STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455455	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Care of Alice	218 219 N King St Alice, TX 78332

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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 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** Based on interviews and record reviews, the facility failed to ensure the right to be free from abuse for two (Residents #15 and Resident #94) of 6 residents reviewed for abuse. The facility failed to ensure Resident #94 was free from sexual abuse on 03/03/26 when Resident #15, who had a history of sexual inappropriate behavior, was seen by CNA A putting his penis on or/in Resident #94's mouth. An Immediate Jeopardy (IJ) was identified on 03/25/26. The IJ template was provided to the facility Administrator on 03/25/26 at 5:42 pm. While the IJ was removed on 03/27/26 at 11:11 am, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because of the facility's need to monitor and evaluate the effectiveness of the corrective systems. This deficient practice placed residents at risk of psychosocial harm and continued abuse. Findings included: Record review of Resident #15's admission record reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included moderate intellectual disabilities (developmental delays resulting in an average mental age of 6 to 9 years old), other frontotemporal neurocognitive disorder (also called frontotemporal dementia- a group of progressive brain diseases that cause neurons to die in the frontal and temporal lobes, causing early-onset dementia with symptoms such as loss of empathy, social inappropriateness, and language difficulties), cognitive communication deficit (difficulty with communication), and dementia with psychotic disturbance (loss of memory, language, problem solving and other thinking abilities which significantly impair a person's ability to perform daily activities with hallucinations or delusions). Record review of Resident #15's quarterly MDS dated [DATE] reflected a BIMS of 00 (severe cognitive impairment). Resident #15's functional abilities reflected independent for, sit to stand, sit to lying, chair/bed to chair-transfer and walking 10 - 50 feet. Resident #15 required setup or clean-up assistance with toileting and supervision or touching assistance for bathing.Record review of Resident #15's care plan revised on 09/25/25 reflected: Resident #15 resides in the secure unit and wanders into other residents' rooms. Resident #15 has acute confusional state characterized by; changes in consciousness, disorientation, environmental awareness, behavior related to: Moderate Intellectual Disabilities. Interventions Included: Assist to reorientation to room and facility Assure that staff are aware Resident #15 wanders Routine resident checks every 2 hours and locate Resident #15's whereabouts Record review of Resident #15's progress note dated 03/03/26 at 9:11 am reflected: resident was caught by [CNA A] during breakfast in female residents room with door closed and was exposing himself to her and had his penis in her mouth, [CNA A] intervened and redirected him out of her room. Will continue to monitor, notified psych services and [RP] has been notified of his behaviors. Record review of Resident #15 progress notes indicated: Resident #15's progress notes indicated he had previous inappropriate sexual behaviors on:8/3/25- Resident #15 in female's room with his pants down with the female in the room.7/19/25- Resident #15 was seen in T.V. room with his penis out and a female resident in the room.6/28/25- Resident #15 exposed genitals to female residents several times6/13/25- Resident #15 in another female resident's room with his hands in his pants while she slept.6/8/25- Resident (continued on next page)

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	#15 pulled his pants down in front of a female resident.5/22/25- Resident #15 continuously tried to enter a female resident's room with his penis exposed. 5/21/25- Resident #15 was seen standing in front of another resident's room with his pants down and his penis exposed.Record review of Resident #94's admission record reflected an [AGE] year-old female originally admitted to the facility on [DATE] and most recent admission was 01/03/24. Her diagnoses included Alzheimer's disease (progressive brain disorder that slowly destroys memory and thinking skills), dementia (loss of memory, language, problem solving and other thinking abilities which significantly impair a person's ability to perform daily activities), major depressive disorder, recurrent (persistently low or depressed mood and a loss of interest in activities that creates significant difficulty in daily life, work, and social functioning), delusional disorder (a type of mental health condition in which a person can't tell what's real from what's imagined), anxiety disorder (mental disorder characterized by excessive and persistent