STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676075	A. BUILDING _____ B. WING _____	06/21/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TRISTAR CARE CENTER INC	619 W LIVE OAK RD FREDERICKSBURG, TX 78624

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 0223 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Protect each resident from all abuse, physical punishment, and being separated from others.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that 2 of 15 residents reviewed for abuse (Resident #s 6 and 7) had the right to be free from abuse in that: 1. Resident #6's electric wheelchair was taken away from him. Resident #6, while crying, said that he was going crazy and was going to kill himself. The administrator told Resident #6 You were crazy when you came here and laughed. 2. The administrator told Resident #7 that she was rude and obnoxious. These failures resulted in an Immediate Jeopardy (IJ) situation identified on 6/16/17. While the IJ was removed on 6/20/17, the facility remained out of compliance at a severity of actual harm with a scope identified as widespread until all staff were in-serviced. This deficient practice could affect all 44 residents at the facility who interacted with the administrator by contributing to feelings of fear, decreased self-esteem, and self-injurious behaviors. The findings were: 1. Record review of Resident #6's facesheet (dated 6/12/17) revealed that he was [AGE] years old, was admitted to the facility on [DATE], and was readmitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #6's quarterly MDS assessment (ARD 5/29/17) revealed that he scored a 10 on the BIMS (indicating moderate cognitive impairment) and had no behaviors or signs/symptoms of [MEDICAL CONDITION]. Record review of Resident #6's 5/17/17 activity quarterly update revealed that he volunteered at the animal shelter 3 times per week, enjoyed feeding the birds, and used an electric wheelchair for mobility. Record review of Resident #6's nursing progress notes revealed that, on 6/5/17 at 12:50 p.m., the administrator received a call from law enforcement dispatch that Resident #6 was crossing a busy street against a traffic light. Several cars had to stop quickly to keep from hitting him. It was documented that this was the second time law enforcement had notified the administrator of Resident #6's reckless and dangerous behaviors while operating his motorized wheelchair on the busy streets. Resident #6 was counseled regarding his unsafe operation of his wheelchair and was instructed not to leave the facility on his own without staff escort. He was advised to be supervised by staff while outside of the facility and to schedule supervised outings with the activities director. Review of Resident #6's 6/5/17 9:25 p.m. nursing progress notes revealed that he was nearly hit by a car when he was on the road going to the library early afternoon. When he returned from his outing, he was counseled about not going out anymore. At 6:00 p.m., he informed the charge nurse that he was going to the grocery store. The charge nurse informed Resident #6 that he was not supposed to leave the building, but Resident #6 left anyway. When he returned to the facility, his power chair was taken away (by the administrator) and a wander guard was attached to it. During an interview with Resident #6 at 10:15 a.m. on 6/15/17, he reported that he was told the week before last (the week of 6/5/17) that he could not go out on pass anymore. He stated If I can't go out, now what? I got places I need to go - (cell phone store), email at the public library, feed the birds - for my own serenity and peace of mind. I need to get away from here. This place is kind of crazy. I can't relate to people here. When asked how no longer having his electric wheelchair affected him, Resident #6 stated I don't want to get out of bed. I'd rather stay in bed. The only reason I am up now is for a doctor's appointment. When asked if the facility had offered other ways for him to leave, Resident #6 said no. He reported that the assistant activity director only went to the grocery store once a month and did not have time to take him to the animal shelter. He reported that, since his electric wheelchair had been taken away, he had not gone anywhere. Resident #6 reported that he had told the ADON and DON about his need to go to the cell phone store and to check his email. They told him It's up to (the administrator). He reported that, when he went to the administrator, she said You need to talk to the treatment team (the ADON and DON). Resident #6 stated They keep putting me off to each other. I am trying to get a hold of the ombudsman. She came in on Tuesday (6/13/17), but I was depressed and didn't want to get out of bed. During an interview with the activity director and assistant activity director at 11:00 a.m. on 6/15/17, the activity director reported that Resident #6 had not informed her that he wanted to go anywhere. She stated We can take him wherever he needs to go. We do have a van and plenty of time. Both the activity director and assistant activity director reported that, since Resident #6's privileges to sign himself out had been taken away on 6/5/17, they had not offered or taken him anywhere. During an interview with the administrator at 2:40 p.m. on 6/16/17, she reported that Resident #6 was refusing to be taken out on pass. She reported that staff were scheduled to take him out 3 times a week, and he refused. During an interview with Resident #6 at 3:28 p.m. on 6/16/17, he asked Can I ask you a question? Can (the administrator) keep me from going off the property? The investigator explained to him that she could keep him from going out unsupervised if he had been unsafe. He then stated Can they do a reevaluation? I've learned my lesson. I'm gonna kill myself. I've gotta get out with tears in his eyes. The investigator asked Resident #6 if he'd be okay with staff taking him to the animal shelter and the library. He stated Yes. That would be great. Resident #6 denied that staff had offered to take him out. During an interview with Resident #6, the administrator, and the DON at 3:58 p.m. on 6/16/17, when Resident #6 told the administrator that he was going crazy in the facility without his electric scooter, the administrator said to him You were crazy before you came here! and laughed. Resident #6, visibly shaking and with tears in his eyes, turned to the investigator and said See? We can't come to her. She hates me. She doesn't care about us. Her job is making sure that the nurses do their jobs. Resident #6 then turned back to the administrator and stated You guys are going to regret not letting me go out. I'm going crazy here. The administrator ended the conversation without resolution by saying that she needed to go see the pharmacist about drug destructions. During an interview with the DON at 5:35 p.m. on 6/16/17, she confirmed that the administrator verbally and mentally abused Resident #6 during the above interview (starting at 3:58 p.m. on 6/16/17) but was hesitant to write a statement. Record review of Resident #6's written statement of the aforementioned conversation revealed At approximately 3:15 p.m., I went to (the investigator's) temporary office because shortly before that (the administrator) had told me that it would take at least 3 months before she would even think about letting me use my power chair. That upset me very much, so I went to (the investigator) to find out why I am being punished so severely. I brought up the fact that when a motorist runs a red light and gets caught, he gets a ticket and goes on his way. Because I have obligations at other places (public library, (cell phone store), store, the need to get away from (facility)), I feel I will go insane being restricted to (the facility). Thank God for (investigator) taking the time to listen to my concerns. Also, I thought my restriction to (the facility) was based solely on my last time in a power chair but now I find out it's an accumulation of all past

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

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.

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F 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) discrepancies. To me, I feel like I am getting a life sentence for a minor infraction. What (the administrator) told me and how it made me feel - sometimes, it's not what a person says, but how they say it. (The administrator) said that (the facility) is willing to take me to (the animal shelter) 3 times a week, but because I sleep in, I don't go (partially true) . (The administrator) makes it seem like this place goes overboard for the residents which, to me, is an outright lie. Her attitude and demeanor makes my stomach turn. I truly believe her dislike of me is why she is being so harsh on me. Record review of the DON's written statement of the aforementioned conversation revealed On 6/16/17 at approximately 5:15 p.m., state surveyor (investigator's name) had spoken with (Resident #6) regarding his concerns about having his electric wheelchair being taken away from him as well as privileges to allow him to go out on pass in his wheelchair without being transported and supervised the entire time. (Resident #6) had been deemed extremely unsafe to do so. When (Resident #6) expressed his feelings, concerns, and needs, the administrator (the administrator's name) responded in several statements and manners which were not only insulting but very demeaning and degrading to (Resident #6). At the time, I (the DON's name) was present along with (the investigator's name), (the administrator's name), (Resident #6's name) in the administrator's office. (The investigator) was trying to communicate and discuss the concerns regarding (Resident #6). (The investigator) informed (the administrator) that (Resident #6) felt confined in our facility . (Resident #6) stated he felt very confined and felt like he was going crazy. (The administrator) laughed at him, threw her arms up in the air, and stated 'You were crazy when you came here!' (Resident #6) was crying and told (the investigator) and me 'See what I mean? She hates me and does not care'. I could go into more detail, however, during the entire meeting, the words, gestures, and overall attitude of (the administrator) were that of both verbal and mental abuse to this resident. During an interview with Resident #6 at 6:45 p.m. on 6/16/17, he said to the investigator You're here once in a while. You don't see the day-to-day things. (The administrator) doesn't care for us residents. She doesn't take the time to listen to us. It's like she doesn't want to be here but has bills to pay. I talk to people and have been through several administrators. It's not just me who dislikes her. The Bible is the only thing that keeps me somewhat grounded. After growing up and working hard all my life, this is not the way I should have to go out. 2. Record review of Resident #7's facesheet (illegible date) revealed that she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #7's quarterly MDS assessment (ARD 5/15/17) revealed that she scored an 8 on the BIMS (indicating moderate cognitive impairment). During an interview with Resident #7 at 10:28 a.m. on 6/14/17, she reported that she was [AGE] years old and had been at the facility since November. She reported that she had a stroke in October, that therapy had been denied, and that she didn't understand it. During an interview with Resident #7 at 11:00 a.m. on 6/15/17, she approached the investigator and again asked about her therapy. The investigator took Resident #7 to the administrator's office so that the administrator could explain the denial of therapy to her. While discussing Resident #7's therapy, the investigator asked the administrator why Resident #7 was at the facility. The administrator, in front of Resident #7, stated She's here because the hospital begged for me to take her. Nobody else wanted her. They discharged her because she was rude and obnoxious. During an interview with Resident #7 at 2:55 p.m. on 6/15/17, when asked about earlier interactions with the administrator, Resident #7 stated It bothered me. She was attacking you. She always gets defensive - like she's trying to hide something. Resident #7 then let the investigator listen to a recording (dated 6/12/17) on her cell phone. The recording was of the administrator's response to Resident #7 knocking on her door to get the Medicaid phone number. The administrator told Resident #7 Here! Here's your number! I'm losing my patience with you. I am taking care of it, but you don't trust me. You're a big girl. Take care of it yourself! During an interview with the administrator at 2:40 p.m. on 6/16/17, she reported that she did not remember the investigator asking her about why Resident #7 was at the facility. The investigator again asked the administrator why Resident #7 was here, and the administrator stated She needed nursing home care. When asked if she remembered telling the investigator that Resident #7 was at the facility because she was rude and obnoxious, the administrator stared blankly and then stated Well - you asked me about her in the hospital and I told you what her behavior was. That was the truth and reality then. If it hurt her feelings, that wasn't the purpose. She's aware of how she was. When asked if that would have hurt her feelings, the administrator stated No. Are you asking me this to prove I was rude? I'm sorry. It was the truth. She knows that's the truth. Record review of the facility's complaints/grievances revealed that, on 6/12/17, an unidentified resident wrote Every time I approach the administrator, she is rude, hostile, and closes the door in my face. The complaint was investigated by the administrator, and the following was documented by her I had a very good talk with (unidentified resident). She admitted I was with someone in my office at the time and closed the door for confidentiality. I also explained to (unidentified resident) that I was not her caregiver and she should direct her questions to her staff. She said they direct her to me. She said I was rude because I always ask her to repeat herself. I explained that I am very hard of hearing but she does not speak up when she wants to talk to me. She also mumbles when she talks according to my ears. Further record review of the facility's complaints/grievances revealed that, on 6/12/17, another identified resident wrote I don't see how (the administrator) calls herself administrator. When I want to talk to her, she tells me to talk to CNA or nurse. When I went to talk to her about a wheelchair, she shut the door in my face. She told me it was too late today and she would talk to me tomorrow. Why couldn't she talk to me for 15 minutes and let me know what the plan was? The complaint was investigated by the administrator, and the following was documented by her (Unidentified resident) calls my name every time she sees me. This was 10 times a day. I just don't have the time to stop and talk to her. She has asked me about an electric wheelchair at least 20 times. I have explained to her that we can request a chair when her Medicaid comes through. We were recently able to talk to the Medicaid supervisor in (unidentified resident's former state). She initiated a form discharging her from (unidentified resident's former state) system. We are now talking to Texas to get her started here. (Unidentified resident) thinks I have nursing duties. Most of what she stops me for are not my job. I am happy to help if necessary, but as administrator, I have too much work to spend a lot of time with residents. (Unidentified resident) stops all staff all day long. She has a compulsive need for constant attention. We are all working together to meet her needs, but she has to learn some boundaries. During an interview with the ADON at 2:10 p.m. on 6/15/17, when asked about the administrator, she was shaking and stated You're not writing anything down? I am on medications because of her. 90% of residents and staff don't like her. She is rude. I don't know what she does besides look at the cameras and smoke. I don't know if she's paranoid or has delusions of grandeur. We wonder what 'the flavor of the day' is - which department is she going to pick on? I don't see how she gets away with what she does. When asked if she felt the residents and staff were afraid to bring issues to the administrator's attention, the ADON stated They come to me and (the DON), and we take their issues to her (the administrator). The ADON told the investigator, before leaving the room, to tell the administrator that we were talking about Resident #7 if the administrator asked what we were talking about. During an interview with the DON at 4:20 p.m. on 6/15/17, she was crying and stated I'm scared to talk to you - can't stay in here long. She will ask what we are talking about. What are we talking about? (The ADON) and I are about to quit. She has made our lives a living hell. The DON reported that residents brought their concerns to her and the ADON instead of to the administrator because they were afraid of her. During an interview with the ombudsman at 9:49 a.m. on 6/16/17, she reported that the facility was an awful place from the top down. She stated There is an attitude of us against them with this administrator. I haven't met the owner but I get the impression that money is the bottom line. The ombudsman reported that she told the administrator about any concerns she had and stated (The administrator) doesn't want me talking to the DON or ADON. The policy is that I sign in and out and give her a list of everyone I talk to. I refuse to do that. She only accepts complaints in writing and on the form (the complaints/grievances form). Later in the conversation, the ombudsman stated The administrator is definitely a problem - awful - awful. I don't think resident care is suffering. I think the nurses do the best they can. I have never gone to either the DON or ADON with care concerns that have not been addressed. The residents come away from (the administrator) with a 'meh' feeling. They aren't comfortable going to her with concerns and say 'She won't do anything. She won't help me' . Why does it have to be so adversarial?. The ombudsman reported that she had never observed verbal/mental abuse but stated Insincere words just flow out of her mouth. During an interview with the DON at 2:33 p.m. on 6/16/17, she reported that she told the administrator she was rude to

