STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676072	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corrigan Ltc Partners Inc	300 Hyde St Corrigan, TX 75939

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47879 Based on interview and record review, the facility failed to immediately inform the resident, consult with the resident's physician, notify, consistent with his or her authority, the resident's representative(s) when there was an accident involving the resident which resulted in injury and had the potential for requiring physician intervention for 1 of 10 residents reviewed for notification of changes. The facility failed to notify the responsible party (FM G) and physician for Resident #2 when she fell causing pain to her knee while ambulating up the steps of the transport van on 6/12/2024. This failure could place residents at risk for a decline in health, and for family members not knowing the health status of the resident, being informed of and participating in care decisions. Findings include: Record review of Resident #2's face sheet, dated 07/29/2024, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included cerebral infarction (lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off), peripheral vascular disease (a blood circulation disorder that causes the blood vessels outside of the heart and brain to narrow, block, or spasm), type 2 diabetes (A chronic condition that affects the way the body processes blood sugar), major depression (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and anxiety disorder (persistent and excessive worry that interferes with daily activities). Record review of Resident #2's Quarterly MDS Assessment, dated 05/48/2024, indicated she was able to make herself understood and understood others. She was cognitively intact, indicated with a BIMS score of 15. She required supervision or touching assistance while walking 10-50 feet and partial/moderate assistance to walk 150 feet. She uses walker for mobility device. Record review of Resident #2's care plan, revised on 11/07/2023, indicated the resident had limited physical mobility related to weakness. The interventions included to monitor/document/report to the MD PRN signs/symptoms of immobility or a fall related injury. The resident was to use her walker, and invite resident to activity programs that encourage activity, physical mobility, such as exercise groups and walking activities. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's care plan, revised on 11/07/2023, indicated the resident was at risk for falls. The interventions included monitor for injury x 72 hours after fall; PT, OT referrals as ordered, PRN; resident to use walker, and follow facility fall protocol. Record review of Resident #2's Progress Note, dated 06/12/2024 at 4:29 p.m., authored by LVN H, indicated: When resident arrived back to facility from doctor's appointment via facility van with x2 staff. Staff informed this nurse the lift was not working, so x4 staff went out to help resident out of van. Resident exited van with no complications. After resident entered facility, this nurse was notified that when leaving the appointment, the lift on the van was not working and the x2 staff had to assist resident up the steps on the van. x2 staff stated that when trying to get up the steps resident fell on to x1 staff that was in front of her while the other x1 staff was behind her. Administrator stated that Resident #2's knee gave out while trying to step up the steps. Administrator said they asked resident if she was okay or hurting anywhere resident stated she was okay and had no pain. When resident got back to facility resident told this nurse her knee was hurting. This nurse asked if resident wanted regular Tylenol or Tylenol #3, resident stated she just wanted regular Tylenol. Then this nurse walked beside resident while she pushed her walker back to residents' room to assess residents' leg, there was no redness, swelling, warmth, or bruising to resident's leg. This nurse asked resident how her leg was feeling, and resident stated it was feeling better. Resident stated she was okay walking on it and just needed to rest. This nurse told resident to let someone know if the pain got worse. No other pain voiced by resident. Record review of Resident #2's Progress Note, dated 06/13/2024 at 6:40 a.m., authored by LVN H, indicated: Resident is sitting in chair down hallway. This nurse asked resident how she was feeling, resident stated she was feeling okay her knee was just hurting a little bit. This nurse asked resident if she wanted her Tylenol #3 or Tylenol extra strength resident stated she just wanted regular Tylenol. Resident then got up and walked to dining room. Record review of Resident #2's Progress Note, dated 06/13/2024 at 7:52 a.m., authored by LVN H, indicated: Residents RP contacted nurses' station when this nurse was on morning round. Administrator answered the phone and RP told Administrator she wanted an x-ray of the knee and thigh of resident because resident is saying she is in a lot of pain. This nurse ask resident if she is hurting more than she told me this morning and resident stated no that her pain was the same and still an 8. This nurse then contacted RP and RP stated that resident told her she is in a lot of pain. RP then told this nurse that she wants an X-ray ordered and she will be at the facility by 9. This nurse informed RP that I will have to get an order from PCP before I can get an x-ray done. No other complaints noted at this time. Record review of Resident #2's Progress Note, dated 06/14/2024 at 6:49 a.m., authored by LVN F, indicated Xray results received and forwarded to PCP. results read no evidence of factures