STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675214	A. Building B. Wing	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solidago Health and Rehabilitation	1720 N Logan St Texas City, TX 77590

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 - Few	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** 44241 Based on observation, interviews, and record reviews, the facility failed to ensure each resident was free from abuse and neglect for 1 (CR #1) of 12 residents reviewed for abuse and neglect. 1. The facility failed to ensure CR #1, who was cognitively impaired and had a history of dementia and combative behaviors, was free from abuse when he was physically dragged, kicked, punched, and thrown into his bed by CNA A and CNA E and sustained a laceration to his left eye, bruising around both eyes and burst blood vessels in both eyes. 2. The facility failed to ensure staff were consistently and sufficiently trained and competent in abuse/neglect prevention and providing care to residents with dementia and aggressive behaviors. 3. CNA A and CNA E failed to follow appropriate procedure and notify a nurse for guidance and assistance when CR #1 exhibited combative/aggressive behaviors. These failures resulted in two Immediate Jeopardy (IJ) situations identified on 10/06/2022 at 4:00 p.m. and 10/08/22 at 12:31 p.m. While the IJs were removed on 10/17/2022, the facility remained out of compliance at the severity level of actual harm with a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems. These failures placed cognitively impaired residents with aggressive behaviors at risk of serious harm and death from possible abuse and neglect. Findings include: (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 - Few	Record review of CR#1's face sheet revealed he was an [AGE] year-old male who was admitted to the facility on [DATE]. He was diagnosed with Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions) ,anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations), protein-calorie malnutrition (inadequate intake of food), contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity) of left lower leg, insomnia (persistent problems falling asleep), polyosteoarthritis (damage to cartilage, resulting in joint pain and swelling), major depression (a persistently depressed mood or loss of interest in activities), pain, dementia (a chronic disorder marked by memory disorders, personality changes, and impaired reasoning), psychotic disturbance (disorder in which one loses contact with reality and experience hallucinations, and delusions), muscle wasting and atrophy, and right leg above knee amputation. Record review of CR #1's MDS dated [DATE] revealed he was usually understood when expressing ideas and wants and he was usually able to understand others; he had a BIMS score of 3 (severe cognitive impairment); he did not have hallucinations or delusions; he rejected care and wandered; he required extensive physical assistance from at least one staff for bed mobility, locomotion, and dressing; he required extensive physical assistance from at least two staff for transfers; he was totally dependent on at least one staff for personal hygiene and bathing; he was wheelchair bound; he was always incontinent of bowel and bladder; and he was prescribed antidepressant medication. Record review of CR #1's care plan, updated on 09/26/2022 revealed the following care areas: *Alzheimer's Disease (Goal: Resident will have positive experiences in the daily routine without having overly demanding tasks and without becoming overly stressed; Approach: Allow adequate time for resident to respond; Maintain a calm environment and approach to the resident; Use non-verbal communication techniques to encourage resident to respond); *he had a history of refusing care at times due to confusion, agitation, and dementia (Goal: Resident will cooperate with care; Approach: Allow resident to make decisions about treatment regime to provide a sense of control; Educate resident and responsible party of possible outcomes of not complying with treatment of care; Encourage as much participation/interaction by the resident as possible during care activities; Give a clear explanation of all care activities prior to and as they occur; If resident refuses care, reassure resident, leave and return 5-10 minutes later and try again; Involve responsible party when resident refuses care; Praise resident when behavior is appropriate); (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*he had a history of being physically aggressive, verbally aggressive, and refusing care related to dementia (Goal: Resident will have a reduction in unwanted mood or behaviors, for an increased quality of life as evidenced by documentation in the medical record; Approach: Attempt non-pharmacological interventions and document on behavior monitoring flow record, such as music therapy, exercise, outdoor time, quiet time [reducing disruptive stimuli], Redirection/Reassurance, Increased observation, Validation, and Consistent caregivers; Ensure his physical needs are met [toileting, pain, hunger, thirst, hot, cold]; Ensure communication is understood [prior to beginning task inform resident of intent, offer verbal one step directions for tasks, Maintain a calm slow approach, do not argue with the resident, allow extra time for them to communicate their needs]; Give medications as ordered; If resident becomes physically agitated or aggressive, remove from other residents to a safe, less stimulating environment, Set firm limits by telling him to stop current behavior and if needed, tell him you will return to complete care/task when he has had a time to calm sufficiently to allow care safely for all, Notify nursing; If resident is hallucinating, do not argue or try to reason, assure them of their safety and notify nursing; Resident specific interventions include: Redirect by [talking about family, favorite music, hanging out in the lobby area, family visit]; Notify family of changes in resident status or of new escalated behaviors; Rule out environmental causes); *he was at risk for falls due to impaired cognition, impaired mobility, incontinence and use of psychotropic medications. The resident has a camera in his room where is responsible party has witnessed him crawl on the floor when he wants to get up (Goal: Resident will not experience major injuries due to falls. Approach: Ensure fall mats are at bedside. Continue all interventions, Patient is not falling but scooting out of bed. Low bed and fall mats in place; Anticipate all needs; Encourage resident to ask staff for assistance. Staff to check frequently, if resident hollering out either put to bed or get up; Encourage socialization; Ensure call light is in reach and use call light; Monitor for incontinence per routine rounds and as needed. Ensure resident has shorts or pants on at all times); *he has impaired communication as evidenced by reduced ability to be understood by other, reduced ability to understand others, impaired daily decision-making ability and speaks Spanish (Goal: Staff will anticipate and meet all needs that resident is not able to communicate effectively. Approach: Allow time for resident to digest information - do not rush; Approach in a calm manner, call by name; Attempt to find an interpreter as needed; Praise resident for communication efforts; Reduce or remove all interfering environmental stimuli; Use terms, gestures that resident can understand and repeat as needed); and *he has dementia as evidenced by short term and long term memory problems and impaired ability to make daily decisions at times (Goal: Resident's needs will be met and dignity maintained. Approach: Allow time for tasks and responses; Explain all procedures using terms/gestures resident can understand; Involve in care as to maintain or increase level of independence; Reorient resident as needed; Repeat information as needed). Record review of CR #1's medical records revealed he arrived at the ER of a local acute care hospital via EMS on 10/02/2022 at 6:02 p.m. CR #1 was admitted to the hospital on 10/02/2022. CT scans of his cervical spine, head/brain, and maxillofacial area (face, jaw, and mouth) were completed. Degenerative changes were found, but there were no acute intracranial abnormalities. X-rays were taken of CR #1's right knee, right hip/pelvis, and chest. No fractures or acute changes were found. CR #1's injuries were not described in the medical records (the complete medical record could not be provided because CR #1 was still a admitted in the hospital at that time). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#1's Progress Note dated 10/02/2022 written by LVN V indicated, At 5:10 p.m. resident was found on floor by CNA. I was down hall 400 giving a resident his medications when CNA A came to me to let me know that CR #1 was found on the floor. Upon arriving, CR #1 had already been lifted off the ground and placed in his bed. I took his vitals: BP 120/77, P: 66, Resp: 17, O2: 95, Temp: 97.3, A&O x2. Resident was conscious upon arrival to his room and was very combative towards the CNAs. After taking his vitals I assisted CNA J in changing the resident because he had already kicked CNA A in the abdomen area and was also trying to kick the CNA E. After changing resident, we placed him in his wheelchair and took him to the nurse's station. I notified emergency contact on file and notified his physician. 911 was called and resident was sent to ER. Record review of CR #1's SBAR Communication Form, dated 10/02/2022 written by LVN K. The document read in part . Situation, The change in condition, symptoms, or signs observed and evaluated is/are: Fall with head injury, This started on 10/02/2022 . Other relevant information: Resident observed on floor by staff . Resident/Patient Evaluation . 3. Behavioral Evaluation: Physical Aggression . 8. Skin Evaluation: Laceration . 9. Pain Evaluation . Does this resident have pain: Yes, New Pain, Description/location of pain: head/bilateral eyes . Does the resident show non-verbal signs of pain (for residents with dementia)? Yes, Complains of pain . Review and Notify: Primary Care Clinician Notified: CR #1's Physician, Date: 10/02/2022, Time: 5:25 p. m. Recommendations of Primary Clinicians: send to ER for evaluation and treatment . Observation and interview on 10/06/2022 at 9:45 a.m., with CR #1 at a local acute care hospital, revealed he had a laceration to the corner of his left eye that was healing. He had dark purple bruising to his bilateral eyelids and underneath both eyelids. Both eyes were slightly red (white parts of eyes). CR #1's left wrist was covered with a dressing (CR #1 pulled out his IV and the new IV was protected by the dressing) and there was some light purple bruising to his left forearm. CR #1 had a right above the knee amputation. Interview with CR #1 via Spanish-speaking RN revealed CR #1 was cognitively impaired. Through the interpreter, CR #1 stated his injuries were caused by five women at his home who were very upset with him. CR #1 said he lived at home with his mother before he was admitted to the hospital (he did not recall living at the facility). CR #1 said nobody ever mistreated him. In a telephone interview on 10/06/2022 at 9:40 a.m., CR #1's RP said he observed CR #1 kicking and yelling, Help me! in his sleep since he was admitted to the hospital (he could not give the date of this observation). The RP said CR #1 told his other family members some girls hit him. He said in the video from the incident on 10/02/2022, CR #1 was in a low bed, and he got himself out of the bed. He said CR #1 had a history of getting himself out of bed and scooting around on the floor. He said CR #1 wanted to be in pants and sometimes, his wheelchair was placed too far away from his bed. He said the facility's staff would get frustrated because they would put CR #1 in the bed, and he would get out over and over. He said CR #1's family put the camera in his room three years ago when he (CR #1) was on a different hallway. He said CR #1's former roommate (who was no longer at the facility) told him the facility's staff were mistreating CR #1. He said when he brought the mistreatment to the Administrator and DON at that time (neither were still employed at the facility) the staff involved was terminated. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation of a video provided by CR #1's RP on 10/06/2022 a 10:30 a.m. (the video was not dated, or time stamped. The video did not have audio. CR #1's RP stated the video was recorded on 10/02/2022 and he identified CR #1 as the resident in the video) revealed it was recorded in CR #1's room. The video revealed a male (the faces of the individuals in the video were not completely clear) with an amputated right leg, slowly lowered himself off the side of a bed which was in a low position. The resident's face did not come in contact with any structure while he was alone in the video. The male scooted himself towards the door of the room. CNA E (CNA E identified herself as the CNA who had on a pink shirt and the other CNA as CNA A in a telephone interview on 10/05/2022 at 3:47 p.m.) entered the room and closed the door. CNA E was seen talking to CR #1 and she pointed towards the bed twice during the conversation. CNA E took a pair of blue pants out of a closet and threw them on the arm of a wheelchair which was near CR #1. When CNA E left the room and closed the door, CR#1 grabbed the blue pants and put them on while he was still on the floor. CNA E returned to the room with CNA A. CNA E walked inside the room, moved a bedside table that was near CR #1, moved back the sheet and blanket on the bed, and handed CNA A some gloves. Both staff approached CR #1. CNA E attempted to grab CR #1's left leg, but he started kicking. CNA A grabbed CR #1's left leg and right arm but let his left leg go because he was kicking. CNA A then grabbed CR #1's right stump with one hand and his right arm with her other hand but let him go because his left leg kicked the wheelchair and pulled it towards him. CNA E grabbed CR #1's left arm. CNA A pulled the wheelchair back and forcefully threw CR #1's left leg from the wheelchair but when he kicked her, she kicked him around his left side buttocks area. CNA E was still holding CR #1's left wrist and she dragged him across the floor several feet towards the bed. CNA A approached CR #1 and grabbed the right side of his pants and right side of his shirt while CNA E grabbed his left arm. The staff lifted CR #1's body. CR #1's head was on the bed, then both staff flipped his bottom half in the air and onto the bed while he was kicking. CNA A was standing in front of CR #1's head and top half and appeared to be struggling with him while he flailed his arms and his left leg and right stump appeared to be kicking in the air. CNA E pulled the privacy curtain but CR #1's left foot (He only had a foot on the left side. When the staff threw CR #1 into the bed, his left side was against the wall) could be seen moving around on the floor underneath the privacy curtain. In an interview with LVN K on 10/05/2022 at 11:30 a.m., she stated she was the weekend supervisor on 10/02/2022. She said CR #1 had dementia, was usually alert and oriented to person, and had a history of wandering, refusing care, crawling out of bed, and combative behaviors. She said CR #1 was mostly Spanish speaking, but he could speak and understand some English. She said she interacted with CR #1 on 10/02/2022 when she passed morning medication and he was ok. She said CR #1 went back to bed after lunch. She said that evening, LVN V approached her and said CR #1 fell out of bed and hit his head, so she started to assist with getting CR #1's paperwork ready to transfer him to the hospital. She said at that time, she did not know anything other than CR #1 had a fall. She said she called the Administrator to inform her of the fall. She said LVN V was fluent in Spanish and when CR #1 was on the stretcher to leave with EMS, he told LVN V one of the aides hit him. She said she stopped and called the Administrator to notify her. She said CR #1's fall was not a surprise because he frequently crawled out of bed, but the head injury was a surprise (because he had never hit his head before). She said when she saw CR #1 at the nurse's station before he left with EMS, he had a laceration at the corner of one of his eyes the other eye was red. LVN K said CR #1 pointed at one of the aides (CNA A or CNA E) and told LVN V she was the one who hit him. She said CR #1's family member arrived at the facility on 10/02/2022 at 6:45p.m. and showed her the video of CR #1's assault before she posted it on social media. She said CNA A and CNA E were both out of the facility when the family member arrived. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview with LVN V on 10/05/2022 at 4:00 p.m., she stated she worked PRN on weekends but 10/02/2022 was not the first day she worked with CR #1. She said CR #1 had dementia and tended to go in and out with memory. She said CR #1 could be combative when he was upset, but she never had issues with him trying to hit or kick her. She said redirecting CR #1 with coffee helped to calm him down. She stated she spoke Spanish. She said CR #1 had one leg, but he could self-propel in his wheelchair. She said staff put CR #1 in bed and he tried to get himself out. She said whenever there was a fall, CNAs were supposed to call a nurse to assess each resident for injuries. She said if the resident hit their head, neuro checks would be initiated. She said on 10/02/2022, she was down 400 hall passing medication when CNA A came and said CR #1 fell out of bed. She said she was confused because she thought CR #1 was already out of bed and in the dining room. She said earlier on 10/02/2022, she was doing medication rounds and CNA E came and said CR #1 was trying to get out of his bed. She said typically, staff put CR #1 in his wheelchair and take him to the nurse's station if he was trying to get up out of bed. She said she asked CNA E to put CR #1's pants on and put him in his wheelchair and take him to the dining room. She said she grabbed the medication cart and went down to CR #1's hall. She said she thought it was strange when she walked into CR #1's room and saw the privacy curtain was closed. She said she pulled open the curtain and saw CR #1 on the bed. She said CR #1's face shocked her. She said CR #1's injuries did not look they were caused by a fall. She said the area under CR #1's left eye was already puffy, liked he got socked (hit) in the face. She said the area above CR #1's eye was swollen and red. She said the blood vessels in both of CR #1's eyes had burst. She said CR #1 had a laceration in the corner of one eye. She said it looked like CR #1's whole eye burst. She said CR #1 kept cursing and yelling at CNA A and CNA E like he did not want them by him. CR #1 was angry. She said she told the CNAs CR #1's injuries were not consistent with a fall. She said one of the CNAs (she could not recall which one) said the laceration was from when CR #1 hit himself on the side rail. She said CR #1 was already in bed, so there was no way for her to tell how he fell or where. She said CNA J was in CR #1's room with her, so she (CNA J) assisted with incontinent care, and they changed his clothes. She said they put CR #1 in his wheelchair and took him to the nurse's station to get ready for transport. She said when LVN K saw CR #1 at the nurse's station, she said, Oh God! She said she told LVN K this (CR #1's injuries) did not look like a fall. LVN V said once EMS arrived, CR #1 was looking at CNA A while he cursed and said that was the fucking black bitch that hit him. She said she told LVN K, CR #1 said he was hit. She said CNA E went down the hall, but CNA A stayed close to the nurse's station watching the nurses and EMS prepare CR #1 for transport. She said when CR #1 saw CNA E walk down the hall, he said that's the fucking black lady that hit him. LVN V said she asked CR #1 who hit him, but he would not initially repeat what he said. She said CR #1 again said that is the other black bitch that hit him. She said after CR #1 left for the hospital, she called his responsible party and told him CR #1 fell but she did not know how he landed on the floor. She said she explained CR #1's injuries and told the responsible party they sent the resident to ER. She said the responsible party was very short and quickly said goodbye. She said within maybe 20-30 minutes, another one of CR #1's family members called and said they reviewed the video from the camera inside CR #1's room. She said the family member said both of the women (CNA A and CNA E) were fighting CR #1. LVN V said as soon as they got the information from CR #1's family member, LVN K walked towards the CNAs (CNA A and CNA E) and she saw one of them clock out. She said both CNAs were out of the building, but CNA A had to wait outside waiting for her ride. She said CNA A asked her who was going around saying CR #1 was assaulted. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the Administrator on 10/05/2022 at 10:30 a.m., she stated one of CR #1's family members posted a video of CR #1 being assaulted by CNA A and CNA E to social media. The Administrator said on Sunday, 10/02/2022, she was called by LVN K, who was the weekend supervisor at that time. She said LVN K initially told her CR #1 fell out of bed and was being sent out to a local hospital because he hit his head as a result of the fall. She said when she was in the process of reporting the unwitnessed fall with injury to HHSC, she received a text message (on 10/02/2022 at 6:03 p.m.) from CR #1's RP. She said the RP sent her the video of CR #1's assault by text. The Administrator said she had LVN K bring CNA A and CNA E to the conference room to question them about the video while she was on speaker phone. She said when she asked the CNAs about abuse and an unusual occurrence, without mentioning the specific resident's name, the CNA's said nothing happened. The Administrator said she told both CNAs to leave the building immediately and she notified the police. The Administrator said the next morning, 10/03/2022, she called both CNAs and asked about the abuse and video. She said both CNAs said nothing happened. She said both CNAs were terminated by phone on 10/03/2022. She said CNA E was calm and said okay, but CNA A reacted and said she wanted to press charges against CR #1 for kicking her. The Administrator said she asked CNA A if she used proper protocol during the incident with CR #1 and she said no. The Administrator said proper protocol would have been for the staff to get a nurse for assistance or walk away from the resident when he got aggressive. The Administrator said CNA A said she did not kick CR #1, but she tripped. The Administrator said an electronic monitoring sign was posted on CR #1's door and the camera had been placed in his room by his family for a while (she could not say how long the camera was in CR #1's room). The Administrator said CR #1 had a history of falls and scooting himself out of bed. She said CR #1's bed was in the lowest position at the time of the incident on 10/02/2022. She said CR #1 also had a history of aggressive/combative behaviors. She said the aides usually worked the same halls, but they rotated every two weeks. She said CNA A and CNA E stayed (worked) on CR #1's hall a while (she could not say how long CNA and CNA E worked on CR #1's hall). She said according to the video she received from CR #1's RP, the incident occurred on 10/02/2022 at 5:00 p.m. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview with CNA E on 10/05/2022 at 3:47 p.m., she stated CR #1 was combative and fought staff every day. She said when CR #1 was combative, she usually left him alone for a period of time, but when she came back, he was always still combative. She said on the day of the incident (10/02/2022), she heard CR #1 screaming and yelling from the hall. She said she went to CR #1's room and saw him on floor around 5:00 p.m. She said she went to get CNA A for assistance. She said when they picked CR #1 up off the floor, he had a laceration on his eye. She said the laceration probably happened when he fell out of the bed, but she did not know because she was not in the room when he fell . She said she did not see the laceration until they put CR #1 in the bed. She said CR #1 must have hit his eye when he fell but the laceration did not appear until they put him in the bed. She said when they proceeded to get CR #1 off the floor, he fought them like normal. She said after they got CR #1 up and back in his bed, they went to get a nurse. She said the nurse assessed CR #1 and told them put him in his wheelchair to send him out to the hospital. She said normal procedure would have been to get a nurse before they picked CR #1 up off the floor, but because he did that (placed himself on the floor) all the time, they just usually picked him up and put him in bed. She said CR #1 only spoke Spanish but the nurse who assessed him (LVN V) spoke Spanish to him. She said normally, she would call for a nurse to assess a resident before she put them in bed, but did not call for that this time. She said this (CR #1 being aggressive with staff) happened all the time with CR #1. She said in reference to the video of the incident from 10/02/2022, she was the woman in the pink shirt. She said she never had to drag CR #1 before as she did in the video, but he always wanted to fight. CNA E said she did not usually work on CR #1's hall and she did not work with CR #1 often. She said she had recently received abuse/neglect training, but she still did not feel she had been sufficiently trained to care for CR #1 and other aggressive residents like him. In a telephone interview with CNA E on 10/06/2022 at 11:06 a.m., she stated she was worried about losing her certification as a result of the incident with CR #1 on 10/02/2022. She said she did not hit CR#1 and his injuries were caused by CNA A hitting him. CNA E said she only held CR #1's arm when she tried to get him off the floor. Unsuccessful attempts were made to contact CNA E by phone for additional information on 10/17/2022 at 11:00 a.m., and 10/19/2022 at 3:42 p.m. Voicemail messages and texts were left. Unsuccessful attempts were made to contact CNA A by phone on 10/04/2022 at 11:09 a.m., 10/06/2022 at 11:37, 10/10/2022 at 3:15 p.m., and 10/19/2022 at 3:45 p.m. Voicemail messages and texts were left. In an interview with the Administrator on 10/06/2022 at 12:13 p.m., she provided CNA A and CNA E's training records and stated the records indicated neither of the CNAs completed two computer-generated trainings on dementia/aggressive behaviors, Alzheimer's Disease and Related Disorders, Behavior and ADL Management and, Caring for the Person with Dementia Behaviors and Communication. Record review of CNA A's employee record revealed she was hired on 06/30/2020 and was terminated on 10/03/2022. All background checks were completed upon hire. Record review of CNA A's training records revealed: Caring for a Guest with Dementia - Completed 06/30/2020. (continued on next page)

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Solidago Health and Rehabilitation	1720 N Logan St Texas City, TX 77590

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Alzheimer's Disease and Related Disorders, Behavior and ADL Management - dated 04/14/2022: Not completed (the Administrator said the training was not completed because there was no grade). Caring for the Person with Dementia Behaviors and Communication - dated 04/14/2022: Not completed (the Administrator said the training was not completed because there was no grade). About Caregiver Conduct, and Preventing, Recognizing, and Reporting Abuse - Completed on 09/16/22. Further review of the records revealed no other trainings/in-services related to residents with aggressive behaviors or Alzheimer's Disease/dementia. Record review of CNA E's employee record revealed she was hired on 01/19/2018 and was terminated on 10/03/2022. All background checks were completed upon hire. Record review of CNA E's training records revealed: Caring for a Guest with Dementia - Completed 01/19/2018. Alzheimer's Disease and Related Disorders, Behavior and ADL Management - dated 06/21/2022: Not completed (the Administrator said the training was not completed because there was no grade). Caring for the Person with Dementia Behaviors and Communication - dated 06/21/2022: Not completed (the Administrator said the training was not completed because there was no grade). About Caregiver Conduct, and Preventing, Recognizing, and Reporting Abuse - Completed on 09/16/22. Further review of the records revealed no other trainings/in-services related to residents with aggressive behaviors or Alzheimer's Disease/dementia In a follow-up interview with the Administrator on 10/18/2022 at 11:53 a.m., she stated the two trainings CNA A and CNA E failed to complete (Alzheimer's Disease and Related Disorders, Behavior and ADL Management and, Caring for the Person with Dementia Behaviors and Communication) were not mandatory trainings and she could not force staff to complete trainings that were not mandatory. She said those subjects (aggressive behaviors and residents with dementia) were mentioned in other mandatory trainings each staff member would have had upon hire. She said she did not think CNA A's and CNA E's competencies had anything to do with them abusing the residents. In an interview with CNA L on 10/09/2022 at 9:43 a.m., she stated she had not received any training at the facility regarding aggressive resident behaviors or caring for residents with Alzheimer's Disease and dementia. In an interview with CNA O on 10/09/2022 at 10:00 a.m., she stated she had not been trained regarding aggressive residents or providing care to residents with Alzheimer's Disease or dementia. In an interview with CNA T on 10/10/2022 at 2:02 p.m., she stated she had not received any training from the facility on how to care for residents with aggressive behaviors or residents with Alzheimer's Disease and dementia. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with CNA N on 10/10/2022 at 2:12 p.m., she stated she had not received any training from the facility regarding providing care to residents with aggressive behaviors or residents Alzheimer's Disease and dementia. In an interview with CNA B on 10/10/2022 at 2:40 p.m., she stated she received training on how to care for residents with Alzheimer's Disease, dementia, and aggressive behaviors at a different facility she worked at previously. She said she had not received those trainings at her current facility. In an interview with the HR Director on 10/11/2022 at 12:21 p.m., she said she and the Administrator were responsible for ensuring staff were current with all training/in-services. She said they ran a report from their electronic training system every two weeks which listed each employee's training to be completed. She said the report was distributed to each department head to ensure their staff were trained. In an interview with the Administrator on 10/11/2022 at 12:42 p.m., she stated she and each department head were responsible for ensuring each staff were trained. She said she and the HR Director run and review a report from their electronic training system which indicated which trainings needed to be completed by each staff. She said the reports were distributed to each department head to make sure their staff complete training. The Administrator said she also frequently spoke to staff about their training needs. The Administrator said she did not know why CNA A and CNA E had not completed trainings listed on their training records. Record review of the facility's document Statement of Resident Rights undated revealed, You, the resident do not give up any rights when you enter a nursing facility. The facility must encourage and assist you to fully exercise your rights. Any violation of these rights is against the law. It is against the law for any nursing facility employee to threaten, coerce, intimidate or retaliate against you for exercising your rights. If anyone hurts you, threatens to hurt you, neglects your care, takes your property, or violates your dignity, you have the right to file a complaint . You have the righ [TRUNCATED]

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44241 Based on observation, interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 12 residents (CR #1) reviewed for quality of care. The facility failed to ensure CNA A and CNA E followed facility protocol and called for a nurse to assist and assess CR #1 before attempting to pick him up off the floor after an assumed fall. CNA A and CNA E failed to seek assistance from a nurse when CR #1 became combative/aggressive and resulted in CR #1 sustaining facial injuries. These failures placed residents at risk of injury and pain. Findings include: Record review of CR#1's face sheet revealed he was an [AGE] year-old male who was admitted to the facility on [DATE]. He was diagnosed with Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions) , anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations), , contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity) of left lower leg, insomnia (persistent problems falling asleep), polyosteoarthritis (repetitive use of joints causes damage to cartilage, resulting in joint pain and swelling - with at least five joints), major depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities), pain, dementia (a chronic disorder marked by memory disorders, personality changes, and impaired reasoning), psychotic disturbance (disorder in which one loses contact with reality and experience hallucinations, and delusions), muscle wasting and atrophy, and right leg above knee amputation. Record review of CR #1's MDS dated [DATE] revealed he was usually understood when expressing ideas and wants and he was usually able to understand other; he had a BIMS score of 3 (severe cognitive impairment); he did not have hallucinations or delusions; he rejected care and wandered; he required extensive physical assistance from at least one staff for bed mobility, locomotion, and dressing; he required extensive physical assistance from at least two staff for transfers; he was totally dependent on at least one staff for personal hygiene and bathing; he was wheelchair bound; he was always incontinent of bowel and bladder; and he was prescribed antidepressant medication. Record review of CR #1's care plan, updated on 09/26/2022 revealed the following care areas: *Alzheimer's Disease (Goal: Resident will have positive experiences in the daily routine without having overly demanding tasks and without becoming overly stressed; Approach: Allow adequate time for resident to respond; Maintain a calm environment and approach to the resident; Use non-verbal communication techniques to encourage resident to respond); (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	*he had a history of refusing care at times due to confusion, agitation, and dementia (Goal: Resident will cooperate with care; Approach: Allow resident to make decisions about treatment regime to provide a sense of control; Educate resident and responsible party of possible outcomes of not complying with treatment of care; Encourage as much participation/interaction by the resident as possible during care activities; Give a clear explanation of all care activities prior to and as they occur; If resident refuses care, reassure resident, leave and return 5-10 minutes later and try again; Involve responsible party when resident refuses care; Praise resident when behavior is appropriate); *he had a history of being physically aggressive, verbally aggressive, and refusing care related to dementia (Goal: Resident will have a reduction in unwanted mood or behaviors, for an increased quality of life as evidenced by documentation in the medical record; Approach: Attempt non-pharmacological interventions and document on behavior monitoring flow record, such as music therapy, exercise, outdoor time, quiet time [reducing disruptive stimuli], Redirection/Reassurance, Increased observation, Validation, and Consistent caregivers; Ensure his physical needs are met [toileting, pain, hunger, thirst, hot, cold]; Ensure communication is understood [prior to beginning task inform resident of intent, offer verbal one step directions for tasks, Maintain a calm slow approach, do not argue with the resident, allow extra time for them to communicate their needs]; Give medications as ordered; If resident becomes physically agitated or aggressive, remove from other residents to a safe, less stimulating environment, Set firm limits by telling him to stop current behavior and if needed, tell him you will return to complete care/task when he has had a time to calm sufficiently to allow care safely for all, Notify nursing; If resident is hallucinating, do not argue or try to reason, assure them of their safety and notify nursing; Resident specific interventions include: Redirect by [talking about family, favorite music, hanging out in the lobby area, family visit]; Notify family of changes in resident status or of new escalated behaviors; Rule out environmental causes); *he was at risk for falls due to impaired cognition, impaired mobility, incontinence and use of psychotropic medications. The resident has a camera in his room where is responsible party has witnessed him crawl on the floor when he wants to get up (Goal: Resident will not experience major injuries due to falls. Approach: Ensure fall mats are at bedside. Continue all interventions, Patient is not falling but scooting out of bed. Low bed and fall mats in place; Anticipate all needs; Encourage resident to ask staff for assistance. Staff to check frequently, if resident hollering out either put to bed or get up; Encourage socialization; Ensure call light is in reach and use call light; Monitor for incontinence per routine rounds and as needed. Ensure resident has shorts or pants on at all times); *he has impaired communication as evidenced by reduced ability to be understood by other, reduced ability to understand others, impaired daily decision-making ability and speaks Spanish (Goal: Staff will anticipate and meet all needs that resident is not able to communicate effectively. Approach: Allow time for resident to digest information - do not rush; Approach in a calm manner, call by name; Attempt to find an interpreter as needed; Praise resident for communication efforts; Reduce or remove all interfering environmental stimuli; Use terms, gestures that resident can understand and repeat as needed); and *he has dementia as evidenced by short term and long term memory problems and impaired ability to make daily decisions at times (Goal: Resident's needs will be met and dignity maintained. Approach: Allow time for tasks and responses; Explain all procedures using terms/gestures resident can understand; Involve in care as to maintain or increase level of independence; Reorient resident as needed; Repeat information as needed). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Observation and interview with CR #1 at a local acute care hospital on 10/06/2022 at 9:45 a.m. revealed he had a laceration to the left corner of his left eye that was healing. He had dark purple bruising to bilateral eyelids and underneath both eyelids. Both eyes were slightly red (white parts of eyes). CR #1's left wrist was covered with a dressing (CR #1 pulled out his IV and the new IV was protected by the dressing) and there was some light purple bruising to his left forearm. CR #1 had a right above the knee amputation. Interview with CR #1 at that via Spanish-speaking RN revealed CR #1 was cognitively impaired. Through the interpreter, CR #1 stated his injuries were caused by five women at his home who were very upset with him. CR #1 said he lived at home with his mother before he was admitted to the hospital (he did not recall living at the facility). CR #1 said nobody ever mistreated him. In a telephone interview with CR #1's RP on 10/06/2022 at 9:40 a.m., he said he observed CR #1 kicking and yelling, Help me! in his sleep since he was admitted to the hospital (he could not give the date of this observation). The RP said CR #1 told his other family members some girls hit him. Observation of a video provided by CR #1's RP on 10/06/2022 at 10:30 a.m. (the video was not dated, or time stamped. The video did not have audio. CR #1's RP stated the video was recorded on 10/02/2022 and he identified CR #1 as the resident in the video) revealed it was recorded in CR #1's room. The video revealed a male (the faces of the individuals in the video were not completely clear) with an amputated right leg, slowly lowered himself off the side of a bed which was in a low position. The resident's face did not come in contact with any structure while he was alone in the video. The male scooted himself towards the door of the room. CNA E (CNA E identified herself as the CNA who had on a pick shirt and the other CNA as CNA A in a telephone interview on 10/05/2022 at 3:47 p.m.) entered the room and closed the door (CNA E did not see CR #1 lower himself to the floor). CNA E could be seen talking to CR #1 and she pointed towards the bed twice during the conversation. CNA E took a pair of blue pants out of a closet and threw them on the arm of a wheelchair which was near CR #1. When CNA E left the room and closed the door, CR#1 grabbed the blue pants and put them on while he was still on the floor. CNA E returned to the room with CNA A. CNA E walked inside the room, moved a bedside table that was near CR #1, moved back the sheet and blanket on the bed, and handed CNA A some gloves. Both staff approached CR #1. CNA E attempted to grab CR #1's left leg, but he started kicking. CNA A grabbed CR #1's left leg and right arm but let his left leg go because he was kicking. CNA A then grabbed CR #1's right stump with one hand and his right arm with her other hand but let him go because his left leg kicked the wheelchair and pulled it towards him. CNA E grabbed CR #1's left arm. CNA A pulled the wheelchair back and forcefully threw CR #1's left leg from the wheelchair but when he kicked her, she kicked him around his left side buttocks area. CNA E was still holding CR #1's left wrist and she dragged him across the floor several feet towards the bed. CNA A approached CR #1 and grabbed the right side of his pants and right side of his shirt while CNA E grabbed his left arm. The staff lifted CR #1's body. CR #1's head was on the bed, then both staff flipped his bottom half in the air and onto the bed while he was kicking. CNA A was standing in front of CR #1's head and top half and appeared to be struggling with him while he flailed his arms and his left leg and right stump appeared to be kicking in the air. CNA E pulled the privacy curtain but CR #1's left foot (He only had a foot on the left side. When the staff threw CR #1 into the bed, his left side was against the wall) could be seen moving around on the floor underneath the privacy curtain. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident Progress Note dated 10/02/2022 revealed LVN V wrote, At 5:10 p.m. resident was found on floor by CNA. I was down hall 400 giving a resident his medications when CNA A came to me to let me know that CR #1 was found on the floor. Upon arriving, CR #1 had already been lifted off the ground and placed in his bed. I took his vitals: BP 120/77, P: 66, Resp: 17, O2: 95, Temp: 97.3, A&O x2. Resident was conscious upon arrival to his room and was very combative towards the CNAs. After taking his vitals I assisted CNA J in changing the resident because he had already kicked CNA A in the abdomen area and was also trying to kick the CNA E. After changing resident, we placed him in his wheelchair and took him to the nurse's station. I notified emergency contact on file and notified his physician. 911 was called and resident was sent to ER. Record review of, SBAR Communication Form, dated 10/02/2022 revealed it was completed by LVN K. The document read in part . Situation, The change in condition, symptoms, or signs observed and evaluated is/are: Fall with head injury, This started on 10/02/2022 . Other relevant information: Resident observed on floor by staff . Resident/Patient Evaluation . 3. Behavioral Evaluation: Physical Aggression . 8. Skin Evaluation: Laceration . 9. Pain Evaluation . Does this resident have pain: Yes, New Pain, Description/location of pain: head/bilateral eyes . Does the resident show non-verbal signs of pain (for residents with dementia)? Yes, Complains of pain . Review and Notify: Primary Care Clinician Notified: CR #1's Physician, Date: 10/02/2022, Time: 5:25 p.m. Recommendations of Primary Clinicians: send to ER for evaluation and treatment . Record review of CNA A's employee record revealed she was hired on 06/30/2020 and was terminated on 10/03/2022. All background checks were completed upon hire. Record review of CNA E's employee record revealed she was hired on 01/19/2018 and was terminated on 10/03/2022. All background checks were completed upon hire. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview with the Administrator on 10/05/2022 at 10:30 a.m., she stated one of CR #1's family members posted a video of CR #1 being assaulted by CNA A and CNA E to social media. The Administrator said on Sunday, 10/02/2022, she was called by LVN K, who was the weekend supervisor at that time. She said LVN K initially told her CR #1 fell out of bed and was being sent out to a local hospital because he hit his head as a result of the fall. She said when she was in the process of reporting the unwitnessed fall with injury to HHSC, she received a text message (on 10/02/2022 at 6:03 p.m.) from CR #1's RP. She said the RP sent her the video of CR #1's assault by text. The Administrator said she had LVN K bring CNA A and CNA E to the conference room to question them about the video while she was on speaker phone. She said when she asked the CNAs about abuse and an unusual occurrence, without mentioning the specific resident's name, the CNA's said nothing happened. The Administrator said she told both CNAs to leave the building immediately and she notified the police. The Administrator said the next morning, 10/03/2022, she called both CNAs and asked about the abuse and video. She said both CNAs said nothing happened. She said both CNAs were terminated by phone on 10/03/2022. She said CNA E was calm and said OK, but CNA A reacted and said she wanted to press charges against CR #1 for kicking her. The Administrator said she asked CNA A if she used proper protocol during the incident with CR #1 and she said no. The Administrator said proper protocol would have been for the staff to get a nurse for assistance or walk away from the resident when he got aggressive. The Administrator said CNA A said she did not kick CR #1, but she tripped. The Administrator said an electronic monitoring sign was posted on CR #1's door and the camera had been placed in his room by his family for a while (she could not say how long the camera was in CR #1's room). The Administrator said CR #1 had a history of falls and scooting himself out of bed. She said CR #1's bed was in the lowest position at the time of the incident on 10/02/2022. She said CR #1 also had a history of aggressive/combative behaviors. She said the aides usually worked the same halls, but they rotated every two weeks. She said CNA A and CNA E stayed (worked) on CR #1's hall a while (she could not say how long CNA and CNA E worked on CR #1's hall). She said according to the video she received from CR #1's RP, the incident occurred on 10/02/2022 at 5:00 p.m. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview with LVN K on 10/05/2022 at 11:30 a.m., she stated she was the weekend supervisor on 10/02/2022. She said CR #1 had dementia, was usually alert and oriented to person, and had a history of wandering, refusing care, crawling out of bed, and combative behaviors. She said CR #1 was mostly Spanish speaking, but he could speak and understand some English. She said she interacted with CR #1 on 10/02/2022 when she passed morning medication and he was ok. She said CR #1 went back to bed after lunch. She said that evening, LVN V approached her and said CR #1 fell out of bed and hit his head, so she started to assist with getting CR #1's paperwork ready to transfer him to the hospital. She said at that time, she did not know anything other than CR #1 had a fall. She said she called the Administrator to inform her of the fall. She said LVN V was fluent in Spanish and when CR #1 was on the stretcher to leave with EMS, he told LVN V one of the aides hit him. She said she stopped and called the Administrator to notify her. She said CR #1's fall was not a surprise because he frequently crawled out of bed, but the head injury was a surprise (because he had never hit his head before). She said when she saw CR #1 at the nurse's station before he left with EMS, he had a laceration at the corner of one of his eyes the other eye was red. LVN K said CR #1 pointed at one of the aides (CNA A or CNA E) and told LVN V she was the one who hit him. She said CR #1's family member arrived at the facility on 10/02/2022 at 6:45 and showed her the video of CR #1's assault before she posted it on social media. She said CNA A and CNA E were both out of facility when the family member arrived. She said the facility's protocol for falls depended on who found the resident. She said if a CNA found a resident on the floor or witnessed a fall, they had to get a nurse to assist and assess for the resident for