neurological condition characterized by episodes of sudden uncontrollable and inappropriate laughing or crying), and intellectual disabilities. During an interview on [DATE] at 1:19 p.m. LVN G stated she learned during change of report (unknown source) that Resident #1 complained that a staff member pulled his hair over the weekend ([DATE]-[DATE]). LVN G stated she reported it to the DON on [DATE]. The DON responded with That's hard to prove, it could have been a joke. During an interview on [DATE] at 5:44 p.m. the DON stated she did not have any knowledge of complaints of abuse or mistreatment of Resident #1 except a report she received on Monday, [DATE]. On [DATE], LVN G informed her Resident #1 stated CNA B pulled his hair. The DON stated she talked to Resident #1 and he said someone touched his hair. The DON stated several residents had expressed concerns about CNA A and CNA B talking to them loudly and the Administrator had spoken to the two CNA's in her office to talk to them about it. The DON indicated Resident #1 had behaviors and repeated things he heard. (continued on next page)

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Bandera Nursing & Rehabilitation	222 Fm 1077 Bandera, TX 78003

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 2:27 p.m., the Speech Pathologist stated she was standing in the 300-hallway on [DATE] near the therapy area when she heard a someone talking aggressively to Resident #1. The Speech Pathologist looked in the direction of the commotion and witnessed CNA B tell Resident #1 in an aggressive manner to go to his room. The resident stated to CNA B that he did not want to go to his room, so CNA B got in Resident #1's face, yelled at the resident and began moving the resident's wheelchair. She also witnessed CNA B aggressively remove Resident #1's hand from his wheelchair. CNA A was observing from 3 feet away and a MA (unknown) was also in the hallway. CNA B stopped what she was doing when she saw she was being observed. Approximately 10 minutes later CNA A was sitting at the nurse's station and said something to Resident #1. The resident responded with no. CNA A then responded with yes and kept going back and forth with the resident and wouldn't let it go. The Speech Pathologist stated she informed the Administrator when the incident occurred either [DATE] or [DATE] via text. The Administrator called her back within 30 minutes of the notification and stated, Yeah, we have been getting some complaints about CNA B. Thank you for letting me know. The Speech Pathologist stated this incident really shook her. She stated, I have seen and heard harsh voice before, but this was to the point of abuse. The Speech Pathologist stated she had not been interviewed, had not been asked to give a witness statement and had not been asked to give any other details to the witnessed event. Record review of a Provider Investigative Report dated [DATE] after surveyor intervention revealed Resident #1 had confirmed allegations of abuse. During an interview on [DATE] at 1:49 the Administrator stated she should have marked the report as unconfirmed instead of confirmed and indicated confirmed had been marked in error. The Administrator confirmed she had not interviewed the Speech Pathologist about her grievances and witnessed abuse because she didn't feel like it was her responsibility. The Speech Pathologist was a contract worker and the Speech Pathologists manager should be the one to interview her. The Administrator stated the Speech Pathologist was required to report abuse to the Administrator. The Administrator stated she was unable to confirm the allegations of abuse because there were no other witnesses to confirm. 1b. Record review of a face sheet for Resident #2, dated [DATE], revealed a [AGE] year-old-female admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis which included chronic systolic congestive heart failure, major depressive disorder and hypothyroidism. Record review of a facility grievance dated [DATE] 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 [DATE]. 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. During an interview on [DATE] at 1:41 p.m., Resident #2 stated she moved from the 300 to the 200-hallway because she wanted to get away from CNA C and CNA D. She stated, They are real mean assholes to me. Resident #2 stated NA C and CNA D also didn't do what they were supposed to do for her. Resident #2 also stated that CNA B was bossy. She stated, she would rather not give any further details because she was afraid of what would happen. Resident #2 stated she had talked to the DON who stated she would take care of it, but nothing improved. Resident #2 stated she had the Administrators cell phone number and tried to reach her without success, so she called her family member and informed them of what had occurred. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] 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). RN N stated he had a hard time believing it was true because he had been up and down the hallway and into the resident room and Resident #2 had never said anything to him about it prior. The Resident's family member was upset when he called and spoke to RN N about the concern. 