STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745019	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
James L West Center for Dementia Care	1111 Summit Ave Fort Worth, TX 76102

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** 41781 Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for 1 of 3 residents (Resident #1) reviewed for abuse. The facility failed to ensure CNA B did not verbally and physically abuse Resident #1 on 04/29/24. The noncompliance was identified as past noncompliance. The Immediate Jeopardy began on 04/29/24 and ended on 04/29/24. The facility had corrected the noncompliance before the investigation began. This failure could affect the residents at the facility and place them at risk for physical, verbal, and/or psychosocial harm. Findings included: Review of Resident #1's electronic health record revealed she was an [AGE] year-old female who admitted to the facility on [DATE]. Review of Resident #1's quarterly MDS Assessment, dated 07/20/24, reflected she had a BIMS score of 02 indicating severe cognitive impairment. Further review revealed she had active diagnoses of Alzheimer's disease (a gradual decline in memory, thinking, behavior and social skills), non-Alzheimer's Dementia (a general term referring to changes in the brain that affect memory and the ability to perform daily abilities), and depression (a mood disorder that causes persistent sadness and loss of interest). Review of Resident #1's care plan, dated 02/15/24, reflected the following: Focus: Resident has anxiety r/t confusion and fear due to dementia .Goal: Residents' anxiety will be controlled and there will be no adverse event related to psychosis in this review period .Interventions: Employ dementia-specific methods to help alleviate anxiety such as Compassionate Touch, Positive Approach to Care, Validation Therapy principles, redirection, and distraction. Review of Resident #1's progress notes revealed the following: (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	- On 04/29/24 LVN A wrote: A call was received from family member who state that the CNA [CNA B] who was in [Resident #2's room] slapped [Resident #1] when she was pulling the bed control. [Resident #2's RP] got it on video and [Resident #2's RP] have already sent it to the DON. The CNA [CNA B] was removed from the unit and I immediately notified the administrator. A head to toe assessment was initiated, no apparent skin injury, redness, or bruising to resident's face or other parts of the body. The resident [Resident #1] denies pain or discomfort at this time no s/s of acute distress noted .MD/The administrator/DON/[Resident #1's RP C] was left a message to call back. I also called [Resident #1's RP D and Resident #1's RP E], but no answer. Observation on 08/06/24 at 9:15 AM of Resident #1 revealed she was sitting in the dining room area at a table with two other residents. Resident #1 was looking to her side, away from the surveyor, and when approached did not make any eye contact or acknowledge the surveyor. Resident #1 did not appear to acknowledge the surveyor after multiple attempts to talk to her and ask questions. There were no visible marks or injuries to Resident #1's face. An attempted telephone interview on 08/06/24 at 10:03 AM to Resident #1's RP C was unsuccessful as there was no answer. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a video provided by the Administrator from Resident #2's RP was dated and time stamped as 04/29/2024 20:01:34 (8:01 PM) CDT in the bottom right corner revealed the following: CNA B was heard talking about someone going downstairs while Resident #1 entered the view of the camera first. CNA B walked in behind Resident #1, as Resident #1 stood in front of the bed, and the CNA B walked around the resident to the head of the bed. Resident #1 responded to CNA B saying, That's why I have to go downstairs and CNA B said something to the effect of Why do you want to go downstairs? and Resident #1 told her I can't go downstairs and sat on the side of Resident #2's bed while CNA B picked up the remote control for the bed. CNA B then told Resident #1 well get the hell out of here and Resident #1 replied saying, I have to have a [unintelligible word and motions with her hands towards herself]. CNA B started pressing a button on the remote control for the bed to lower the head of the bed and told Resident #1 well I don't give a damn. Resident #1 asked her why? and CNA B said to her Why should I? You don't give a damn about me. Resident #1 then reached towards CNA B to grab the cord part of the remote control for the bed, and the two begin to physically struggle over it for a second. CNA B then took her hand off the cord of the remote control for the bed and raised it to slap Resident #1 across her face. Resident #1 then fell back onto the bed and began calling CNA B a motherfucker while the two still physically struggled with the cord of the remote. Resident #1 tried to kick and push CNA B away from her while CNA B tried to take the remote control for the bed away from Resident #1. Resident #1 stood up from the bed and started walking backwards towards the entrance to the room while holding