or dislocation. no new orders received, informed resident of results and resident stated with smile on face come here girl and take this thing off (ace bandage wrap). this nurse complied with resident's request and removed ace wrap. left voicemail on RP phone with x-ray results. During an interview on 7/29/2024 at 2:15 p.m., Resident #2 said she had a history of falling and recalled the incident of falling while trying to get back in the transport van on 6/12/2024. Resident #2 said the van lift broke, so she had to go up the steps of the van and her knee gave out and she fell . The resident said she did not recall when her knee started hurting but recalled it hurting after the incident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/30/2024 at 8:12 a.m., FM G (Resident #2's RP) said she was not notified by the facility of Resident #2 having a fall while trying to get in the transport van on 06/12/2024. She said when Resident #2 complained of knee pain to her on 6/13/2024, Resident #2 told her about the incident. FM G said she called and visited the facility requesting the physician be notified, and x-rays be obtained because Resident #2 was complaining of severe pain to her knees. FM G said she was not notified regarding Resident #2's fall. During an interview on 08/1/2024 at 11:10 a.m., LVN H said she worked 6 a.m. to 6 p.m. on 06/12/2024 when Resident #2 returned from her MD appointment. She said the Administrator informed her the van lift was not working, and they required staff assistance to get Resident #2 out of the van back in the facility. Resident #2 was assisted out of the van down the steps and into a wheelchair and back to the facility. LVN H said the Administrator informed her the transport van lift would not work after the appointment and Resident #2 had to be assisted up the steps of the van to get in. She said Resident #2's knee gave out and she fell forward onto the Administrator, and they were able to get the resident into the van. LVN H said she assessed Resident #2 when she returned to the facility and the resident complained of pain to her knee and she provided her with pain medication. LVN H said Resident #2 was able to ambulate without difficulty and no redness, swelling, warmth or bruising was noted. LVN H said she did not complete an incident report or notify the physician because she did not witness the fall and thought the involved staff would complete the incident report. LVN H said if she notified the physician, it would be documented. During an interview on 8/1/2024 at 11:45 a.m., NP J said he did not show record of him being notified of Resident #2's initial fall on 6/12/2024. He said he received a request from the facility for orders for x-rays of the resident's knee on 6/13/2024 due to a fall while entering the transport van. NP J said he gave an order for the x-rays and the x-rays did not indicate any acute injuries. NP J said that he expected to be notified of falls and/or incidents at the time they occur. During an interview on 08/01/2024 at 10:25 a.m., the DON said she would have expected a resident who fell to be assessed by licensed facility staff and the fall be reported to the Charge Nurse, ADON, herself, Administrator, and RP if applicable. The DON said she was aware of Resident #2's fall while entering the transport van. The DON said she was not aware that the fall was not reported to Resident #2's RP and physician. The DON said staff should have notified the resident's RP and physician of the fall. She said falls not being reported in a timely manner to the RP and physician could cause a resident to not receive care for injuries or delayed care. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/01/2024 at 11:35 a.m., the Administrator said she was the driver of the transport van when the incident occurred with Resident #2, the transport van lift malfunctioned while Resident #2 was being loaded into van after appointment, and Resident #2 had to use the van steps to enter the van, when she stepped into the van her knee gave away and Resident #2 fell forward landing on her inside the van. The Administrator said she, another transport attendant, and a bystander in the community assisted Resident #2 up and into the van. The Administrator said Resident #2 did not have any complaints at the time of the incident. The Administrator said when she returned to the facility, she had facility staff assist her to get Resident #2 out of the transport van and the charge nurse complete an assessment. The Administrator said she notified the RP of the incident but did not recall the date and time and there was no documentation available noting the notification. The Administrator said she did not complete an incident report because the incident did not happen at the facility. The Administrator said there was controversy whether an incident report should have been completed because of the location of the incident. The Administrator said Resident #2's fall should have been reported to the physician and RP the day it occurred. She said falls not being reported in a timely manner to the RP and physician could cause a resident to not receive care for injuries or delayed care. The Administrator said the van was not utilized for transport until after the van lift was repaired. Record review of the facility's Accident and Incident policy, dated 2017, indicated All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. 2. The following data, as applicable, shall be included on the report of incident/accident form: g. the time the injured person's attending physician was notified, as well as the time the physician responded and hir or her instructions; h. the date/time the injured person's family was notified and by whom.