worry, fear, or anxiousness which significantly interferes with daily life), and unspecified psychosis (psychotic symptoms not aligned with a specific psychotic disorder or mental illness). Record review of Resident #94's annual MDS dated [DATE] reflected a BIMS score of 3 (severe cognitive impairment). Record review of Resident #94's care plan dated 05/16/20 reflected: Resident #94 wanders in the nursing home and into other residents' rooms. DX: Dementia/Alzheimer's. Resident #94 resides in the secured unit. Resident #94 had cognitive loss; moderately impaired in decisions making; short term memory loss. DX: Alzheimer's/dementia Interventions included: Assist to reorientation to room and facility, assure that staff is aware that resident wanders, routine resident check Q 2Hrs and locate resident whereabouts. Assist in decision making by giving simple choices, assure that resident's wishes are understood by being patient, keep environment free of hazards In an interview on 03/24/26 at 3:30 pm, Resident #94 stated she did not have a boyfriend, and could not recall how old she was and was not able to answer if she felt fearful. In a phone interview on 03/24/26 at 3:41 pm, the RP of Resident #94 stated he would not have given consent for Resident #94 to be involved with any sexual activity. The RP stated Resident #94 had dementia and was incapacitated (made incapable of or unfit for normal functioning) and was not in her right mind. In an interview on 3/24/26 at 3:56 pm, the ADON stated she was at the nurse's station when CNA A started yelling out for her from the doorway of Resident #94's room. The ADON stated she went over and into Resident #94's room and saw Resident #15 with his pants up and standing next to the head of Resident #94's bed. The ADON stated CNA A informed her she saw Resident #15's penis in Resident #94's mouth. The ADON stated Resident #15 was redirected out of the room, and she immediately reported the incident to the ADM and DON. The ADON stated shortly after, Resident #15 left to the day habilitation center that he attends on Mondays, Tuesdays, and Thursdays. The ADON stated Resident #15 did not have a history of any sexual behaviors with any resident. The ADON stated Resident #94 was acting normal, not fearful or crying. The ADON stated Resident #94 had no facial grimacing, and she appeared to be comfortable. The ADON stated she did not recall if a head-to-toe assessment was done for the incident, but if there was not an assessment done, it would not have hurt to have done one. The ADON stated Resident #94's FM was seen talking to LVN B the next day, and the FM did not appear to be upset. The ADON stated Resident #94's FM said something along the lines of well she's been married 3 times, what do you expect. The ADON stated she could not recall if there was an IDT meeting with the family present after the incident. The ADON stated she could not recall what the doctor stated when notified about the incident. The ADON stated she did not witness any consent between Resident #15 and Resident #94, but when she walked into the room during the incident, it appeared consensual. The ADON stated Resident #15's BIMS was a 0 and meant he had severe cognitive impairment. The ADON stated she would have to look but was pretty sure Resident #94 had severe cognitive impairment as well. The ADON could not answer if both residents could consent. The ADON stated that to get consent it would have had to have been discussed through the IDT because the residents had rights. The ADON stated she did not feel comfortable answering if both Resident #15 and Resident #94 could consent since they both had severe cognitive impairment. The ADON (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	stated she did not witness the actual incident, but from what she was told by CNA A, both residents appeared to be consenting due to not showing any fear. In an interview on 03/25/26 at 8:31 am, CNA A stated she was collecting breakfast trays when she went to check on Resident #94 and observed Resident #15 in the room. CNA A stated she observed Resident #94 sitting up in bed and Resident #15 was positioned at the head of the bed, making thrusting movements with his pelvis. CNA A stated she asked Resident #15 what he was doing, at which time he pulled away from the bed. CNA A reported that she then observed Resident #94 with her hands raised, in a grabbing position. CNA A stated she immediately called out for the ADON, who responded to the room and removed Resident #15. CNA A stated Resident #94 indicated she was okay but was unable to explain what had occurred. CNA A reported that, to her knowledge, Resident #94's family had not provided consent for the resident to engage in any sexual activity. In an interview on 03/25/26 at 8:44 am, LVN B stated she did not witness the incident but was informed of it by the ADON. LVN B stated that upon being notified, she contacted the doctor, the PA, and called Resident #94's RP. LVN B