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F 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) residents and staff in (MONTH) of (YEAR) and was, consequently, suspended for the day. Record review of the facility's abuse/neglect policy and procedures (dated (MONTH) 2014) revealed Definitions: Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Abuse includes the following: Verbal Abuse: Is defined as any use of oral, written, or gestured language that includes disparaging and derogatory terms to a resident or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability . Mental Abuse: Is defined but nor limited to humiliation, harrassment, threats of punishment, or withholding of treatment or services . Neglect: Is defined as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . Signs and symptoms . A neglected or abused resident may: . withdraw, behave fearfully . The facility's abuse prevention coordinator was the administrator. The owner was notified on 6/16/17 at 7:02 p.m. of the Immediate Jeopardy for the above failures and a Plan of Removal was requested. The facility's Plan of Removal was provided by the owner and accepted at 2:06 p.m. on 6/17/17 and included the following steps to be taken by the facility: 1. The administrator has been terminated as of 6/16/17. 2. The administrator will vacate the premises and will not interact with the residents, and all resident interactions will be initiated by the DON. 3. The administrator will call the owner and schedule the time she will come to the facility to collect her personal affects. The DON will supervise the visit by the administrator and make sure the administrator does not interact with any resident. 4. The DON will immediately in-service the staff on floor and the weekend staff beginning 6/16/17 9:30 p.m. about not allowing the administrator to enter the premises or interact with any of the residents. If administrator is seen on the premises, staff will call the police and will inform the owner. This in-service will be completed for all shifts by 6/17/17. 5. The DON will also in-service the staff immediately, beginning 6/16/17, on how to report abuse to DADS - no matter who the perpetrator is. This in-service will be completed for all shifts by 6/17/17. 6. The DON called in the abuse to the DADS hotline on 6/16/17. 7. An interim administrator has been retained and will start on 6/19/17. Verification of the Plan of Removal was as follows: Observations of the facility from 8:10 p.m. to 9:20 p.m. on 6/16/17, 6:05 p.m. to 7:22 p.m. on 6/17/17, 1:30 p.m. to 4:07 p.m. on 6/18/17, 9:50 a.m. to 4:42 p.m. on 6/19/17, and 12:51 p.m. to 4:47 p.m. on 6/20/17 revealed that the administrator was not on the premises. In-service sign-in sheets and material covered by the in-services was reviewed. The interim administrator, the DON, the ADON, 1 RN, 2 nurses, 1 social worker, 1 maintenance supervisor, and 7 CNAs were interviewed on 6/17/17, 6/18/17, 6/19/17, and 6/20/17. Interviews confirmed staff knowledge regarding abuse and neglect. These failures resulted in an Immediate Jeopardy (IJ) situation identified on 6/16/17. While the IJ was removed on 6/20/17, the facility remained out of compliance at a severity of actual harm with a scope identified as widespread until all staff were in-serviced. According to information provided by the interim administrator on 6/27/17, there were 44 residents who resided in the facility and interacted with the administrator.
F 0225 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse/neglect were thoroughly investigated for 1 of 2 residents (Resident #3) whose abuse/neglect allegations were reviewed in that: Resident #3 alleged that CNA D twisted her arm. The facility did not address or investigate the allegation for more than 2 weeks. This deficient practice could affect 2 residents who made abuse/neglect allegations within the past 3 months by contributing to continued abuse, exposure to the perpetrator, and injury. The findings were: Record review of Resident #3's facesheet (date illegible) revealed that she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #3's quarterly MDS assessment (ARD 5/22/17) revealed that she scored a 14 on the BIMS (indicating that she was cognitively intact). During an interview with CNA E at 6:40 p.m. on 6/17/17, she stated Last week or the week before, (Resident #3) came to me about one of the CNAs and what happened to her. She said that (CNA D) put a pillow over her head and squeezed her hand. She didn't want me to say anything because it was Sunday (6/4/17) and he was still working but she asked that I put her to bed. (Resident #3) was crying. I checked her out and I didn't see anything. I waited to report until Monday (6/5/17) when I came in at 2:00 p.m. (Resident #3) and I were in the hallway with (the administrator). (Resident #3) told (the administrator) '(CNA E) knows and will tell you'. (The administrator) said 'You know how (Resident #3) is. I don't have time for this' and then turned around and walked off. (Resident #3) told her 'I'm not finished yet'. (The administrator) turned and walked off. I felt like an idiot so I know (Resident #3) must have felt like an idiot. I can't go to (the administrator) because she doesn't want to listen. We're trying to do the best we can with these people. When they (administrative staff) don't listen to us or back us up, where do we go? Our hands are tied. When asked if she thought CNA D abused Resident #3, CNA E stated (Resident #3) asked me to look at her hand. She showed me how he grabbed her hand - like he was shaking it. I put my hand the same way, and it fit. There was bruising as if he had grabbed her. Bruising is still on her arm. CNA E reported that CNA D was let go at one point and allowed to come back. She reported that the administrator told the staff Get over it. He was a good aide. CNA E reported that every time she went to the administrator with concerns, she was told I don't have time. CNA E stated I felt like she was coercing me when I wanted to write reports - for (Resident #3), for example. Maybe not coercing - leading me to say things the way she wanted them said. During an interview with CNA F at 1:46 p.m. on 6/18/17, she reported that Resident #3 did not like CNA D and accused him of grabbing her hands and twisting them hard. CNA F stated (Resident #3) told me she talked to (the administrator) and nobody listened. When asked if Resident #3 had bruising, CNA F stated Si! and described fingerprint bruising on top of Resident #3's hand and forearm. During an interview with CNA G at 2:24 p.m. on 6/18/17, she reported that she was afraid to go to the administator and would go to the DON and ADON instead. CNA G reported that residents would try to talk to the administrator and were told I don't have time. CNA G reported that Resident #3 said, approximately 2 weeks ago, that CNA D smothered her with a pillow and that he scratched her. CNA G reported that Resident #3 did make false allegations but had scratches and bruising on her hand and forearm. During an interview with CNA H at 3:15 p.m. on 6/18/17, she reported that the administrator did not give residents a chance to explain and didn't listen to residents or staff. During an interview with CNA H at 2:40 p.m. on 6/19/17, she reported that Resident #3 had bruising on her forearm approximately 2 weeks ago and said that CNA D grabbed her. Observation of Resident #3 at 4:26 p.m. on 6/18/17 revealed that she had a bruise on her right upper shoulder that was approximately 2 and a half inches in diameter and fading. On her left forearm, she had 5 circular bruises. During an interview with Resident #3 at this time, she reported that CNA D pushed her down into the bed and pulled her arm. Resident

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F 0225 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) #3 reported that she told CNA E and the administrator about what CNA D did to her. She said (The administrator) came to look at the bruising and said 'CNA D's a good worker - I can't fire him'. She also said (CNA D) says '(The administrator) likes me. She's not gonna get rid of me'. During an interview with the ADON at 12:59 p.m. on 6/20/17, she reported that she knew nothing about Resident #3's allegation of CNA D grabbing her arm/hand or bruising until the investigator informed her on 6/19/17. During an interview with the DON at 1:25 p.m. on 6/20/17, she reported that she knew nothing about Resident #3's allegation of CNA D grabbing her arm/hand or bruising until the investigator informed her on 6/19/17. During an interview with CNA I at 1:43 p.m. on 6/20/17, she reported that she was present when CNA E and Resident #3 told the administrator about CNA D grabbing Resident #3's wrist. CNA I stated I didn't see the incident, but I did see (CNA E) tell (the administrator). (CNA E) did say that he grabbed her wrist. Record review of the facility's abuse/neglect policy and procedures (dated (MONTH) 2014) revealed Definitions: Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Abuse includes the following: Verbal Abuse: Is defined as any use of oral, written, or gestured language that includes disparaging and derogatory terms to a resident or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability . Mental Abuse: Is defined but nor limited to humiliation, harrassment, threats of punishment, or withholding of treatment or services . Neglect: Is defined as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . Signs and symptoms . A neglected or abused resident may: . withdraw, behave fearfully . The facility's abuse coordinator was the administrator. According to the facility-provided provider investigation reports, there were 2 residents who made abuse/neglect allegations within the past 3 months.
F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement written policies and procedures that prohibited and prevented abuse for 2 of 15 residents reviewed for abuse (Resident #s 6 and 7) in that: 1. Resident #6's electric wheelchair was taken away from him. Resident #6, while crying, said that he was going crazy and was going to kill himself. The administrator told Resident #6 You were crazy when you came here and laughed. 2. The administrator told Resident #7 that she was rude and obnoxious. These failures resulted in an Immediate Jeopardy (IJ) situation identified on 6/16/17. While the IJ was removed on 6/20/17, the facility remained out of compliance at a severity of actual harm with a scope identified as widespread until all staff were in-serviced. This deficient practice could affect all 44 residents at the facility who interacted with the administrator by contributing to feelings of fear, decreased self-esteem, and self-injurious behaviors. The findings were: Record review of the facility's abuse/neglect policy and procedures (dated (MONTH) 2014) revealed Definitions: Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Abuse includes the following: Verbal Abuse: Is defined as any use of oral, written, or gestured language that includes disparaging and derogatory terms to a resident or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability . Mental Abuse: Is defined but nor limited to humiliation, harrassment, threats of punishment, or withholding of treatment or services . Neglect: Is defined as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . Signs and symptoms . A neglected or abused resident may: . withdraw, behave fearfully . The facility's abuse prevention coordinator was the administrator. 1. Record review of Resident #6's facesheet (dated 6/12/17) revealed that he was [AGE] years old, was admitted to the facility on [DATE], and was readmitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #6's quarterly MDS assessment (ARD 5/29/17) revealed that he scored a 10 on the BIMS (indicating moderate cognitive impairment) and had no behaviors or signs/symptoms of [MEDICAL CONDITION]. Record review of Resident #6's 5/17/17 activity quarterly update revealed that he volunteered at the animal shelter 3 times per week, enjoyed feeding the birds, and used an electric wheelchair for mobility. Record review of Resident #6's nursing progress notes revealed that, on 6/5/17 at 12:50 p.m., the administrator received a call from law enforcement dispatch that Resident #6 was crossing a busy street against a traffic light. Several cars had to stop quickly to keep from hitting him. It was documented that this was the second time law enforcement had notified the administrator of Resident #6's reckless and dangerous behaviors while operating his motorized wheelchair on the busy streets. Resident #6 was counseled regarding his unsafe operation of his wheelchair and was instructed not to leave the facility on his own without staff escort. He was advised to be supervised by staff while outside of the facility and to schedule supervised outings with the activities director. Review of Resident #6's 6/5/17 9:25 p.m. nursing progress notes revealed that he was nearly hit by a car when he was on the road going to the library early afternoon. When he returned from his outing, he was counseled about not going out anymore. At 6:00 p.m., he informed the charge nurse that he was going to the grocery store. The charge nurse informed Resident #6 that he was not supposed to leave the building, but Resident #6 left anyway. When he returned to the facility, his power chair was taken away (by the administrator) and a wander guard was attached to it. During an interview with Resident #6 at 10:15 a.m. on 6/15/17, he reported that he was told the week before last (the week of 6/5/17) that he could not go out on pass anymore. He stated If I can't go out, now what? I got places I need to go - (cell phone store), email at the public library, feed the birds - for my own serenity and peace of mind. I need to get away from here. This place is kind of crazy. I can't relate to people here. When asked how no longer having his electric wheelchair affected him, Resident #6 stated I don't want to get out of bed. I'd rather stay in bed. The only reason I am up now is for a doctor's appointment. When asked if the facility had offered other ways for him to leave, Resident #6 said no. He reported that the assistant activity director only went to the grocery store once a month and did not have time to take him to the animal shelter. He reported that, since his electric wheelchair had been taken away, he had not gone anywhere. Resident #6 reported that he had told the ADON and DON about his need to go to the cell phone store and to check his email. They told him It's up to (the administrator). He reported that, when he went to the administrator, she said You need to talk to the treatment team (the ADON and DON). Resident #6 stated They keep putting me off to each other. I am trying to get a hold of the ombudsman. She came in on Tuesday (6/13/17), but I was depressed and didn't want to get out of bed. During an interview with the activity director and assistant activity director at 11:00 a.m. on 6/15/17, the activity director reported that Resident #6 had not informed her that he wanted to go anywhere. She stated We can take him wherever he needs to go. We do have a van and plenty of time. Both the activity director and assistant activity director reported that, since Resident #6's privileges to sign himself out had been taken away on 6/5/17, they had not offered or taken him anywhere. During an interview with the administrator at 2:40 p.m. on 6/16/17, she reported that Resident #6 was refusing to be taken out on pass. She reported that staff were scheduled to take him out 3 times a week, and he refused. During an interview with Resident #6 at 3:28 p.m. on 6/16/17, he asked Can I ask you a question? Can (the administrator) keep me from going off the property? The investigator explained to him that she could keep him from going out unsupervised if he had been unsafe. He then stated Can they do a reevaluation? I've learned my lesson. I'm gonna kill myself. I've gotta