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F 0600 Level of Harm - Actual harm 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** 47879 Based on interview and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 8 residents (Resident #1) reviewed for abuse. The facility failed to ensure CNA A did not verbally and physically abuse Resident #1 when she yelled, cursed and aggressively removed the resident's clothes, on 05/17/2024. This failure could place residents at risk for emotional distress, fear, decreased quality of life and further abuse. Findings included: Record review of Resident #1's face sheet, dated 07/29/2024, indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included type 2 diabetes (a chronic condition that affects the way the body processes blood sugar), hypothyroidism (condition where the thyroid doesn't create and release enough thyroid hormone into your bloodstream), schizophrenia (mental health condition with a combination of symptoms of schizophrenia and mood disorder), bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs), major depression (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and anxiety disorder (persistent and excessive worry that interferes with daily activities). Record review of Resident #1's quarterly MDS Assessment, dated 05/18/2024, indicated she was usually able to make herself understood and usually understood others. She had moderate cognitive impairment, identified with a BIMS score of 9. Record review of Resident #1's care plan, revised on 05/19/2024, indicated the resident was resistive to care related to she refused to go to bed, have personal care and clothes changed. The interventions included allow resident to make decisions about treatment regimen, to provide sense of control, encourage as much participation/interaction by the resident as possible during care activities, give clear explanations of all care activities prior to and as they occurred during each contact. Record review of the Grievance/Complaint Report, dated 05/18/2024, indicated Resident #1 was verbally abused by CNA A speaking to her in a verbally abusive tone. During the investigation, Resident #1 also reported physical abuse from CNA A the evening of 05/17/2024. On interview by LVN C and the Administrator, Resident #1 corroborated the statement. Resident #1 stated she had shoulder pain following the incident but denied pain medications or x-rays. Assessment of Resident #1 showed no signs of physical injury. Record review of a Facility Investigation Report, dated 05/22/2024, indicated the incident was reported on 05/18/2024 and occurred on the evening of 05/17/2024. The Administrator and Social Worker interviewed Resident #1 individually as part of the facility investigation and she reported feeling safe at the facility. Psychology services conducted an interview and counseling services provided. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The alleged perpetrator (CNA A) was placed on suspension during the investigation and quit during the investigation process. Facility staff were in-serviced on Abuse Neglect and Resident Rights. During an interview on 07/31/2024 at 1:45 p.m., LVN C said CNA B reported to her on 05/18/2024 at 8:20 a. m. that she received a phone call from CNA A on 05/17/2024 around 8:30 p.m.- 9:00 p.m. questioning her why Resident #1 was not in bed. CNA could hear Resident #1 in the background telling CNA A no, could hear CNA A and Resident #1 arguing about removing clothing, and then she heard CNA A say, you are going to take the damn things off or I am going to take it off for you! LVN C said CNA B reported CNA A's voice changed from her normal voice to a voice whose tone was cruel and angry. LVN C said she immediately told CNA B to write a statement regarding the incident, reported the incident to the DON and the Administrator due to the allegation of verbal abuse. LVN C said she went to Resident #1's room and investigated and interviewed her regarding the allegation. LVN C said she confirmed with Resident #1 that CNA A had verbally and physically abused her by verbally telling her loudly and angrily you are going to take it off or I will take it off for you and forcing her to remove a jacket and shirt. CNA A physically forcefully removed the jacket and shirt after Resident #1 told her No multiple times and grabbed the jacket/shirt no allowing it to be removed. LVN C said during the assessment no marks or bruising was observed but Resident #1 did complain of mild shoulder pain related to the struggle between her and CNA A the night prior. LVN C said Resident #1 was a religious/devout Catholic, and she made statements she thought the abuse occurred because God was punishing her for a sin she had done. LVN C said the resident was upset during the statement process but refused any PRN pain medications or x-rays for her shoulders. During an interview on 08/01/2024 at 10:30 a.m., Ombudsman L reported she was aware of the allegation of abuse