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 [DATE] at 4:13 p.m., the BOM confirmed Resident #2 complained on [DATE] that staff (unknown) kept turning off her call light when she put the call light on without assisting her. The BOM stated the resident's family called and spoke to her and was very upset about the incident, The BOM stated immediately after finishing the conversation with Resident #2 she walked straight from the conversation to the Administrator's office and informed her of Resident #2's concern. The BOM stated the Administrator responded by stating, Resident #2 isn't happy about a lot of things. The BOM stated to the Administrator who was the Abuse Coordinator, I know, but I feel like we have to do something. During an interview on [DATE] at 1:18 p.m., the Administrator stated an example of abuse/neglect was staff not answering a call light or turning it off without attending to the resident leaving them soiled. The Administrator stated RN G called her at home and stated Resident #2 was not soiled (unknown date and unknown time). The Administrator confirmed she also spoke with Resident #2's family member (unknown date and unknown time) who was really upset about the resident being soiled and call lights turned off. The Administrator explained to the family member that staff would change Resident #2 immediately. The Administrator stated knowing that RN G had been in the resident room and the resident was just waiting for a CNA to finish with another resident she did not consider the grievance and complaint as neglect. The Administrator stated she felt like Resident #3 tended to exaggerate. The Administrator stated she wanted to see if what the resident reported was true and stated I do not want to call her a liar, but she sees things differently. I do not have staff here who would ignore a resident. The Administrator stated she had Resident #2 moved to a different hallway away from NA C and CNA D and Resident #2 was content on the new hallway. The Administrator stated Resident #2's behaviors were much better on the new hallway. When asked why she thought Resident #2's behaviors would improve on a new hallway away from NA C and CNA D? The Administrator stated that the new staff baby Resident #2 more. Their voices were not so stern. The Administrator confirmed she herself would not want to be spoken to in such a manner, with a stern voice. The Administrator stated she did not take written statements, or interview other staff who might have observed the incident or other residents because the resident didn't say she felt like she had any harm and the problem had been resolved as a grievance. 1c. Record review of a face sheet for Resident #3, dated [DATE], revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affection left non-dominant side (weakness and paralysis on the left side of the body caused by damage to the brain from a stroke), major depression and anxiety disorder. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 10:55 a.m. on the 300-hallway with Resident #3 who stated CNA A had been rough with care since she made a complaint about CNA A's mother, CNA B. Resident #3 stated, CNA A would not get me out of bed when asked for assistance and stated, If you push the button (call light) and nobody comes, you know why. Resident #3 stated she did not want to talk about the complaint against CNA B because she had already caused enough trouble by making the complaint. The resident became emotional with tears and added, I cannot do anything to suit, CNA B. She constantly takes the little blanket off my feet and puts the blanket where I can't reach it. She says I am freezing out my roommate (with the air-conditioning). She takes my (food) tray away before I am done with my food. CNA B asked me if I am finished (with the food) but I know better than to say no. She will take my food anyway. Since they (unknown) talked to CNA B, I get attitude from CNA A. I feel terrorized. CNA B is always yelling. I jump when I hear any loud noise because I am scared it's her. When asked if she felt safe, Resident #3 stated, I know there will be pain. I want to ask for someone else (to provide care) but I am afraid If I say anything I won't get changed and I will have to sit in my own waste. Resident #3 she had reported her concerns to LVN G and had talked to the DON about them. During an interview on [DATE] 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 when she spoke to Resident #3, she reminded the resident that she herself makes comments about her leg and plays around with talking about her leg and the resident responded with Yeah, but I wasn't playing that day. It 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 suspend CNA B from work or remove her from resident care and did not perform an investigation because the resident was fine with the incident and understood it was a joke. The Administrator stated Resident #3 never used the word abuse and didn't indicate she was harmed. The Administrator stated based on her conversation with Resident #3 she did not feel like there was any abuse. During an interview on [DATE] at 2:27 p.m., the Speech Pathologist stated several residents had complained about CNA A, CNA B and NA