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	676075	A. BUILDING _____ B. WING _____	06/21/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TRISTAR CARE CENTER INC	619 W LIVE OAK RD FREDERICKSBURG, TX 78624

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

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 4) get out with tears in his eyes. The investigator asked Resident #6 if he'd be okay with staff taking him to the animal shelter and the library. He stated Yes. That would be great. Resident #6 denied that staff had offered to take him out. During an interview with Resident #6, the administrator, and the DON at 3:58 p.m. on 6/16/17, when Resident #6 told the administrator that he was going crazy in the facility without his electric scooter, the administrator said to him You were crazy before you came here! and laughed. Resident #6, visibly shaking and with tears in his eyes, turned to the investigator and said See? We can't come to her. She hates me. She doesn't care about us. Her job is making sure that the nurses do their jobs. Resident #6 then turned back to the administrator and stated You guys are going to regret not letting me go out. I'm going crazy here. The administrator ended the conversation without resolution by saying that she needed to go see the pharmacist about drug destructions. During an interview with the DON at 5:35 p.m. on 6/16/17, she confirmed that the administrator verbally and mentally abused Resident #6 during the above interview (starting at 3:58 p.m. on 6/16/17) but was hesitant to write a statement. Record review of Resident #6's written statement of the aforementioned conversation revealed At approximately 3:15 p.m., I went to (the investigator's) temporary office because shortly before that (the administrator) had told me that it would take at least 3 months before she would even think about letting me use my power chair. That upset me very much, so I went to (the investigator) to find out why I am being punished so severely. I brought up the fact that when a motorist runs a red light and gets caught, he gets a ticket and goes on his way. Because I have obligations at other places (public library, (cell phone store), store, the need to get away from (facility)), I feel I will go insane being restricted to (the facility). Thank God for (investigator) taking the time to listen to my concerns. Also, I thought my restriction to (the facility) was based solely on my last time in a power chair but now I find out it's an accumulation of all past discrepancies. To me, I feel like I am getting a life sentence for a minor infraction. What (the administrator) told me and how it made me feel - sometimes, it's not what a person says, but how they say it. (The administrator) said that (the facility) is willing to take me to (the animal shelter) 3 times a week, but because I sleep in, I don't go (partially true) . (The administrator) makes it seem like this place goes overboard for the residents which, to me, is an outright lie. Her attitude and demeanor makes my stomach turn. I truly believe her dislike of me is why she is being so harsh on me. Record review of the DON's written statement of the aforementioned conversation revealed On 6/16/17 at approximately 5:15 p.m., state surveyor (investigator's name) had spoken with (Resident #6) regarding his concerns about having his electric wheelchair being taken away from him as well as privileges to allow him to go out on pass in his wheelchair without being transported and supervised the entire time. (Resident #6) had been deemed extremely unsafe to do so. When (Resident #6) expressed his feelings, concerns, and needs, the administrator (the administrator's name) responded in several statements and manners which were not only insulting but very demeaning and degrading to (Resident #6). At the time, I (the DON's name) was present along with (the investigator's name), (the administrator's name), (Resident #6's name) in the administrator's office. (The investigator) was trying to communicate and discuss the concerns regarding (Resident #6). (The investigator) informed (the administrator) that (Resident #6) felt confined in our facility . (Resident #6) stated he felt very confined and felt like he was going crazy. (The administrator) laughed at him, threw her arms up in the air, and stated 'You were crazy when you came here!' (Resident #6) was crying and told (the investigator) and me 'See what I mean? She hates me and does not care'. I could go into more detail, however, during the entire meeting, the words, gestures, and overall attitude of (the administrator) were that of both verbal and mental abuse to this resident. During an interview with Resident #6 at 6:45 p.m. on 6/16/17, he said to the investigator You're here once in a while. You don't see the day-to-day things. (The administrator) doesn't care for us residents. She doesn't take the time to listen to us. It's like she doesn't want to be here but has bills to pay. I talk to people and have been through several administrators. It's not just me who dislikes her. The Bible is the only thing that keeps me somewhat grounded. After growing up and working hard all my life, this is not the way I should have to go out. 2. Record review of Resident #7's facesheet (illegible date) revealed that she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #7's quarterly MDS assessment (ARD 5/15/17) revealed that she scored an 8 on the BIMS (indicating moderate cognitive impairment). During an interview with Resident #7 at 10:28 a.m. on 6/14/17, she reported that she was [AGE] years old and had been at the facility since November. She reported that she had a stroke in October, that therapy had been denied, and that she didn't understand it. During an interview with Resident #7 at 11:00 a.m. on 6/15/17, she approached the investigator and again asked about her therapy. The investigator took Resident #7 to the administrator's office so that the administrator could explain the denial of therapy to her. While discussing Resident #7's therapy, the investigator asked the administrator why Resident #7 was at the facility. The administrator, in front of Resident #7, stated She's here because the hospital begged for me to take her. Nobody else wanted her. They discharged her because she was rude and obnoxious. During an interview with Resident #7 at 2:55 p.m. on 6/15/17, when asked about earlier interactions with the administrator, Resident #7 stated It bothered me. She was attacking you. She always gets defensive - like she's trying to hide something. Resident #7 then let the investigator listen to a recording (dated 6/12/17) on her cell phone. The recording was of the administrator's response to Resident #7 knocking on her door to get the Medicaid phone number. The administrator told Resident #7 Here! Here's your number! I'm losing my patience with you. I am taking care of it, but you don't trust me. You're a big girl. Take care of it yourself! During an interview with the administrator at 2:40 p.m. on 6/16/17, she reported that she did not remember the investigator asking her about why Resident #7 was at the facility. The investigator again asked the administrator why Resident #7 was here, and the administrator stated She needed nursing home care. When asked if she remembered telling the investigator that Resident #7 was at the facility because she was rude and obnoxious, the administrator stared blankly and then stated Well - you asked me about her in the hospital and I told you what her behavior was. That was the truth and reality then. If it hurt her feelings, that wasn't the purpose. She's aware of how she was. When asked if that would have hurt her feelings, the administrator stated No. Are you asking me this to prove I was rude? I'm sorry. It was the truth. She knows that's the truth. Record review of the facility's complaints/grievances revealed that, on 6/12/17, an unidentified resident wrote Every time I approach the administrator, she is rude, hostile, and closes the door in my face. The complaint was investigated by the administrator, and the following was documented by her I had a very good talk with (unidentified resident). She admitted I was with someone in my office at the time and closed the door for confidentiality. I also explained to (unidentified resident) that I was not her caregiver and she should direct her questions to her staff. She said they direct her to me. She said I was rude because I always ask her to repeat herself. I explained that I am very hard of hearing but she does not speak up when she wants to talk to me. She also mumbles when she talks according to my ears. Further record review of the facility's complaints/grievances revealed that, on 6/12/17, another identified resident wrote I don't see how (the administrator) calls herself administrator. When I want to talk to her, she tells me to talk to CNA or nurse. When I went to talk to her about a wheelchair, she shut the door in my face. She told me it was too late today and she would talk to me tomorrow. Why couldn't she talk to me for 15 minutes and let me know what the plan was? The complaint was investigated by the administrator, and the following was documented by her (Unidentified resident) calls my name every time she sees me. This was 10 times a day. I just don't have the time to stop and talk to her. She has asked me about an electric wheelchair at least 20 times. I have explained to her that we can request a chair when her Medicaid comes through. We were recently able to talk to the Medicaid supervisor in (unidentified resident's former state). She initiated a form discharging her from (unidentified resident's former state) system. We are now talking to Texas to get her started here. (Unidentified resident) thinks I have nursing duties. Most of what she stops me for are not my job. I am happy to help if necessary, but as administrator, I have too much work to spend a lot of time with residents. (Unidentified resident) stops all staff all day long. She has a compulsive need for constant attention. We are all working together to meet her needs, but she has to learn some boundaries. During an interview with the ADON at 2:10 p.m. on 6/15/17, when asked about the administrator, she was shaking and stated You're not writing anything down? I am on medications because of her. 90% of residents and staff don't like her. She is rude. I don't know what she does besides look at the cameras and smoke. I don't know if she's paranoid or has delusions of grandeur. We wonder what 'the flavor of the day' is - which department is she going to pick on? I don't see how she gets away with what she does. When asked if she felt the residents and staff were afraid to bring issues to the administrator's

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	676075	A. BUILDING _____ B. WING _____	06/21/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TRISTAR CARE CENTER INC	619 W LIVE OAK RD FREDERICKSBURG, TX 78624