reported that she left a message for Resident #15's RP and called Resident #94's second contact. LVN B stated that after notifying the PA, the PA reviewed Resident #15's medications and made adjustments; however, LVN B could not recall the specific changes. LVN B reported that Resident #94's RP did not return her call. LVN B stated that on the day following the incident, 03/04/26, the FM of Resident #94 came to the facility, and she informed the FM of the incident that had occurred on the previous day. LVN B stated that the FM did not appear upset regarding the situation. LVN B stated she was not aware of any consent given by Resident #94's RP to have a sexual relationship. LVN B stated she could not determine whether Resident #15 and Resident #94 were able to consent. LVN B stated that the residents had rights. LVN B stated, as far as she knew, Resident #15 did not have any prior inappropriate sexual behavior. In a phone interview on 03/25/26 at 10:49 am, the FM of Resident #94 stated she was informed about an inappropriate incident that occurred with Resident #94 but was not given details about the incident. The FM stated she assumed a male resident was just wandering in Resident #94's room and the facility was keeping them apart. The FM stated she did not give consent to Resident #94 to have any sexual activity with any resident, and stated Resident #94 did not have the cognition to consent. In a phone interview on 3/25/26 at 10:28 am, the MD stated he was notified about the incident between Resident #15 and Resident #94 on 03/03/26. The MD stated he did not believe Resident #15 or Resident #94 had the capacity to consent to sexual activity and reported that Resident #94 was bed confined. The MD stated Resident #15 may require a transfer to an all-male facility due to his behaviors. The MD further stated Resident #15 had some type of autistic disorder or [NAME]-[NAME] disorder (rare genetic condition that leads to physical, mental and behavioral problems). The MD stated Resident #15 was not able to make independent cognitive decisions. The MD stated that the incident between Resident #15 and Resident #94 should have been reported to the state. The MD further stated he had not participated in an IDT meeting with the RP or FM of Resident #15 and Resident #94 regarding the incident. In a phone interview on 3/25/26 at 10:53 am, the PA stated she was aware of the incident involving Resident #15 and Resident #94 that occurred on 03/03/26. The PA stated she could not recall if she was notified the same day or the following day. The PA stated there had been changes to Resident #15's antipsychotic medication prior to the incident, including a GDR, and reported the incident occurred following the GDR. The PA stated she was upset regarding the situation. The PA stated both Resident #15 and Resident #94 had the cognitive ability of a child between approximately four and five years old and stated neither resident had the capacity to consent to sexual activity or make adult decisions regarding such activity. The PA stated she was not involved in an IDR meeting with Resident #15 and Resident #94's RP or FM, but she knew both families were notified. The PA stated she had not personally spoken to either family. The PA stated the incident should have been reported to the state. In an interview on 03/25/26 at 11:01 am, the DON stated she became aware of the incident on 03/03/26 at approximately 8:30 - 9:00 am, following breakfast. The DON reported that the ADON informed her and the ADM, the Abuse (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Coordinator, during the morning meeting that staff had reported Resident #15 was in Resident #94's room, and they were being inappropriate with each other. The DON stated after the meeting, CNA A reported she was collecting breakfast trays when she observed Resident #15 in Resident #94's room with his penis exposed and believed it was in Resident #94's mouth. The DON stated the ADON was at the nurse's station and was the first individual CNA A reported the incident to. The DON further stated the ADON reported she did not observe Resident #15's penis upon entering the room, as his pants were up at that time. The DON stated she and the ADM entered the room and spoke with Resident #94, who was in bed and did not appear to be in any distress. The DON reported Resident #94 was unable to recall the incident. The DON stated at that time Resident #15 was getting ready to leave to a day rehabilitation center. The DON stated that she and the ADM initiated staff interviews regarding the incident. The DON reported the MD and psychiatric services were notified, and Resident #15's medication was adjusted. The DON stated the resident's RP's were also notified. The DON stated at times Resident #15 had a history of behaviors, including exposing himself in his room; however, she could not recall any prior incidents involving another female resident. The DON reported the facility had previously