injuries. She said if a resident was found on the floor, they should be left on the floor until they are assessed by a nurse. She said based LVN V's progress note, CR #1 was already in bed when she came entered the room and that was not proper protocol. In a telephone interview with CNA E on 10/05/2022 at 3:47 p.m., she stated CR #1 was combative and fought staff every day. She said when CR #1 was combative, she usually left him alone for a period of time, but when she came back, he was always still combative. She said on the day of the incident (10/02/2022), she heard CR #1 screaming and yelling from the hall. She said she went to CR #1's room and saw him on floor around 5:00 p.m. She said she went to get CNA A for assistance. She said when they picked CR #1 up off the floor, he had a laceration on his eye. She said the laceration probably happened when he fell out of the bed, but she did not know because she was not in the room when he fell . She said she did not see the laceration until they put CR #1 in the bed. She said CR #1 must have hit his eye when he fell but the laceration did not appear until they put him in the bed. She said when they proceeded to get CR #1 off the floor, he fought them like normal. She said after they got CR #1 up and back in his bed, they went to get a nurse. She said the nurse assessed CR #1 and told them put him in his wheelchair to send him out to the hospital. She said normal procedure would have been to get a nurse before they picked CR #1 up off the floor, but because he did that (placed himself on the floor) all the time, they just usually picked him up and put him in bed. She said CR #1 only spoke Spanish but the nurse who assessed him (LVN V) spoke Spanish to him. She said normally, she would call for a nurse to assess a resident before she put them in bed, but it did not call for that this time. She said this (CR #1 being aggressive with staff) happened all the time with CR #1. She said in reference to the video of the incident from 10/02/2022, she was the woman in the pink shirt. She said she never had to drag CR #1 before as she did in the video, but he always wanted to fight. CNA E said she did not usually work on CR #1's hall and she did not work with CR #1 often. She said she had recently received abuse/neglect training, but she still did not feel she had been sufficiently trained to care for CR #1 and other aggressive residents like him. (continued on next page)

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Solidago Health and Rehabilitation	1720 N Logan St Texas City, TX 77590

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Unsuccessful attempts were made to contact CNA E by phone for additional information on 10/04/2022 at 11:06 a.m., 10/17/2022 at 11:00 a.m., and 10/19/2022 at 3:42 p.m. Voicemail messages and texts were left. Unsuccessful attempts were made to contact CNA A by phone on 10/04/2022 at 11:09 a.m., 10/06/2022 at 11:37, 10/10/2022 at 3:15 p.m., and 10/19/2022 at 3:45 p.m. Voicemail messages and texts were left. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In a telephone interview with LVN V on 10/05/2022 at 4:00 p.m., she stated she worked PRN on weekends but 10/02/2022 was not the first day she worked with CR #1. She said CR #1 had dementia and tended to go in and out with memory. She said CR #1 could be combative when he was upset, but she never had issues with him trying to hit or kick her. She said redirecting CR #1 with coffee helped to calm him down. She stated she spoke Spanish. She said CR #1 had one leg, but he could self-propel in his wheelchair. She said staff put CR #1 in bed and he tried to get himself out. She said whenever there was a fall, CNAs were supposed to call a nurse to assess each resident for injuries. She said if the resident hit their head, neuro checks would be initiated. She said on 10/02/2022, she was down 400 hall passing medication when CNA A came and said CR #1 fell out of bed. She said she was confused because she thought CR #1 was already out of bed and in the dining room. She said earlier on 10/02/2022, she was doing medication rounds and LVN E came and said CR #1 was trying to get out of his bed. She said typically, staff put CR #1 in his wheelchair and take him to the nurse's station if he was trying to get up out of bed. She said she asked CNA E to put CR #1's pants on and put him in his wheelchair and take him to the dining room. She said she grabbed the medication cart and went down to CR #1's hall. She said she thought it was strange when she walked into CR #1's room and saw the privacy curtain was closed. She said she pulled open the curtain and saw CR #1 on the bed. She said CR #1's face shocked her. She said CR #1's injuries did not look they were caused by a fall. She said the area under CR #1's left eye was already puffy, liked he got socked (hit) in the face. She said the area above CR #1's eye was swollen and red. She said the blood vessels in both of CR #1's eyes had burst. She said CR #1 had a laceration in the corner of one eye. She said it looked like CR #1's whole eye burst. She said CR #1 kept cursing and yelling at CNA A and CNA E like he did not want them by him. CR #1 was angry. She said she told the CNAs CR #1's injuries were not consistent with a fall. She said one of the CNAs (she could not recall which one) said the laceration was from when CR #1 hit himself on the side rail. She said CR #1 was already in bed, so there was no way for her to tell how he fell or where. She said CNA J was in CR #1's room with her, so she (CNA J) assisted with incontinent care, and they changed his clothes. She said they put CR #1 in his wheelchair and took him to the nurse's station to get ready for transport. She said when LVN K saw CR #1 at the nurse's station, she said, Oh God! She said she told LVN K this (CR #1's injuries) did not look like a fall. LVN A said once EMS arrived, CR #1 was looking at CNA A while he cursed and said that was the fucking black bitch that hit him. She said she told LVN K CR #1 said he was hit. She said CNA E went down the hall, but CNA A stayed close to the nurse's station watching the nurses and EMS prepare CR #1 for transport. She said when CR #1 saw CNA E walk down the hall, he said that's the fucking black lady that hit him. LVN V said she asked CR #1 who hit him, but he would not initially repeat what he said. She said CR #1 again said that is the other black bitch that hit him. She said after CR #1 left for the hospital, she called his responsible party and told him CR #1 fell but she did not know how he landed on the floor. She said she explained CR #1's injuries and told the responsible party they sent the resident to ER. She said the responsible party was very short and quickly said goodbye. She said within maybe 20-30 minutes, another one of CR #1's family members called and said they reviewed the video from the camera inside CR #1's room. She said the family member said both of the women (CNA A and CNA E) were fighting CR #1. LVN V said as soon as they got the information from CR #1's family member, LVN K walked towards the CNAs (CNA A and CNA E) and she saw one of them clock out. She said both CNAs were out o the building, but CNA A had to wait outside waiting for her ride. She said CNA asked her who was going around saying CR #1 was assaulted. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of undated facility document Statement of Resident Rights revealed, You, the resident do not give up any rights when you enter a nursing facility. The facility must encourage and assist you to fully exercise your rights. Any violation of these rights is against the law. It is against the law for any nursing facility employee to threaten, coerce, intimidate or retaliate against you for exercising your rights. If anyone hurts you, threatens to hurt you, neglects your care, takes your property, or violates your dignity, you have the right to file a complaint . You have the right to: . 3. Be free from abuse and exploitation; 4. Be treated with courtesy, consideration, and respect . Record review of Abuse, Neglect, Exploitation, Or Mistreatment, revised 10/23/2019 revealed, Policy: 1. The facility's Leadership prohibits neglect, mental, physical and/or verbal abuse, use of a physical and/or chemical restraint not required to treat a medical condition, involuntary seclusion, corporal punishment and misappropriation of a patient's/resident's property and/or funds and ensures that alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, and are reported immediately . 1. Abuse. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish . Willful, as used in this individual must have intended to inflict injury or harm . 6. Neglect is 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 . Procedures: . Component II: Training. 1. All new and current employees including volunteers receive continuous education, training and reinforcement that identify all aspects of abuse prohibition . 2. Education/training materials include: . B. Education on the rights of the resident and the responsibilities of a facility to properly care for its residents . D. Dementia management and resident abuse prevention . III: Prevention . 4. Adequate supervision of staff is maintained in order to identify and prevent inappropriate behaviors, such as: A. The use of derogatory/harassing language; B. Rough handling; and C. Ignoring the patient's/resident's needs, requests. 5. Ongoing assessments, care planning, and monitoring of those patients/residents with special needs that may lead to neglect, for example: A. History of aggressive behavior; B. History of entering other patient/resident rooms; C. History of self-injury; D. Communication disorder; and/or, E. Patients/residents requiring excessive nursing care or staff attention. F. Residents with history of resident-to-resident altercation . Record review of Combative Resident, Care And Safety revised on 03/02/2018 revealed, Policy: The Facility has procedures in place to protect the health and safety of residents, staff, visitors and other in the care or proximity of a combative resident. Procedures: 1. Any person who identifies a resident with a change in behavior or an escalation of behavior which may lead to physical combativeness, reports observation to a licensed nurse. 2. A licensed professional, e.g., nurse, social worker, licensed independent practitioner evaluates the resident and may intervene with behavior de-escalation techniques, if appropriate. 3. Individuals deemed to be combative or otherwise dangerous to self or other may be placed on close observation, which may include but is not limited to: A. Relocating individual to a less stimulating environment. B. Conducting frequent checks on the individual. C. Providing a one-on-one staff member for continuous observation and intervention. D. Redirecting attention or use of other therapeutic techniques for de-escalation. 4. Notification of change in condition and escalation of behaviors is made to: A. Physician or licensed independent practitioner. B. Family or responsible party. C. Law enforcement, emergency medical services or others as may be necessary or appropriate to ensure the safety and wellbeing of the combative person or persons in proximity to the situation . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of Fall Management revised 03/29/2019 revealed, Policy: 1. The facility will identify each patient/resident who is at risk for falls and will plan care and implement interventions to manage falls . 3. A patient/resident fall management program will be implemented that educates staff in creative, functional strategies while recognizing patients/resident's rights and their need to maintain the highest practical level of function. Definitions: fall refers to the unintentional coming to rest on the ground, floor, or other lower level, but not because of an overwhelming external force . A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred . Procedures: . 5. If a fall occurs, qualified staff evaluates patient/resident for injury from the fall and determines what may have caused or contributed to the fall, including ascertaining what the resident was trying to do before he or she fell , addresses the risk factors for the fall such as the resident's medical condition, facility environmental issues, or staffing issue; and determines appropriate interventions to prevent future falls and completes a Fall Investigation Worksheet .