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 5) attention, the ADON stated They come to me and (the DON), and we take their issues to her (the administrator). The ADON told the investigator, before leaving the room, to tell the administrator that we were talking about Resident #7 if the administrator asked what we were talking about. During an interview with the DON at 4:20 p.m. on 6/15/17, she was crying and stated I'm scared to talk to you - can't stay in here long. She will ask what we are talking about. What are we talking about? (The ADON) and I are about to quit. She has made our lives a living hell. The DON reported that residents brought their concerns to her and the ADON instead of to the administrator because they were afraid of her. During an interview with the ombudsman at 9:49 a.m. on 6/16/17, she reported that the facility was an awful place from the top down. She stated There is an attitude of us against them with this administrator. I haven't met the owner but I get the impression that money is the bottom line. The ombudsman reported that she told the administrator about any concerns she had and stated (The administrator) doesn't want me talking to the DON or ADON. The policy is that I sign in and out and give her a list of everyone I talk to. I refuse to do that. She only accepts complaints in writing and on the form (the complaints/grievances form). Later in the conversation, the ombudsman stated The administrator is definitely a problem - awful - awful. I don't think resident care is suffering. I think the nurses do the best they can. I have never gone to either the DON or ADON with care concerns that have not been addressed. The residents come away from (the administrator) with a 'meh' feeling. They aren't comfortable going to her with concerns and say 'She won't do anything. She won't help me' . Why does it have to be so adversarial?. The ombudsman reported that she had never observed verbal/mental abuse but stated Insincere words just flow out of her mouth. During an interview with the DON at 2:33 p.m. on 6/16/17, she reported that she told the administrator she was rude to residents and staff in (MONTH) of (YEAR) and was, consequently, suspended for the day. The owner was notified on 6/16/17 at 7:02 p.m. of the Immediate Jeopardy for the above failures and a Plan of Removal was requested. The facility's Plan of Removal was provided by the owner and accepted at 2:06 p.m. on 6/17/17 and included the following steps to be taken by the facility: 1. The administrator has been terminated as of 6/16/17. 2. The administrator will vacate the premises and will not interact with the residents, and all resident interactions will be initiated by the DON. 3. The administrator will call the owner and schedule the time she will come to the facility to collect her personal affects. The DON will supervise the visit by the administrator and make sure the administrator does not interact with any resident. 4. The DON will immediately in-service the staff on floor and the weekend staff beginning 6/16/17 9:30 p.m. about not allowing the administrator to enter the premises or interact with any of the residents. If administrator is seen on the premises, staff will call the police and will inform the owner. This in-service will be completed for all shifts by 6/17/17. 5. The DON will also in-service the staff immediately, beginning 6/16/17, on how to report abuse to DADS - no matter who the perpetrator is. This in-service will be completed for all shifts by 6/17/17. 6. The DON called in the abuse to the DADS hotline on 6/16/17. 7. An interim administrator has been retained and will start on 6/19/17. Verification of the Plan of Removal was as follows: Observations of the facility from 8:10 p.m. to 9:20 p.m. on 6/16/17, 6:05 p.m. to 7:22 p.m. on 6/17/17, 1:30 p.m. to 4:07 p.m. on 6/18/17, 9:50 a.m. to 4:42 p.m. on 6/19/17, and 12:51 p.m. to 4:47 p.m. on 6/20/17 revealed that the administrator was not on the premises. In-service sign-in sheets and material covered by the in-services was reviewed. The interim administrator, the DON, the ADON, 1 RN, 2 nurses, 1 social worker, 1 maintenance supervisor, and 7 CNAs were interviewed on 6/17/17, 6/18/17, 6/19/17, and 6/20/17. Interviews confirmed staff knowledge regarding abuse and neglect. These failures resulted in an Immediate Jeopardy (IJ) situation identified on 6/16/17. While the IJ was removed on 6/20/17, the facility remained out of compliance at a severity of actual harm with a scope identified as widespread until all staff were in-serviced. According to information provided by the interim administrator on 6/27/17, there were 44 residents who resided at the facility and interacted with the administrator.
F 0250 **Level of harm -** Actual harm **Residents Affected -** Some	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 3 of 15 residents (Resident #s 7, 1, and 8) whose care was reviewed in that: 1. Resident #7 was not assisted with funding for therapy services within 120 days of her qualifying event (a stroke). Consequently, her health plan denied coverage of therapy services. Resident #7 demonstrated humiliation, anxiety, and depression as a result of not getting therapy. 2. Resident #1 was not assisted with discharge planning. 3. Resident #8 was not assisted with transportation to the sheriff's office for sex offender registration/verification. This deficient practice could affect 3 residents needing therapy, 9 residents wanting to discharge, and 15 residents requiring sex offender registration/verification by contributing to untimely discharge and/or unmet medical and social needs. The findings were: 1. Record review of Resident #7's facesheet (illegible date) revealed that she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #7's quarterly MDS assessment (ARD 5/15/17) revealed that she scored an 8 on the BIMS (indicating moderate cognitive impairment). Record review of Resident #7's 11/10/16 nursing progress note revealed that she fell in her room when working on strengthening alone. Record review of Resident #7's nursing progress note dated 11/13/16 revealed Resident very agitated this morning . States she feels bad/embarrassed that others see her in this condition. Resident stated that wheelchair is not comfortable, she needs another chair and a non slip pad because she slips out of her chair due to not having any control of her left side. Resident wants therapy, states she should have Medicaid and wants to rehabilitate as soon as possible with physical therapy. Record review of Resident #7's 12/28/16 social services assessment revealed that she was in need of physical, occupational, and therapy services for a cerebrovascular accident and was awaiting Medicaid approval. Record review of Resident #7's nursing progress note dated 2/15/17 revealed Resident fixated on therapy and wanting to use a cane. Resident saw nurse pracitioner and began asking her about insurance, Medicaid, therapy, cane use. LVN discussed the need to have physical and occupational therapy evaluation and treatment and if they saw need for cane or other assistive device, they will order. Resident still unaware of Medicaid status and is frustrated with having to wait. Resident saying 'I can't wait for physical therapy. I have to get out of here. I have a child that needs me. I am doing therapy alone trying to get better'. Resident was taught range of motion exercises by staff to keep movement in affected extremities. Resident asked not to attempt walking unassisted to prevent injury to self. Record review of Resident #7's Medicaid card revealed that is was sent to the facility on [DATE]. On 2/16/17, after receiving a Medicaid number for Resident #7, the facility got a physician's orders [REDACTED]. Record review of Resident #7's physician telephone orders (dated 2/16/17 and 3/29/17) revealed that she was to be evaluated and treated by physical and occupational therapy post cerebrovascular accident. Record review of Resident #7's medical enrollment form for her health plan revealed that it was mailed by the facility on 2/27/17. Record review of Resident #7's health plan card revealed that it was effective 4/1/17. Record review of Resident #7's physician telephone order (dated 4/10/17) revealed that she was to be provided with physical

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	676075	A. BUILDING _____ B. WING _____	06/21/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0250 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 6) therapy 3 times a week for 4 weeks after approval was received from Medicaid. Record review of Resident #7's physician telephone order (dated 4/14/17) revealed that she was to be provided with occupational therapy 3 times a week for 4 weeks pending Medicaid approval. Record review of a notice of denial of medical coverage from Resident #7's health plan (dated 4/13/17) revealed that physical therapy 3 times a week for 4 weeks was denied because there was no clinical information presented to show that therapy was needed for the treatment of [REDACTED]. Record review of a letter from Physical Therapist A (not dated or addressed) revealed that Resident #7 needed therapy services for a cerebrovascular accident [DIAGNOSES REDACTED]. Her therapy treatment plan and goals were specified in this appeal letter. Record review of a letter from Resident #7's health plan to Resident #7 (dated 4/26/17) revealed that they had received the facility's 4/24/17 appeal and would complete the appeal request within 30 days. However, at the bottom of this letter was Fast appeals: You have the right to request a fast appeal. You can request a fast appeal if you or your provider thinks that waiting 30 days for a standard appeal could put your life or health in danger. Record review of an email (dated 4/26/17) from Resident #7's primary care physician to her health plan revealed that he was appealing the denial for Resident #7's therapy services based on her [DIAGNOSES REDACTED]. On 5/4/17, Resident #7's health plan informed the facility (by letter) that, because Resident #7's qualifying event was more than 120 days before, they could not cover therapy services for her. Resident #7's primary care physician was notified about the second denial on 5/4/17 and there was no documentation of further action. During the entrance conference at 9:30 a.m. on 6/14/17, the administrator reported that the facility had a young resident who needed therapy services and couldn't get them because it had been more than 120 days since her qualifying event and her Medicaid wouldn't cover them. During an interview with Resident #7 at 10:28 a.m. on 6/14/17, she reported that she was [AGE] years old and had been at the facility since November. She reported that she had a stroke in October, that therapy had been denied, and that she didn't understand it. She reported that she tried to exercise on her own but was a fall hazard. She stated It's harder than I thought it would be and I need help. Observation of Resident #7 at 9:45 a.m. on 6/15/17 revealed that she was sitting in her wheelchair, talking on the phone, and crying about not getting therapy. She reported that there were no CNAs to walk her and that they were too busy. I have to do it where the cameras can't see me. During an interview with Resident #7 at 11:00 a.m. on 6/15/17, she approached the investigator and again asked about her therapy. The investigator took Resident #7 to the administrator's office so that the administrator could explain the denial of therapy to her. The business office manager was called in. Record review of correspondence between the facility and the Medicaid/health plan offices pertaining to Resident #7's coverage at this time revealed that no action was taken by the facility from 11/8/16 to 2/27/17 and from 5/4/17 to present. The administrator confirmed this during the 6/15/17 11:05 a.m. meeting with Resident #7 and the business office manager. During a phone interview with Physical Therapist A at 1:54 p.m. on 6/16/17, she reported that therapy had been requested for Resident #7 and that Medicaid had denied it. Physical Therapist A reported that she had tried to appeal the decision but that therapy for Resident #7 still had not been approved. Physical Therapist A stated She needs it. We were all shocked that it was denied. (Her health plan) said that it was a very old stroke, but I don't believe that. Documentation shows old stroke, recovery, and another stroke. I think she has potential for progress and should have therapy. Physical Therapist A reported that she wrote her appeal letter the day after the facility got notice that coverage for Resident #7 had been denied. She stated This lady has really good rehab potential. An evaluation was done on 4/10/17 and was sent to Medicaid. Medicaid denied therapy. I wrote the appeal letter and have heard nothing from the facility. I asked about it, and the facility said they hadn't gotten a response. During an interview with the facility's social worker at 1:30 p.m. on 6/19/17, she reported that Resident #7 had wanted therapy for a long time and was frustrated about the situation. The social worker stated She knew her muscles would decline, but it is difficult to get therapy with no funding source. I tried to get her to another facility because they offered services pro bono, but they denied her because of her history of behaviors. The social worker reported that the business office manager had been doing the funding work pertaining to Resident #7. She then stated If I was a full-time social worker, I would be working with the business office manager hand in hand and pushing to get it done quicker. Observation of Resident #7 talking to staff at 12:15 p.m. on 6/21/17 revealed that she stated I had a dream about being in my wheelchair. That's not cool. I used to dream about walking around. 2. Record review of Resident #1's facesheet (date illegible) revealed that he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. There was a post-it note on his facesheet that showed his location monitor was taken off on 4/20/17. Record review of Resident #1's initial social services assessment (dated 4/2/15) revealed that he wanted to go back to another city where he had previously resided. Record review of Resident #1's 5/30/17 social services quarterly MDS assessment revealed that he scored a 14 on the BIMS (indicating that he was cognitively intact). Record review of Resident #1's social services progress notes revealed that he had been expressing a desire to discharge to the community since 9/21/15. On 12/7/15, 4/12/16, and 5/30/17, the desire to discharge was again expressed. During an interview with the ombudsman at 9:49 a.m. on 6/16/17, she stated This place will not do anything to actively help someone who wants to live in another city. When asked if that was because there was no full-time social worker, the ombudsman said yes. She reported that the facility was the only one who took Medicaid-pending residents and stated They tend to get people from places who want to move people out. Once requests come in, the facility sends records but they don't try to send people out. The ombudsman reported that nobody was advocating for the residents at the facility and that she spent most of her time there. During an interview with Resident #1 at 10:55 a.m. on 6/16/17, he reported that he had been at the facility for 2 and half years and wanted to leave but got no help. He reported that his case worker was not full-time staff. During an interview with the social worker at 1:30 p.m. on 6/19/17, she reported that she was working on discharge planning for Resident #s 1, 7, and 6 other unidentified residents and then stated Some of these might not be so rushed to get out of here now that (the administrator) is gone. When asked what the normal timeline for discharge planning was, the social worker stated It's harder for this population secondary to mental illness and criminal backgrounds. They don't have family to transport them. The time is lengthier here than normal . (Resident #1) just got his monitor off . He doesn't want to just go to another facility . If Medicaid, he almost has to. I am trying to get him to go to a nursing home in (the city where he previously resided). I was just made aware of his desire to discharge at the time of his last quarterly - 5/30/17. 3. Record review of Resident #8's facesheet (date illegible) revealed that he was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #8's 5/18/17 BIMS assessment revealed that he scored a 10 (indicating moderate cognitive impairment). Record review of Resident #8's Texas Department of Public Safety Sex Offender Update Form (at the front of his chart) revealed that he last registered on 1/12/17 and was supposed to verfiy his registration every 90 days. During an interview with the parole officer at 11:21 a.m. on 6/16/17, he reported that his sex offender residents had to register and that the facility had to take them to the sheriff's office to do this. He reported that Resident #8 was supposed to verify his registration every 90 days and that he last registered in January. The facility had not taken him to verify his registration since January. During an interview with the administrator at 2:40 p.m. on 6/16/17, she reported that it was the parolee's responsibility to keep up with registration/verification. She said If the resident and the parole officer don't tell us, we have no way of knowing. During an interview with the administrator at 12:00 p.m. on 6/15/17, she reported that a social worker came to the facility twice a month and spent her time figuring out where she was when she was at the facility last. When asked if the facility could benefit from a full-time social worker, the administrator stated That's a stupid question. Of course. During an interview with the social worker at 1:30 p.m. on 6/19/17, she reported that she came to the facility twice a month and usually stayed for about 7 hours. When asked what determined her workload, the social worker reported that she went to the DON's office and that the DON let her know what residents' needs were. She reported that the facility's MDS nurse left

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	676075	A. BUILDING _____ B. WING _____	06/21/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TRISTAR CARE CENTER INC	619 W LIVE OAK RD FREDERICKSBURG, TX 78624