and pulling the cord to the remote control for the bed and called CNA B a motherfucker. CNA B then walked to Resident #1 trying to take the remote control for the bed away from her and told her, Didn't I tell you to get out of here? Resident #1 then told CNA B to shut up and then shut up you bitch. CNA B looked up into the camera a few times during this exchange while Resident #1 said these things to CNA B and kept telling her to shut up. CNA B was still trying to take the remote control for the bed away from Resident #1 while Resident #1 called CNA B a dirty, dirty, dirty, pushy, man. CNA B replied to Resident #1 saying I ain't no man and Resident #1 told her, Well I don't see a lot of men around you. And I see now why. CNA B then let go of the remote control for the bed and started walking away from Resident #1 towards the bed saying, Oh Lord [unintelligible word]. CNA B then walked up to the bed and pulled the top blanket and sheet back and took the pillow off the bed and placed it on the counter to the left of the bed. Resident #1 could be heard saying of course you do to CNA B. CNA B began stripping the sheets off the bed and Resident #1 pulled the cord for the remote control for the bed off and walked out of the frame of the camera. CNA B gathered up the linens she removed from the bed and walked out of the frame of the camera. An attempted telephone interview on 08/06/24 at 11:23 AM to CNA B was unsuccessful as there was no answer or call back. Review of an untitled and undated piece of paper provided by the facility reflected the following: To whom it may concern: I was walking in the room the resident was behind me talking mess while she grabbed me pushing me and I got away and went over to the bed. She came a sat on the bed while I was trying to make it she was still talking mess then she spit on me and my reaction kick in I wasn't trying to hit her but I did, I was trying to get the remote from her and she was holding on to it pulled it out of the bed and then I walked out .4/29/24 the abuse statement was from [CNA B]. She wrote this from 9:00p-9:15p tonight while waiting for [City Name] Police Department to arrive. (signed by the Administrator) [sic]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a piece of paper, dated 5/3/24, reflected the following: Statement regarding intake number [xxxxxx]; On 4/29/24 around 8:15pm I got a call from the nurse [LVN A] that was working on [the unit] that evening. [LVN A] stated that [Resident #2's RP], the witness, called her and told her that he saw a CNA [CNA B] slap a female resident [Resident #1] in his [family member's] room. No other residents were in the room. I asked [LVN A] where the CNA [CNA B] was that he had accused. [LVN A] said she had the CNA, [CNA B], sitting with her and was not letting her around any residents per our policy .While speaking with [the DON] on the phone, we both got emails from [Resident #2's RP] that contained a video. As we watched the video, I stopped once the CNA [CNA B] struck the resident [Resident #1]. [the DON] called the facility and had the CNA [CNA B] wait downstairs in the lobby area .The resident [Resident #1] showed no signs of being slapped. There was no redness or anything. The resident [Resident #1] was in her bed getting ready for bed .I called the [City Name] Police department to come to [the facility] as soon as possible .[CNA B] admitted to striking the resident. She stated the resident [Resident #1] spit on her. I told her [CNA B] there was no evidence of the spitting and it didn't matter as there is no reason for her to ever hit a resident .The officers put her [CNA B] in handcuffs and arrested her after seeing the video .****Please note the incident took place in [Resident #2's] room which is [Resident #2's room number]. Neither [Resident #2] or [their] roommate were in the room .[CNA B] had entered the room with [Resident #1] following her. [CNA B] was attempting to change the linen on the bed. [Resident #1] was sitting on the bed. [CNA B] becomes verbally aggressive with [Resident #1] and [Resident #1] starts mimicking [CNA B]. [Resident #1] wanted the bed remote and that is when [CNA B] slapped her on the side of her face. At that point there is tussling over the bed remote and at some point [CNA B] lets her have it. [CNA B] continues to make the bed. [Resident #2's RP] was checking the video to check on his [family member] when he noticed that a woman [Resident #1] and the CNA [CNA B] were in the room and he saw the incident which then he sent the video to the DON and Administrator and called the nurse [LVN A] to make sure and call Administration. ***** .I called the victim's [Resident #1's] family. I explained the situation and they understood she is showing no signs of the slap and doesn't remember the incident. In servicing began that night and continued for several days regarding reporting and abuse and neglect. [sic] (signed by the Administrator). In an interview via phone on 08/06/24 at 3:03 PM with LVN A revealed she was doing her normal nursing duties that evening on 04/29/24. LVN A said she saw CNA B and was told by her that Resident #1 had broken the remote control for the bed of the