sought out psychiatric services for Resident #15, and that medication adjustments and psychiatric interventions appeared to have improved his behaviors. The DON stated there was uncertainty regarding whether Resident #15 and Resident #94 had the capacity to consent to sexual activity and described the situation as a gray area. The DON stated she did not believe the incident constituted sexual abuse and stated that if the facility had determined the incident to be sexual abuse, it would have been reported. The DON stated both residents had similar cognitive impairments.The DON stated sexual abuse was any unwanted sexual activity by either person and was when one person forces one person to do a sexual act that the other person does not want or consent to. The DON further stated, it appeared like both residents were engaging in the act. The DON stated she was unsure whether a head-to-toe assessment was completed following the incident but acknowledged that such an assessment, along with safe/safety assessments, should have been conducted. The DON stated she could not recall any specific interventions implemented for Resident #94 following the incident. The DON further stated she was unaware of a history of similar behaviors for Resident #94 but did state she had called out to Resident #15 to go into her room. In an interview on 03/25/26 at 11:47 am, the ADM stated she became aware of the incident on 03/03/26 that morning through the ADON. The ADM reported the ADON informed her that CNA A entered Resident #94's room and observed Resident #15 with his penis exposed and near Resident #94's mouth. The ADM stated she immediately went to assess Resident #94, who was in bed, did not appear [NAME] in distress, and denied that anything had occurred. The ADM stated Resident #15 also did not appear to be in distress. The ADM reported the ADON was in the process of notifying the MD, psychiatric services, and the family. The ADM stated Resident #15 had a history of exposing himself. The DON stated she was not aware of prior incidents involving exposure to other female residents. The ADM reported staff would redirect Resident #15 away from female residents as needed. The ADM stated she believed Resident #15 and Resident #94 may have been able to consent to sexual activity but stated she was unsure how to determine whether either resident had the cognitive capacity to consent. The ADM stated the incident was not investigated as potential sexual abuse. The ADM further stated the facility determined the incident did not constitute sexual abuse, as neither resident appeared to be in distress and neither voiced concern. The ADM stated it appeared that both residents were willing participants. Record review of the facility's undated Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Resident Property Policy reflected in part: Preface- It is the policy of this facility to encourage and support all residents, staff, families, visitors, volunteers, and resident representatives in reporting any suspected acts of abuse. Any nursing home employee or volunteer who becomes aware of abuse. shall immediately report to the Nursing Home Administrator. The Nursing Home Administrator or designee will report abuse to the state agency per State and Federal requirements. Centers for Medicaid and Medicare Services (CMS) - Definitions Definitions of Abuse (continued on next page)

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Immediately: means as soon as possible but ought not to exceed 24 hours after discovery of the incident, in the absence of a shorter State time frame requirement. Abuse Policy It is the policy of [Facility] that each resident will be free from Abuse. Additionally, residents will be protected from abuse, neglect, and harm while they are residing at the facility. No abuse of any type will be tolerated and residents and staff will be monitored for Protection. Objective of Abuse Policy The objective of the abuse policy is to comply with the seven-step approach to abuse and neglect detection and prevention. C. Prevention The facility leadership will assess the needs of the residents in the facility to be able to identify concerns to prevent potential abuse. Procedure: 1. Resident Assessment Every resident is unique and may be subject to abuse based on a variety of circumstances, including facility physical plant, environment, the resident's health, behavior or cognitive level. c. The interdisciplinary team will identify the vulnerabilities and interventions on the resident care plan. 4. Population a. The facility's population presents the following factors, (May include, but not limited to) which could result in maltreatment of residents: The assessment, planning of care and services, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents who have behaviors such as entering other residents' rooms, wandering behaviors. socially inappropriate behaviors.residents with communications disorders. b. The facility will ensure a comprehensive dementia management program to prevent resident abuse. 