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0250 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 7) her a list of quarterly assessments that were due. She reported that most of her visits were spent doing MDS and BIMS assessments and some discharge planning. When asked who handled social services issues in her absence, the social worker stated The DON and ADON. The administrator let me know of things but didn't handle it - kind of deferred it. The social worker reported no real interaction with the administrator or the ombudsman. The social worker stated With this population, for sure, the facility could use more social services hours. When I initially started, I was doing quarterly MDS assessments and was not doing the BIMS assessments. When (the administrator) started, I got the BIMS stuff. That leaves little time for real social services work. (The administrator) said she would handle everything else if I would do the BIMS assessments. Even if I wasn't doing the BIMS assessments though, this facility could use more social services hours. One time a week would be good for social services - at least 3 times a month - 16 hours a month isn't enough. She stated (The administrator) could handle discharge planning if it was somebody she wanted gone. If she didn't want somebody to discharge because of census and not a problem resident, she'd say family had to help - didn't give me a list of other facilities like she gave me for other residents - I'd have to come up with a list myself and that takes time. The social worker reported that the administrator would not allow the business office manager to attend morning meetings and rehabilitation meetings and that the business office manager was not aware of discharges. She stated There are forms regarding coming off Medicare, etc. The DON and ADON didn't even know what these forms were. The business office manager said somebody went off Medicaid at the end of (MONTH) - nobody knew or told her. She found out when the therapist called. How can nurses not know about therapy?! The whole census has been wrong since the end of (MONTH) because of this resident. The social worker reported that she was not invited to attend interdisciplinary team meetings. She stated I tried to keep myself from (the administrator) because I never knew which (administrator's name) I was going to get. One month, I went over my hours and she got on me. The next month, I only put in 12 hours and she chewed me out for that too. She did ask me to come to one QA meeting because the medical director wanted to talk to me about a certain resident. The medical director wanted me to do something. (The administrator) wasn't in agreement with the medical director and me. She never let me come to a QA meeting again. Most of the discharges and stuff I was working on, I couldn't tell her about. If she found out, she probably would have fired me. It's my duty as a social worker to help plan if someone says they want to discharge. Record review of the facility's director of social services job description (dated 11/1/99) revealed Responsible for admissions procedure from preadmission through admission and discharge. Responsible for managing policies and procedures for determining and assessing residents' long range and short range goals for social, psychological, emotional, and financial needs . A social worker, licensed of temporarily licensed by the State of Texas, must be utilized as Community/Family Support Coordinator whose functions must include: a. evaluation of resident's initial social history on admission, b. utilization of community resources . Assists with financial needs of resident, stressing confidentiality of records, and notifies proper facility departments of Medicaid coverage . According to information provided by the interim administrator on 6/26/17, there were 2 residents (in addition to Resident #7) in need of therapy. According to the social worker on 6/19/17, there were 9 residents in need of discharge planning. According to the ADON on 6/14/17, the facility had 15 sex offender residents.
F 0253 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide housekeeping and maintenance services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 1 of 15 residents reviewed for environment issues (Resident #1) in that: The linoleum in Resident #1's bathroom was coming up, and half of his closet door was missing. This deficient practice could affect the 2 residents in Resident #1's room by contributing to feelings of unimportance and institutionalized living. The findings were: Record review of Resident #1's facesheet (date illegible) revealed that he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's 5/30/17 social services quarterly MDS assessment revealed that he scored a 14 on the BIMS (indicating that he was cognitively intact). Observation of Resident #1's room at 10:50 a.m. on 6/16/17 revealed that the linoleum in his bathroom was coming up along the edges of the wall and at the toilet base. The right half of his folding closet door was missing. During an interview with Resident #1 at 10:55 a.m. on 6/16/17, he reported that his closet door and bathroom made him feel bad. I am paying $3,750 a month here. It's my home. This whole place needs to be bulldozed. Resident #1 reported that the new maintenance supervisor tried to fix everything but needed help. Record review of the maintenance log book revealed no documentation pertaining to Resident #1's broken/missing closet door or detached bathroom linoleum. During an interview with the maintenance supervisor at 1:32 p.m. on 6/16/17, he reported that he started working at the facility 2 weeks ago and wasn't aware of Resident #1's detached linoleum or broken/missing closet door. During an interview with the administrator at 2:40 p.m. on 6/16/17, she reported that she had no knowledge of Resident #1's broken/missing closet door or detached bathroom floor. She reported that the facility policy/procedure was for residents/staff to fill out a written request for needed maintenance and put in the maintenance log book. The maintenance supervisor then reviewed the log book and fixed items according to documentation there. During an interview with Resident #1 at 3:48 p.m. on 6/16/17, he reported that his closet door had been broken/missing for 6 months and that his bathroom floor had been coming up since he was admitted to the facility. He reported that he had informed the maintenance supervisor and several other staff but that there had been turnover since. Record review of the facility's room roster (provided on 6/14/17) revealed that there were 2 residents in Resident #1's room.
F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs for 1 of 8 residents (Resident #4) whose care plans were reviewed in that: Resident #4's wandering and aggressive behaviors were not addressed in his care plan. This deficient practice could affect 17 residents at the facility with behaviors by contributing to continued behaviors and injury. The findings were: Record review of Resident #4's facesheet (dated 5/8/17) revealed that he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #4's initial MDS assessment (ARD 5/15/17) revealed no behaviors. He was unable to complete the BIMS. Record review of Resident #4's care plan (last reviewed by the interdisciplinary team on 5/17/17) revealed no address of behaviors other than elopement. During an interview with Resident #5 at 11:13 a.m. on 6/14/17, he reported that Resident #4 wandered into male and female rooms, pulled the curtains and shut the doors, and hid in their beds and wet them. Resident #5 reported that staff just said He don't know any better. Resident #5 reported that Resident #4 did know better because he knew enough to close the door and pull the curtain. Record review of Resident #5's MDS assessment (ARD 6/5/17) revealed that he scored a 14 on the BIMS (indicating that he was cognitively intact). During an interview with Resident #11 at 12:35 p.m. on 6/14/17, she reported that Resident #4 had been in her bed 3 times

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	676075	A. BUILDING _____ B. WING _____	06/21/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TRISTAR CARE CENTER INC	619 W LIVE OAK RD FREDERICKSBURG, TX 78624

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F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) and that staff did nothing but say Oh he doesn't know any better. Resident #11 reported that Resident #4 did know better because he pulled the curtain. She reported that staff were not watching Resident #4 closely enough and that it made her feel bad. Record review of Resident #11's BIMS assessment (dated 6/6/17) revealed that she scored a 15 (indicating that she was cognitively intact). During an interview with the ADON at 2:08 p.m. on 6/14/17, when asked what the facility was doing to address Resident #4's wandering behaviors, she reported that they put a sign up on his room door to let him know that room was his. They told other residents to pull their call lights when he was in their rooms. The ADON stated He does frustrate the other residents. The aides change the linens on their beds after he has been in them. With his mental status, keeping an eye on him is hard. He is normally within eyesight and hasn't done that in a week. He sits across from the nursing station and asks to be taken to the bathroom. The ADON reported that the facility had enough staff to monitor Resident #4. However, when asked how he was repeatedly getting into other residents' beds, she stated He's fast. Any time you get 40 people with behaviors under one roof, things are going to happen. During an interview with the assistant activity director at 4:15 p.m. on 6/14/17, she reported that Resident #4 wandered into other residents' rooms, closed the door, pulled the curtain, and got in their bed. She reported that the facility tried to monitor and redirect him. She reported that Resident #4 usually did not participate in activities and just roamed the building. During a phone interview with CNA D at 9:49 a.m. on 6/15/17, he reported that Resident #4 wandered into other residents' rooms. CNA D reported that Resident #11 got upset with Resident #4 for laying in her bed and threatened to kill him. When asked what he did when he saw Resident #4 go into someone else's room, CNA D stated There's not much I can do. He knows where his room is. I think he does it intentionally. We are used to him roaming around the building. He gets caught quick and is not in rooms for a long period of time. During an interview with the ombudsman at 9:49 a.m. on 6/16/17, she reported that she submitted a complaint from Resident #1 pertaining to Resident #4. She reported that Resident #1 was afraid he was going to explode, punch Resident #4, and have to go back to prison. Resident #1 told her that he felt on edge every day because of Resident #4's behaviors. The ombudsman reported that other residents had complained to her about Resident #4's bed hopping as well. During an interview with Resident #1 at 10:55 a.m. on 6/16/17, he reported that Resident #4 would lay in his bed and talk about killing people. He reported that it had gotten better and that facility staff were coming to get Resident #4 from the room at 5:30 a.m. and putting him at the nursing station for observation. Record review of Resident #1's MDS assessment (ARD 5/30/17) revealed that he scored a 14 on the BIMS (indicating that he was cognitively intact). During an interview with Resident #4's parole officer at 11:21 a.m. on 6/16/17, he reported that he advised the administrator not to take Resident #4 secondary to his cases of aggravated sexual assault and dementia. The parole officer reported that the administrator took Resident #4 anyway and that Resident #4 immediately started getting in/out of other residents' beds. He stated I did talk to the administrator about (Resident #4). All these guys have are their beds. Record review of the facility's complaints/grievances revealed that Resident #1 found Resident #4 in his bed on 5/24/17 and 5/31/17, that Resident #1 complained about Resident #4's aggressive and destructive behaviors on 5/15/17 and 5/17/17, that Resident #13 found Resident #4 in his bed twice the week of 5/24/17, and that Resident #19 complained about Resident #4's behaviors of wandering/rummaging on 5/24/17. Record review of the facility's incident/accident reports revealed that Resident #4 was physically aggressive with Resident #3 on 5/4/17. Observations of Resident #4 in his wheelchair at the nursing station at 12:42 p.m. and 2:25 p.m. on 6/14/17; 9:30 a.m., 10:09 a.m., 10:32 a.m., and 1:00 p.m. on 6/15/17; 10:48 a.m. and 1:33 p.m. on 6/16/17; 6:05 p.m. on 6/17/17; 1:39 p.m. on 6/18/17; and 11:23 a.m. on 6/19/17 revealed that he was being supervised. During the exit conference at 4:56 p.m. on 6/20/17, the ADON and DON confirmed that Resident #4's wandering and aggressive behaviors were not addressed in his care plan and should have been. They reported that the facility had no policy for care plans but based them on MDS assessments. They reported that they tried to individualize care plans and tried to care plan any behaviors, changes in condition, etc. According to information provided by the interim administrator on 6/26/17, there were 17 residents with behaviors.
F 0287 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Encode and automate the resident's assessment data.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to, within 14 days after they completed a resident's assessment, electronically transmit encoded, accurate, and complete MDS data to the CMS system for 1 of 15 residents (Resident #4) whose MDS assessments were reviewed in that: Resident #4's initial MDS assessment had not been electronically transmitted to the CMS assessment 30 days after its completion. This deficient practice could affect 46 residents at the facility more than 14 days by contributing to inadequate care and reduced funding for care needs. The findings were: Record review of Resident #4's facesheet (dated 5/8/17) revealed that he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #4's clinical record revealed no MDS assessment. During an interview with the ADON at 2:08 p.m. on 6/14/17, she reported that an MDS assessment for Resident #4 had not been completed. During an interview with the ADON at 1:38 p.m. on 6/15/17, she reported that Resident #4's initial MDS assessment had been done but had not been electronically tranmitted into the CMS system. The ADON presented the investigator with Resident #4's initial MDS assessment (ARD 5/15/17) at this time. According to the ADON and DON at the exit conference on 6/21/17, all 46 residents had been at the facility more than 14 days.
F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that 1 of 15 residents reviewed for safety (Resident #6) received adequate supervision to prevent accidents in that: Resident #6 was determined to be unsafe outside of the facility in his electric wheelchair. He was observed in his electric wheelchair outside of the facility, and staff were unaware. This deficient practice could affect 6 residents who signed themselves out on pass unsupervised by contributing to accidents with or without injury. The findings were: Record review of Resident #6's facesheet (dated 6/12/17) revealed that he was admitted to the facility on [DATE] and was readmitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #6's quarterly MDS assessment (ARD 5/29/17) revealed that he scored a 10 on the BIMS (indicating moderate cognitive impairment) and had no behaviors or signs/symptoms of delirium. He was assessed as needing the extensive assistance of one person for locomotion off the unit. Record review of Resident #6's nursing progress notes revealed that, on 6/5/17 at 12:50 p.m., the administrator received a call from law enforcement dispatch that Resident #6 was crossing a busy street against a traffic light. Several cars had to stop quickly to keep from hitting him. It was documented that this was the second time law enforcement had notified the administrator of Resident #6's reckless and dangerous behaviors while operating his motorized wheelchair on the busy streets. Resident #6 was counseled regarding his unsafe operation of his wheelchair and was instructed not to leave the facility on his own without staff escort. He was advised to be supervised by staff while outside of the facility and to

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	676075	A. BUILDING _____ B. WING _____	06/21/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TRISTAR CARE CENTER INC	619 W LIVE OAK RD FREDERICKSBURG, TX 78624