of Resident #1. She said she visited Resident #1 on 05/21/2024 and she reported to her that CNA A got angry with her because she asked to be put to bed, she was rough with her and had forced her to take off her jacket even when she said no because she was cold. Ombudsman L said Resident #1 said she did not feel safe with CNA A providing her care and she reported the findings to the facility ADM. She said the ADM informed her CNA A was suspended pending investigation and CNA A quit during the investigation process, so she would not be providing care to Resident #1. She said Resident #1 said she felt safe at facility since CNA A was no longer working there. During an interview on 07/30/2024 at 2:45 p.m., Resident #1 said she felt safe in the nursing facility. Resident #1 acknowledged the abuse incident occurred but would not provide details of the incident, would shake her head yes and avert her eyes when speaking to the state surveyor. Resident said, everything is ok now. Attempts to interview CNA A were unsuccessful, three attempts were made to reach her by telephone on 07/29/2024 at 12:15 p.m., 07/30/2024 at 12:00 p.m., and 07/31/2024 at 11:35 p.m No return call was received. Attempts to interview CNA B were unsuccessful, three attempts were made to reach her by telephone on 07/29/2024 at 12:30 p.m., 07/30/2024 at 12:05 p.m., and 07/31/2024 at 11:38 p.m (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 07/31/2024 at 6:00 p.m., CNA E said she assisted CNA A with placing Resident #1 back to bed on 05/17/2024 at 8:30 p.m. CNA E said she assisted CNA A and when they were positioning the Hoyer lift sling under her they noticed Resident #1's shirt was wet and soiled with feces. CNA E said CNA A called CNA B to ask her why Resident #1 was heavily wet and soiled, and not put in bed prior to her leaving shift. CNA E said CNA A tried to take off the soiled shirt and jacket and Resident #1 resisted CNA A removing her shirt saying she was cold and wanted to sleep in the shirt. CNA E said CNA A tried to explain to Resident #1 the shirt and jacket were soiled, and she could not sleep in the soiled clothes. CNA E said Resident #1 became angry and began shaking her fists saying No, No I don't want it off. CNA E said CNA A told Resident #1 she needed to take the soiled clothes off and Resident #1 resisted. CNA E said Resident #1 was clinching the shirt and refused for it to be removed and was upset and made a fist. CNA E warned CNA A resident might hit her. CNA E said CNA A was able to convince Resident #1 to remove the soiled clothes and allowed them to provide care and assist her to bed. CNA E said she did not see CNA A actions as abusive but looking back at the situation, they should have notified the charge nurse and maybe let the charge nurse intervene or try to deescalate the situation by leaving the resident alone or talking with her more calmly. CNA E denied CNA A cussed at Resident #1. CNA E said Resident #1 did resist her jacket and shirt being removed and CNA A and Resident #1 were both pulling on the shirt, CNA A pulled to attempt to remove and Resident #1 pulling to keep it on. During an interview on 8/01/2024 at 11:30 a.m., the Administrator stated Resident #1 confirmed CNA A had verbally and physically abused her when she yelled and cursed at her regarding removing the residents clothes and physically aggressively removed her clothes. The Administrator stated the facility investigation confirmed verbal and physical abuse and CNA A was suspended during the investigation and quit during the investigation period. Record review of CNA A's employee file indicated she received training regarding abuse, neglect and misappropriation of property during initial orientation on 9/17/2021 and annually. CNA A was suspended on 5/18/2024 for abuse allegation, with last day of work on 5/17/2024 and called administrator on 5/23/2024 and quit. Record review of a statement from CNA A indicated CNA A said she and CNA E provided care and assisted Resident #1 back to bed on 05/17/2024 around 8:30 p.m. CNA A said she was at the nurses' station talking to the charge nurse when Resident #1 came out of her room saying she was waiting on CNA B to lay her in bed. CNA A said she and CNA E assisted Resident #1 to her room and began helping her take off her clothes because Resident #1 was a Hoyer lift/2 person assist transfer. CNA A said her clothes were soiled and she was wet, her shirt and jacket were soiled. CNA A said she and CNA E provided care (changes soiled clothes and diaper) to Resident #1 and transferred her to the bed. Record review of statement from CNA B indicated CNA B said she received a phone call on 05/17/2024 from CNA A asking her why Resident #1 was not in bed, and she told her Resident #1 was asked two times if she wanted to go to bed and she said no both times. CNA B said while she was on the phone with CNA A she could hear CNA A and Resident #1 arguing about taking her clothes off. CNA B said CNA A told Resident #1 that she was going to take the damn thing off or I am going to take it off for you. CNA B said CNA A voice changed from normal voice to a voice whose tone and inflection were very cruel and angry when making the statement. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 2021, indicated Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47879 Based on interview and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation to include but not limited to freedom from corporal punishment, involuntary seclusion and any physicial or chemical restraint not required to treat the resident's medical symptoms for 1 of 7 residents (Resident #3) reviewed for misappropriation and exploitation. The facility failed to ensure CNA Student D did not steal Resident #3's personal information and attempt to obtained multiple car loans and fast cash with Resident #3's personal information. This failure could place residents at risk of left of money, identity theft, unauthorized or coerced purchases from resident's funds, and feelings of loss. The findings include: Record review of Resident #3's face sheet, dated 07/29/2024, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included angina pectoris (chest pain or pressure), dysphasia (a condition that affects your ability to produce and understand spoken language), cognitive communication deficit (difficulty with any aspect of communication that is affected by disruption of cognition), Parkinson's disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves), schizophrenia (mental health condition with a combination of symptoms of schizophrenia and mood disorder and anxiety disorder (persistent and excessive worry that interferes with daily activities). Record review of Resident #3's quarterly MDS Assessment, dated 06/7/2024, indicated she was usually able to make herself understood and usually understood others. She had severe cognitive impairment, identified with a BIMS score of 7. Record review of Resident #3's care plan, revised on 05/29/2024, indicated the resident had impaired cognitive function or impaired thought process. The interventions included use resident's preferred name, identify yourself each interaction, face the resident when speaking and make eye contact, reduce any distractions, use consistent, simple, directive sentences, provide the resident with necessary cues stop and return if agitated; discuss concerns about confusion, disease process, nursing home placement with family; keep routine consistent and try to provide consistent caregiver as much as possible in order to decrease confusion. Record review of the Facility Provider Investigation report written by the facility administrator, dated 11/3/2023, reflected: She was contacted by Resident #3's family member regarding a previous CNA Student D had used Resident #3's personal information (date of birth and social security number) for her personal gain. Resident #3's family member provided information that previous employee/CNA Student D used Resident #3's personal information to attempt to obtain multiple car loans and fast cash. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/29/2024 at 11:00 a.m., the Administrator stated she received information from Resident #3's family member that indicated a previous employee of the facility used Resident #3's personal information to attempt to obtain multiple car loans and fast cash. The Administrator said the alleged perpetrator was no longer employed at the facility, and she turned all the evidence over to the local police department for investigation. The Administrator said Resident #3 could have verbally provided CNA Student D the personal information, CNA Student D could have picked up information out of the resident's room or she could have collected the information from Resident #3's paper chart. The Administrator said she was unsure how CNA Student D obtained the personal information. The Administrator said the resident's personal information was confidential and CNA students usually did not have access to that information. During an observation on 07/30/2024 at 11:00 a.m., revealed resident paper charts observed on shelves behind the nurses' station. Resident #3's paper chart opened, and face sheet easily accessible at the front of the chart with Resident # 3's personal information (Date of birth, Address, Social Security Number, Medicare Number, Medicaid Number). During an interview on 7/30/2024 at 11:30 a.m., Resident #3 said she did not recall the incident with her personal information being used without her knowledge and requested the State Surveyor contact her family member for additional information. During an interview on 07/31/2024 at 9:14 a.m., Resident # 3's family member, FM K said when she retrieved Resident #3's mail back in 11/2023 she noticed several car loans and cash advances were made under Resident #3's name. FM K said she did some research and realized the name identified on the documents was an employee (CNA Student D) from