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44241 Based on observation, interview, and record review, the facility failed to ensure staff who provide direct services to residents had the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population, including knowledge of and appropriate training and supervision for 2 of 8 (CNA A and CNA E) staff reviewed for staff competency. The facility failed to ensure CNA A and CNA E, who were observed on video dragging, kicking, and throwing CR #1 into bed, had adequate, updated, and effective training specifically related to providing care to residents with dementia and aggressive/combative behaviors. An Immediate Jeopardy (IJ) situation was identified on 10/08/2022 at 12:32 p.m. While the IJ was removed on 10/17/2022, the facility remained out of compliance at severity level of actual harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems. This failure placed cognitively impaired residents with aggressive behaviors at risk of being physical abuse, neglect, hospitalization , or death. Findings include: Record review of CR#1's face sheet revealed he was an [AGE] year-old male who was admitted to the facility on [DATE]. He was diagnosed with Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions) , anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations), protein-calorie malnutrition (inadequate intake of food), contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity) of left lower leg, insomnia (persistent problems falling asleep), polyosteoarthritis (damage to cartilage, resulting in joint pain and swelling), major depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities), pain, dementia (a chronic disorder marked by memory disorders, personality changes, and impaired reasoning), psychotic disturbance (disorder in which one loses contact with reality and experience hallucinations, and delusions), muscle wasting and atrophy, and right leg above knee amputation. Record review of CR #1's MDS dated [DATE] revealed he was usually understood when expressing ideas and wants and he was usually able to understand others; he had a BIMS score of 3 (severe cognitive impairment); he did not have hallucinations or delusions; he rejected care and wandered; he required extensive physical assistance from at least one staff for bed mobility, locomotion, and dressing; he required extensive physical assistance from at least two staff for transfers; he was totally dependent on at least one staff for personal hygiene and bathing; he was wheelchair bound; he was always incontinent of bowel and bladder; and he was prescribed antidepressant medication. Record review of CR #1's care plan, updated on 09/26/2022 revealed the following care areas: (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*Alzheimer's Disease (Goal: Resident will have positive experiences in the daily routine without having overly demanding tasks and without becoming overly stressed; Approach: Allow adequate time for resident to respond; Maintain a calm environment and approach to the resident; Use non-verbal communication techniques to encourage resident to respond); *he had a history of refusing care at times due to confusion, agitation, and dementia (Goal: Resident will cooperate with care; Approach: Allow resident to make decisions about treatment regime to provide a sense of control; Educate resident and responsible party of possible outcomes of not complying with treatment of care; Encourage as much participation/interaction by the resident as possible during care activities; Give a clear explanation of all care activities prior to and as they occur; If resident refuses care, reassure resident, leave and return 5-10 minutes later and try again; Involve responsible party when resident refuses care; Praise resident when behavior is appropriate); *he had a history of being physically aggressive, verbally aggressive, and refusing care related to dementia (Goal: Resident will have a reduction in unwanted mood or behaviors, for an increased quality of life as evidenced by documentation in the medical record; Approach: Attempt non-pharmacological interventions and document on behavior monitoring flow record, such as music therapy, exercise, outdoor time, quiet time [reducing disruptive stimuli], Redirection/Reassurance, Increased observation, Validation, and Consistent caregivers; Ensure his physical needs are met [toileting, pain, hunger, thirst, hot, cold]; Ensure communication is understood [prior to beginning task inform resident of intent, offer verbal one step directions for tasks, Maintain a calm slow approach, do not argue with the resident, allow extra time for them to communicate their needs]; Give medications as ordered; If resident becomes physically agitated or aggressive, remove from other residents to a safe, less stimulating environment, Set firm limits by telling him to stop current behavior and if needed, tell him you will return to complete care/task when he has had a time to calm sufficiently to allow care safely for all, Notify nursing; If resident is hallucinating, do not argue or try to reason, assure them of their safety and notify nursing; Resident specific interventions include: Redirect by [talking about family, favorite music, hanging out in the lobby area, family visit]; Notify family of changes in resident status or of new escalated behaviors; Rule out environmental causes); *he was at risk for falls due to impaired cognition, impaired mobility, incontinence and use of psychotropic medications. The resident has a camera in his room where is responsible party has witnessed him crawl on the floor when he wants to get up (Goal: Resident will not experience major injuries due to falls. Approach: Ensure fall mats are at bedside. Continue all interventions, Patient is not falling but scooting out of bed. Low bed and fall mats in place; Anticipate all needs; Encourage resident to ask staff for assistance. Staff to check frequently, if resident hollering out either put to bed or get up; Encourage socialization; Ensure call light is in reach and use call light; Monitor for incontinence per routine rounds and as needed. Ensure resident has shorts or pants on at all times); *he has impaired communication as evidenced by reduced ability to be understood by other, reduced ability to understand others, impaired daily decision-making ability and speaks Spanish (Goal: Staff will anticipate and meet all needs that resident is not able to communicate effectively. Approach: Allow time for resident to digest information - do not rush; Approach in a calm manner, call by name; Attempt to find an interpreter as needed; Praise resident for communication efforts; Reduce or remove all interfering environmental stimuli; Use terms, gestures that resident can understand and repeat as needed); and (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*he has dementia as evidenced by short term and long term memory problems and impaired ability to make daily decisions at times (Goal: Resident's needs will be met and dignity maintained. Approach: Allow time for tasks and responses; Explain all procedures using terms/gestures resident can understand; Involve in care as to maintain or increase level of independence; Reorient resident as needed; Repeat information as needed). Record review of CR #1's medical records revealed he arrived at the ER of a local acute care hospital via EMS on 10/02/2022 at 6:02 p.m. CR #1 was admitted to the hospital on 10/02/2022. CT scans of his cervical spine, head/brain, and maxillofacial area (face, jaw, and mouth) were completed. Degenerative changes were found, but there were no acute intracranial abnormalities. X-rays were taken of CR #1's right knee, right hip/pelvis, and chest. No fractures or acute changes were found. CR #1's injuries were not described in the medical records (the complete medical record could not be provided because CR #1 was still a admitted in the hospital at that time). Record review of Resident Progress Note dated 10/02/2022 revealed LVN V wrote, At 5:10 p.m. resident was found on floor by CNA. I was down hall 400 giving a resident his medications when CNA A came to me to let me know that CR #1 was found on the floor. Upon arriving, CR #1 had already been lifted off the ground and placed in his bed. I took his vitals: BP 120/77, P: 66, Resp: 17, O2: 95, Temp: 97.3, A&O x2. Resident was conscious upon arrival to his room and was very combative towards the CNAs. After taking his vitals I assisted CNA J in changing the resident because he had already kicked CNA A in the abdomen area and was also trying to kick the CNA E. After changing resident, we placed him in his wheelchair and took him to the nurse's station. I notified emergency contact on file and notified his physician. 911 was called and resident was sent to ER. Record review of, SBAR Communication Form, dated 10/02/2022 revealed it was completed by LVN K. The document read in part . Situation, The change in condition, symptoms, or signs observed and evaluated is/are: Fall with head injury, This started on 10/02/2022 . Other relevant information: Resident observed on floor by staff . Resident/Patient Evaluation . 3. Behavioral Evaluation: Physical Aggression . 8. Skin Evaluation: Laceration . 