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F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 9) schedule supervised outings with the activities director. Further review of Resident #6's 6/5/17 9:25 p.m. nursing progress notes revealed that he was nearly hit by a car when he was on the road going to the library early afternoon. When he returned from his outing, he was counseled about not going out anymore. At 6:00 p.m., he informed the charge nurse that he was going to the grocery store. The charge nurse informed Resident #6 that he was not supposed to leave the building, but Resident #6 left anyway. When he returned to the facility, his power chair was taken away and a wander guard was attached to it. Record review of Resident #6's 5/17/17 activity quarterly update revealed that he volunteered at the animal shelter 3 times per week, enjoyed feeding the birds, and used an electric wheelchair for mobility. Record review of Resident #6's care plan (last reviewed by the interdisciplinary team on 5/18/17) revealed that he was counseled regarding unsafe and reckless operation of his motorized wheelchair on 6/5/17. His knowledge deficit related to safety awareness and potential dangers of leaving the facility independently was documented, and he was informed of the hazards - electric wheelchairs prohibited on the streets, no sidewalks around the vicinity of the facility, heavy traffic, streets not level, no bicycle lanes, and unsafe road conditions. He was encouraged to utilize the facility's safe transportation by scheduling outings with the activity director. During an interview with the administrator and the DON at 3:00 p.m. on 6/14/17, when asked how the facility determined whether or not a resident was able to sign out on pass independently, the administrator stated We base it on cognition and diagnosis - if they can walk down the street. The DON nodded in agreement. They reported that there was no formal assessment. When asked how the facility determined whether a resident was safe enough to sign out on pass independently, the administrator and DON gave the investigator a blank stare. The administrator then reported that residents proved themselves capable and stated They're free, white, and over 21. They're adults - not in prison - and then have the right to come and go as they choose. During an interview with the administrator at 5:00 p.m. on 6/14/17, she reported that law enforcement first reported Resident #6 was doing wheelies. When she questioned Resident #6 about it, he told her he was turning himself around. The administrator stated The police are suspect of all our residents. He is an intelligent man. The administrator reported that Resident #6 was then accused of drinking at the facility with alcohol that he bought while out on pass. The facility called Resident #6's physician and got an order prohibiting him from drinking alcohol with his medications. The administrator reported that Resident #6 then signed himself out on pass, volunteered at the animal shelter, and adjusted his behavior. She reported that law enforcement called about Resident #6 again and said that he was crossing a busy street against a light, the light turned, and several cars had to stop to avoid hitting him. She stated At that point, we determined he was unsafe and we took away his privileges. If he can't follow the rules, we'll have to discharge him. Three times in his past, he tried to commit suicide. His unsafe maneuvering of the electric wheelchair is suspect of suicide - traffic danger. During an interview with Resident #6 at 10:15 a.m. on 6/15/17, he reported that he was told the week before last that he could not go out on pass anymore. He stated If I can't go out, now what? I got places I need to go - (cell phone store), email at the public library, feed the birds - for my own serenity and peace of mind. I need to get away from here. This place is kind of crazy. I can't relate to people here. When asked if the facility had offered other ways for him to leave, Resident #6 said no. He reported that, since his electric wheelchair had been taken away, he had not gone anywhere. Resident #6 reported that he had told the ADON and DON about his need to go to the cell phone store and to check his email. They told him It's up to (the administrator). He reported that, when he went to the administrator, she said You need to talk to the treatment team (the ADON and DON). Observation of Resident #6 at 10:15 a.m. on 6/15/17 revealed that he was in a regular wheelchair. During an interview with Resident #6 at 3:28 p.m. on 6/16/17, he reported that he'd be okay with staff taking him to the animal shelter and the library. Resident #6 denied that staff had offered to take him out. Observation of Resident #6 at 3:28 p.m. on 6/15/17 revealed that he was in a regular wheelchair. During an interview with Resident #6, the administrator, and the DON at 3:58 p.m. on 6/16/17, Resident #6 told the administrator that he was going crazy in the facility without his electric scooter. He felt that he was being punished severely and had obligations at other places. The DON reported that Resident #6's electric wheelchair had been taken away from him and that he was no longer allowed to go out on pass in his wheelchair without being transported and supervised the entire time. The DON reported that Resident #6 had been deemed extremely unsafe to do so. During an interview with the DON at 10:08 a.m. on 6/19/17, she reported that the facility was going to give Resident #6 his electric wheelchair back for inside use only. She reported that Resident #6 had been instructed not to take his electric wheelchair outside of the facility and not to sign himself out on pass with it. Observation of Resident #6 in his electric wheelchair at 12:29 p.m. on 6/21/17 revealed that he was down the street from the facility - unsupervised and close to a bridge. During an interview with the DON at 1:05 p.m. on 6/21/17, when told that Resident #6 was observed in his electric wheelchair down the street from the facility, she stated That was NOT part of the agreement. He was given his scooter for inside use only and was told it was for inside use only. The DON was observed going to the nursing station to check the sign-out book. She reported that Resident #6 had not signed out, and both of the nurses at the nursing station had no knowledge of him leaving the facility. During an interview with Resident #6, the DON, and the interim administrator at 1:14 p.m. on 6/21/17, Resident #6 confirmed that he had been told not to leave the facility unsupervised with his electric wheelchair. He reported that he did it anyway because he felt confined. Resident #6 reported that he went to a drug store. The drug store was approximately one mile from the facility, and Resident #6 had to cross a high-traffic street to get there. According to the administrator at 3:00 p.m. on 6/14/17, there were 6 residents who signed themselves out on pass without staff supervision or family.
F 0363 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Make sure menus meet the resident's nutritional needs and that there is a prepared menu by which nutritious meals have been planned for the resident and followed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the menus were followed at 2 of 3 observed meals in that: 1. The menu indicated 2 pancakes and 2 sausage patties were to be served for dinner. One pancake and 1 sausage patty were served. 2. The menu indicated cottage cheese and peaches were to be served for dinner. Bread pudding was served instead. 3. The menu indicated baked potatoes, Texas toast, and gelatin with whipped topping were to be served for lunch. Au gratin potatoes, bread slices, and peach cobbler were served instead. This deficient practice could affect 45 residents at the facility who received meals/snacks provided by the kitchen by contributing to poor intake and weight loss. The findings were: Record review of the facility's extended menu cycle revealed that, for dinner on 6/16/17, 2 pancakes, 2 sausage patties, syrup, and cottage cheese and peaches were to be served. For lunch on 6/21/17, country-fried steak and gravy, a baked potato, California vegetable medley, Texas toast, and gelatin with whipped topping were to be served. Observation of the dining room at 5:38 p.m. on 6/16/17 revealed that residents were served 1 pancake, 1 sausage patty, a tossed salad, and bread pudding. Observation of the dining room at 11:50 a.m. on 6/21/17 revealed that residents were served country-fried steak and gravy, au gratin potatoes, mixed vegetables, a slice of bread, and peach cobbler. During an interview with Cook C at 3:15 p.m. on 6/21/17, she reported that the dietary manager had left for the day. She reported that, when substitutions to the planned menu were needed, she would call the dietary manager and check with him first. Cook C reported that she did not record menu substitutions anywhere. During a phone interview with the dietary manager at 3:40 p.m. on 6/21/17, when asked why au gratin potatoes were served instead of baked potatoes at lunch, he reported that the residents meal of the month was on 6/22/17 and that they were serving baked potatoes for that meal. The dietary manager reported hat he recorded menu substitutions for review by the

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	676075	A. BUILDING _____ B. WING _____	06/21/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TRISTAR CARE CENTER INC	619 W LIVE OAK RD FREDERICKSBURG, TX 78624

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

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F 0363 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 10) facility's consultant dietitian. He reported that bread pudding was served instead of cottage cheese with peaches on 6/16/17 because the residents didn't like cottage cheese. The dietary manager had no explanations for the pancake and sausage patty serving sizes not in accordance with the planned menu, the bread instead of the Texas toast, and the peach cobbler instead of the gelatin. Record review of the menu substitution record revealed that, on 6/16/17, bread pudding was served instead of peaches and cottage cheese because the kitchen was out of cottage cheese and that, on 6/21/17, au gratin potatoes were served instead of a baked potato (no reason documented). No other meal substitutions for 6/16/17 and 6/21/17 were documented. Record review of the facility's Trayline Checklist (2013) revealed Extended menu posted at trayline. Menu is followed. Any substitutions are documented on sub form . Check menu for portion sizes . According to information provided by the interim administrator on 6/26/17, there was one resident who needed a [DEVICE] for nutrition. The census at entry was 46.
F 0364 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Prepare food that is nutritional, appetizing, tasty, attractive, well-cooked, and at the right temperature.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that each resident received and the facility provided food that was palatable for 2 of 4 residents (Resident #s 12 and 18) observed at meal time in that: Resident #s 12 and 18 were served hard French fries for dinner. This deficient practice could affect 45 residents at the facility who received meals/snacks provided by the kitchen by contributing to poor intake and weight loss. The findings were: Observation of the dining room at 5:38 p.m. on 6/16/17 revealed that fish and French fries were served as the alternate to the regular menu of pancakes and sausage. Resident #s 12 and 18 had plates of fish and French fries in front of them. During an interview with Resident #12 at 5:38 p.m. on 6/16/17, he reported that the French fries were as hard as a rock. Resident #18 nodded in agreement. The investigator, with Resident #12's permission, tried to cut one of his French fries with a fork. The French fry broke apart, and half of it flew across the table. Record review of Resident #12's facesheet (date illegible) revealed that he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #12's 3/3/17 BIMS assessment revealed that he refused to complete it. Record review of the facility's menu cycle revealed that the regular menu for lunch on 6/16/17 included oven-fried fish, steak fries, cole slaw, bread, and strawberry cake. During an interview with Cook B at 5:46 p.m. on 6/16/17 (Resident #17 brought Resident #12's plate to her and helped with translation), she confirmed that the French fries served for dinner were hard. She reported that they were baked in the oven and were leftovers from the lunch meal. Record review of the facility's Trayline Checklist (2013) revealed Food is appetizing, not over or undercooked. According to information provided by the interim administrator on 6/26/17, there was one resident who needed a [DEVICE] for nutrition. The census at entry was 46.
F 0406 **Level of harm** - Actual harm **Residents Affected** - Few	**Give or get specialized rehabilitative services per the patient's assessment or plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide or obtain the required physical and occupational therapy services required in 1 of 15 residents (Resident #7's) comprehensive plan of care in that: Resident #7 was not assisted with funding for therapy services within 120 days of her qualifying event (a stroke). Consequently, her health plan denied coverage of therapy services. Resident #7 demonstrated humiliation, anxiety, and depression as a result of not getting therapy. This deficient practice could affect 3 residents at the facility who needed therapy by contributing to a decline in Activities of Daily Living function. The findings were: Record review of Resident #7's facesheet (illegible date) revealed that she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #7's quarterly MDS assessment (ARD 5/15/17) revealed that she scored an 8 on the BIMS (indicating moderate cognitive impairment). Record review of Resident #7's 11/10/16 nursing progress note revealed that she fell in her room when working on strengthening alone. Record review of Resident #7's nursing progress note dated 11/13/16 revealed Resident very agitated this morning . States she feels bad/embarrassed that others see her in this condition. Resident stated that wheelchair is not comfortable, she needs another chair and a non slip pad because she slips out of her chair due to not having any control of her left side. Resident wants therapy, states she should have Medicaid and wants to rehabilitate as soon as possible with physical therapy. Record review of Resident #7's 12/28/16 social services assessment revealed that she was in need of physical, occupational, and therapy services for a [MEDICAL CONDITION] and was awaiting Medicaid approval. Record review of Resident #7's nursing progress note dated 2/15/17 revealed Resident fixated on therapy and wanting to use a cane. Resident saw nurse pracitioner and began asking her about insurance, Medicaid, therapy, cane use. LVN discussed the need to have physical and occupational therapy evaluation and treatment and if they saw need for cane or other assistive device, they will order. Resident still unaware of Medicaid status and is frustrated with having to wait. Resident saying 'I can't wait for physical therapy. I have to get out of here. I have a child that needs me. I am doing therapy alone trying to get better'. Resident was taught range of motion exercises by staff to keep movement in affected extremities. Resident asked not to attempt walking unassisted to prevent injury to self. Record review of Resident #7's Medicaid card revealed that is was sent to the facility on [DATE]. On 2/16/17, after receiving a Medicaid number for Resident #7, the facility got a physician's orders [REDACTED]. Record review of Resident #7's physician telephone orders (dated 2/16/17 and 3/29/17) revealed that she was to be evaluated and treated by physical and occupational therapy post [MEDICAL CONDITION]. Record review of Resident #7's medical enrollment form for her health plan revealed that it was mailed by the facility on 2/27/17. Record review of Resident #7's health plan card revealed that it was effective 4/1/17. Record review of Resident #7's physician telephone order (dated 4/10/17) revealed that she was to be provided with physical therapy 3 times a week for 4 weeks after approval was received from Medicaid. Record review of Resident #7's physician telephone order (dated 4/14/17) revealed that she was to be provided with occupational therapy 3 times a week for 4 weeks pending Medicaid approval. Record review of a notice of denial of medical coverage from Resident #7's health plan (dated 4/13/17) revealed that physical therapy 3 times a week for 4 weeks was denied because there was no clinical information presented to show that therapy was needed for the treatment of [REDACTED]. Record review of a letter from Physical Therapist A (not dated or addressed) revealed that Resident #7 needed therapy services for a [MEDICAL CONDITION] [DIAGNOSES REDACTED]. Her therapy treatment plan and goals were specified in this appeal letter. Record review of a letter from Resident #7's health plan to Resident #7 (dated 4/26/17) revealed that they had received the facility's 4/24/17 appeal and would complete the appeal request within 30 days. However, at the bottom of this letter was Fast appeals: You have the right to request a fast appeal. You can request a fast appeal if you or your provider thinks that waiting 30 days for a standard appeal could put your life or health in danger.