5. Predatory Offender Provisions When assessing a person's risk of abusing other vulnerable adults, or if a predatory offender is seeking or has been admitted to the facility: The facility must notify other residents that a predatory offender has been admitted . If it is determined that notice to a resident not be appropriate because of the resident's medical, emotional, or mental status, the resident's next of kin or emergency contact (resident representative) must be notified. D. Identification Abuse policy requirements: It is the policy of this facility that all staff monitor residents and will know how to identify potential signs and symptoms of abuse. Occurrences, patterns, and trends that may constitute abuse will be investigated. E. Investigation Abuse policy requirements: It is the policy of this facility that reports of abuse (mistreatment, neglect, or abuse.) are promptly and thoroughly investigated. Procedure: The investigation is the process used to try to determine what happened. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. The information gathered is given to administration. a. Investigation of abuse: When an incident of suspected incident of abuse is reported, the Administrator or designee will investigate the incident with the assistance of appropriate personnel. The investigation will include: i. Who was involved ii. Residents' statements a. For non-verbal residents, cognitively impaired residents or residents who refuse to be interviewed, attempt to interview resident first. If unable, observe resident, complete an evaluation of resident behavior, affect, and response to interaction, and document findings. IV. Involved staff and witness statements of events. v. A description of the resident's behavior and environment at the time of the incident. vi. Injuries present including a resident assessment. vii. Observation of resident and staff behaviors during the investigation. viii. Environmental considerations. Additional Investigation Protocols i. If the alleged perpetrator is a facility resident, the staff member will immediately remove the perpetrator from the situation and another staff member will stay with the alleged perpetrator and wait for further instruction from administration, if possible. ii. Examine, assess and interview the resident and other residents potentially affected immediately to determine any injury and identify any (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	immediate clinical interventions necessary. F. Reporting and Response Abuse Policy Requirements: It is the policy of this facility that abuse allegations are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse. are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse.to the administrator of the facility and to other officials (including to the State Survey Agency.) in accordance with State law through established procedures. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility. Initial reporting of allegations: If an incident or allegation is considered reportable, the Administrator or designee will make an initial (immediate or within 24 hours) report to the State Agency. A follow-up investigation will be submitted to the State Agency within five (5) working days. Law Enforcement: All reports of suspected crime and or alleged sexual abuse must be immediately reported to local law enforcement to be investigated. Facility staff will fully cooperate with the local law enforcement designee. The Administrator or Designee will inform the resident or resident's representative of the report of an incident and that an investigation is being conducted. Covered individuals are obligated to comply with reporting requirements. If uncertain whether to report an incident, call the State Agency for further direction. Informing the Resident and or Responsible Party: The Administrator or designee will inform the resident and or responsible party the results of the investigation. This was determined to be an Immediate Jeopardy (IJ) on 03/25/26 at 5:25 pm. The ADM and DON were notified on 03/25/26 at 5:42 pm. The ADM was provided with the IJ template on 03/26/26 at 3:26 pm. The following Plan of Removal submitted by the facility was accepted on 03/26/26 at 8:04 pm. Plan of Removal for Immediate Jeopardy Problem: F600 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation Interventions: On March 25, 2026, the facility reviewed the BIMS of all admitted Residents on the secured memory unit and determined there were 20 female residents with severe cognitive impairment and 16 males with severe cognitive impairment. -Verified on 03/27/26 through record review and interview with the ADM. Training: Conducted on 3/24/26: The facility Administrator and Director of Nursing were in-serviced on reportable incidents. -Verified on 03/27/26 through in-service record review and interview with ADM and DON. Training: Conducted on 3/25/26: The facility Administrator and Director of Nursing were in-serviced by the Corporate Nurse on implementing the company Abuse policy, with emphasis that the policy should be followed for any type of abuse. -Verified on 03/27/26 through in-service record review and staff interviews from various shifts. Training: Conducted on 3/25/26: The facility Administrator and Director of Nursing were in-serviced by the Corporate Nurse on the reporting timeframe for allegations of abuse utilizing PL 2024-14. -Verified on 03/27/26 through in-service record review and interviews with the Corporate Nurse, ADM, and DON. Training: Conducted on 3/25/26: The facility Administrator and Director of Nursing were in-serviced by the Corporate Nurse that all allegations of abuse must be investigated, and notification of the allegation details must be made to the Resident's Responsible Party. -Verified on 03/27/26 through in-service record review and interviews with the Corporate Nurse, ADM, and DON. Staff interviews from various shifts beginning on 03/27/26 at 8:00 am, revealed the ADM, DON, ADON, MDS, CNA A, LVN B, RNVC, LVN D, RN E, CNA F, LVN G, CNA H, CNA I, CNA J, LA, CMA K, CMA L, LVN M, LVN N, CNA O, HK, RN R, the AD, and RN T were able to identify the different types of abuse, neglect and who the Abuse Coordinator was. Staff stated regardless of the resident's cognition, all suspected abuse/sexual abuse would be stopped and reported to the ADM immediately. All staff were able to identify the yellow dot program and where it would be located. All CNA's were able to state in addition to the yellow dot being located on the resident's name plate outside of their room, those residents would also be listed on their shower sheets. Training: Will be completed by 3/26/26 as follows: All staff in-servicing on: what is abuse utilizing a combined definition of reportable incidents for the THHS and CMS definitions. what is sexual abuse; and reporting of all sexual abuse and/or sexual behaviors to the Administrator. (This includes all incidents regardless of a Resident's (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	diagnosis and/or cognitive status as the Administrator will then follow the new procedure outlined below). a Resident's cognitive status influences their ability to consent. all instances of staff encounters with Resident sexual behaviors, especially those Residents with dementia, will be stopped, Resident's separated, Resident safety ensured, and immediate report made to the Administrator. Residents will be kept separated and monitored while Administrator makes a determination on ability to consent of Resident(s). Administrator and/or Designee will ensure continuity of transfer of information to staff between shifts. immediate reporting to Administrator of any suspected instances of abuse. going forward, any Residents with a diagnosis of dementia and an occurrence of inappropriate sexual behaviors with another Resident and place a yellow dot on the Resident's nameplate to identify to staff 1) the Resident has the diagnosis and inappropriate sexual behavior with another Resident, and 2) to be more vigilant in monitoring the Resident's location. All newly admitted Residents will be reviewed for a diagnosis of dementia and a history of inappropriate sexual behaviors; any Residents who meet these criteria will have a yellow dot added to their nameplate. In-service sign in sheets will be cross referenced with employee roster. New Procedures: Effective 3/25/26: The Administrator and DON were verbally educated that all instances of sexual activity, sexual contact, sexual behaviors, and/or sexual abuse will be called to the Corporate Nurse for review. The review will include use of Attachment 2: How to Report Abuse, Neglect, Exploitation (ANE), Other Incidents and Sexual Activity included with PL 2024-14. The review process will involve the Resident's physician, and Resident and/or the Resident's Responsible Party. The Administrator will keep a log of all reported instances along with the outcome of the call. Special emphasis will be placed on any Resident(s) with BIMS of 12 or below. Going forward, the Facility will identify Residents with a diagnosis of dementia and an occurrence of inappropriate sexual behaviors with another Resident and place a yellow dot on the Resident's nameplate to signify to staff 1) the Resident has the diagnosis and inappropriate sexual behavior with another Resident, and 2) to be more vigilant in monitoring the Resident's location. All newly admitted Residents will be reviewed for a diagnosis of dementia and a history of inappropriate sexual behaviors; any Residents who meet these criteria will have a yellow dot added to their nameplate. The DON and/or Designee will be responsible for ensuring the yellow dot is placed on the Resident's nameplate in a timely manner. Quality Assurance Performance Improvement: On March 25, 2026, the Quality Assessment and Assurance Committee members to include the