9. Pain Evaluation . Does this resident have pain: Yes, New Pain, Description/location of pain: head/bilateral eyes . Does the resident show non-verbal signs of pain (for residents with dementia)? Yes, Complains of pain . Review and Notify: Primary Care Clinician Notified: CR #1's Physician, Date: 10/02/2022, Time: 5:25 p.m. Recommendations of Primary Clinicians: send to ER for evaluation and treatment . (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation of a video provided by CR #1's RP on 10/06/2022 at 10:30 a.m. (the video was not dated, or time stamped. The video did not have audio. CR #1's RP stated the video was recorded on 10/02/2022 and he identified CR #1 as the resident in the video) revealed it was recorded in CR #1's room. The video revealed a male (the faces of the individuals in the video were not completely clear) with an amputated right leg, slowly lowered himself off the side of a bed which was in a low position. The resident's face did not come in contact with any structure while he was alone in the video. The male scooted himself towards the door of the room. CNA E (CNA E identified herself as the CNA who had on a pick shirt and the other CNA as CNA A in a telephone interview on 10/05/2022 at 3:47 p.m.) entered the room and closed the door. CNA E could be seen talking to CR #1 and she pointed towards the bed twice during the conversation. CNA E took a pair of blue pants out of a closet and threw them on the arm of a wheelchair which was near CR #1. When CNA E left the room and closed the door, CR#1 grabbed the blue pants and put them on while he was still on the floor. CNA E returned to the room with CNA A. CNA E walked inside the room, moved a bedside table that was near CR #1, moved back the sheet and blanket on the bed, and handed CNA A some gloves. Both staff approached CR #1. CNA E attempted to grab CR #1's left leg, but he started kicking. CNA A grabbed CR #1's left leg and right arm but let his left leg go because he was kicking. CNA A then grabbed CR #1's right stump with one hand and his right arm with her other hand but let him go because his left leg kicked the wheelchair and pulled it towards him. CNA E grabbed CR #1's left arm. CNA A pulled the wheelchair back and forcefully threw CR #1's left leg from the wheelchair but when he kicked her, she kicked him around his left side buttocks area. CNA E was still holding CR #1's left wrist and she dragged him across the floor several feet towards the bed. CNA A approached CR #1 and grabbed the right side of his pants and right side of his shirt while CNA E grabbed his left arm. The staff lifted CR #1's body. CR #1's head was on the bed, then both staff flipped his bottom half in the air and onto the bed while he was kicking. CNA A was standing in front of CR #1's head and top half and appeared to be struggling with him while he flailed his arms and his left leg and right stump appeared to be kicking in the air. CNA E pulled the privacy curtain but CR #1's left foot (He only had a foot on the left side. When the staff threw CR #1 into the bed, his left side was against the wall) could be seen moving around on the floor underneath the privacy curtain. Observation and interview with CR #1 at a local acute care hospital on 10/06/2022 at 9:45 a.m. revealed he had a laceration to the left corner of his left eye that was healing. He had dark purple bruising to bilateral eyelids and underneath both eyelids. Both eyes were slightly red (white parts of eyes). CR #1's left wrist was covered with a dressing (CR #1 pulled out his IV and the new IV was protected by the dressing) and there was some light purple bruising to his left forearm. CR #1 had a right above the knee amputation. Interview with CR #1 at that via Spanish-speaking RN revealed CR #1 was cognitively impaired. Through the interpreter, CR #1 stated his injuries were caused by five women at his home who were very upset with him. CR #1 said he lived at home with his mother before he was admitted to the hospital (he did not recall living at the facility). CR #1 said nobody ever mistreated him. (continued on next page)

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	675214	A. Building B. Wing	10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solidago Health and Rehabilitation	1720 N Logan St Texas City, TX 77590

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview with CR #1's RP on 10/06/2022 at 9:40 a.m., he said he observed CR #1 kicking and yelling, Help me! in his sleep since he was admitted to the hospital (he could not give the date of this observation). The RP said CR #1 told his other family members some girls hit him. He said in the video from the incident on 10/02/2022, CR #1 was in a low bed, and he got himself out of the bed. He said CR #1 had a history of getting himself out of bed and scooting around on the floor. He said CR #1 wanted to be in pants and sometimes, his wheelchair was placed too far away from his bed. He said the facility's staff would get frustrated because they would put CR #1 in the bed, and he would get out over and over. He said CR #1's family put the camera in his room three years ago when he (CR #1) was on a different hallway. He said CR #1's former roommate (who was no longer at the facility) told him the facility's staff were mistreating CR #1. He said when he brought the mistreatment to the Administrator and DON at that time (neither the Administrator nor DON were still employed at the facility) the staff involved was terminated. In an interview with the Administrator on 10/05/2022 at 10:30 a.m., she stated one of CR #1's family members posted a video of CR #1 being assaulted by CNA A and CNA E to social media. The Administrator said on Sunday, 10/02/2022, she was called by LVN K, who was the weekend supervisor at that time. She said LVN K initially told her CR #1 fell out of bed and was being sent out to a local hospital because he hit his head as a result of the fall. She said when she was in the process of reporting the unwitnessed fall with injury to HHSC, she received a text message (on 10/02/2022 at 6:03 p.m.) from CR #1's RP. She said the RP sent her the video of CR #1's assault by text. The Administrator said she had LVN K bring CNA A and CNA E to the conference room to question them about the video while she was on speaker phone. She said when she asked the CNAs about abuse and an unusual occurrence, without mentioning the specific resident's name, the CNAs said nothing happened. The Administrator said she told both CNAs to leave the building immediately and she notified the police. The Administrator said the next morning, 10/03/2022, she called both CNAs and asked about the abuse and video. She said both CNAs said nothing happened. She said both CNAs were terminated by phone on 10/03/2022. She said CNA E was calm and said ok but CNA A reacted and said she wanted to press charges against CR #1 for kicking her. The Administrator said she asked CNA A if she used proper protocol during the incident with CR #1 and she said no. The Administrator said proper protocol would have been for the staff to get a nurse for assistance or walk away from the resident when he got aggressive. The Administrator said CNA A said she did not kick CR #1, but she tripped. The Administrator said an electronic monitoring sign was posted on CR #1's door and the camera had been placed in his room by his family for a while (she could not say how long the camera was in CR #1's room). The Administrator said CR #1 had a history of falls and scooting himself out of bed. She said CR #1's bed was in the lowest position at the time of the incident on 10/02/2022. She said CR #1 also had a history of aggressive/combative behaviors. She said the aides usually worked the same halls, but they rotated every two weeks. She said CNA A and CNA E stayed (worked) on CR #1's hall a while (she could not say how long CNA and CNA E worked on CR #1's hall). She said according to the video she received from CR #1's RP, the incident occurred on 10/02/2022 at 5:00 p.m. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with LVN K on 10/05/2022 at 11:30 a.m., she stated she was the weekend supervisor on 10/02/2022. She said CR #1 had dementia, was usually alert and oriented to person, and had a history of wandering, refusing care, crawling out of bed, and combative behaviors. She said CR #1 was mostly Spanish speaking, but he could speak and understand some English. She said she interacted with CR #1 on 10/02/2022 when she passed morning medication and he was ok. She said CR #1 went back to bed after lunch. She said that evening, LVN V approached her and said CR #1 fell out of bed and hit his head, so she started to assist with getting CR #1's paperwork ready to transfer him to the hospital. She said at that time, she did not know anything other than CR #1 had a fall. She said she called the Administrator to inform her of the fall. She said LVN V was fluent in Spanish and when CR #1 was on the stretcher to leave with EMS, he told LVN V one of the aides hit him. She said she stopped and called the Administrator to notify her. She said CR #1's fall was not a surprise because he frequently crawled out of bed, but the head injury was a surprise (because he had never hit his head before). She said when she saw CR #1 at the nurse's station before he left with EMS, he had a laceration at the corner of one of his eyes the other eye was red. LVN K said CR #1 pointed at one of the aides (CNA A or CNA E) and told LVN V she was the one who hit him. She said CR #1's family member arrived at the facility on 10/02/2022 at 6:45 and showed her the video of CR #1's assault before she posted it on social media. She said CNA A and CNA E were both out of facility when the family member arrived. In a telephone interview with CNA E on 10/05/2022 at 3:47 p.m., she stated CR #1 was combative and fought staff every day. She said when CR #1 was combative, she usually left him alone for a period of time, but when she came back, he was always still combative. She said on the day of the incident (10/02/2022), she heard CR #1 screaming and yelling from the hall. She said she went to CR #1's room and saw him on floor around 5:00 p.m. She said she went to get CNA A for assistance. She said when they picked CR #1 up off the floor, he had a laceration on his eye. She said the laceration probably happened when he fell out of the bed, but she did not know because she was not in the room when he fell . She said she did not see the laceration until they put CR #1 in the bed. She said CR #1 must have hit his eye when he fell but the laceration did not appear until they put him in the bed. She said when they proceeded to get CR #1 off the floor, he fought them like normal. She said after they got CR #1 up and back in his bed, they went to get a nurse. She said the nurse assessed CR #1 and told them put him in his wheelchair to send him out to the hospital. She said normal procedure would have been to get a nurse before they picked CR #1 up off the floor, but because he did that (placed himself on the floor) all the time, they just usually picked him up and put him in bed. She said CR #1 only spoke Spanish but the nurse who assessed him (LVN V) spoke Spanish to him. She said normally, she would call for a nurse to assess a resident before she put them in bed, but it did not call for that this time. She said this (CR #1 being aggressive with staff) happened all the time with CR #1. She said in reference to the video of the incident from 10/02/2022, she was the woman in the pick shirt. She said she never had to drag CR #1 before as she did in the video, but he always wanted to fight. CNA E said she did not usually work on CR #1's hall and she did not work with CR #1 often. She said she had recently received abuse/neglect training, but she still did not feel she had been sufficiently trained to care for CR #1 and other aggressive residents like him. Unsuccessful attempts were made to contact CNA E by phone for additional information on 10/04/2022 at 11:06 a.m., 10/17/2022 at 11:00 a.m., and 10/19/2022 at 3:42 p.m. Voicemail messages and texts were left. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Unsuccessful attempts were made to contact CNA A by phone on 10/04/2022 at 11:09 a.m., 10/06/2022 at 11:37, 10/10/2022 at 3:15 p.m., and 10/19/2022 at 3:45 p.m. Voicemail messages and texts were left. In a telephone interview with LVN V on 10/05/2022 at 4:00 p.m., she stated she worked PRN on weekends but 10/02/2022 was not the first day she worked with CR #1. She said CR #1 had dementia and tended to go in and out with memory. She said CR #1 could be combative when he was upset, but she never had issues with him trying to hit or kick her. She said redirecting CR #1 with coffee helped to calm him down. She stated she spoke Spanish. She said CR #1 had one leg, but he could self-propel in his wheelchair. She said staff put CR #1 in bed and he tried to get himself out. She said whenever there was a fall, CNAs were supposed to call a nurse to assess each resident for injuries. She said if the resident hit their head, neuro checks would be initiated. She said on 10/02/2022, she was down 400 hall passing medication when CNA A came and said CR #1 fell out of bed. She said she was confused because she thought CR #1 was already out of bed and in the dining room. She said earlier on 10/02/2022, she was doing medication rounds and LVN E came and said CR #1 was trying to get out of his bed. She said typically, staff put CR #1 in his wheelchair and take him to the nurse's station if he was trying to get up out of bed. She said she asked CNA E to put CR #1's pants on and put him in his wheelchair and take him to the dining room. She said she grabbed the medication cart and went down to CR #1's hall. She said she thought it was strange when she walked into CR #1's room and saw the privacy curtain was closed. She said she pulled open the curtain and saw CR #1 on the bed. She said CR #1's face shocked her. She said CR #1's injuries did not look they were caused by a fall. She said the area under CR #1's left eye was already puffy, liked he got socked (hit) in the face. She said the area above CR #1's eye was swollen and red. She said the blood vessels in both of CR #1's eyes had burst. She said CR #1 had a laceration in the corner of one eye. She said it looked like CR #1's whole eye burst. She said CR #1 kept cursing and yelling at CNA A and CNA E like he did not want them by him. CR #1 was angry. She said she told the CNAs CR #1's injuries were not consistent with a fall. She said one of the CNAs (she could not recall which one) said the laceration was from when CR #1 hit himself on the side rail. She said CR #1 was already in bed, so there was no way for her to tell how he fell or where. She said CNA J was in CR #1's room with her, so she (CNA J) assisted with incontinent care, and they changed his clothes. She said they put CR #1 in his wheelchair and took him to the nurse's station to get ready for transport. She said when LVN K saw CR #1 at the nurse's station, she said, Oh God! She said she told LVN K this (CR #1's injuries) did not look like a fall. LVN A said once EMS arrived, CR #1 was looking at CNA A while he cursed and said that was the fucking black bitch that hit him. She said she told LVN K CR #1 said he was hit. She said CNA E went down the hall, but CNA A stayed close to the nurse's station watching the nurses and EMS prepare CR #1 for transport. She said when CR #1 saw CNA E walk down the hall, he said that's the fucking black lady that hit him. LVN V said she asked CR #1 who hit him, but he would not initially repeat what he said. She said CR #1 again said that is the other black bitch that hit him. She said after CR #1 left for the hospital, she called his responsible party and told him CR #1 fell but she did not know how he landed on the floor. She said she explained CR #1's injuries and told the responsible party they sent the resident to ER. She said the responsible party was very short and quickly said goodbye. She said within maybe 20-30 minutes, another one of CR #1's family members called and said they reviewed the video from the camera inside CR #1's room. She said the family member said both of the women (CNA A and CNA E) were fighting CR #1. LVN V said as soon as they got the information from CR #1's family member, LVN K walked towards the CNAs (CNA A and CNA E) and she saw one of them clock out. She said both CNAs were out o the building, but CNA A had to wait outside waiting for her ride. She said CNA asked her who was going around saying CR #1 was assaulted. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the Administrator on 10/06/2022 at 12:13 p.m., she provided CNA A and CNA E's training records and stated the records indicated neither of the CNAs completed two computer-generated trainings on dementia/aggressive behaviors, Alzheimer's Disease and Related Disorders, Behavior and ADL Management and, Caring for the Person with Dementia Behaviors and Communication. Record review of CNA A's employee record revealed she was hired on 06/30/2020 and was terminated on 10/03/2022. All background checks were completed upon hire. Record review of CNA A's training records revealed: Caring for a Guest with Dementia - Completed 06/30/2020. Alzheimer's Disease and Related Disorders, Behavior and ADL Management - dated 04/14/2022: Not completed (the Administrator said the training was not completed because there was no grade). Caring for the Person with Dementia Behaviors and Communication - dated 04/14/2022: Not completed (the Administrator said the training was not completed because there was no grade). About Caregiver Conduct, and Preventing, Recognizing, and Reporting Abuse - Completed on 09/16/22. Further review of the records revealed no other trainings/in-services related to residents with aggressive behaviors or Alzheimer's Disease/dementia. Record review of CNA E's employee record revealed she was hired on 01/19/2018 and was terminated on 10/03/2022. All background checks were completed upon hire. Record review of CNA E's training records revealed: Caring for a Guest with Dementia - Completed 01/19/2018. Alzheimer's Disease and Related Disorders, Behavior and ADL Management - dated 06/21/2022: Not completed (the Administrator said the training was not completed because there was no grade). Caring for the Person with Dementia Behaviors and Communication - dated 06/21/2022: Not completed (the Administrator said the training was not completed because there was no grade). About Caregiver Conduct, and Preventing, Recognizing, and Reporting Abuse - Completed on 09/16/22. Further review of the records revealed no other trainings/in-services related to residents with aggressive behaviors or Alzheimer's Disease/dementia. In a follow-up interview with the Administrator on 10/18/2022 at 11:53 a.m., she stated the two trainings CNA A and CNA E failed to complete (Alzheimer's Disease and Related Disorders, Behavior and ADL Management and, Caring for the Person with Dementia Behaviors and Communication) were not mandatory trainings and she could not force staff to complete trainings that were not mandatory. She said those subjects (aggressive behaviors and residents with dementia) were mentioned in other mandatory trainings each staff member would have had upon hire. She said she did not think CNA A's and CNA E's competencies had anything to do with them abusing the residents. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview with CNA E on 10/06/2022 at 11:06 a.m., she stated she was worried about losing her certification as a result of the incident with CR #1 on 10/02/2022. She said she did not hit CR#1 and his injuries were caused by CNA A hitting him. CNA E said she only held CR #1's arm when she tried to get him off the floor. In an interview with CNA L on 10/09/2022 at 9:43 a.m., she stated she had not received any training at the facility regarding aggressive resident behaviors or caring for residents with Alzheimer's Disease and dementia. In an interview with CNA O on 10/09/2022 at 10:00 a.m., she stated she had not been trained regarding aggressive residents or providing care to residents with Alzheimer's Disease or dementia. In an interview with CNA T on 10/10/2022 at 2:02 p.m., she stated she had not received any training from the facility on how to care for residents with aggressive behaviors or residents with Alzheimer's Disease and dementia. In an interview with CNA N on 10/10/2022 at 2:12 p.m., she stated she had not received any training from the facility regarding providing care to residents with aggressive behaviors or residents Alzheimer's Disease and dementia. In an interview with CNA B on 10/10/2022 at 2:40 p.m., she stated she received training on how to care for residents with Alzheimer's Disease, dementia, and aggressive behaviors at a different facility she worked at previously. She said she had not received those trainings at her current facility. In an interview with the HR Director on 10/11/2022 at 12:21 p.m., she said she and the Administrator were responsible for ensuring staff were current with all training/in-services. She said they ran a report from their electronic training system every two weeks which listed each employee's training to be completed. She said the report was distributed to each department head to ensure their staff were trained. In an interview with the Administrator on 10/11/2022 at 12:42 p.m., she stated she and each department head were responsible for ensuring each staff were trained. She said she and the HR Director run and review a report from their electronic training system which indicated which trainings needed to be completed by each staff. She said the reports were distributed to each department head to make sure their staff complete training. The Administrator said she also frequently spoke to staff about their training needs. The Administrator said she did not know why CNA A and CNA E had not completed trainings listed on their training records. Record review of Abuse, Neglect, Exploitation, Or Mistreatment, revised 10/23/2019 revealed, Policy: 1. The facility's Leadership prohibits neglect, mental, physical and/or verbal abuse, use of a physical and/or chemical restraint not required to treat a medical condition, involuntary seclusion, corporal punishment and misappropriation of a patient's/resident's property and/or funds and ensures that alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappro [TRUNCATED]