STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675814	A. Building B. Wing	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Grace Guest Care Center	2700 S Henderson Blvd Kilgore, TX 75662

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47339 Based on observation, interview and record review the facility failed to ensure that all alleged violations involving abuse, are reported to Texas Health and Human Services Commission immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury for 1 of 5 (Resident #8) residents reviewed for abuse and neglect. The facility did not report an allegation of abuse that occurred between 3/8/24-3/10/24 when Resident #8 reported to LVN A that CNA B had been rough while providing care and had caused a bruise on her right thigh. This failure could place residents at risk of injuries, abuse, and/or neglect. Findings included: Record review of a facility face sheet dated 3/19/24 for Resident #8 indicated that she was a [AGE] year-old female that admitted to the facility on [DATE] with diagnosis of chronic obstructive pulmonary disease (causes airflow blockage and breathing related problems), schizophrenia (affects a person's ability to think, feel, and behave clearly), and muscle weakness. Record review of a Quarterly MDS assessment dated [DATE] for Resident #8 indicated that he had a BIMS score of 11 indicating that she had a mildly impaired cognitive deficit. Record review of a comprehensive care plan for Resident #8 revised on 11/14/23 indicated that she was PASRR positive due to a severe mental illness. Resident #8 refused all PASRR services and had signed refusal of PASRR MI specialized services form 1041. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/18/24 at 10:42 AM, Resident #8 said on Thursday 3/14/24 or sometime last week (could not remember exact day) CNA B had come into her room to put on her nighttime brief, and CNA B jerked the right side of the brief up causing a tear in the skin at the crease of her thigh and groin area. Resident #8 said she yelled out that it hurt, and CNA B jerked up the right side of the brief again causing a bruise to her right upper thigh. Resident #8 said she reported the incident to LVN A the night it happened. Resident #8 said LVN A went and filled out a report about the incident and brought it back for her to sign. Resident #8 said after she signed the report LVN A told her she was going to place it under the door of [NAME] (no known staff by that name). Resident #8 said after she reported the incident to LVN A she had not heard anything else about the incident. During an interview by phone on 3/18/24 at 6:52 PM, LVN A said Resident #8 did report to her that CNA B had pulled Resident #8's brief up to rough while putting on her nighttime brief. LVN A said she told Resident #8 to talk to the Administrator. LVN A said she did not fill out any kind of report or have Resident #8 sign anything. LVN A said she did not report the incident to the Administrator or DON because Resident #8 said she was going to report the incident to administration on Monday. LVN A said she did not feel like CNA B had intentionally hurt Resident #8 and felt like Resident #8 had a personal issue with CNA B. LVN A said she did not remember what specific day the incident took place but thought it happened over the weekend of 3/8/24-3/10/24. LVN A said she had been trained on reporting abuse and neglect but did not think Resident #8 had been abused so she did not report it. LVN A said the facility policy was to report all allegations of abuse to the Administrator. On 03/19/24 8:41 AM, Attempted phone interview with CNA B, she did not answer or return call by the time of exit. During an interview on 3/19/24 at 9:30 AM Resident #8 said the Administrator had come to her room earlier that morning and talked to her regarding the incident with CNA B. Resident #8 said she did not get to tell the Administrator the whole story of what happened during the incident because the Administrator did all the talking and would not let her finish telling him what had happened. During an observation and interview on 03/19/24 at 09:33 AM with the ADON C present observed Resident #8's groin area with red raw irritated with no obvious skin tear in the crease of the groin, no bruises observed to the right thigh area. Resident #8 said the bruises are healing up now because it happened last week. While skin was being observed Resident #8 told ADON C that CNA B had come in to put on her nighttime brief and jerked the right side of her brief up and caused a tear in the crease of her right leg. Resident #8 said she yelled out ouch that hurt and CNA B jerked the brief up again causing a bruise to her right leg. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/19/24 at 9:37 AM, the ADON C said she worked at the facility for about 1 year. She said LVN A called her on 3/18/24 around 7:30pm after speaking to the surveyor and asked her if she was going to lose her job because she did not report that Resident #8 had said CNA B was being rough with her. The ADON C said she returned to the facility and the ADON C and LVN A went to Resident #8's room and Resident #8 described her interaction with CNA B as rough. Stating that CNA B pulled her brief up too tight causing bruising. The ADON C said Resident #8 also stated that she had told someone about the situation a week ago on a Monday. The ADON C said she felt like the incident was more of a personality conflict between Resident #8 and CNA B. The ADON C said CNA B normally dotes on Resident #8 and she thought CNA B told Resident #8 that she could be more independent and do some of her own tasks and it would make her stronger and Resident #8 got mad at CNA B for that. The ADON C said CNA B was on vacation out of state and had not spoken with her. The ADON C said she started staff education on: Skin Assessments/Reporting Skin Changes, Safe Handling, Skin Integrity on 3/18/24. The ADON C said she had not started abuse education training. During an interview on 3/19/24 at 9:58 AM the Administrator said he was notified that a surveyor was asking questions about Resident #8 and a possible allegation of abuse at approximately 9:00pm on 3/18/24. He said he did not report the incident to HHSC because he did not feel like the incident was abuse. The Administrator said he and the SW spoke with Resident #8 and she told him CNA B was hateful and talking to her in a way she did not like and did not like CNA B's approach. The Administrator said Resident #8 told him CNA B put a brief on her and that she had a bruise on her leg but did not say what the bruise was from. He said he did not speak with LVN A that the complaint was originally reported to because the DON was handling the investigation on 3/18/24 due to him being in the ER with his 1 1/2 year old child. He said he had not reported the incident as of 3/19/24 at 9:58am because Resident #8 did not make the allegation of abuse to him. During an interview on 3/19/24 at 10:30 AM, the SW she said she went to speak with Resident #8 with the administrator the morning of 3/19/24. She said Resident #8 said CNA B has an attitude and said to her what do you want but did not say anything about the CNA B being physical. The SW said Resident #8 said CNA B told Resident #8 to not push her call light. The SW said Resident #8 did not mention anything about the brief or bruise. The SW said she had not received any complaints about CNA B before. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/20/24 at 9:16 AM, the DON said she had worked at the facility for about 1 year. The DON said she received a text message from the ADON C and was notified of the alleged abuse by Resident #8 on 3/18/24 at 7:40pm and said she notified the administrator on 3/18/24 at 7:55pm. The DON said she was notified that Resident #8 complained to a the surveyor that CNA B was too rough putting a brief on her and had bruised her. The DON said the ADON C and LVN A did a skin assessment on 3/18/24 and did not find a bruise. She said the ADON C started in-servicing staff on Skin Assessments/Reporting Skin Changes, Safe Handling, Skin Integrity. The DON said she identified who the CNA was and made sure she was not working. The DON said the ADON C made sure Resident #8 was safe. The DON said she had not spoken with CNA B due to her being out of state on vacation. The DON said whether or not the abuse occurred, CNA B will not care for Resident #8 anymore. The DON said on 3/18/24 was the first time she had heard of the incident and LVN A had not reported the incident to her. The DON said that LVN A felt like Resident #8 was a constant complainer and took it as being another issue verses something she should report. The DON said the investigation was still pending and the SW had been doing safe surveys. The DON said her expectation was for staff to report all allegations of abuse to the administrator or if it was reported to a nurse manager, they would get that information to the administrator. The DON said the potential negative outcome for staff not reporting alleged abuse was the potential for further abuse to the resident. On 03/20/24 11:28 AM Attempted phone interview with CNA B, she did not answer or return call by the time of exit. During an interview on 3/20/24 at 1:08 PM the Administrator said his expectation was that staff were to report all allegations of abuse to him or their supervisor immediately. The Administrator said the resident could potentially continue to be subjected to abuse if staff did not follow the facility abuse policy. Record Review of the ADON C statement dated 3/18/24. The statement revealed: On the evening of March 18, 2024, I returned to the facility after receiving a call from the charge nurse, LVN A, in regard to Resident #8. After arriving I had LVN A to go with me to resident room. I was able to visit with Resident #8 in regard to her concern with night CNA B. Resident #8 described her interaction with CNA B as Rough. Stating that CNA B pulled her brief up too tight causing bruising . Record review of a facility incident log for March 2024 indicated that no incident report was filed for an incident regarding Resident #8. Review of website for state complaints and incidents on 3/18/24 revealed there was no self-report to HHSC for incident on Resident #8 from facility. Record review of in-service dated 1/2/24 titled Abuse/Neglect Reporting/Identifying revealed CNA had been educated prior to the incident. Record review of in-service dated 2/29/24 titled Abuse/Neglect Reporting/Identifying revealed LVN had been educated prior to the incident. Review of website for state complaints and incidents on 3/19/24 revealed the incident with Resident #8 had been reported to HHSC on 3/19/24 at 10:39am. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating with a revised date of September 2022 revealed: 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The Administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility;.