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	676075	A. BUILDING _____ B. WING _____	06/21/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TRISTAR CARE CENTER INC	619 W LIVE OAK RD FREDERICKSBURG, TX 78624

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F 0406 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 11) Record review of an email (dated 4/26/17) from Resident #7's primary care physician to her health plan revealed that he was appealing the denial for Resident #7's therapy services based on her [DIAGNOSES REDACTED]. On 5/4/17, Resident #7's health plan informed the facility (by letter) that, because Resident #7's qualifying event was more than 120 days before, they could not cover therapy services for her. Resident #7's primary care physician was notified about the second denial on 5/4/17 and there was no documentation of further action. During the entrance conference at 9:30 a.m. on 6/14/17, the administrator reported that the facility had a young resident who needed therapy services and couldn't get them because it had been more than 120 days since her qualifying event and her Medicaid wouldn't cover them. During an interview with Resident #7 at 10:28 a.m. on 6/14/17, she reported that she was [AGE] years old and had been at the facility since November. She reported that she had a stroke in October, that therapy had been denied, and that she didn't understand it. She reported that she tried to exercise on her own but was a fall hazard. She stated It's harder than I thought it would be and I need help. Observation of Resident #7 at 9:45 a.m. on 6/15/17 revealed that she was sitting in her wheelchair, talking on the phone, and crying about not getting therapy. She reported that there were no CNAs to walk her and that they were too busy. I have to do it where the cameras can't see me. During an interview with Resident #7 at 11:00 a.m. on 6/15/17, she approached the investigator and again asked about her therapy. The investigator took Resident #7 to the administrator's office so that the administrator could explain the denial of therapy to her. The business office manager was called in. Record review of correspondence between the facility and the Medicaid/health plan offices pertaining to Resident #7's coverage at this time revealed that no action was taken by the facility from 11/8/16 to 2/27/17 and from 5/4/17 to present. The administrator confirmed this during the 6/15/17 11:05 a.m. meeting with Resident #7 and the business office manager. During an interview with the ADON at 2:23 p.m. on 6/15/17, she reported that the CNAs tried to walk with Resident #7 daily. The ADON reported that Resident #7 was able to self-transfer, that her speech had improved, and that she hadn't fallen recently. The ADON stated She may have had more improvement with therapy perhaps, but she hasn't had any decline. During a phone interview with Physical Therapist A at 1:54 p.m. on 6/16/17, she reported that therapy had been requested for Resident #7 and that Medicaid had denied it. Physical Therapist A reported that she had tried to appeal the decision but that therapy for Resident #7 still had not been approved. Physical Therapist A stated She needs it. We were all shocked that it was denied. (Her health plan) said that it was a very old stroke, but I don't believe that. Documentation shows old stroke, recovery, and another stroke. I think she has potential for progress and should have therapy. Physical Therapist A reported that she wrote her appeal letter the day after the facility got notice that coverage for Resident #7 had been denied. She stated This lady has really good rehab potential. An evaluation was done on 4/10/17 and was sent to Medicaid. Medicaid denied therapy. I wrote the appeal letter and have heard nothing from the facility. I asked about it, and the facility said they hadn't gotten a response. During an interview with the facility's social worker at 1:30 p.m. on 6/19/17, she reported that Resident #7 had wanted therapy for a long time and was frustrated about the situation. The social worker stated She knew her muscles would decline, but it is difficult to get therapy with no funding source. I tried to get her to another facility because they offered services pro bono, but they denied her because of her history of behaviors. The social worker reported that the business office manager had been doing the funding work pertaining to Resident #7. She then stated If I was a full-time social worker, I would be working with the business office manager hand in hand and pushing to get it done quicker. Observation of Resident #7 talking to staff at 12:15 p.m. on 6/21/17 revealed that she stated I had a dream about being in my wheelchair. That's not cool. I used to dream about walking around. Record review of the facility's therapy policy (not dated) revealed The facility ensures that specialized services such as physical therapy, speech therapy, and occupational therapy meet the rehabilitation and functional needs of all residents and are readily available. According to information provided by the interim administrator on 6/26/17, there were 2 other residents (in addition to Resident #7) who needed therapy services.
F 0490 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of 2 of 15 residents reviewed for abuse (Resident #s 6 and 7) in that: The administrator failed to follow the facility's policy on abuse. As the abuse prevention coordinator, she did not listen or respond to resident and staff reports of abuse. She verbally/mentally abused Resident #s 6 and 7. 1. Resident #6's electric wheelchair was taken away from him. Resident #6, while crying, said that he was going crazy and was going to kill himself. The administrator told Resident #6 You were crazy when you came here and laughed. 2. The administrator told Resident #7 that she was rude and obnoxious. These failures resulted in an Immediate Jeopardy (IJ) situation identified on 6/16/17. While the IJ was removed on 6/20/17, the facility remained out of compliance at a severity of actual harm with a scope identified as widespread until all staff were in-serviced. This deficient practice could affect all 44 residents at the facility who interacted with the administrator by contributing to feelings of fear, decreased self-esteem, and self-injurious behaviors. The findings were: 1. Record review of Resident #6's facesheet (dated 6/12/17) revealed that he was [AGE] years old, was admitted to the facility on [DATE], and was readmitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #6's quarterly MDS assessment (ARD 5/29/17) revealed that he scored a 10 on the BIMS (indicating moderate cognitive impairment) and had no behaviors or signs/symptoms of [MEDICAL CONDITION]. Record review of Resident #6's 5/17/17 activity quarterly update revealed that he volunteered at the animal shelter 3 times per week, enjoyed feeding the birds, and used an electric wheelchair for mobility. Record review of Resident #6's nursing progress notes revealed that, on 6/5/17 at 12:50 p.m., the administrator received a call from law enforcement dispatch that Resident #6 was crossing a busy street against a traffic light. Several cars had to stop quickly to keep from hitting him. It was documented that this was the second time law enforcement had notified the administrator of Resident #6's reckless and dangerous behaviors while operating his motorized wheelchair on the busy streets. Resident #6 was counseled regarding his unsafe operation of his wheelchair and was instructed not to leave the facility on his own without staff escort. He was advised to be supervised by staff while outside of the facility and to schedule supervised outings with the activities director. Review of Resident #6's 6/5/17 9:25 p.m. nursing progress notes revealed that he was nearly hit by a car when he was on the road going to the library early afternoon. When he returned from his outing, he was counseled about not going out anymore. At 6:00 p.m., he informed the charge nurse that he was going to the grocery store. The charge nurse informed Resident #6 that he was not supposed to leave the building, but Resident #6 left anyway. When he returned to the facility, his power chair was taken away (by the administrator) and a wander guard was attached to it. During an interview with Resident #6 at 10:15 a.m. on 6/15/17, he reported that he was told the week before last (the week of 6/5/17) that he could not go out on pass anymore. He stated If I can't go out, now what? I got places I need to go - (cell phone store), email at the public library, feed the birds - for my own serenity and peace of mind. I need to get away from here. This place is kind of crazy. I can't relate to people here. When asked how no longer having his electric wheelchair affected him, Resident #6 stated I don't want to get out of bed. I'd rather stay in bed. The only reason I am up now is for a doctor's appointment. When asked if the facility had offered other ways for him to leave, Resident #6 said no. He reported that the assistant activity director only went to the grocery store once a month and did not have time to take him to the animal shelter. He reported that, since his electric wheelchair had been taken away, he had not gone anywhere. Resident #6 reported that he had told the ADON and DON about his need to go to the cell phone store and to check his email. They told him It's up to (the administrator). He reported that, when he went to the administrator, she said You need to talk to the treatment team (the ADON and DON). Resident #6 stated They keep putting me off to each other. I am trying to get a hold of the ombudsman. She came in on Tuesday (6/13/17), but I was depressed and didn't want to get out of bed.

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 12) During an interview with the activity director and assistant activity director at 11:00 a.m. on 6/15/17, the activity director reported that Resident #6 had not informed her that he wanted to go anywhere. She stated We can take him wherever he needs to go. We do have a van and plenty of time. Both the activity director and assistant activity director reported that, since Resident #6's privileges to sign himself out had been taken away on 6/5/17, they had not offered or taken him anywhere. During an interview with the administrator at 2:40 p.m. on 6/16/17, she reported that Resident #6 was refusing to be taken out on pass. She reported that staff were scheduled to take him out 3 times a week, and he refused. During an interview with Resident #6 at 3:28 p.m. on 6/16/17, he asked Can I ask you a question? Can (the administrator) keep me from going off the property? The investigator explained to him that she could keep him from going out unsupervised if he had been unsafe. He then stated Can they do a reevaluation? I've learned my lesson. I'm gonna kill myself. I've gotta get out with tears in his eyes. The investigator asked Resident #6 if he'd be okay with staff taking him to the animal shelter and the library. He stated Yes. That would be great. Resident #6 denied that staff had offered to take him out. During an interview with Resident #6, the administrator, and the DON at 3:58 p.m. on 6/16/17, when Resident #6 told the administrator that he was going crazy in the facility without his electric scooter, the administrator said to him You were crazy before you came here! and laughed. Resident #6, visibly shaking and with tears in his eyes, turned to the investigator and said See? We can't come to her. She hates me. She doesn't care about us. Her job is making sure that the nurses do their jobs. Resident #6 then turned back to the administrator and stated You guys are going to regret not letting me go out. I'm going crazy here. The administrator ended the conversation without resolution by saying that she needed to go see the pharmacist about drug destructions. During an interview with the DON at 5:35 p.m. on 6/16/17, she confirmed that the administrator verbally and mentally abused Resident #6 during the above interview (starting at 3:58 p.m. on 6/16/17) but was hesitant to write a statement. Record review of Resident #6's written statement of the aforementioned conversation revealed At approximately 3:15 p.m., I went to (the investigator's) temporary office because shortly before that (the administrator) had told me that it would take at least 3 months before she would even think about letting me use my power chair. That upset me very much, so I went to (the investigator) to find out why I am being punished so severely. I brought up the fact that when a motorist runs a red light and gets caught, he gets a ticket and goes on his way. Because I have obligations at other places (public library, (cell phone store), store, the need to get away from (facility)), I feel I will go insane being restricted to (the facility). Thank God for (investigator) taking the time to listen to my concerns. Also, I thought my restriction to (the facility) was based solely on my last time in a power chair but now I find out it's an accumulation of all past discrepancies. To me, I feel like I am getting a life sentence for a minor infraction. What (the administrator) told me and how it made me feel - sometimes, it's not what a person says, but how they say it. (The administrator) said that (the facility) is willing to take me to (the animal shelter) 3 times a week, but because I sleep in, I don't go (partially true) . (The administrator) makes it seem like this place goes overboard for the residents which, to me, is an outright lie. Her attitude and demeanor makes my stomach turn. I truly believe her dislike of me is why she is being so harsh on me. Record review of the DON's written statement of the aforementioned conversation revealed On 6/16/17 at approximately 5:15 p.m., state surveyor (investigator's name) had spoken with (Resident #6) regarding his concerns about having his electric wheelchair being taken away from him as well as privileges to allow him to go out on pass in his wheelchair without being transported and supervised the entire time. (Resident #6) had been deemed extremely unsafe to do so. When (Resident #6) expressed his feelings, concerns, and needs, the administrator (the administrator's name) responded in several statements and manners which were not only insulting but very demeaning and degrading to (Resident #6). At the time, I (the DON's name) was present along with (the investigator's name), (the administrator's name), (Resident #6's name) in the administrator's office. (The investigator) was trying to communicate and discuss the concerns regarding (Resident #6). (The investigator) informed (the administrator) that (Resident #6) felt confined in our facility . (Resident #6) stated he felt very confined and felt like he was going crazy. (The administrator) laughed at him, threw her arms up in the air, and stated 'You were crazy when you came here!' (Resident #6) was crying and told (the investigator) and me 'See what I mean? She hates me and does not care'. I could go into more detail, however, during the entire meeting, the words, gestures, and overall attitude of (the administrator) were that of both verbal and mental abuse to this resident. During an interview with Resident #6 at 6:45 p.m. on 6/16/17, he said to the investigator You're here once in a while. You don't see the day-to-day things. (The administrator) doesn't care for us residents. She doesn't take the time to listen to us. It's like she doesn't want to be here but has bills to pay. I talk to people and have been through several administrators. It's not just me who dislikes her. The Bible is the only thing that keeps me somewhat grounded. After growing up and working hard all my life, this is not the way I should have to go out. 2. Record review of Resident #7's facesheet (illegible date) revealed that she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #7's quarterly MDS assessment (ARD 5/15/17) revealed that she scored an 8 on the BIMS (indicating moderate cognitive impairment). During an interview with Resident #7 at 10:28 a.m. on 6/14/17, she reported that she was [AGE] years old and had been at the facility since November. She reported that she had a stroke in October, that therapy had been denied, and that she didn't understand it. During an interview with Resident #7 at 11:00 a.m. on 6/15/17, she approached the investigator and again asked about her therapy. The investigator took Resident #7 to the administrator's office so that the administrator could explain the denial of therapy to her. While discussing Resident #7's therapy, the investigator asked the administrator why Resident #7 was at the facility. The administrator, in front of Resident #7, stated She's here because the hospital begged for me to take her. Nobody else wanted her. They discharged her because she was rude and obnoxious. During an interview with Resident #7 at 2:55 p.m. on 6/15/17, when asked about earlier interactions with the administrator, Resident #7 stated It bothered me. She was attacking you. She always gets defensive - like she's trying to hide something. Resident #7 then let the investigator listen to a recording (dated 6/12/17) on her cell phone. The recording was of the administrator's response to Resident #7 knocking on her door to get the Medicaid phone number. The administrator told Resident #7 Here! Here's your number! I'm losing my patience with you. I am taking care of it, but you don't trust me. You're a big girl. Take care of it yourself! During an interview with the administrator at 2:40 p.m. on 6/16/17, she reported that she did not remember the investigator asking her about why Resident #7 was at the facility. The investigator again asked the administrator why Resident #7 was here, and the administrator stated She needed nursing home care. When asked if she remembered telling the investigator that Resident #7 was at the facility because she was rude and obnoxious, the administrator stared blankly and then stated Well - you asked me about her in the hospital and I told you what her behavior was. That was the truth and reality then. If it hurt her feelings, that wasn't the purpose. She's aware of how she was. When asked if that would have hurt her feelings, the administrator stated No. Are you asking me this to prove I was rude? I'm sorry. It was the truth. She knows that's the truth. Record review of the facility's complaints/grievances revealed that, on 6/12/17, an unidentified resident wrote Every time I approach the administrator, she is rude, hostile, and closes the door in my face. The complaint was investigated by the administrator, and the following was documented by her I had a very good talk with (unidentified resident). She admitted I was with someone in my office at the time and closed the door for confidentiality. I also explained to (unidentified resident) that I was not her caregiver and she should direct her questions to her staff. She said they direct her to me. She said I was rude because I always ask her to repeat herself. I explained that I am very hard of hearing but she does not speak up when she wants to talk to me. She also mumbles when she talks according to my ears. Further record review of the facility's complaints/grievances revealed that, on 6/12/17, another identified resident wrote I don't see how (the administrator) calls herself administrator. When I want to talk to her, she tells me to talk to CNA or nurse. When I went to talk to her about a wheelchair, she shut the door in my face. She told me it was too late today and she would talk to me tomorrow. Why couldn't she talk to me for 15 minutes and let me know what the plan was? The complaint was investigated by the administrator, and the following was documented by her (Unidentified resident) calls my name every time she sees me. This was 10 times a day. I just don't have the time to stop and talk to her. She has asked me about an electric wheelchair at least 20 times. I have explained to her that we can request a chair when her Medicaid comes through. We were recently able to talk to the Medicaid supervisor in (unidentified resident's former state). She initiated a form

