STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455565	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palestine Healthcare Center	1816 Tile Factory Rd Palestine, TX 75801

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46299 Based on observation, interview and record review, the facility failed to ensure the right of the residents to be free from abuse for 3 of 21 residents reviewed for abuse and neglect. (Resident #29, Resident #49, and Resident #1) - Resident #29 was hit multiple times in the face and bit on the thigh by TCNA O during a physical altercation. -After suspension of 3 days,TCNA O returned to work at the facility which later resulted in TCNA O verbally abusing Resident #49 on [DATE]. TCNA O continued to work until she quit on [DATE]. -The facility did not provide appropriate intervention to protect all residents, after a resident-to-resident altercation in which Resident #1 repeatedly kicked another vulnerable resident in the head. -The facility failed to follow the care plan of assessing Resident #1 for a specially designed therapeutic unit upon readmission to the facility. These failures could place residents at risk abuse, neglect, and serious bodily harm. An Immediate Jeopardy (IJ) situation was identified on [DATE] at 1:15 p.m. While the IJ was lifted on [DATE] at 8:00 p.m. the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of patterned due to the facility's need to evaluate the effectiveness of their corrective systems. Findings included: 1. Record review of a face sheet dated [DATE] indicated Resident #29 is a [AGE] year-old female and was admitted to the facility on [DATE]. The resident had diagnoses of mental/mood/behavioral disorders, Major Depressive Disorder and Dementia (the loss of cognitive functioning (thinking, remembering, and reasoning) to such an extent that it interferes with a person's daily life and activities). Record review of the [DATE] Quarterly MDS assessment indicated Resident #29 was understood and had a BIMs of 06, indicating severely impaired cognition at times. She did reject care for 4 to 6 days of the 7-day review period. She required supervision set-up only for walking. (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #29's Comprehensive Care Plan dated [DATE] revealed staff must maintain a calm environment and approach when caring for Resident #29. Record review of complaint intake #360678 and facility investigation dated [DATE] indicated the incident was reported on [DATE], revealed TCNA O bit Resident #29 on the thigh during an altercation, which also resulted in a scrape on Resident #29s left elbow. TCNA O was suspended during the investigation, a police report was completed, a staff in-service on abuse was completed and the completed investigation was faxed to the state on [DATE] with the allegations noted as unconfirmed. Record review of the [local] Police Department Case report dated [DATE] at 08:31 AM revealed an assault against elderly or disabled individual (Resident #29). TCNA O physically assaulted Resident #29 after she wanted to call daughter around 10:00 PM and staff would not allow it. TCNA O came into the resident's room, sat on her bed and hit her. TCNA O entered Resident #29s room again, jumped on her bed and hit her with her fists, causing the resident to become unconscious at times; also told Resident #29 she was in a mental institution. Then when the resident said she would report TCNA O to the administration, both (Resident #29 and TCNA O) fell off the resident's bed and hit the tile floor, the resident wrapped her thighs around TCNA O's neck and then the TCNA O bit the resident on the thigh. TCNA O then hit the resident again in the face with closed fists and left the room. Resident #29 had an injury to her left elbow with a band aid covering it with blood on it, her shirt and sheets, but her right thigh did not have teeth marks. TCNA O was read her [NAME] Rights. Due to the fact that TCNA O was an employee with the nursing home and was working in the Mental health side of the facility she has the duty to protect and care for the residents who she oversees. TCNA O did not show restraint verbally or physically to Resident #29 due to being upset with the threat of being reported to administration. Resident #29 was a [AGE] year-old fragile elderly woman who could not protect herself against a healthy young [AGE] year-old TCNA O. The nursing home did not call for police when this assault occurred, they called 9 hours after the assault to report this to the police. Record review of the CPS/APS Intake Report dated [DATE] revealed Resident #29 resided at facility and had been physically assaulted three times by TCNA O working overnight, between 11:00 PM and 01:00 AM. TCNA O had bit the resident on her inner right thigh with her teeth and punched her multiple times with a closed fist causing the resident to lose consciousness. A wound to Resident #29s left elbow was band aided over and still had bleeding noted. TCNA O was suspended, and a report was filed for assault against elderly or disabled individual. During an interview on [DATE] at 04:48 PM with Resident #29, stated she went down the hallway, and asked TCNA O to talk/call to her family member, and the staff would not let her. I tried to open doors and pulled the fire alarm to get the employees attention. TCNA O asked me to go to my room. So, I did. But I still wanted to call my daughter. TCNA O came into my room, jumped on my bed, saying this was a mental institution. I told her (TCNA O) no, this was a place for the elderly. She came back in my room more than once; I said some things and she said, don't talk to me. I threw a bottle hard at TCNA O that missed her because she kept getting near my face, so I pulled her hair and we both fell to the floor, and then TCNA O did bite me on my thigh. I was in fear for my safety with her working here, none of that had to happen if they would have let me call my family member none of that would have happened. She kept coming back in my room, antagonizing me and then left the building. I had an injury to my left elbow that bled and a bite mark on one of my thighs. I filed a police report and staff talked to me about the incident. I thought TCNA O was fired because she should not treat residents that way. Nothing like that had ever happened before that incident at the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an attempted telephone interview with TCNA O on [DATE] at 04:58 PM revealed message call cannot be completed due to the called party is unavailable. During an interview on [DATE] at 09:00 a.m., with the Administrator and DON, they were asked if they could get ahold of TCNA O. During an interview on [DATE] at 05:37p.m., the Regional Nurse reported she made attempts to reach TCNA O all day and were unsuccessful. The facility eventually had contact with TCNA O on [DATE] and she gave her notice of termination. During an interview on [DATE] at 04:49 PM, CNA CC revealed he stated he was there during the incident with Resident #29 and TCNA O. It was a verbal confrontation between Resident #29 and TCNA O, it then became physical from what I heard, and then when TCNA O went back into the room with Resident #29, I went back to the unit for security reasons. Resident #29 said that TCNA O had bit her, and there was a bite mark on Resident #29's leg. I had abuse training prior to this incident, in-services, and have been a CNA for [AGE] years, I have learned some things. He did not feel TCNA O was abusive towards the resident, even after hearing what took place. Interviews on [DATE] at 12:24 PM with LVN F, revealed she stated I worked the night shift on whatever night that happened, and at approximately 10:00 PM or later, I got back from my break and RN DD and CNA CC were back in the secured unit. TCNA O was the aide on the secure unit and had left the facility after an incident with Resident #29 without telling staff what happened. Resident #29 said she and TCNA O had exchanged words, ended up on the ground, Resident #29s legs around the aide's neck, and the aide bit her. LVN did note a circular red mark on Resident #29s right thigh near her pelvis, but she did not chart a skin assessment. TCNA O was not at work for a while after that incident. She called the DON after that to report what happened. LVN F stated I had abuse training prior to the incident and definitely after the incident. Resident #29 had never been aggressive to any staff physically; this was not like her, so I settled her down and made sure she felt safe, because TCNA O was gone from the building, and she had no other issues that night. LVN F stated allowing the residents to call her family member maybe would have helped prevent this whole incident, she may have asked TCNA O to call her family member, I do not know. During an interview on [DATE] at 02:57 PM with the Police Officer revealed that night ([DATE]) around 11:30 PM on the secured unit at the facility, TCNA O said Resident #29 could not call her family member at night. This upset the resident and so she pushed on alarmed doors to irritate the staff. The resident was just upset, saying she wanted to report TCNA O, and TCNA O was mad that Resident #29 was going to report her. The resident had gone to her room, and TCNA O came into her room, sat on her bed. The resident wrapped her legs around TCNA O's neck, they both fell to ground and TCNA O bit her leg. Resident #29 was protecting herself she said, that was why she protected herself. The resident's elbow was busted open, black, blue and purple and there was dried blood on her bedding and clothing. I took pictures of the teeth marks on her leg/thigh, and TCNA O admitted she had punched Resident #29 in the face and bit her. The facility should have called the police right away when it happened so we could have taken Resident #29 to the hospital to get checked out. TCNA O should have never been seated on the resident's bed, antagonizing her. Resident #29 was with it, she remembered everything. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 5:00PM, the Administrator stated she was aware of the incident from the DON that morning after the incident between TCNA O and Resident #29 and reported it. It happened because the staff would not allow the resident to call her family member. This upset the resident and she acted out, pulling the fire alarm for attention. It was reported by TCNA O that Resident #29 attacked her, kicked her causing them to fall to the floor. The resident wrapped her legs around the NAs neck and TCNA O bit the thigh of the resident for her to release. The Administrator stated the facility had trained their employees on de-escalation of combative residents and TCNA O should have left the resident alone and allowed her to call her family member to calm the resident down. TCNA O just worked the front hall instead of the secured unit after the incident. During an interview on [DATE] at 5:00PM, the Corporate RN stated police had come out and read TCNA O her [NAME] rights, so the facility thought that meant she had to be terminated. TCNAs references and background check were fine, that is why she was hired. Not firing her could affect every resident in the facility she had contact with after this incident by allowing further abuse. During an interview on [DATE] at 01:04 PM, the DON stated I got a call from LVN F about the incident that morning and reported it to the Administrator right away. Record review of the facility staffing schedules [DATE] to [DATE] revealed TCNA O worked at least 20 shifts at the facility since the abuse to Resident #29 and Resident #49. 2. Record review of the face sheet dated [DATE] revealed Resident #49 was [AGE] years old, male, and admitted on [DATE] with diagnoses including multiple sclerosis (a disease that impacts the brain, spinal cord, and optic nerves), need assistance with personal care, schizoaffective disorder, bipolar type (a chronic mental health condition that involves symptoms of both schizophrenia and a mood disorder), anxiety disorder, and depression. Record review of the MDS dated [DATE] revealed Resident #49 was understood and understood others. The MDS revealed Resident #49 had a BIMS of 7 which indicated severe cognitive impairment and required extensive assistance to total dependence for ADLs. Record review of an undated care plan revealed Resident #49 exhibited verbally abusive behavioral symptoms. Interventions included ignore resident's verbal abuse when directed at you and refocus conversation when resident becomes verbally abusive. During an interview on [DATE] at 11:49 a.m., Resident #49 stated he and a staff member exchanged words one day. He said it made me mad and sad because she talked about his mother, and she was his best friend. During an interview on [DATE] at 4:23 p.m., Resident #30 said last month, TCNA O cursed out a resident because Resident # 49 threw a tray at her. Resident #30 said I could hear her all the way down to my room and she talked about his momma and dad. She stated TCNA O said, Your mom is bitch and Your dad is a __ and my auntie works here. She said TCNA O was CNA N's niece. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 2:30 p.m., Resident #30 said a verbal altercation between a resident and a CNA happened. She said the altercation was so loud, staff from the front of the building came to the back to see what was happening. She said she was not sure what occurred, but TCNA O cursed a resident down the hall and talking about his mom was a whore and stated, she was going to lose her job today. She said TCNA O cursed the resident out. During an anonymous interview on [DATE] at 11:00 a.m., AR said ,d+[DATE] weeks ago, he/she heard an aide cursed out a resident. AR said the resident threw his tray and the aide screamed, your mom is a bitch. AR said it happened on [DATE]. AR said he/she did not know who the resident or aide were. During an interview on [DATE] at 10:03 a.m., TCNA L said on [DATE], TCNA O did curse out Resident #49. She said the facility was short staffed that weekend and TCNA O came to the back hall to help. She said TCNA O went into Resident #49's room to drop off his lunch tray and screaming started. She said Resident #49 did not throw a plate at TCNA O, put tossed the plate cover on the floor and it did not touch her. TCNA L said her and LVN A pulled TCNA O out of the room and told her to go outside. TCNA L said she told CNA N, the CNA supervisor, about the verbal altercation. She said she had received abuse training upon hire. During an interview on [DATE] at 8:45 a.m., LVN A said a loud altercation happened between TCNA O and Resident #49 on [DATE]. She said Resident #49 threw the lid to the plate and it almost hit TCNA O. TCNA O then cursed Resident #49 and screamed at her aunt who worked here and stated she would lose her job today. LVN A said she attempted to deescalate the situation by separating TCNA O from Resident #49 and told her to go outside for a while then back to the front hall. LVN A said the CNA N showed up at the facility and took TCNA O outside. LVN A said she did not see TCNA O for the rest of the day. She was not sure if TCNA O went home or just stayed down on the front hall. LVN A said she did not assess Resident #49 after the altercation, physically or mentally. LVN A said she felt the altercation was verbal abuse. LVN A said because the on-call nurse and CNA N, who was the CNA supervisor, were in the building they would report the abuse to the administrator. During an interview on [DATE] at 5:43 p.m., LVN C said Resident #57 told him about a ruckus that happened over the weekend. He said Resident #57 attempted to play a recording, but it was not working properly. LVN C said he could hear people screaming at each other, but he only heard it for a few seconds. He said Resident #57 said he did not know who was in the recording, but they created a big ruckus. LVN C said he called the administrator on [DATE] and told her about the recording because he felt obligated to notify her in case it was verbal abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 10:37 a.m., CNA N said TCNA O and Resident #49 did have an altercation on [DATE]. She said TCNA O called her and told her about it. She said TCNA O told her Resident #49 threw a plate at her and called her out of her name. She said she told her to leave, and she could not talk to residents like that even if they call you the N word. She said on [DATE], LVN C told the Administrator about a recording Resident #57 had on his phone, but he could not hear enough to decipher who it was. LVN C told the administrator Resident #57's phone was not acting right but he felt like she should look into it. CNA N said the Administrator called her to investigate the recording Resident #57 had. She said she asked Resident #57 to listen to the recording he told LVN C about, but he said he did not have it. She said since I could not hear the recording, then there was nothing to investigate. She said the altercation between TCNA O and Resident #49 was abuse. She said TCNA O did not have sufficient abuse and deescalating training before hire. She said the facility was so short staffed when she started, we just need her to work and did not have time to give her sufficient training. She said she did not fire TCNA O because she asked other residents about her care, and no one complained and some even requested her to work on their hall. She said she asked staff about her behaviors, and no one complained. During an interview on [DATE] at 12:45 p.m., the Administrator was notified by this surveyor and the team lead of the survey, of reports from staff and residents, verbal abuse had occurred between a resident and staff. The Administrator was also notified of reports from staff, she was notified of the verbal altercation prior to the survey. The Administrator denied any knowledge of abuse in the facility. The Administrator indicated TCNA O was suspended from [DATE] to [DATE]. TCNA O returned to work and quit on [DATE], but her last day worked was [DATE]. During an interview on [DATE] at 5:40 p.m., the DON said TCNA O's last day worked was [DATE]. She said she was not told about the incident with Resident #49 and TCNA O. She said she was out of town, and no one called her. She said after the first incident with, she did in-service on the prosperity unit, and asked staff about her behavior towards other residents. She said no one complained about her. She said TCNA O was suspended for ,d+[DATE] days but disciplinary action was not done. She said she only probably signed the suspension paperwork. She said it should be in her personnel file. During an interview on [DATE] at 6:30 p.m., the Administrator said abuse was not tolerated and everyone had been educated on the chain of reporting. She stated she was unaware of the verbal abuse that occurred between TCNA O and Resident #49. She said verbal abuse could make a resident feel threatened and scared. She said it could make residents not trust the staff and have decreased quality of life. 3. Record review of the face sheet revealed Resident #62 was a [AGE] year old male with diagnoses including CVA (stroke), hemiplegia to dominant side (paralysis of one side of the body) and a PEG tube (feeding tube). Record review of a progress noted dated [DATE] indicated Resident #62 was up ambulating at 7:25pm, was found on the floor non responsive at 9:00PM, CPR was initiated, and at 9:15pm Resident #62 was transported by EMS to the local hospital where he was pronounced dead. Record review of the face sheet revealed Resident #1 was [AGE] year-old male that admitted on [DATE] with diagnoses including CVA (stroke), bipolar disorder (disorder associated with episodes of mood swings) and hemiplegia (one-sided paralysis). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the quarterly MDS dated [DATE] indicated Resident #1 had a BIMS of 15, which indicated no cognitive impairment. The MDS indicated he required limited assistance with ADLs, and he had physical behavioral symptoms directed towards others and verbal behavioral symptoms directed toward others exhibited 1 to 3 days. Record review of a care plan for Resident #1 dated [DATE] stated: -Resident has socially inappropriate/disruptive behavioral symptoms as evidenced by aggressive behavior. Resident was noted kicking another resident in the head. -The goal stated: Resident will not harm self or others secondary to socially inappropriate/disruptive behavior. Current behavior pattern: physically aggressive behavior (kicking another resident). -The approaches stated: Assess resident for placement in a special designated therapeutic unit. Assess whether the behavior endangers the resident, and/or other residents. Intervene if necessary. Remove resident and/or other resident's unsafe situations. When resident begins to become socially inappropriate/ disruptive, remove from situation, assess needs, and provide care if needed. Record review of a nurses note dated [DATE] at 7:55AM, written by LVN C indicated I could hear the resident yelling from his room as I was assisting CNA to pass breakfast trays, I stopped, ran to the resident's room, and noted him kicking another resident who was on the floor in the head, I immediately stopped the altercation and assessed both residents (Resident #1 and Resident #62). I removed fell ow resident (Resident #62) from the floor once I assessed him only noted he had a reopened skin tear above right brow from a previous fall. Resident #1 stated that Resident #62 came in his room and grabbed his shirt and would not let go so he pushed him off him and when he fell , he began to kick him (Resident #62) in the head. DON notified who is to notify the administrator. Record review of a nurses note dated [DATE] at 8:15 AM written by LVN C, indicated NP Q was notified of the altercation, but no new orders and ISNP R called no answer. Record review of a nurses note dated [DATE] at 8:19AM, written by LVN C, indicated ISNP R was made aware of the altercation with no new orders. Record review of nurses note dated [DATE] at 2:44PM, written by LVN R indicated Resident (Resident #1) requested to talk to his family member, Called family member. Resident #1 got upset after talked. Shouting move, bitches. Redirected resident and took him to his room. Record review of nurses note dated [DATE] at 10:45 AM, written by the SW indicated, Resident # 1 had been referred to [local] Behavioral hospital . Record review of progress notes dated [DATE] at 6:09 PM written by LVN P revealed Resident #1 returned to facility on [DATE] from [local] Behavioral Hospital. Record review of progress notes revealed Resident #1 was seen by psychologist on [DATE], one month after readmission from the behavioral hospital. Record review of EHR on [DATE] revealed, no assessment for placement in a special designated therapeutic unit upon readmission to the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation on [DATE] at 8:45am, Resident #1 was observed yelling at another resident, I will kill you! Get out of my room. Resident #26 was noted wandering in and out of several rooms on the central hallway that morning. Resident #26 was removed from Resident #1's room and redirected by TCNA L. During an interview on [DATE] at 10:08AM, the SW revealed Resident #1 had been to the behavioral hospital several times since his admission for being verbally and physically aggressive. The SW also revealed, Resident #1 did not want to discharge to the behavioral hospital again after the incident on [DATE], so the facility made a deal with him. If he would go to the behavioral hospital, take his medications, and had no behaviors while he was gone then the facility would try him outside of the secure unit. The SW indicated Resident #1 had no further physically aggressive behavior and he did not feel his roommate was in any danger of physical or verbal abuse. During an interview on [DATE] at 10:37 AM, CNA N revealed that Resident #1 had a temper problem. CNA N revealed Resident #1 had to be redirected several times a week for yelling and cursing at residents and staff members. Resident #1 did not like other people in his room and would become irate and throw things if residents wandered into his room. CNA stated there were several little ladies that wandered on the central hall where Resident #1 lived. CNA N stated the staff tried to keep an extra eye on him and answer his call light as quickly as possible because he had zero patience. CNA N revealed Resident #1 was still having these behaviors since his readmission from the behavioral hospital. During an interview on [DATE] at 5:40pm the DON stated she was unaware of Resident #1 being verbally aggressive with wandering residents. The DON stated, Resident #1 had no reported behavior problems since he returned from [local] Behavioral Hospital. During an interview on [DATE] at 6:40pm the Administrator stated she was unaware of any verbal aggression with wandering residents. Resident #1 had no reported behavioral problems since he returned from the behavioral hospital. Resident #1 was seen by the psychologist and no aggression was noted during that assessment. A facility policy titled Resident to Resident Altercations dated February 2021 stated the facility will make any necessary changes in the care plan approaches to any or all of the involved individuals; review the events with the nursing supervisor and possible measures to try to prevent additional incidents; document in the resident's clinical record all interventions and their effectiveness. Record review of the facility Abuse Prevention Program Policy dated February 2021 revealed our residents have the right to be free from abuse, including verbal, mental or physical abuse. Our center will protect residents from harm during investigations of all abuse investigations. All reports of resident abuse shall be promptly reported to local, state and federal agencies and thoroughly investigated by management. The administrator was notified on [DATE] at 3:19 p.m., an Immediate Jeopardy situation was identified due to the above failures and the IJ template was emailed to the administrator on [DATE] at 3:37 p.m. The facility's plan of removal was accepted on [DATE] at 6:55p.m. and included: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Plan of Removal Please accept this Plan of Removal as a credible allegation of compliance for immediate jeopardy initiated on [DATE], for abuse. Action Item: The Temporary C.N.A. is suspended pending investigation - Person Responsible: Nursing and administration - Timeline for completion: [DATE] Action Item: Verbal abuse allegation reported to the administrator by the surveyor on [DATE] was reported to the state on [DATE]. Resident safe surveys were completed on [DATE] no other resident concerns were noted. Staff interviews will be completed by [DATE]. Investigation on verbal abuse will be completed by [DATE]. - Person Responsible: Nursing and administration - Timeline for completion: [DATE] Action Item: The aggressor was assessed at [behavioral center]and deemed not to be a risk to others on [DATE] and was sent back to the center on [DATE]. The psychologist assessed the resident on [DATE] and deemed the resident not to be a risk to others. The Regional Nurse Manager reviewed the residents care plan and interventions in place to care for the resident on [DATE], one intervention was resolved as related to the approaches: assess for placement in a therapeutic unit. The resident was treated at [behavioral center] and did not need the therapeutic unit post care. Duplicate interventions were resolved on [DATE] by the Regional Nurse Manager. A staff member will be present outside of the resident's room to protect other residents until resident is deemed not a threat to others. Referral to psychiatric/behavioral service provider on [DATE]. Care plan updated to reflect monitoring on [DATE] by the Regional Nurse Manager. - Person Responsible: Nursing and administration - Timeline for completion: [DATE] Action Item: Staff education completed on abuse prevention, abuse reporting, abuse investigation, de-escalation, managing unwanted behaviors, and interventions to protect other residents from altercations. Staff will receive education prior to working their next shift. The center performance improvement plan was initiated on [DATE] and updated on [DATE] by the Regional Nurse Manager. - Person Responsible: Nursing and administration - Timeline for completion: [DATE] MONITORING: On [DATE], the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy by: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palestine Healthcare Center	1816 Tile Factory Rd Palestine, TX 75801

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Interview on [DATE] at 10:10am, the administrator stated she suspended temporary CNA O pending investigation of abuse. - Observation on [DATE] at 8:20 am, Resident #1 had an employee stationed in front of door. - Interview on [DATE] at 2:15pm, the administrator stated a tele visit was held between Resident #1 and psychologist. - Record review of psychologist note dated [DATE] revealed Resident #1was calm, sociable, upbeat. Resident #1 interacted well, and mood appeared stable. No behavioral symptoms noted. - Interviews on [DATE] at (8:20 p.m., LVNC); (8:25 p.m., Med Aide D); (6:08 p.m. CNA E), (6:30pm LVN F); (6:35 p.m. G), (6:21 p.m. CNAN), (6:38 p.m. LVN I), (6:50p.m. SSD), (6:51p.m. BOM) and (6:52pm TCNA L) revealed they had received education on abuse prevention, abuse reporting, abuse investigation, de-escalation, managing unwanted behaviors, and interventions to protect other residents from altercations. - Inservice records dated [DATE] revealed they had received education on abuse prevention, abuse reporting, abuse investigation, de-escalation, managing unwanted behaviors, and interventions to protect other residents from altercations. - Safe surveys for all cognitive residents revealed no reported abuse. Family surveys for all cognitively impaired residents revealed no suspicions of abuse. On [DATE] at 8:00 p.m., the administrator was informed the IJ was removed; however, the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of patterned due to the facility's need to continue to monitor the effectiveness of their plan of correction. 44933