room that they were just in. LVN A said she would go and get a new one from the empty bed in another room. LVN A said CNA B went into Resident #2's room with her and helped to lift the mattress up and replace the remote control for the bed. LVN A said she went to the nurse's station a few moments later and received a call from a family member. LVN A said the family member said they saw CNA B slap Resident #1 in the room, and it was so bad, and they sent the video the management. LVN A said CNA B said nothing to her about it while they were fixing the remote control for the bed. LVN A said she thanked the family member and told CNA B to go downstairs and called the Administrator. LVN A said she assessed Resident #1, and she did not have any injuries to her. LVN A said the Administrator, the DON, and the police arrived to also check on Resident #1 after that, but CNA B was not on the floor anymore. (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 on 08/06/24 at 3:16 PM with the DON revealed she was at home and received a call that a staff member (CNA B) had slapped Resident #1. The DON said she called the facility and instructed them to take CNA B off the floor immediately. The DON said when she arrived at the facility, she went to check on Resident #1 to make sure she was safe and had no injuries. The DON said when she spoke with CNA B, she was told that Resident #1 was aggressive and trying to pull on the remote control for the bed. The DON said even with that behavior, no matter what, CNA B had no right to slap Resident #1. The DON said the police were called and CNA B was arrested and escorted off the property that evening on 04/29/24. The DON said all staff were in-serviced on abuse immediately and it was explained to them that any form of abuse would not be tolerated. The DON said she did watch the video that was sent by Resident #2's RP and saw that Resident #1 walked in pleasantly and sat on the end of the bed and had a conversation with CNA B. The DON said from her perspective, it appeared like Resident #1 was having a conversation with a friend. The DON said further into the conversation, after CNA B slapped her, Resident #1 stood at the door of the room waiting on her. The DON said LVN A told her that night she saw both Resident #1 and CNA B walking out of the room together holding CNA B's hand. The DON said there had never been any abuse allegations or accusations made against CNA B prior to this incident. The DON said CNA B had entered Resident #2's room to strip the bed because it was his shower day. The DON said Resident #1 was known to walk with staff often, so she assumed Resident #1 saw CNA B walk into Resident #2's room and just followed her. The DON said she and the police checked on Resident #1 three different times that evening and she had no recollection of what happened to her afterwards. In an interview on 08/06/24 at 3:35 PM with the Administrator revealed she got a call from the nurse that Resident #2's RP told her that while he was looking at the camera, he saw CNA B slap a resident. The Administrator said she asked the nurse where CNA B was to which she told her she was right there with the nurse. The Administrator said she watched the video that was sent by Resident #2's RP and decided to drive to the facility. The Administrator said she instructed staff to send CNA B downstairs off the floor. The Administrator said when she saw Resident #1, she was not harmed and had no recollection of what happened to her. The Administrator said she gave CNA B a piece of paper to write down what happened and meanwhile she called the police. The Administrator said she started to fill out CNA B's termination paperwork and when she gave it to CNA B, CNA B was confused and refused to sign it. The Administrator said the police arrested CNA B onsite at the facility. The Administrator said she also called Resident #1's family to inform them of what happened. The Administrator said the DON began an in-service regarding abuse that evening on 04/29/24 with staff and continued until all staff had been in-serviced. The Administrator said she did watch the video, but it was hard for her to watch it. The Administrator said when she did watch the video, she saw Resident #1 sitting on the bed and CNA B was focused on making up the bed. The Administrator said she thought Resident #1 said she was going downstairs repeatedly and then somehow, she got the remote to the bed and did not let go. The Administrator said CNA B whacked Resident #1 and a loud pop could be heard on the video and Resident #1 began to scream and called CNA B names. The Administrator said later on someone told her they saw Resident #1 and CNA B walking to the nurse's station to say the bed remote was not working. The Administrator said she thought there was something very wrong in CNA B's head that night. The Administrator said she remembered hearing CNA B cursing at Resident #1 which was not appropriate at all. The Administrator said Resident #1 liked to follow staff around which was probably why she followed CNA B into Resident #2's room. The Administrator said there had never been any allegations or accusations against CNA B prior to