C. Specifically, Resident #3 complained that CNA A and CNA B had complained about the residents bowel movements and stated, this is fucking bullshit, I am tired of this. The Speech Pathologist stated she filled out a grievance form and listed the resident as anonymous to try to protect the resident. The Speech Pathologist stated she signed her own name on the grievance and handed the grievance to the Administrator personally on [DATE]. The Administrator stated Thank you at the time she turned it in. The Administrator later called her back into the office and stated she needed the name of the resident. The Speech Pathologist identified Resident #3. The Administrator responded with, Okay, I just needed to know because I need to filter them because sometimes certain residents fill out a lot of grievance papers. The Speech Pathologist stated she was never asked to give any additional information other than what was written on the grievance and when she was asked to identify the resident. The Speech Pathologist stated she was not asked to write a written statement and had not been interviewed. Record review of a text message from the Rehabilitation Director and the Speech Pathologist dated [DATE] at 4:30 p.m., that read Administrator wanted to talk to you about a grievance. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 Resident #3 prior to surveyor intervention. The Administrator stated she had never received any grievances from the Speech Pathologist. Record review of a Provider Investigative Report dated [DATE] after surveyor intervention for Resident #3 revealed the Administrator had unconfirmed the allegation of abuse. During an interview with the Administrator on [DATE] at 1:54 p.m. the Administrator stated the DON had completed a grievance at the time it occurred, but LVN G brought it back up because Resident #3 commented to her the comment hurt her feelings. The Administrator stated the resident had moods and gets depressed, thinks about the comment and then gets depressed again. The Administrator stated she couldn't make a judgement for Resident #3, but the resident stated she didn't feel abused and that is why she unconfirmed abuse. The Administrator confirmed the facility abuse policy indicated someone didn't have to use the word abuse and it could absolutely still be abuse. Record review of a facility grievance, dated [DATE] revealed Resident #3 voiced to nurse, LVN G that CNA B had made {an} ugly comment about her leg not working and that she should just chop it off. The grievance was made and signed by the DON who assigned the investigation to herself on [DATE]. The DON signed off on the grievance as resolved on [DATE]. 1d. Record review of Resident #4's face sheet, dated [DATE] revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease, adult failure to thrive, dementia with behavioral disturbance and colostomy status. During an interview on [DATE] 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. During an interview on [DATE] 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. Record review of a Provider Investigative Report dated [DATE] after surveyor intervention for Resident #4 revealed: Investigative summary unconfirmed. A Review of the supporting documents revealed the facility Administrator had not included any interviews that were negative from any of the residents or staff members whom had indicated concerns about resident treatment. During an interview with the Administrator on [DATE] at 2:01 p.m. the Administrator stated there was no evidence of abuse to Resident #4. The Administrator confirmed none of the interviews with residents who stated staff were rough and rude were included in the investigative packet. The Administrator stated those interviews were considered but were not part of the investigation (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1e. Record review of Resident #5's face sheet, dated [DATE] revealed a [AGE] year-old-female admitted to the facility on [DATE] with diagnoses which included major depressive disorder recurrent, heart failure, and cerebral infarction. During an interview on [DATE] at 10:34 a.m. on the 300-hallway Resident #5 stated she didn't like living at the nursing facility and didn't feel safe. She stated NA C was rough with me and he hurts my roommate, Resident #16 when providing care (unknown date and time). Resident #5 stated Resident #16 cried out like she was being hurt when NA C was taking care of her. She also stated staff (refused to give names) said she was fat when providing care and that makes her feel bad. Resident #5 stated she had talked to the DON at one time about the rough care but did not remember when this conversation occurred. She stated the DON stated because she was fat, the care may be rough which in turn made the resident feel bad. The resident stated she was afraid of getting in trouble for talking to this surveyor and turned her head to the side and refused to answer further questions. During an interview on [DATE] at 2:34 p.m., the Administrator confirmed she did not thoroughly investigate Resident #5's concerns because when she interviewed Resident #5 the resident stated she felt safe now. The Administrator stated although Resident #5 indicated