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F 0610 Level of Harm - Actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46299 Based on observation, interview and record review, the facility failed to fully investigate, prevent and correct an alleged violation of abuse for 2 of 18 residents reviewed for alleged violations. (Resident #29 and Resident #49) The facility did not thoroughly investigate and correct an allegation of abuse that resulted in Resident #29 being bitten by a CNA, incorrectly unconfirmed abuse, and allowed alleged perpetrator to continue working with residents in the facility. The facility did not throughly investigate and correct an allegation of verbal abuse by TCNA O when she used derogatory lanuage towards Resident #49. These failures could place residents at risk for poor investigations, further allegations of abuse and actual abuse. Findings included: 1. A record review of face sheet and current physician orders dated 07/01/22 indicated Resident #29 was born on 10/06/58 (age 63) and was admitted to this facility on 11/06/21. The resident had diagnosis including a history of mental/mood/behavioral disorders, Major Depressive Disorder and Dementia (the loss of cognitive functioning (thinking, remembering, and reasoning) to such an extent that it interferes with a person's daily life and activities). Record review of the 06/04/22 Quarterly MDS assessment indicated Resident #29 was understood and had a BIMs of 06, indicating severely impaired cognition at times. She did reject care for 4 to 6 days of the 7-day review period. She required supervision set-up only for walking. Record review of the 11/06/21 Comprehensive Care Plan revealed for Resident #29 staff must maintain a calm environment and approach. Record review of complaint intake #360678 and facility investigation dated 06/29/22 indicated the incident was reported on 06/28/22, revealed TCNA O bit Resident #29 on the thigh during an altercation, which also resulted in a scrape on Resident #29s left elbow. TCNA O was suspended during the investigation, a police report was completed, a staff in-service on abuse was completed and the completed investigation was faxed to the state on 07/04/22 with the allegations noted as unconfirmed. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	Record review of the Police Department Case #P2200955 dated 06/28/22 at 08:31 AM revealed assault against elderly or disabled individual (Resident #29). TCNA O physically assaulted Resident #29 after she wanted to call family member around 10:00 PM and staff would not allow it. TCNA O came into the resident's room, sat on her bed and hit her. TCNA O entered Resident #29s room again, jumped on her bed and hit her with her fists, causing the resident to become unconscious at times; also told Resident #29 she was in a mental institution. Then when the resident said she would report TCNA O to administration, both fell off the resident's bed and hit the tile floor, the resident wrapped her thighs around TCNA Os neck and then the TCNA bit the resident on the thigh. TCNA O then hit the resident again in the face with closed fists and left the room. Resident #29 had an injury to her left elbow with a band aid covering it with blood on it, her shirt and sheets, but her right thigh did not have teeth marks. TCNA O was read her [NAME] Rights. Due to the fact that TCNA O is an employee with the nursing home and was working in the Mental health side of the facility she has the duty to protect and care for the residents who she oversees. TCNA O did not show restraint verbally or physically to Resident #29 due to being upset with the threat of being reported to administration. Resident #29 is a [AGE] year-old fragile elderly woman who could not protect herself against a healthy young [AGE] year-old TCNA. The nursing home did not call for police when this assault occurred, they called 9 hours after the assault to report this to the police. Record review of the CPS/APS Intake Report dated 06/28/22 revealed Resident #29 resides at facility and had been physically assaulted three times by TCNA O working overnight. between 11:00 PM and 01:00 AM. TCNA O had bit the resident on her inner right thigh with her teeth and punched her multiple times with a closed fist causing the resident to lose consciousness. A wound to Resident #29s left elbow was band aided over and still had bleeding noted. TCNA O was suspended, and a report was filed for assault against elderly or disabled individual. Record review of the facility staffing schedules 07/01/22 to 08/02/22 revealed TCNA O worked at least 20 shifts at the facility since the abuse to Resident #29. During an interview on 08/02/22 at 04:48 PM with Resident #29, stated she went down the hallway, and asked TCNA O to talk/call to her family member, and the staff would not let her. I tried to open doors and pulled the fire alarm to get the employees attention. TCNA O asked me to go to my room. So, I did. But I still wanted to call my daughter. TCNA O came into my room, jumped on my bed, saying this was a mental institution. I told her (TCNA O) no, this was a place for the elderly. She came back in my room more than once; I said some things and she said, don't talk to me. I threw a bottle hard at TCNA O that missed her because she kept getting near my face, so I pulled her hair and we both fell to the floor, and then TCNA O did bite me on my thigh. I was in fear for my safety with her working here, none of that had to happen if they would have let me call my family member none of that would have happened. She kept coming back in my room, antagonizing me and then left the building. I had an injury to my left elbow that bled and a bite mark on one of my thighs. I filed a police report and staff talked to me about the incident. I thought TCNA O was fired because she should not treat residents that way. Nothing like that had ever happened before that incident at the facility. In an attempted telephone interview with TCNA O on 08/02/22 at 04:58 PM revealed message call cannot be completed due to the called party is unavailable. During an interview on 08/03/22 at 09:00 a.m., with the Administrator and DON, they were asked if they could get ahold of TCNA O. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/03/22 at 05:37p.m., the Regional Nurse reported she made attempts to reach TCNA O all day and were unsuccessful. The facility eventually had contact with TCNA O on 08/04/22 and she gave her notice of termination. During an interview on 08/02/22 at 04:49 PM, CNA CC revealed he stated he was there during the incident with Resident #29 and TCNA O. It was a verbal confrontation between Resident #29 and TCNA O, it then became physical from what I heard, and then when TCNA O went back into the room with Resident #29, I went back to the unit for security reasons. Resident #29 said that TCNA O had bit her, and there was a bite mark on Resident #29s leg. I had abuse training prior to this incident, in-services, and have been a CNA for [AGE] years, I have learned some things. He did not feel TCNA O was abusive towards the resident, even after hearing what took place. Interviews on 08/03/22 at 12:24 PM with LVN F, revealed she stated I worked the night shift on whatever night the incident between Resident #29 and TCNA O occurred, and at approximately 10:00 PM or later, I got back from my break and RN DD and CNA CC were back in the secured unit. TCNA O was the aide on the secure unit and had left the facility after an incident with Resident #29 without telling staff what happened. Resident #29 said she and TCNA O had exchanged words, ended up on the ground, Resident #29s legs around the aide's neck, and the aide bit her. LVN did note a circular red mark on Resident #29s right thigh near her pelvis, but she did not chart a skin assessment. TCNA O was not at work for a while after that incident. She called the DON after that to report what happened. LVN F stated I had abuse training prior to the incident and definitely after the incident. Resident #29 had never been aggressive to any staff physically; this was not like her, so I settled her down and made sure she felt safe, because TCNA O was gone from the building, and she had no other issues that night. LVN F stated allowing the residents to call her family member maybe would have helped prevent this whole incident, she may have asked TCNA O to call her family member, I do not know. During an interview on 08/03/22 at 02:57 PM with the Police Officer revealed that night (06/27/22) around 11:30 PM on the secured unit at the facility, TCNA O said Resident #29 could not call her family member at night. This upset the resident and so she pushed on alarmed doors to irritate the staff. The resident was just upset, saying she wanted to report TCNA O, and TCNA O was mad that Resident #29 was going to report her. The resident had gone to her room, and TCNA O came into her room, sat on her bed. The resident wrapped her legs around TCNA O's neck, they both fell to ground and TCNA O bit her leg. Resident #29 was protecting herself she said, that was why she protected herself. The resident's elbow was busted open, black, blue and purple and there was dried blood on her bedding and clothing. I took pictures of the teeth marks on her leg/thigh, and TCNA O admitted she had punched Resident #29 in the face and bit her. The facility should have called the police right away when it happened so we could have taken Resident #29 to the hospital to get checked out. TCNA O should have never been seated on the resident's bed, antagonizing her. Resident #29 was with it, she remembered everything. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	During an interview on 08/02/22 at 5:00PM, the Administrator stated she was aware of the incident from the DON that morning after the incident between TCNA O and Resident #29 and reported it. It happened because the staff would not allow the resident to call her family member. This upset the resident and she acted out, pulling the fire alarm for attention. It was reported by TCNA O that Resident #29 attacked her, kicked her causing them to fall to the floor. The resident wrapped her legs around the NAs neck and TCNA O bit the thigh of the resident for her to release. The Administrator stated the facility had trained their employees on de-escalation of combative residents and TCNA O should have left the resident alone and allowed her to call her family member to calm the resident down. TCNA O just worked the front hall instead of the secured unit after the incident. During an interview on 08/02/22 at 5:00PM, the Corporate RN stated police had come out and read TCNA O her [NAME] rights, so the facility thought that meant she had to be terminated. TCNAs references and background check were fine, that is why she was hired. Not firing her could affect every resident in the facility she had contact with after this incident by allowing further abuse. During an interview on 08/16/22 at 01:04 PM, the DON stated I got a call from LVN F about the incident that morning and reported it to the Administrator right away. During an interview on 08/03/22 at 02:57 PM with the Police Officer who was dispatched to this incident revealed that night around 11:30 PM on the secured unit at the facility, TCNA O said Resident #29 could not call her family member at night. This upset the resident and so she pushed on alarmed doors to irritate the staff. The resident was just upset, saying she wanted to report TCNA O, and TCNA O was mad that Resident #29 was going to report her. The resident had gone to her room, and TCNA O came into her room, sat on her bed. The resident wrapped her legs around TCNA O's neck, they both fell to ground and TCNA O bit her leg. Resident #29 was protecting herself she said, that was why she protected herself. The resident's elbow was busted open, black, blue and purple and there was dried blood on her bedding and clothing. The office said he took pictures of the teeth marks on her leg/thigh, and TCNA O admitted she had punched Resident #29 in the face and bit her. He said the facility should have called the police right away when it happened so we could have taken Resident #29 to the hospital to get checked out. TCNA O should have never been seated on the resident's bed, antagonizing her. Resident #29 was with it, she remembered everything. 2. Record review of the face sheet dated 8/2/22 revealed Resident #49 was [AGE] years old, male, and admitted on [DATE] with diagnoses including multiple sclerosis (a disease that impacts the brain, spinal cord, and optic nerves), need assistance with personal care, schizoaffective disorder, bipolar type (a chronic mental health condition that involves symptoms of both schizophrenia and a mood disorder), anxiety disorder, and depression. Record review of the MDS dated [DATE] revealed Resident #49 was understood and understood others. The MDS revealed Resident #49 had a BIMS of 7 which indicated severe cognitive impairment and required extensive assistance to total dependence for ADLs. Record review of an undated care plan revealed Resident #49 exhibited verbally abusive behavioral symptoms. Interventions included ignore resident's verbal abuse when directed at you and refocus conversation when resident becomes verbally abusive. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/3/22 at 11:49 a.m., Resident #49 stated he and a staff member exchanged words one day. He said it made me mad and sad because she talked about his mother, and she was his best friend. During an interview on 8/2/22 at 4:23 p.m., Resident #30 said last month, TCNA O cursed out a resident because Resident # 49 threw a tray at her. Resident #30 said I could hear her all the way down to my room and she talked about his momma and dad. She stated TCNA O said, Your mom is bitch and Your dad is a __ and my auntie works here. She said TCNA O was CNA N's niece. During an interview on 8/3/22 at 2:30 p.m., Resident #30 said a verbal altercation between a resident and a CNA happened. She said the altercation was so loud, staff from the front of the building came to the back to see what was happening. She said she was not sure what occurred, but TCNA O cursed a resident down the hall and talking about his mom was a whore and stated, she was going to lose her job today. She said TCNA O cursed the resident out. During an anonymous interview on 8/1/22 at 11:00 a.m., AR said 2-3 weeks ago, he/she heard an aide cursed out a resident. AR said the resident threw his tray and the aide screamed, your mom is a bitch. AR said it happened on 07/03/22. AR said he/she did not know who the resident or aide were. During an interview on 8/3/22 at 10:03 a.m., TCNA L said on 07/03/22, TCNA O did curse out Resident #49. She said the facility was short staffed that weekend and TCNA O came to the back hall to help. She said TCNA O went into Resident #49's room to drop off his lunch tray and screaming started. She said Resident #49 did not throw a plate at TCNA O, put tossed the plate cover on the floor and it did not touch her. TCNA L said her and LVN A pulled TCNA O out of the room and told her to go outside. TCNA L said she told CNA N, the CNA supervisor, about the verbal altercation. She said she had received abuse training upon hire. During an interview on 8/4/22 at 8:45 a.m., LVN A said a loud altercation happened between TCNA O and Resident #49 on 07/03/22. She said Resident #49 threw the lid to the plate and it almost hit TCNA O. TCNA O then cursed Resident #49 and screamed at her aunt who worked here and stated she would lose her job today. LVN A said she attempted to deescalate the situation by separating TCNA O from Resident #49 and told her to go outside for a while then back to the front hall. LVN A said the CNA N showed up at the facility and took TCNA O outside. LVN A said she did not see TCNA O for the rest of the day. She was not sure if TCNA O went home or just stayed down on the front hall. LVN A said she did not assess Resident #49 after the altercation, physically or mentally. LVN A said she felt the altercation was verbal abuse. LVN A said because the on-call nurse and CNA N, who was the CNA supervisor, were in the building they would report the abuse to the administrator. During an interview on 8/3/22 at 5:43 p.m., LVN C said Resident #57 told him about a ruckus that happened over the weekend. He said Resident #57 attempted to play a recording, but it was not working properly. LVN C said he could hear people screaming at each other, but he only heard it for a few seconds. He said Resident #57 said he did not know who was in the recording, but they created a big ruckus. LVN C said he called the administrator on 07/04/22 and told her about the recording because he felt obligated to notify her in case it was verbal abuse. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/3/22 at 10:37 a.m., CNA N said TCNA O and Resident #49 did have an altercation on 07/03/22. She said TCNA O called her and told her about it. She said TCNA O told her Resident #49 threw a plate at her and called her out of her name. She said she told her to leave, and she could not talk to residents like that even if they call you the N word. She said on 07/04/22, LVN C told the Administrator about a recording Resident #57 had on his phone, but he could not hear enough to decipher who it was. LVN C told the administrator Resident #57's phone was not acting right but he felt like she should look into it. CNA N said the Administrator called her to investigate the recording Resident #57 had. She said she asked Resident #57 to listen to the recording he told LVN C about, but he said he did not have it. She said since I could not hear the recording, then there was nothing to investigate. She said the altercation between TCNA O and Resident #49 was abuse. She said TCNA O did not have sufficient abuse and deescalating training before hire. She said the facility was so short staffed when she started, we just need her to work and did not have time to give her sufficient training. She said she did not fire TCNA O because she asked other residents about her care, and no one complained and some even requested her to work on their hall. She said she asked staff about her behaviors, and no one complained. During an interview on 8/3/22 at 12:45 p.m., the Administrator was notified by this surveyor and the team lead of the survey, of reports from staff and residents, verbal abuse had occurred between a resident and staff. The Administrator was also notified of reports from staff, she was notified of the verbal altercation prior to the survey. The Administrator denied any knowledge of abuse in the facility. During an interview on 8/4/22 at 5:40 p.m., the DON said TCNA O's last day worked was 7/31/22. She said she was not told about the incident with Resident #49. She said she was out of town, and no one called her. She said after the first incident with, she did in-service on the prosperity unit, and asked staff about her behavior towards other residents. She said no one complained about her. She said TCNA O was suspended for 2-3 days but disciplinary action was not done. She said she only probably signed the suspension paperwork. She said it should be in her personnel file. During an interview on 8/4/22 at 6:30 p.m., the Administrator said abuse was not tolerated and everyone had been educated on the chain of reporting. She stated she was unaware of the verbal abuse that occurred between TCNA O and Resident #49. She said verbal abuse could make a resident feel threatened and scared. She said it could make residents not trust the staff and have decreased quality of life. Record review of the facility Abuse Prevention Program Policy dated 02/2021 revealed our residents have the right to be free from abuse, including verbal, mental or physical abuse. Our center will protect residents from harm during investigations of all abuse investigations. All reports of resident abuse shall be promptly reported and thoroughly investigated by management.