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676075	A. BUILDING _____ B. WING _____	06/21/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TRISTAR CARE CENTER INC	619 W LIVE OAK RD FREDERICKSBURG, TX 78624

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 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 13) discharging her from (unidentified resident's former state) system. We are now talking to Texas to get her started here. (Unidentified resident) thinks I have nursing duties. Most of what she stops me for are not my job. I am happy to help if necessary, but as administrator, I have too much work to spend a lot of time with residents. (Unidentified resident) stops all staff all day long. She has a compulsive need for constant attention. We are all working together to meet her needs, but she has to learn some boundaries. During an interview with the ADON at 2:10 p.m. on 6/15/17, when asked about the administrator, she was shaking and stated You're not writing anything down? I am on medications because of her. 90% of residents and staff don't like her. She is rude. I don't know what she does besides look at the cameras and smoke. I don't know if she's paranoid or has delusions of grandeur. We wonder what 'the flavor of the day' is - which department is she going to pick on? I don't see how she gets away with what she does. When asked if she felt the residents and staff were afraid to bring issues to the administrator's attention, the ADON stated They come to me and (the DON), and we take their issues to her (the administrator). The ADON told the investigator, before leaving the room, to tell the administrator that we were talking about Resident #7 if the administrator asked what we were talking about. During an interview with the DON at 4:20 p.m. on 6/15/17, she was crying and stated I'm scared to talk to you - can't stay in here long. She will ask what we are talking about. What are we talking about? (The ADON) and I are about to quit. She has made our lives a living hell. The DON reported that residents brought their concerns to her and the ADON instead of to the administrator because they were afraid of her. During an interview with the ombudsman at 9:49 a.m. on 6/16/17, she reported that the facility was an awful place from the top down. She stated There is an attitude of us against them with this administrator. I haven't met the owner but I get the impression that money is the bottom line. The ombudsman reported that she told the administrator about any concerns she had and stated (The administrator) doesn't want me talking to the DON or ADON. The policy is that I sign in and out and give her a list of everyone I talk to. I refuse to do that. She only accepts complaints in writing and on the form (the complaints/grievances form). Later in the conversation, the ombudsman stated The administrator is definitely a problem - awful - awful. I don't think resident care is suffering. I think the nurses do the best they can. I have never gone to either the DON or ADON with care concerns that have not been addressed. The residents come away from (the administrator) with a 'meh' feeling. They aren't comfortable going to her with concerns and say 'She won't do anything. She won't help me' . Why does it have to be so adversarial?. The ombudsman reported that she had never observed verbal/mental abuse but stated Insincere words just flow out of her mouth. During an interview with the parole officer at 11:21 a.m. on 6/16/17, he stated The administrator seems to not really care. I know she's going to take anybody. When I ask her if the staff can handle someone, her answer is always yes. She's all about census. She'll take anybody. They try to hide everything. Staff are too afraid of what the administrator is going to do. She's gonna make everything lesser than what it is. It could be fine - it's just the way they run it. Staff aren't trained, and everything is swept under the rug. Staff here don't communicate very well. When asked whose job it was to facilitate communication, the parole officer stated The administrator's - because that's what administration is. During an interview with the DON at 2:33 p.m. on 6/16/17, she reported that she told the administrator she was rude to residents and staff in (MONTH) of (YEAR) and was, consequently, suspended for the day. Record review of the facility's abuse/neglect policy and procedures (dated (MONTH) 2014) revealed Definitions: Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Abuse includes the following: Verbal Abuse: Is defined as any use of oral, written, or gestured language that includes disparaging and derogatory terms to a resident or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability . Mental Abuse: Is defined but nor limited to humiliation, harrassment, threats of punishment, or withholding of treatment or services . Neglect: Is defined as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . Signs and symptoms . A neglected or abused resident may: . withdraw, behave fearfully . The facility's abuse prevention coordinator was the administrator. The owner was notified on 6/16/17 at 7:02 p.m. of the Immediate Jeopardy for the above failures and a Plan of Removal was requested. The facility's Plan of Removal was provided by the owner and accepted at 2:06 p.m. on 6/17/17 and included the following steps to be taken by the facility: 1. The administrator has been terminated as of 6/16/17. 2. The administrator will vacate the premises and will not interact with the residents, and all resident interactions will be initiated by the DON. 3. The administrator will call the owner and schedule the time she will come to the facility to collect her personal affects. The DON will supervise the visit by the administrator and make sure the administrator does not interact with any resident. 4. The DON will immediately in-service the staff on floor and the weekend staff beginning 6/16/17 9:30 p.m. about not allowing the administrator to enter the premises or interact with any of the residents. If administrator is seen on the premises, staff will call the police and will inform the owner. This in-service will be completed for all shifts by 6/17/17. 5. The DON will also in-service the staff immediately, beginning 6/16/17, on how to report abuse to DADS - no matter who the perpetrator is. This in-service will be completed for all shifts by 6/17/17. 6. The DON called in the abuse to the DADS hotline on 6/16/17. 7. An interim administrator has been retained and will start on 6/19/17. Verification of the Plan of Removal was as follows: Observations of the facility from 8:10 p.m. to 9:20 p.m. on 6/16/17, 6:05 p.m. to 7:22 p.m. on 6/17/17, 1:30 p.m. to 4:07 p.m. on 6/18/17, 9:50 a.m. to 4:42 p.m. on 6/19/17, and 12:51 p.m. to 4:47 p.m. on 6/20/17 revealed that the administrator was not on the premises. In-service sign-in sheets and material covered by the in-services was reviewed. The interim administrator, the DON, the ADON, 1 RN, 2 nurses, 1 social worker, 1 maintenance supervisor, and 7 CNAs were interviewed on 6/17/17, 6/18/17, 6/19/17, and 6/20/17. Interviews confirmed staff knowledge regarding abuse and neglect. These failures resulted in an Immediate Jeopardy (IJ) situation identified on 6/16/17. While the IJ was removed on 6/20/17, the facility remained out of compliance at a severity of actual harm with a scope identified as widespread until all staff were in-serviced. During an interview with CNA E at 6:40 p.m. on 6/17/17, she reported bad interactions with the administrator. CNA E reported that she tried to report abuse of a resident by a CNA to the administrator a week or 2 ago. The administrator told her I don't have time for this and turned around and walked off. CNA E stated I felt like an idiot so I know (the resident) must have felt like an idiot. I can't go to (the administrator) because she doesn't want to listen. We're trying to do the best we can with these people. When they (administrative staff) don't listen to us or back us up, where do we go? Our hands are tied. CNA E reported that every time she went to the administrator with concerns, she was told I don't have time. During an interview with CNA F at 1:46 p.m. on 6/18/17, she stated When (the administrator) came in, problems - confusion - she's mad for everything - always mad. She doesn't talk to people privately. She does it in front of other people - for residents too . She say 'I'm tired. Leave me alone. I'm on my break. I'm on my lunch' - sometimes screaming too. Today happy, tomorrow not. CNA F reported that the administrator never gave aides an opportunity to talk, and when she did talk, it was always in front of everybody. When asked if she was afraid to report things to the administrator, CNA F said yes and stated If you report, always she cover - say things like 'You don't have proof. That's not true'. During an interview with CNA G at 2:24 p.m. on 6/18/17, she reported that she was afraid to go to the administator and would go to the DON and ADON instead. CNA G reported that residents would try to talk to the administrator and were told I don't have time. During an interview with CNA H at 3:15 p.m. on 6/18/17, she reported that the administrator did not give residents a chance to explain and didn't listen to residents or staff. CNA H stated (The administrator) tells us not to abuse and neglect, but she is the first one to do it. She reported that the DON and ADON were scared of the administrator and that the administrator had made several CNAs cry.

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	676075	A. BUILDING _____ B. WING _____	**06/21/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TRISTAR CARE CENTER INC	**619 W LIVE OAK RD FREDERICKSBURG, TX 78624**

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 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 14) According to information provided by the interim administrator on 6/27/17, there were 44 residents who resided at the facility and interacted with the administrator.
F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain medical records on each resident that were complete and accurately documented for 3 of 10 residents (Resident #s 3, 19, and 4) whose records were reviewed in that: 1. Skin sheets for Resident #s 3 and 19 did not include observed bruising. 2. Resident #4's initial medical assessment was not included in his clinical record. This deficient practice could affect 46 residents at the facility with medical records by contributing to inadequate care based on inaccurate and incomplete documentation. The findings were: 1. Observation of Resident #3 at 4:26 p.m. on 6/18/17 and at 11:51 a.m. on 6/20/17 revealed that she had faded bruising on her left forearm and upper right chest. During an interview with CNA H at 2:40 p.m. on 6/19/17, she reported that Resident #3 told her 2 weeks ago that CNA D had grabbed her forearm and caused the bruising. Record review of Resident #3's skin assessments for 4/11/17, 4/18/17, 4/25/17, 5/2/17, 5/9/17, 5/16/17, 5/23/17, 5/30/17, 6/5/17, and 6/12/17 revealed no documentation of bruising. 2. Observation of Resident #19 at 2:50 p.m. on 6/19/17 revealed that she had faded, yellowing bruising on her right forearm. During an interview with CNA H at this time, she reported that she had informed LVN I about Resident #19's bruising. Record review of Resident #19's skin assessments for 5/11/17, 5/18/17, 5/25/17, 5/31/17, 6/7/17, and 6/14/17 revealed no documentation of bruising. During an interview with the DON and ADON at 1:25 p.m. on 6/20/17, they confirmed that the skin assessments for Resident #s 3 and 19 weren't accurate. 3. Record review of Resident #4's facesheet (dated 5/8/17) revealed that he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #4's clinical record revealed no initial medical assessment by his primary care physician. During an interview with the ADON at 5:35 p.m. on 6/16/17, she reported that Resident #4 had been seen by his primary care physician on 5/26/17 and that the doctor's office was faxing over the progress notes from this visit. The ADON confirmed that the progress notes were not included in Resident #4's chart and should have been. According to Form CMS-672 dated 6/14/17, there were 46 residents at the facility - all with clinical records.