this. The Administrator said employees should never abuse residents and everyone was aware of the policy to not abuse residents since they have a right to be free from abuse. (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 on 08/06/24 at 1:28 PM with CNA F revealed she knew the facility's policy on abuse and knew de-escalation techniques for when a resident became agitated with them or anyone else in the facility. In an interview on 08/06/24 at 1:44 PM with CNA G revealed she knew the facility's policy on abuse and knew de-escalation techniques for when a resident became agitated with them or anyone else in the facility. In an interview on 08/06/24 at 2:00 PM with CNA H revealed she knew the facility's policy on abuse and knew de-escalation techniques for when a resident became agitated with them or anyone else in the facility. In an interview on 08/06/24 at 2:14 PM with LVN I revealed she knew the facility's policy on abuse and knew de-escalation techniques for when a resident became agitated with them or anyone else in the facility. Review of an in-service, dated 04/25/24, revealed CNA B and other staff had been in-serviced regarding abuse and neglect. Review of an in-service, dated 04/29/24, revealed staff had been in-serviced regarding abuse and neglect, stress management, and de-escalation strategies. Review of an Employee Warning Notice for CNA B, dated 04/29/24, reflected under the Violation Type section an x was next to Inappropriate Behavior, Violation of Company Policies, and Other: Abuse. Further review under the section titled Description, including date(s) of incidents was: Admits to striking a resident. Under the section Actions to be Taken (verbal warning, written warning, final warning, termination) was Current Action: Termination. At the bottom of the page was signatures from the Administrator and DON with a note that read employee refused to sign. Review of the facility's policy, revised March 2018, and titled Abuse and Neglect reflected: 1. 'Abuse' is defined at [symbol]483.5 as 'the willful infliction of injury, reasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.'

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on interview and record review, the facility failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents, for 1 of 3 residents (Resident #1) reviewed for abuse. The facility failed to ensure Resident #1 was free from abuse per the policy. The noncompliance was identified as past noncompliance. The Immediate Jeopardy began on 04/29/24 and ended on 04/29/24. The facility had corrected the noncompliance before the investigation began. These failures could place residents at risk for physical harm, psychosocial harm, unsafe environment, and further abuse. Findings included: Review of the facility's policy, revised March 2018, and titled Abuse and Neglect reflected: 1. 'Abuse' is defined at [symbol]483.5 as 'the willful infliction of injury, reasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.' Review of the facility's undated policy, titled Abuse, Neglect, Exploitation, and Misappropriation of Property in Nursing Homes: What You Need to Know reflected: Abuse: Definition: a deliberate act that results in physical harm, pain, or mental anguish. It can be physical, verbal, sexual or mental. Abusers can be staff, residents, or visitors. There are four types of abuse- physical, verbal, mental, or sexual. Examples: rough handling, withholding care or assistance, isolating or restricting a resident, improper use of physical or chemical restraints, yelling, ridiculing, hitting, pushing, grabbing, or taking or using photographs or recordings of residents that would demean or humiliate a resident. Signs: unusual bruising, unexplained injury, sudden changes in a resident's behavior or activities .How Can Abuse, Neglect, Exploitation, and Misappropriation of Property be Prevented? Know and Exercise Your Rights: Right to be free from abuse, neglect, and exploitation . Review of Resident #1's electronic health record revealed she was an [AGE] year-old female who admitted to the facility on [DATE]. Review of Resident #1's quarterly MDS Assessment, dated 07/20/24, reflected she had a BIMS score of 02 indicating severe cognitive impairment. Further review revealed she had active diagnoses of Alzheimer's disease (a gradual decline in memory, thinking, behavior and social skills), non-Alzheimer's Dementia (a general term referring to changes in the brain that affect memory and the ability to perform daily abilities), and depression (a mood disorder that causes persistent sadness and loss of interest). (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's care plan, dated 02/15/24, reflected the following: Focus: Resident has anxiety r/t confusion and fear due to dementia .Goal: Residents' anxiety will be controlled and there will be no adverse event related to psychosis in this review period .Interventions: Employ dementia-specific methods to help alleviate anxiety such as Compassionate Touch, Positive Approach to Care, Validation Therapy principles, redirection, and distraction. Review of Resident #1's progress notes revealed the following: -On 04/29/24 LVN A wrote: A call