the nursing facility. FM K said she contacted the administrator of the facility and provided her a copy of the documents and the local police department was notified. FM K said she was unsure if any loans were granted with Resident #3's personal information. FM K said she locked Resident #3's credit down and had all her mail forwarded to her residence for immediate review. FM K said she was working with the local police department, but she did not feel like anything was getting done. FM K said she was concerned CNA Student D might have used Resident #3's personal information for personal gain and changed the address information so FM K would not receive the documents. FM K said Resident #3 had been in the nursing facility since 2/2021 and FM K was the medical and financial power of attorney for Resident #3 and these applications and transactions were not approved. FM K said Resident #3 had no psychosocial harm from the incident because she was unaware that it had occurred due to her cognitive status. FM K said this was elderly identity theft. Attempted to call CNA Student D on 07/30/2024 at 9:02 a.m. and the phone number called was not a working number. During an interview on 08/01/2024 at 10:25 a.m., the DON said when staff were hired, they received training on abuse, neglect, misappropriation of property and exploitation. She said they had zero tolerance for stealing. She said any staff caught stealing would be terminated. She said she was not employed as the DON at the facility at the time of the incident concerning Resident #3 misappropriation of property. (continued on next page)

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	676072	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corrigan Ltc Partners Inc	300 Hyde St Corrigan, TX 75939

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/31/2024 at 10:57 a.m., the Administrator said she did not condone any staff members taking any items from residents. She said she was unsure how CNA Student D obtained Resident #3's personal information but as soon as she was made aware of the situation, she notified the local police department because the alleged perpetrator was no longer employed at the facility. She said that FM K reported the incident in November 2023 and CNA Student D was terminated in March 2023. She said that Resident #3 was unaware that the incident occurred, so no psychosocial harm identified. She said misappropriation of property was a big deal, and it was the facility's goal to keep all resident's personal information and personal items safe and secure. She said residents have access to a locked drawer to keep personal belongings safe and secure, and/or funds can be placed in resident's personal funds. She said paper charts should be kept in secure location and/or personal information should be encrypted to prevent access to personal information. She said personal information and items being stolen could lead to identity theft, unauthorized use of information and this could affect a resident emotionally. Record review of CNA Student D's employee file indicated she received training regarding abuse, neglect and misappropriation of property during orientation on 11/1/2022. CNA Student D was terminated on 3/15/2023. Record review of documents from the bank, dated 09/12/2023, indicated CNA Student D as the recipient to a previous address for Resident #3, which indicated we were recently informed by lending agency that it was considering the credit sale or lease of a 2019 [NAME] to you and asked whether we would be prepared to accept your obligation if the transaction was completed. On the application, you were the co-applicant and [Resident #3] was the applicant. We must regretfully inform you that we were not agreeable to handling the proposed transaction. Record review of documents from the lending services bank, dated 09/21/2023, indicated that application from the car dealership in [name of city] thanking [Resident #3] for applying for an auto loan. We regret to inform you that we were unable to offer you credit on the terms original requested. CNA Student D as the recipient to a previous address for [Resident #3], indicating we were recently informed by lending agency that it was considering the credit sale or lease of a 2019 [NAME] to you and asked whether we would be prepared to accept your obligation if the transaction was completed. On the application, you were the co-applicant and [Resident #3] was the applicant. We must regretfully inform you that we were not agreeable to handling the proposed transaction. However, we could approve your application if certain terms or conditions are met. Record review of documents from a cash advanced facility, with recipient as [Resident #3] to previous address, dated 09/3/2024 and 09/20/2023 indicated that this was notification of past due payment for the above reference payment of $176.30 had not been made. Your immediate attention is required to rectify this situation and prevent cash