Medical Director (via telephone), Administrator, Director of Nursing, Assistant Director of Nursing, Social Worker, and Corporate Nurse met to review and approve this plan. Verified on 03/27/26 through in-service record review and interviews with ADM, DON, and ADON. The Administrator and/or Designee will provide a copy of the log of instances of reported sexual activity, sexual contact, sexual behaviors, and/or sexual abuse to the Corporate Nurse for a second review weekly for 2 months. Verified on 03/27/26 through an interview with the Corporate Nurse. The results of the Administrator and/or Designee reviews will be presented to the Quality Assessment and Assurance Committee for review of trends and/or negative findings and further recommendations during the scheduled meetings for 2 months. The committee will make recommendations for further education as warranted and develop further performance improvement plans as necessary. Verified on 03/27/26 through interview with the ADM and DON. The ADM was informed that the Immediate Jeopardy was removed on 03/27/26 at 11:11 am. The facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455455	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Care of Alice	218 219 N King St Alice, TX 78332

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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** Based on interviews and record reviews, the facility failed to implement written policies and procedures to prohibit and prevent abuse, neglect, and misappropriation for 2 of 6 residents (Resident #15 and Resident #94) reviewed for developing and implementing abuse and neglect policies and procedures. The facility failed to follow their policy to investigate suspected sexual abuse of Resident #94 by Resident #15 on 03/03/26 when Resident #15 was witnessed in Resident #94's room with his penis in and or on Resident #94's mouth. An Immediate Jeopardy (IJ) was identified on 03/25/26. The IJ template was provided to the facility Administrator on 03/25/26 at 5:42 pm. While the IJ was removed on 03/27/26 at 11:11 am, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because of the facility's need to monitor and evaluate the effectiveness of the corrective systems. This failure could place residents at risk of abuse and or continued abuse and could lead to a diminished quality of life and psychosocial harm. The findings included: Record review of Resident #94's admission record reflected an [AGE] year-old female originally admitted to the facility on [DATE] and most recent admission was 01/03/24. Her diagnoses included Alzheimer's disease (progressive brain disorder that slowly destroys memory and thinking skills), dementia (loss of memory, language, problem solving and other thinking abilities which significantly impair a person's ability to perform daily activities), major depressive disorder, recurrent (persistently low or depressed mood and a loss of interest in activities that creates significant difficulty in daily life, work, and social functioning), delusional disorder (a type of mental health condition in which a person can't tell what's real from what's imagined), anxiety disorder (mental disorder characterized by excessive and persistent worry, fear, or anxiousness which significantly interferes with daily life), and unspecified psychosis (psychotic symptoms not aligned with a specific psychotic disorder or mental illness). Record review of Resident #94's annual MDS dated [DATE] reflected a BIMS score of 3 which indicated she had severe cognitive impairment. Resident #94's functional abilities reflected she required partial to moderate assistance for sit to stand, sitting to lying, chair/bed to chair-transfer, toileting, bathing, and walking 10 - 50 feet. Resident #94 also had behavioral symptoms directed toward others (such as hitting, scratching, and kicking) and verbal behavioral symptoms directed toward others (such as threatening others, screaming at others, cursing at others) on 1 to 3 days of the observation period. Record review of Resident #94's care plan dated 05/16/20 reflected: Focus: I have a dx: Cognitive Communication [sic] created 11/29/20. Interventions included: Involve in activities that do not rely on communication, monitor for changes in condition, reassurance and patience when resident attempts communication, use hand gestures as needed, use short phrases that require yes or no answers. Focus: I wander in the nursing home and into other resident's rooms. DX: Dementia/Alzheimer's. I am in a secured unit. Initiated on 11/29/20. Interventions included: Assist to reorientation to room and facility, assure that staff is aware that resident wanders, routine resident check Q 2Hrs and locate resident whereabouts. Focus: I have cognitive loss; moderately impaired in decisions making; short term memory loss. DX: Alzheimer's/Dementia. Interventions included: Assist in decision making by giving simple choices, assure that resident's wishes are