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 44933 Based on observation, interview, and record review, the facility failed to provide sufficient number of CNAs on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans and the facility assessment for 8 of 21 residents reviewed for care and services. (Residents #1, #23, #32, #10, #49, #30, #57 and #56) The facility failed to provide sufficient staff on the 6 am-6 pm (07/01/2022-08/02/2022) and the 6 pm-6 am (07/01/2022-08/02/2022) shifts to meet the needs of the residents who required assistance with transfers, incontinent care, and activities of daily living. These failures lead to residents being transferred unsafely with one person for mechanical lifts, not receiving timely incontinent care leading to skin irritations, and not receiving baths leading to embarrassment and harm to health and safety of residents This failure could place residents who required assistance from staff for ADLs at risk for infection, skin breakdown, low self-esteem, and or depression. Findings included: Upon entrance into the facility on [DATE] at 9:00am the Administrator took the surveyors through the building to the back hall to an empty room. On the way there was a resident walking in the hall with t-shirt and soggy brief down to her knees, no pants with hair in disarray. The pungent odor made surveyors gag all the way down the hall and eyes water from the ammonia smell. Breakfast was still being served at this time. On the way down the hall the Administrator kicked a large (2-3 inch) water bug with her foot to the side. The survey team was placed in room with yellow stains on the wall with a strong urine odor. [NAME] stains were noted on the bathroom walls also. Record review of the Facility Assessment Tool updated on 7/26/2022, revealed the facility's average census for the past 12 months was 62 residents and the number of staff needed to work was 5 CNAs on day shift and 5 CNAs on evening/night shift, for a total of 10 CNAs in a 24 hour period. Updated on 7/26/2022 related to the addition of the specialized behavioral unit and 12-hour CNA shifts. Record review of the 2021 Facility Assessment Tool with the average census of 61 required 11 CNA's in a 24-hour period. Record review of the Daily Staffing Sheets dated 7/1/2022 to 8/2/2022 showed the following worked: average census 62 *07/01/2022 (6am-6pm) 2 CNAs and 2 CNAs (6pm-6am) *07/02/2022 (6am-6pm) 3 CNAs and 4 CNAs (6pm-6am) *07/03/2022 (6am-6pm) 3 CNAs and 3 CNAs (6pm-6am) (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Actual harm Residents Affected - Few	*07/04/2022 (6am-6pm) 2.5 CNAs and 3 CNAs (6pm-6am) *07/05/2022 (6am-6pm) 2 CNAs and 3 CNAs (6pm-6am) *07/06/2022 (6am-6pm) 3 CNAs and 3 CNAs (6pm-6am) *07/07/2022 (6am-6pm) 3 CNAs and 3 CNAs (6pm-6am) *07/08/2022 (6am-6pm) 2 CNAs and 3 CNAs (6pm-6am) *07/09/2022 (6am-6pm) 2 CNAs and 2 CNAs (6pm-6am) *07/10/2022 (6am-6pm) 2 CNAs and 3 CNAs (6pm-6am) *07/11/2022 (6am-6pm) 3 CNAs and 3 CNAs (6pm-6am) *07/12/2022 (6am-6pm) 2 CNAs and 4 CNAs (6pm-6am) *07/13/2022 (6am-6pm) 3 CNAs and 3 CNAs (6pm-6am) *07/14/2022 (6am-6pm) 3 CNAs and 4 CNAs (6pm-6am) *07/15/2022 (6am-6pm) 4 CNAs and 4 CNAs (6pm-6am) *07/16/2022 (6am-6pm) 4 CNAs and 4 CNAs (6pm-6am) *07/17/2022 (6am-6pm) 4 CNAs and 4 CNAs (6pm-6am) *07/18/2022 (6am-6pm) 3 CNAs and 3 CNAs (6pm-6am) *07/19/2022 (6am-6pm) 3 CNAs and 3 CNAs (6pm-6am) *07/20/2022 (6am-6pm) 4 CNAs and 4 CNAs (6pm-6am) *07/21/2022 (6am-6pm) 3 CNAs and 3 CNAs (6pm-6am) *07/22/2022 (6am-6pm) 4 CNAs and 3 CNAs (6pm-6am) *07/23/2022 (6am-6pm) 2 CNAs and 3 CNAs (6pm-6am) *07/24/2022 (6am-6pm) 2 CNAs and 3 CNAs (6pm-6am) *07/25/2022 (6am-6pm) 3 CNAs and 3 CNAs (6pm-6am) *07/26/2022 (6am-6pm) 4 CNAs and 3 CNAs (6pm-6am) *07/27/2022 (6am-6pm) 3 CNAs and 4 CNAs (6pm-6am) (continued on next page)

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	455565	A. Building B. Wing	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palestine Healthcare Center	1816 Tile Factory Rd Palestine, TX 75801

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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 0725 Level of Harm - Actual harm Residents Affected - Few	*07/28/2022 (6am-6pm) 4 CNAs and 4 CNAs (6pm-6am) *07/29/2022 (6am-6pm) 3 CNAs and 4 CNAs (6pm-6am) *07/30/2022 (6am-6pm) 3 CNAs and 4 CNAs (6pm-6am) *07/31/2022 (6am-6pm) 3 CNAs and 4 CNAs (6pm-6am) *08/01/2022 (6am-6pm) 3 CNAs and 1 CNAs (6pm-6am) *08/02/2022 (6am-6pm) 4 CNAs and 2 CNAs (6pm-6am) Record review of the CMS 672 dated 08/01/2022 indicated a census of 62 with the following: *20 residents required assist of one or two staff for bathing. *39 residents were dependent for bathing. *53 residents required assist of one or two staff for dressing. *9 residents were dependent for dressing. *51 residents required assist of one or two staff for transfers. *10 residents were dependent for transfers. *44 residents required assist of one or two staff for toilet use. *18 residents were dependent for toilet use. *58 residents required assist of one or two staff for eating: and *3 residents were dependent for eating. 1. Record review of the face sheet revealed Resident #1 was [AGE] year-old male that was admitted on [DATE] with diagnoses including CVA (stroke), bipolar disorder (disorder associated with episodes of mood swings) and hemiplegia (one-sided paralysis). Record review of the annual MDS dated [DATE] indicated Resident #1 had a BIMS of 15, which indicated no cognitive impairment. The MDS indicated he required limited assistance with ADLs, and he had physical behavioral symptoms directed towards others and verbal behavioral symptoms directed toward others exhibited 1 to 3 days. During an interview on 8/3/2022 at 8:12 am, Resident #1 stated he was upset and wanted to file a grievance because he did not get a supper tray the previous night and did not get any nighttime medication. Resident #1 stated he had his call light on for hours without it being answered and when they came in the aide said she was the only one here. Resident #1 stated there is never enough staff. It does not matter the day of the week of the time of day, it takes forever to get assistance. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	2. Record review of a face sheet revealed Resident #23 was a [AGE] year-old male, that admitted to the facility on [DATE] with the diagnoses of anemia (low iron in the blood), hypothyroidism (A condition in which the thyroid gland doesn't produce enough thyroid hormone), and edema (swelling). Record review of an MDS dated 6 /08/2022 indicated Resident #23 had a BIMS of 08, which indicated a mild cognitive deficit. Resident #23 required extensive to extensive assistance with ADLs of personal hygiene and bathing. Resident #32 was understood and understood others. Record review of a care plan dated 7/27/2022 titled ADL care listed an intervention to aid with bathing/showering 3 times per week and a sponge bed bath on non-shower days if needed. During an observation on 8/1/2022 at 9:33AM, Resident #23 stated he only got a bath about once every 2 weeks and had not had his hair washed in a couple months. Resident #23's hair was noted to be greasy. There was a strong smell of urine noted when entering the room. When asked if he would like a bath 3 days a week, he stated at least twice a week would be nice since he peed on himself so he could keep my skin clean. Resident #23 was noted to have long dirty fingernails. They were noted to be 3/4 inch from fingertips with a brown substance under all nails. There were yellow stains noted to his pillowcase when he lifted his head. Gray stubble covered Resident #23s face, approximately 1/2 inch long. Resident #23 stated the facility shaved him last week when he got his bath, but he liked to be shaved clean. Resident #23 stated he would like more than one bath a week but not every day. He stated he liked to feel clean it made him feel and smell better. Record review of the point of care ADL report dated 5/26/2022-6/30/2022, there was documentation of 5 baths being given (6/11,6/21, 6/23,6/25, and 6/30). According to the bath schedule Resident #23 should have received 15 baths in this time. No refusals were documented, or care planned for Resident #23. 3.Record review of a face sheet revealed Resident #32 was a [AGE] year-old-male that was admitted to the facility on [DATE] with the diagnosis of CVA (stroke), hemiplegia of dominant side (paralysis on right side of body), and protein calorie malnutrition. Record review of the MDS dated [DATE] revealed Resident #32 was usually understood and usually understood others. Resident #32 was noted to have a BIMS of 04 which indicated a significant cognitive impairment and he required extensive assistance with ADLs such as transfer, bathing, and bed mobility. Record review of a care plan for Resident #32 dated 6/29/2022 titled general had interventions listed for nail care to be done every Tuesday, Thursday, and Saturday on the 6pm to 6am shift. The interventions also listed bathing to occur every Tuesday, Thursday, and Saturday on the 6pm-6am shift. During an observation and interview on 8/1/2022 at 9:33AM, Resident #32 was noted to have a foul odor of ammonia and feces. The resident had dirty long fingernails with thick brown gummy like substance underneath that were 3/4 to 1 inch from the tip of fingers. When asked if he would like a bath, Resident #32 shook his head yes and stated yeah. Record review of the point of care ADL report dated 5/26/2022-6/30/2022, there was documentation of 6 baths being given of the 15 baths due during this time frame. No refusals were documented, or care planned for Resident #32. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	4. Record review of the face sheet dated 8/4/22 revealed Resident #10 was [AGE] years old, male, and admitted on [DATE] with diagnoses including muscle wasting and atrophy, and quadriplegia (paralysis of all four limbs). Record review of the MDS dated [DATE] revealed Resident #10 was understood and understood others. The MDS revealed Resident #10 had adequate vision. The MDS revealed Resident #10 had a BIMS of 14 which indicated intact cognition and required extensive assistance with two people assist for dressing, bed mobility, and transfers. And required total dependence with two people assist for toilet use, personal hygiene, and bathing. Record review of the care plan dated 7/13/22 revealed Resident #10 had self-care deficit related to quadriplegia as evidence by required assistance with ADLs. Intervention included total x 1-2 assistance with bath/showering 3 times a week. The care plan revealed Resident #10 had episodes of resisting care including showers. Interventions included monitor for early signs of behavior, approach in calm manner, and when refuses care re-approach later, notify nurse to document in chart. Record review of a care plan dated 7/13/22 revealed Resident #10 required total assist x2 (with lift) for transfers. Record review of the point of care history dated 5/4/22-8/4/22 revealed Resident #10 received no baths documented in May 2022. In June 2022, Resident #10 received 3 (6/23/22,6/25/22,6/27/22) partial bed baths (bathing the following areas: face, hands, underarms, back, buttocks and genital) and showers (6/24/22, 6/25/22, 6/30) out of 13 days. In July 2022, Resident #10 received 12 partial bed baths (7/1/22,7/3/22, 7/6/22, 7/7/22, 7/8/22, 7/11/22,7/12/22, 7/25/22, 7/26/22, 7/27/22, 7/29/22, 7/30/22) 2 showers (7/5/22,7/23/22), and 1 complete bed bath (7/26/22) out of 13 days. No refusals were documented on the point of care history. During an interview and observation on 8/1/22 at 10:30 a.m., Resident #10 said he had not had a shower since Wednesday (7/27/22). Resident #10 had greasy hair with dry, white patched noted to his scalp. Resident #10 said his hall only had one CNAs for a lot of residents. He said on the weekends, folks barely came to work. 5. Record review of the face sheet dated 8/4/22 revealed Resident #49 was [AGE] years old, male, and admitted on [DATE] with diagnoses including multiple sclerosis, need assistance with personal care, and muscle wasting and atrophy (shortening). Record review of the MDS dated [DATE] revealed Resident #49 was understood and understood others. The MDS revealed Resident #49 had a BIMS of 7 which indicated severe cognitive impairment and required extensive assistance for bed mobility, transfers, and personal hygiene. And total dependence for dressing and bathing. The MDS dated [DATE] revealed Resident #49 was a tobacco user. Record review of the undated care plan revealed Resident #49 was a fall, safety, elopement risk with interventions of encourage use of call light and keep call light within reach. The undated care plan revealed Resident #49 would have the following tasks documented in POC. Intervention included bath/showers on Tuesday, Thursday, and Saturday on the 6am-6pm shift. Bathing/hygiene assist amount not specified. Record review of the undated care plan revealed Resident #49 was a smoker. Intervention included need to wear a smoking apron. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	During an observation and interview on 8/1/22 at 10:30 a.m., Resident #49 was in bed with his call light on the floor. Resident #49 said he did not know where his call light was but even if he had it, staff do not answer it. He said if he needed assistance then he must holler out but he said his voice was not that loud so he could not be heard. During an interview on 8/2/22 at 10:00 p.m., Resident #49 said he was out of snuff and the person who used to buy it for him does not anymore. He said he would really like to smoke a cigarette, but no one will get him up. He said staff do not want to get him up to smoke because he needs to be put back to bed soon afterwards. He said he cannot sit up for long periods of time because of his back issues. He said he has been a smoker for half of his life, and it sucked he could not do it now. During an interview on 8/3/22 at 10:37 a.m., CNA N said Resident #49 was a smoker, but he wanted staff to immediately put him back to be afterwards. She said due to lack of staffing, she could not accommodate him. She said she normally worked the back hall which had 15 residents and most to all required some type of assistance with ADLs. She said the back hall had a lot of smokers so that took a lot of time and non-smoking resident's call lights were not being answered timely. She said since she was the CNA coordinator, if she could not find staffing after call ins, she had to come in to cover the shift. During an interview on 8/4/22 at 5:40 p.m., the DON said it was not right for Resident #49 to be denied smoke breaks because staff did not want to put him back to bed. She said it infringed on his right to smoke. She said Resident #49 being denied his smoke breaks could cause depression because he cannot do something he likes. She said he already had depression issues because of his loss of independence. During an interview on 8/4/22 at 6:30 p.m., the Administrator said not allowing Resident #49 to smoke due to lack of staffing was not an excuse. She said Resident #49 had the right to smoke and to be assisted out of bed to smoke. She said she did not know that Resident #49 wanted to smoke cigarettes and was being denied by staff. She said the resident rights were supposed to be reviewed in resident council meetings but a copy of it was in the admission packet. She said not all residents sign their admission packets and may not have received a copy of the resident rights. She said residents not knowing their residents' rights could make them feel unheard with no voice in their home leading to depression and anxiety. 6. Record review of the face sheet dated 8/1/22 revealed Resident #57 was [AGE] years old, male, and admitted on [DATE] with diagnoses including chronic pain syndrome, muscle wasting and atrophy, functional quadriplegia (a person affected by paralysis of all four limbs), and polymyositis (an uncommon inflammatory disease that causes muscle weakness affecting both sides of your body) with myopathy (a disorder of the skeletal muscles). Record review of the MDS dated [DATE] revealed Resident #57 was understood and understood others. The MDS revealed Resident #57 had a BIMS of 15 which indicated intact cognition and required total dependence for all ADLs. The MDS revealed Resident #57 rejected evaluation or care 1 to 3 days. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Record review of the undated care plan revealed Resident #57 the following tasks will be documented in POC. Interventions included bath/showers and nail care on Tuesday, Thursday, and Saturday on the 6pm-6am shift. The care plan revealed Resident #57 had limited physical mobility, bedfast all or most of the time related to diagnosis of functional quadriplegia. Intervention included reposition every 2 hours. Record review of the point of care history dated 5/4/22-8/4/22 revealed Resident #57 received 2 complete bed bath (5/28/22,5/29/22) and 1 partial bed bath (5/31/22) out 13 days in May 2022. In June 2022, Resident #57 received 5 complete bed baths (6/1/22, 6/2/22, 6/3/22, 6/7/22, 6/8/22), 3 partial bed baths (6/4/22, 6/5/22, 6/8/22), and 2 showers (6/3/22, 6/9/22) out of 13 days. In July 2022, Resident #57 had no documentation of bed bath or shower. No refusals were documented on the point of care history. Record review of the progress notes dated 7/11/22 -8/1/22 revealed no nursing documentation of bed bath/shower refusals. During an observation and interview on 8/1/22 at 11:27 a.m., Resident #57 was lying in bed with a large, yellow stained pillow. Resident #57 had greasy hair, flaky, dry skin to his face with redness noted, and long nails with brown matter underneath. Resident #57 said he had not had his hair washed since he was admitted . He said he sometimes gets bed bath, but they do not wash his hair. He said on 7/31/22, his urinal overflowed on to his sheets and no one came to change his linens for 12 hours. He said on the weekends and nights staffing was short, which is when he has the most issues. He said he had to call 911 to get help sometimes because they did not answer his call light or phone call to the front desk. Record review of meal report dated 7/3/22-8/3/22 revealed on 8/2/22 at 10:29 p.m. and 10:30 p.m., 51-75% supplements were taken by Resident #57 given by LVN I. The meal report revealed Resident #57 last documentation of intake on 8/2/22 was at 1:10 p.m. During an interview on 8/2/22 at 9:41 p.m., CNA H said she was doing the best she could as the only CNA for the back hall (15 residents) and the secured unit (21 residents). She said she did not have time to feed Resident #57. During an interview on 8/2/22 at 10:00 p.m., Resident #57 said he had not been fed supper yet. He said staff brought his dinner tray around 5:45 p.m., and he did not like the look of the pureed food, so he asked for a sandwich or bowl of fruit loops. He said staff took his tray and never came back. During an interview on 8/2/22 at 10:10 p.m., LVN I said she was unsure if Resident #57 was fed his supper, she said she had not fed him. She said she would not be surprised if he was not fed because night shift was short staffed. During an interview on 8/3/22 at 8:45 a.m., the Administrator said she sent the CNA, who came in to work to help night shift, feed Resident #57 a bowl of cereal around 10:45 p.m. 7. Record review of the face sheet dated 8/3/22 revealed Resident #30 was [AGE] years old, female, and admitted on [DATE] with diagnoses including spastic diplegic cerebral palsy (a form of cerebral palsy, a neurological condition that usually appears in infancy or early childhood, and permanently affects muscle control and coordination), lack of coordination, and muscle weakness. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Record review of the MDS dated [DATE] revealed Resident #30 was understood and understood others. The MDS revealed Resident #30 had a BIMS of 15 which indicated intact cognition and required total dependence with 2 plus people assist with all ADLs. Record review of the care plan dated 4/27/22 revealed Resident #30 required total x 2 people with lift for transfers. During an interview on 8/2/22 at 4:23 p.m., Resident #30 said call lights were not regularly answered timely. She said the facility was short staffed especially on the weekends and if there was not enough staff, CNAs will not get you up. She said she was transferred with lift x 1 person 98% of the time. 8. Record review of the face sheet dated 8/4/22 revealed Resident #56 was [AGE] years old, female, and admitted on [DATE] with diagnoses including osteoarthritis, need for assistance with personal care, and muscle wasting and atrophy (shortening). Record review of the MDS dated [DATE] revealed Resident #56 was understood and understood others. The MDS revealed Resident #56 had a BIMS of 7 which indicated severe cognitive impairment and required total dependence with transfers. Record review of a care plan dated 7/27/22 revealed Resident #56 had self-care deficit related to dementia/bipolar disorder/muscle weakness as evidence by required assistance with ADLs. Intervention included total assist x 1-2 people for transfers. During an interview on 8/1/22 at 2:50 p.m., Resident #56 said she had not been changed since breakfast time around 7:00 a.m. She said it burned when she urinated and the odor when they change her was embarrassing. She said she got a bed bath about once a week. She said staff took about 1-2 hours to answer call lights and it happened about three times a week. During an interview on 8/2/22 at 9:41 p.m., CNA H said she was doing the best she could as the only CNA for the back hall and the secured unit. She said she had not given any bathes this evening. She said there was no way she could do that by herself. She said it was short staffed 90% of the time. CNA H stated she had no choice but to leave the secured unit unattended to help the nurse get people to bed. CNA H said occasionally there will be a day we have 4 CNA on night shift. During an interview on 8/2/22 at 10:30 p.m., the Administrator said the staffing numbers for the facility was to have 5 CNAs on day and night shifts, but she felt the facility ran well with 3 staff members. The Administrator was made aware of having only 2 CNA's this night shift, no showers had been given, and the secure unit was left unattended. During an interview on 8/3/22 at 10:03 a.m., TCNA L said she had been at the facility for a month. She said she normally worked the front and center halls. She said residents do not get their scheduled bed baths or showers due to lack of staff. She said if a resident was scheduled for a bed bath or shower on the night shift, it probably was not going to get done. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/3/22 at 10:37 a.m., CNA N said she was the CNA staff coordinator and worked the floor. She said call lights should be always in reach and functioning. She said due to lack of staffing, call lights were not answered timely, and residents did complain to her about call light response time. She said call lights not being in reach or non-functioning could cause falls and resident's needs not being met. She said due to lack of staff, residents did not get their scheduled bath/showers, nail care or oral care. She said she tells the CNAs to at least wash the residents face and hands. She said CNAs did not wash resident's hair if they got bed baths. During an interview on 8/4/22 at 5:40 p.m., the DON said call lights not being answered, in reach, or non-functioning could cause more falls. She said anyone that enters the room to provide care for the residents, was responsible for the call light being in reach. She said resident having to wait for long period of time to get changed could cause skin issues. She said it could make the resident feel sad because they may not feel important or seen. The DON said she knew ADLs were not getting done due to staffing issues. She said staff are burnout and don't want to come in on their off day. She said residents not getting showers/bed baths, hair washed, nail care, and overall personal hygiene could cause skin integrity issues and infections. She said resident can become depressed from not getting ADLs done. She said residents needs not being met can cause behaviors. The DON stated the administrator and corporate come up with the staffing numbers based on census and acuity and those are the numbers that the staffing coordinator are instructed to staff. However, it was a matter of not having enough people employed to fill those positions. She stated it had been discussed several times in the past to slow down on or stop taking admissions until the facility was staffed properly but corporate would not hear of it. During an interview on 8/4/22 at 6:30 p.m., the Administrator said residents having their call light in reach and functioning was very important for everyone. She said having non-functioning call light or call light not within reach could lead to falls, increased skin problems, and unhappy residents. She said all CNAs and nurses were responsible for ensuring call lights in reach and functioning properly. She said if staff found a call light out of reach, they need to put it within reach. The Administrator said being short of staff can affect resident care and make them miss baths, grooming, activities, have skin issues, miss medications, and have decreased quality of life. The Administrator stated she was responsible for making the facility assessment and she did include thing like acuity of residents and diagnosis to come up with the numbers for care givers. During record review an in service titled Secure Unit Staffing form 3/2/2022 stated: The secure unit will have a minimum of two nursing staff members on the unit at all times. If one member leaves the unit, the nurse must be notified so that a replacement can be placed. The secure unit nurse is accountable for having appropriate staff on the unit at all times. During an observation on 8/2/2022 at 9:50PM there were no employees on the secured unit with 18 residents present. The one CNA assigned to the unit was outside of the unit assisting the nurse to put other residents to bed. There were 2 CNAs and 2 nurses in the entire building with 63 residents at that time. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Actual harm Residents Affected - Few	Record review of grievances and in services revealed grievances filed concerning call lights not being answered timely on 2/11/2022 (Resident #1), 3/18/2022(Resident #56), 4/14/2022 (family member), 4/14/2022 (ombudsman), and 8/3/2022 (Resident #1). An in service was done on 3/2/2022 by that revealed: call lights will be answered promptly and in a timely manner. Residents are to be addressed in a professional manner using their last name unless they are direct otherwise. If upon entering the resident's room, you are not able to address the resident's need you will leave the call light on and get the appropriate help. If you are able to meet the resident's need you will turn off the light and complete the desired task. Call lights must always be within reach and in working order. During an interview on 8/3/2022 at 10:03 am TCNA L stated residents do not get scheduled baths or call lights answered timely. TCNA L stated it was hard to get help because the facility was always short staffed. TCNA L said she was seriously considering quitting because how stressful the job was. TCNA L stated some of the resident's behaviors are due to not having enough staff and waiting such a long time for help. During an interview on 8/3/2022 at 10:37 pm CNA N stated there was supposed to be 10 CNAs staffed in the building every 24 hours due to the number and type of residents they cared for. CNA N stated they staffed 4 CNAs on day shift which included her and 3 on night shift on average. CNA N stated everyone was aware of shortage and it was because they paid $9.00 or $10.00 an hour and the gas station across the street paid $13.00 an hour. CNA N stated the population in the building was difficult to work with and people were not going to do it for nothing. CNA N stated she was aware that call lights were not answered timely, of the lack of showers and bed baths given, and that the residents did not get their hair washed when getting a bed bath. CNA N stated she knew mechanical lifts should always be done with 2 people, but she did them on her own because there was not enough staff and she considered herself a seasoned CNA. A policy was requested on 8/3/2022 at 3:45pm for sufficient staffing from the administrator. The policy was requested again on 8/4/2022 at 1:10pm from the RN consultant. No policy was given regarding sufficient staffing.