STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455351	A. BUILDING _____ B. WING _____	**05/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEGACY NURSING AND REHABILITATION	**2817 KENT STREET BRYAN, TX 77802**

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** - Minimal harm or potential for 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** Based on Interview and Record Review the Facility failed to ensure residents are free from abuse for one (1) of one (1) resident reviewed for resident abuse (Resident #1). CNA A pulled Resident #1's hair while removing a rubber hair band without securing her hair first, she poured two cups of water over the residents hair while Resident #1 sat on the toilet in the shower room, she scrubbed her roughly during the shower and turned off the emergency pull cord when Resident #1 attempted to call someone else to the shower room. This failure could result in residents in the facility suffering physical, verbal or mental abuse. Findings included: Review of Resident #1's Face Sheet reflected a [AGE] year old female admitted [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's Care Plan reflected she had an ADL self-care performance deficit r/t weakness s/p hospitalization and h/o falls. The care plan interventions included: Bathing/Showering: The resident is able to assist during ADL care dated 2/4/2020, Dressing: Allow sufficient time for dressing and undressing, Transfer: The resident uses walker to maximize independence with transferring. The care plan also indicated she was at risk of fall and injury related to h/o falls and weakness. Interventions included: 3/8/2020 encourage res to call for assistance for transfers, encourage res to inform staff of falls, injuries promptly, One person assist added 2/4/2020. Review of Resident #1's Admission MDS assessment dated [DATE] indicated the resident had a BIMS score of 15 which indicated the resident's cognition was intact. In an interview on 4/22/2020 at 5:12 PM DON stated Resident #1 informed CNA B on 2/9/2020 that CNA A had been rough with shower on 2/8/2020. RN C called the Administrator. The DON state the ADM and DON both went down and interviewed Resident #1. CNA A denied the allegation. The DON said Resident #1 stated she yanked her hair when pulling the pony tail holder out of her hair. CNA A washed her hair and didn't rinse completely. Resident #1 told CNA A that all the soap wasn't rinsed from her hair. Resident #1 said CNA A had her sit on the toilet and took cups by the sink and poured them over her head. Resident #1 stated CNA A pushed her into her room in her wheelchair and she was cold. CNA A helped her put her clothes on but left her hair wet. DON stated during all interviews Resident #1's story remained the same. In an interview on 4/29/2020 at 10:13 AM MA D stated she was not in the room, was on the hall preparing medications. CNA B had gone in to the room came out and told her what the Resident #1 said. She stated Resident #1 was nervous and appeared scared of the CNA A. CNA B stated Resident #1 pulled the call light and CNA A snatched it out of her hand. Resident #1 told the CNA A she didn't finish rinsing her hair - CNA A then poured 2 cups of water over her head. In an interview on 4/29/2020 at 4:44 PM CNA B stated she was assisting Resident #1 with care the morning after the alleged incident when Resident #1 stated her hair was going to be tangled because the caregiver yesterday left soap in it. She stated she tried to tell her it was still soapy and the caregiver took two cups, filled them with water and poured them over her head. RN C was in the room and overheard the conversation. RN C stated she would take care of it. CNA B stated, I finished her hair and left the room. In an interview on 5/5/2020 at 9:30 AM Resident #1 stated she was given a shower on the morning of February 8, 2020. She was in the shower room with CNA A and asked if she could have her hair washed. (CNA A) pulled the rubber band off without holding my head, I told her it hurt. She used body wash instead of shampoo. She put it on my body and started scrubbing very hard. I had a cut place on my butt crack and told her I think you're taking skin. She then said you're ready to get out. I told her no, it's still soapy so she told me to sit on commode. She got a plastic cup and started pouring water over my head. I asked what do you have against me and she said I don't even know you what would I have against you. She had a hold of my arm and it showed up the next day as a large bruise. I reached over her shoulder and pulled the emergency cord because I was scared. She reached behind her and turned it off. She transferred me to the w/c and rolled me back to my room with still wet hair and I was very cold. Someone came in and dried me off. I didn't see her again. In an interview on 5/5/2020 at 10:45 AM the ADM stated a police report was not filed. She didn't recall if the ombudsmen was notified. Her expectation was for residents to not be abused. She stated her expectations regarding reporting of alleged abuse was met. In an interview on 5/5/2020 at 10:53 AM CNA A stated I asked the resident if I was being too rough, I'm sort of a tom boy and she didn't tell me I was being rough. She went on to say, I started washing her hair but the soap wouldn't get soapy so I just quit. When asked about pouring cups of water of the Residents head she stated, Where would I get cups? That doesn't even make sense. When asked about turning off the emergency light she stated she did not turn the light off and denied the resident pulling the emergency light. She then added, That's a terrible place to work, I felt overwhelmed and unappreciated when I worked hard. I shouldn't have even been on the hall that day, that wasn't my hall. Review of facility policy, SB 9 Statement of Nursing Home Policy and Employee Acknowledgement dated 6/27/2019 and signed by CNA A reflected Mistreatment or abuse of any nature will not be tolerated. Any employee guilty of abusing a resident or patient is subject to immediate discharge. Local authorities will be notified immediately and criminal charges may be filed against any employee guilty of abuse. Review of facility policy, Abuse Investigation and Reporting dated 02/2020 reflected All reports of resident abuse, neglect, . shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Review of facility's document, Legacy Nursing & Rehabilitation, Personnel Action dated 2/13/2020 reflected Employee (CNA A) was terminated for carelessness and discourteous to patients, physicians, fell ow employees, or visitor with the following remarks: (Resident #1) made allegations on 2/9/2020 that (CNA A) pulled her hair while showering her. (CNA A) also was reported to have sat resident on toilet seat, after she complained of still having soap in her hair and poured two cups of hot water over Resident #1's head. (Resident #1) also attempted to call for assistance by pulling the call cord in the bathroom. However, according to (Resident #1) (CNA A) turned it off. (Resident #1) was very consistent with her story and repeated it several times to various staff members over a period of five days.

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

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.