was received from family member who state that the CNA [CNA B] who was in [Resident #2's room] slapped [Resident #1] when she was pulling the bed control. [Resident #2's RP] got it on video and [Resident #2's RP] have already sent it to the DON. The CNA [CNA B] was removed from the unit and I immediately notified the administrator. A head to toe assessment was initiated, no apparent skin injury, redness, or bruising to resident's face or other parts of the body. The resident [Resident #1] denies pain or discomfort at this time no s/s of acute distress noted .MD/The administrator/DON/[Resident #1's RP C] was left a message to call back. I also called [Resident #1's RP D and Resident #1's RP E], but no answer. Observation on 08/06/24 at 9:15 AM of Resident #1 revealed she was sitting in the dining room area at a table with two other residents. Resident #1 was looking to her side, away from the surveyor, and when approached did not make any eye contact or acknowledge the surveyor. Resident #1 did not appear to acknowledge the surveyor after multiple attempts to talk to her and ask questions. There were no visible marks or injuries to Resident #1's face. An attempted telephone interview on 08/06/24 at 10:03 AM to Resident #1's RP C was unsuccessful as there was no answer. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a video provided by the Administrator from Resident #2's RP was dated and time stamped as 04/29/2024 20:01:34 (8:01 PM) CDT in the bottom right corner revealed the following: CNA B was heard talking about someone going downstairs while Resident #1 entered the view of the camera first. CNA B walked in behind her and Resident #1 stood in front of the bed and CNA B walked around her to the head of the bed. Resident #1 responded to her saying that's why I have to go downstairs and CNA B said something to the effect of why do you want to go downstairs? and Resident #1 told her I can't go downstairs and sat on the side of Resident #2's bed while CNA B picked up the remote control for the bed. CNA B then told Resident #1 well get the hell out of here and Resident #1 replied saying I have to have a [unintelligible word and motions with her hands towards herself]. CNA B started pressing a button on the remote control for the bed to lower the head of the bed and told Resident #1 well I don't give a damn. Resident #1 asked her why? and CNA B said to her why should I? You don't give a damn about me. Resident #1 then reached towards CNA B to grab the cord part of the remote control for the bed and the two begin to physically struggle over it for a second. CNA B then took her hand off the cord of the remote control for the bed and raised it to slap Resident #1 across her face. Resident #1 then fell back onto the bed and began calling CNA B a motherfucker while the two still physically struggled with the cord of the remote. Resident #1 tried to kick and push CNA B away from her while CNA B tried to take the remote control for the bed away from Resident #1. Resident #1 stood up from the bed and started walking backwards towards the entrance to the room while holding and pulling the cord to the remote control for the bed and called CNA B a motherfucker. CNA B then walked to Resident #1 trying to take the remote control for the bed away from her and tells her didn't I tell you to get out of here? and Resident #1 tells her to shut up and then shut up you bitch. CNA B looked up into the camera a few times during this exchange while Resident #1 said these things to CNA B and kept telling her to shut up. CNA B was still trying to take the remote control for the bed away from Resident #1 while Resident #1 called CNA B a dirty, dirty, dirty, pushy, man. CNA B replied to Resident #1 saying I ain't no man and Resident #1 told her, Well I don't see a lot of men around you. And I see now why. CNA B then let go of the remote control for the bed and started walking away from Resident #1 towards the bed saying, Oh Lord [unintelligible word]. CNA B then walked up to the bed and pulled the top blanket and sheet back and took the pillow off the bed and placed it on the counter to the left of the bed. Resident #1 could be heard saying of course you do to CNA B. CNA B began stripping the sheets off the bed and Resident #1 pulled the cord for the remote control for the bed off and walked out of the frame of the camera. CNA B gathered up the linens she removed from the bed and walked out of the frame of the camera. An attempted telephone interview on 08/06/24 at 11:23 AM to CNA B was unsuccessful as there was no answer or call back. Review of an untitled and undated piece of paper provided by the facility reflected the following: To whom it may concern: I was walking in the room the resident was behind me talking mess while she grabbed me pushing me and I got away and went over to the bed. She came a sat on the bed while I was trying to make it she was still talking mess then she spit on me and my reaction kick in I wasn't trying to hit her but I did, I was trying to get the remote from her and she was holding on to it pulled it out of the bed and then I walked out .4/29/24 the abuse statement was from [CNA B]. She wrote this from 9:00p-9:15p tonight while waiting for [City Name] Police Department to arrive. (signed by the Administrator) [sic]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745019	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