NA C was rough with her roommate, Resident #16, the Administrator did not feel like there was any abuse. The Administrator stated the resident gave her a blank stare and then eventually stated CNA A was rough with her roommate. Resident #5 stated the roommate said ow and no during care by CNA A. The Administrator confirmed the roommate was not interviewable due to cognitive status, but sometimes is able to answer simple questions. The Administrator stated she asked the roommate if she felt safe and she responded with oh yeah. The Administrator stated she told Resident #5 to come to her for any concerns. Record review of a Provider Investigative Report dated [DATE] after surveyor intervention revealed Resident #5 had confirmed allegations of abuse. During an interview on [DATE] at 1:49 the Administrator stated she should have marked the report as unconfirmed instead of confirmed and indicated confirmed had been marked in error. The Administrator stated she was unable to confirm the allegations of abuse because there were no witnesses to confirm abuse. 1f. Record review of Resident #6's face sheet, dated [DATE], 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). During an interview on [DATE] at 2:27 p.m., the Speech Pathologist stated Resident #6 was in tears on Monday [DATE]. Resident #6 stated that the weekend had been terrible because staff had been ignoring call lights, when the staff would come, she would ask for assistance and the staff would never come back. Resident #6 stated she needed help in the bathroom and NA C came into her room. Resident #6 reported that she screamed at him to get out because she didn't want NA C to take care of her because he was male and because he shook her roommate Resident #7 right before Resident #7 had to go to the hospital. Resident #6 informed the Speech Pathologist she didn't tell anyone about the incident because she wasn't comfortable reporting it. The Speech Pathologist stated she had filled out a grievance which she had previously been instructed to do and on [DATE] put it directly on top of the Administrator's desk. The Speech Pathologist stated the Administrator did not follow up with any questions. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 11:25 a.m., the DON stated she had received complaints about CNA A, CNA B, NA C and CNA D, The DON stated she doesn't remember who made the complaints or the specifics of the complaints and does not keep a log. She stated never was the word abuse or disrespect used when she received a report about other staff. The DON stated she communicated with the Administrator verbally and via text daily throughout the day. The DON stated she tells the Administrator everything and they discuss issues and concerns. During an interview on [DATE] at 12:40 p.m. the Administrator confirmed she was the Abuse Coordinator and stated a grievance is something that can be fixed and did not cause harm. An allegation is something that caused harm or is not right. An incident that needs to be reported is intentional. Abuse is intentional. Neglect is intentional. The Administrator stated she follows the facility abuse policy. When she received an allegation of abuse/neglect or exploitation she immediately performs an investigation of the allegation. She stated if the investigation is very clear and there are witnesses and everything matches up then it shows her the results and she documents everything. The Administrator stated none of these allegations were abuse. 2a. During an interview on [DATE] at 2:27 p.m., the Speech Pathologist stated she was standing in the 300-hallway on [DATE] near the therapy area when she heard a someone talking aggressively to Resident #1. The Speech Pathologist looked in the direction of the commotion and witnessed CNA B tell Resident #1 in an aggressive manner to go to his room. The resident stated to CNA B that he did not want to go to his room, so CNA B got in Resident #1's face, yelled at the resident and began moving the resident's wheelchair. She also witnessed CNA B aggressively remove Resident #1's hand from his wheelchair. CNA A was observing from 3 feet away and a MA (unknown) was also in the hallway. CNA B stopped what she was doing when she saw she was being observed. Approximately 10 minutes later CNA A was sitting at the nurse's station and said something to Resident #1. The resident responded with no. CNA A then responded with yes and kept going back and forth with the resident and wouldn't let it go. The Speech Pathologist stated she informed the Administrator when the incident occurred either [DATE] or [DATE] via text. The Administrator called her back within 30 minutes of the notification and stated, Yeah, we have been getting some complaints about CNA B. Thank you for letting me know. The Speech Pathologist stated this incident really shook her. She stated, I have seen and heard harsh voice before, but this was to the point of abuse. The Speech Pathologist stated she had not been interviewed, had not been asked to give a witness statement and had not been asked to give any other details to the witnessed event. Record review of a text message dated Sunday, [DATE] 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 [TRUNCATED]