advance facility from reviewing your file for possible assignment to a third-party collection agency Record Review of facility in-service dated 11/03/2023 indicated facility staff were provided training on Abuse, Neglect, Exploitation and Misappropriation prevention program to ensure resident's personal property is placed in secure areas. Record review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 2021, indicated Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 47879 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials, including to the State Survey Agency an d adult protective services where state law provides jurisdiction in long-term care facilities, in accordance with State Law though established procedures for 1 of 8 residents (Resident #1) reviewed for abuse. CNA B failed to immediately report verbal abuse to the Administrator when she overheard CNA A verbally abuse Resident #1 on 05/17/2024 at 9:00 p.m. This failure could place residents at risk for further abuse and neglect. Findings include: Record review of Resident #1's face sheet, dated 07/29/2024, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had with of diagnoses which included type 2 diabetes (a chronic condition that affects the way the body processes blood sugar), hypothyroidism (condition where the thyroid doesn't create and release enough thyroid hormone into your bloodstream), schizophrenia (mental health condition with a combination of symptoms of schizophrenia and mood disorder), bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs), major depression (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and anxiety disorder (persistent and excessive worry that interferes with daily activities). Record review of Resident #1's quarterly MDS Assessment, dated 05/18/2024, indicated she was usually able to make herself understood and usually understood others. She had moderate cognitive impairment, indicated with a BIMS score of 9. Record review of Resident #1's care plan, revised on 05/19/2024, indicated the resident was resistive to care related to she refused to go to bed, had pesonal care and clothes changed. The interventions included allow resident to make decisions about treatment regimen, to provide sense of control, encourage as much participation/interaction by the resident as possible during care activities, give clear explanations of all care activities prior to an as they occur during each contact. Record review of the statement from CNA B revealed she received a phone call on 05/17/2024 from CNA A asking her why Resident #1 was not in bed, and she told her Resident #1 was asked two times if she wanted to go to bed and she said no both times. CNA B said while she was on the phone with CNA A she could hear CNA A and Resident #1 arguing about taking clothes off. CNA B said CNA A told Resident #1 that she was going to take the damn thing off or I am going to take it off for you. CNA B said that CNA A voice changed from normal voice to a voice whose tone and inflection were very cruel and angry when making the statement. (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 07/31/2024 at 1:45 p.m., LVN C said CNA B reported to her on 05/18/2024 at 8:20 a.m. that she received a phone call from CNA A on 05/17/2024 around 8:30 p.m.- 9:00 p.m. questioning her why Resident #1 was not in bed. CNA could hear Resident #1 in the background telling CNA A no, could hear CNA A and Resident #1 arguing about removing clothing, and then she heard CNA A say, you are going to take the damn things off or I am going to take it off for you! LVN C said CNA B reported CNA A's voice changed from her normal voice to a voice whose tone was cruel and angry. LVN C said she immediately told CNA B to write a statement regarding the incident, reported the incident to the DON and the Administrator due to the allegation of verbal abuse. LVN C said she went to Resident #1's room and investigated and interviewed her regarding the allegation. LVN C said she confirmed with Resident #1 that CNA A had verbally and physically abused her by verbally telling her loudly and angrily you are going to take it off or I will take it off for you and forcing her to remove a jacket and shirt. CNA A physically forcefully removed the jacket and shirt after Resident #1 told her No multiple times and grabbed the jacket/shirt no allowing it to be removed. LVN C said during the assessment no marks or bruising was observed but Resident #1 did complain of mild shoulder pain related to the struggle between her and CNA A the night prior. LVN C said Resident #1 was a religious/devout Catholic, and she made statements she thought the abuse occurred because God was punishing her for a sin she had done. LVN C said the resident was upset during the statement process but refused any PRN pain medications or x-rays for her shoulders. During an interview on 07/31/2024 at 2:30 p.m., LVN F said she was sitting at the nurses' station on 05/18/2024 at 8:20 a.m. when CNA B reported