James L West Center for Dementia Care	1111 Summit Ave Fort Worth, TX 76102

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a piece of paper, dated 5/3/24, reflected the following: Statement regarding intake number [xxxxxx]; On 4/29/24 around 8:15pm I got a call from the nurse [LVN A] that was working on [the unit] that evening. [LVN A] stated that [Resident #2's RP], the witness, called her and told her that he saw a CNA [CNA B] slap a female resident [Resident #1] in his [family member's] room. No other residents were in the room. I asked [LVN A] where the CNA [CNA B] was that he had accused. [LVN A] said she had the CNA, [CNA B], sitting with her and was not letting her around any residents per our policy .While speaking with [the DON] on the phone, we both got emails from [Resident #2's RP] that contained a video. As we watched the video, I stopped once the CNA [CNA B] struck the resident [Resident #1]. [the DON] called the facility and had the CNA [CNA B] wait downstairs in the lobby area .The resident [Resident #1] showed no signs of being slapped. There was no redness or anything. The resident [Resident #1] was in her bed getting ready for bed .I called the [City Name] Police department to come to [the facility] as soon as possible .[CNA B] admitted to striking the resident. She stated the resident [Resident #1] spit on her. I told her [CNA B] there was no evidence of the spitting and it didn't matter as there is no reason for her to ever hit a resident .The officers put her [CNA B] in handcuffs and arrested her after seeing the video .****Please note the incident took place in [Resident #2's] room which is [Resident #2's room number]. Neither [Resident #2] or [their] roommate were in the room .[CNA B] had entered the room with [Resident #1] following her. [CNA B] was attempting to change the linen on the bed. [Resident #1] was sitting on the bed. [CNA B] becomes verbally aggressive with [Resident #1] and [Resident #1] starts mimicking [CNA B]. [Resident #1] wanted the bed remote and that is when [CNA B] slapped her on the side of her face. At that point there is tussling over the bed remote and at some point [CNA B] lets her have it. [CNA B] continues to make the bed. [Resident #2's RP] was checking the video to check on his [family member] when he noticed that a woman [Resident #1] and the CNA [CNA B] were in the room and he saw the incident which then he sent the video to the DON and Administrator and called the nurse [LVN A] to make sure and call Administration. ***** .I called the victim's [Resident #1's] family. I explained the situation and they understood she is showing no signs of the slap and doesn't remember the incident. In servicing began that night and continued for several days regarding reporting and abuse and neglect. [sic] (signed by the Administrator). In an interview via phone on 08/06/24 at 3:03 PM with LVN A revealed she was doing her normal nursing duties that evening on 04/29/24. LVN A said she saw CNA B and was told by her that Resident #1 had broken the remote control for the bed of the room that they were just in. LVN A said she would go and get a new one from the empty bed in another room. LVN A said CNA B went into Resident #2's room with her and helped to lift the mattress up and replace the remote control for the bed. LVN A said she went to the nurse's station a few moments later and received a call from a family member. LVN A said the family member said they saw CNA B slap Resident #1 in the room, and it was so bad and they sent the video the management. LVN A said CNA B said nothing to her about it while they were fixing the remote control for the bed. LVN A said she thanked the family member and told CNA B to go downstairs and called the Administrator. LVN A said she assessed Resident #1, and she did not have any injuries to her. LVN A said the Administrator, the DON, and the police arrived to also check on Resident #1 after that, but CNA B was not on the floor anymore. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 08/06/24 at 3:16 PM with the DON revealed she was at home and received a call that a staff member (CNA B) had slapped Resident #1. The DON said she called the facility and instructed them to take CNA B off the floor immediately. The DON said when she arrived at the facility, she went to check on Resident #1 to make sure she was safe and had no injuries. The DON said when she spoke with CNA B, she was told that Resident #1 was aggressive and trying to pull on the remote control for the bed. The DON said even with that behavior, no matter what, CNA B had no right to slap Resident #1. The DON said the police were called and CNA B was arrested and escorted off the property that evening on 04/29/24. The DON said all staff were in-serviced on abuse immediately and it was explained to them that any form of abuse would not be tolerated. The DON said she did watch the video that was sent by Resident #2's RP and saw that Resident #1 walked in pleasantly and sat on the end of the bed and had a conversation with CNA B. The DON said from her perspective, it appeared like Resident #1 was having a conversation with a friend. The DON said further into the conversation, after CNA B slapped her, Resident #1 stood at the door of the room waiting on her. The DON said LVN A told her that night she saw both Resident #1 and CNA B walking out of the room together holding CNA B's hand. The DON said there had never been any abuse allegations or accusations made against CNA B prior to this incident. The DON said CNA B had entered Resident #2's room to strip the bed because it was his shower day. The DON said Resident #1 was known to walk with staff often, so she assumed Resident #1 saw CNA B walk into Resident #2's room and just followed her. The DON said she and the police checked on Resident #1 three different times that evening and she had no recollection of what happened to her afterwards. In an interview on 08/06/24 at 3:35 PM with the Administrator revealed she got a call from the nurse that Resident #2's RP told her that while he was looking at the camera, he saw CNA B slap a resident. The Administrator said she asked the nurse where CNA B was to which she told her she was right there with the nurse. The Administrator said she watched the video that was sent by Resident #2's RP and decided to drive to the facility. The Administrator said she instructed staff to send CNA B downstairs off the floor. The Administrator said when she saw Resident #1, she was not harmed and had no recollection of what happened to her. The Administrator said she gave CNA B a piece of paper to write down what happened and meanwhile she called the police. The Administrator said she started to fill out CNA B's termination paperwork and when she gave it to CNA B, CNA B was confused and refused to sign it. The Administrator said the police arrested CNA B onsite at the facility. The Administrator said she also called Resident #1's family to inform them of what happened. The Administrator said the DON began an in-service regarding abuse that evening on 04/29/24 with staff and continued until all staff had been in-serviced. The Administrator said she did watch the video, but it was hard for her to watch it. The Administrator said when she did watch the video, she saw Resident #1 sitting on the bed and CNA B was focused on making up the bed. The Administrator said she thought Resident #1 said she was going downstairs repeatedly and then somehow she got the remote to the bed and did not let go. The Administrator said CNA B whacked Resident #1 and a loud pop could be heard on the video and Resident #1 began to scream and called CNA B names. The Administrator said later on someone told her they saw Resident #1 and CNA B walking to the nurse's station to say the bed remote was not working. The Administrator said she thought there was something very wrong in CNA B's head that night. The Administrator said she remembered hearing CNA B cursing at Resident #1 which was not appropriate at all. The Administrator said Resident #1 liked to follow staff around which was probably why she followed CNA B into Resident #2's room. The Administrator said there had never been any allegations or accusations against CNA B prior to this. The Administrator said employees should never abuse residents and everyone was aware of the policy to not abuse residents since they have a right to be free from abuse. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 08/06/24 at 1:28 PM with CNA F revealed she knew the facility's policy on abuse and knew de-escalation techniques for when a resident became agitated with them or anyone else in the facility. In an interview on 08/06/24 at 1:44 PM with CNA G revealed she knew the facility's policy on abuse and knew de-escalation techniques for when a resident became agitated with them or anyone else in the facility. In an interview on 08/06/24 at 2:00 PM with CNA H revealed she knew the facility's policy on abuse and knew de-escalation techniques for when a resident became agitated with them or anyone else in the facility. In an interview on 08/06/24 at 2:14 PM with LVN I revealed she knew the facility's policy on abuse and knew de-escalation techniques for when a resident became agitated with them or anyone else in the facility. Review of an in-service, dated 04/25/24, revealed CNA B and other staff had been in-serviced regarding abuse and neglect. Review of an in-service, dated 04/29/24, revealed staff had been in-serviced regarding abuse and neglect, stress management, and de-escalation strategies. Review of an Employee Warning Notice for CNA B, dated 04/29/24, reflected under the Violation Type section an x was next to Inappropriate Behavior, Violation of Company Policies, and Other: Abuse. Further review under the section titled Description, including date(s) of incidents was: Admits to striking a resident. Under the section Actions to be Taken (verbal warning, written warning, final warning, termination) was Current Action: Termination. At the bottom of the page was signatures from the Administrator and DON with a note that read employee refused to sign.