to her and LVN C, the concerns she overheard the night prior between CNA A and Resident #1 when to CNA A called her questioning her why Resident #1 was not put to bed. She said CNA B, during phone call, overheard CNA A arguing with Resident #1 about removing her clothes and then she clearly overheard CNA A say, you are going to take the damn things off or I am going to take it off for you!, she said the CNA B mimicked what she heard CNA A say and her voice changed to a tone that was angry and cruel. LVN F said she and LVN C requested CNA B to write a statement because this was considered verbal abuse and it needed to be reported immediately to the Administrator. LVN F said LVN C reported the allegation to the DON and the Administrator and LVN C was directed to start interviewing regarding the incident. LVN F said allegations of abuse should be reported to the abuse coordinator/administrator immediately. During an interview on 08/1/2024 at 11:05 a.m., RN G said he worked as the charge nurse the evening of 05/17/2024 when the alleged abuse occurred, and he was not notified on any incident with Resident #1 and CNA A during his shift. RN G said he did see CNA A and CNA E going into the Resident #1's room with the Hoyer lift to put her to bed around 8:30 - 8:45 p.m. because she requested to go to bed. RN G said he interacted with Resident #1 that evening with giving her medications and checking her blood sugar, but she did not report any concerns to him. RN G said Resident #1, at that time, was reserved and stayed to herself, as she was still acclimating to the facility. RN G said he did not see, feel, suspect, that any abuse, neglect, nor incident of any type had occurred. RN G said he was in and out of rooms that evening on Halls A & B and did not hear anything out of the ordinary from Resident #1's hall. RN G said he was not aware of the alleged incident until returning to work the following evening. RN G said he did not receive any reports of any incidents nor concerns regarding Resident #1 from CNA A, CNA B or CNA E during his shift on 05/17/2024 to 05/18/2024. (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 08/01/2024 at 10:25 a.m., the DON said she was aware of the abuse allegation for Resident #1, she was notified by LVN C and CNA B the morning of 05/18/2024 at 8:30 a.m. and was involved with the interviewing and investigation following the allegation. She said if CNA B suspected abuse that she should have called the facility that night and reported the allegation of abuse to the charge nurse on duty or contacted management staff, not waited until the next morning. DON said she expects all allegation of abuse to be reported immediately to the charge nurse, herself or the Administrator. She said allegations of abuse not being reported in a timely manner could cause a resident to not receive the care they need or continue to be abused. During an interview on 8/01/2024 at 11:30 a.m., the Administrator said she was aware of the abuse allegation for Resident #1, she was notified by DON on 05/18/2024 at 8:40 a.m. and was involved with the interviewing and investigation following the allegation. She said if CNA B suspected abuse that she should have immediately called the facility that night and reported the allegation of abuse to the charge nurse on duty or contacted management staff, not waited until the next morning. The Administrator said Resident #1 confirmed CNA A had verbally and physically abused her when she yelled, cursed at her regarding removing clothes and physically aggressively removed her clothes. The Administrator stated the facility investigation confirmed verbal and physical abuse and the CNA A was suspended during the investigation and quit during the investigation period. The Administrator said her expectations were allegations of abuse were to be reported immediately to the charge nurse, herself or the DON. She said allegations of abuse not reported in a timely manner could cause a resident to not receive the care they need or continue to be abused. Record review of an Abuse and Neglect in-service dated 05/18/2024 indicated CNA A was in-serviced on the Abuse and Neglect policy. Record review of the facility's policy Preventing Resident Abuse, dated 2001, indicated 1. The facility's goal is to achieve and maintain an abuse-free environment. 2. Our abuse prevention/intervention program includes but is not limited to, the following: . g. Training staff to understand and manage a resident's verbal or physical aggression; . j. Assessing, care planning and monitoring residents with needs and behaviors that may lead to conflict or neglect; k. Assessing residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issues; . striving to maintain adequate staffing on all shifts to ensure that needs of each resident are met Record review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 2021, indicated . 9. Investigate and report any allegations within timeframes required by federal requirements