understood by being patient, keep environment free of hazards. Initiated on 11/29/20. Record review of Resident #94's progress notes reflected: A nursing Note dated 03/03/26 at 9:29 am by LVN B stated, Male resident had been going into resident's room exposing himself and this particular incident he made physical contact with her inappropriately and was needing to be redirected. RP called and no answer, left message to call facility. A nursing note effective 03/03/26 at 1:28 pm, created 3/9/2026 at 4:32 pm by the ADON stated, Charge nurse witnessed Female Resident door open calling out for the male resident previously in her room. Hey come here, come here. Female resident inviting male resident to come into her room. Redirected male resident. Record review of Resident #94's (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	pm stated, Inappropriate behavior at 12:29 pm in from of female resident. Redirected by staff. Constant monitoring, cont. with hourly checks. A nursing note dated 06/28/25 at 6:49 am which stated, resident continues with inappropriate behaviors such as exposing his genitals to female residents several times throughout the day. he requires frequent checks and continuous redirection by staff due to this. ADON is aware. Nursing note dated 07/19/25 at 1:21 pm stated, CNA reported she witnessed resident in TV room, with penis out. Male resident hands were placed on his penis. Female resident in TV room and sitting on the chair, when CNA saw she called out for resident and male resident put his penis back in pants. Female resident turned head. Female resident removed from TV room, denies pain or distress. Male resident placed on 15 min checks, notified on call and ADON. UA orders, notified psych services, pending call back. Resident observed lying in bed, eyes closed. No distress or pain noted. A nursing note dated 07/19/25 at 2:05 pm stated, new order from psych services: increase Paxil 40mg and one time order Ativan 0.5mg x1 dose. Oncoming nurse aware. Care endorsed. An interdisciplinary note dated 07/24/25 at 10:27 am stated, IDT weekly psych meeting: Paxil increased by psych PA. No side effects noted. Continue to monitor. A nursing note dated 07/26/25 at 7:15 am stated, Resident attempting to enter female's room. CNA redirected resident out of the room. Resident cooperative. Will continue to monitor. A nursing note dated 08/03/25 at 1:37 pm stated, Informed by housekeeper she observed resident in female's room [room number] with his pants down and female bent forward. Removed resident from room and instructed not to go into female's rooms anymore. Started on 15 min checks. ADON notified of resident's inappropriate sexual behavior. Will continue to monitor. A nursing noted dated 08/18/25 at 10:11 am stated, Notified [PA] of resident increased sexual behavior in female resident room. Pending response. A nursing note effective 03/02/26 at 10:01 am, created 03/03/26 at 9:11 am, and struck out (incorrect documentation) on 03/25/26 at 7:34 am by LVN B stated, Resident was caught by CNA after breakfast in a female resident's room with his pants down exposing himself to her and having her grab his penis. CNA intervened and redirected him and got him out of female's room. But after a while resident cont. to try and walk back towards that female's room and required constant redirection until he left to center. Cont. to monitor and redirect resident. A nursing note dated 03/03/26 at 9:11 am by LVN B stated, Resident was caught by CNA during breakfast in female resident's room with door closed and was exposing himself to her and had his penis in her mouth. CNA intervened and redirected him out of her room. Will continue to monitor. Notified psych services and RP has been notified of his behaviors. A nursing note dated 03/03/26 at 10:00 am by LVN B stated, Psych services re-evaluated his meds and n/o given. Increase back his abilify. Discontinue abilify 7.5mg QD to start 10mg QD. RP was notified. A nursing note dated 03/03/26 at 10:04 am by the ADON stated, ADON at nurse's station was called by CNA into female resident's room. Male resident had his pants up. Male resident was easily redirected out of female resident's room. Female resident was calm with no verbal refusal, no facial grimacing. Female resident had no signs of distress. Reported to ADM/DON/IDT. Will continue to monitor. A nursing note dated 03/03/26 at 8:20 pm stated, Resident continues with hypersexual behavior. Goes into females room, redirected PRN. Med as ordered. Will continue to monitor. A nursing note dated 03/14/26 at 4:35 pm stated, Resident continues going into female resident room. Redirected this shift and as needed. Will continue to monitor. In an interview on 03/24/26 at 3:30 pm, Resident #94 stated she did not have a boyfriend, and could not recall how old she was and was not able to answer if she felt fearful. In a phone interview on 03/24/26 at 3:41 pm, the RP of Resident #94 stated he would not have given consent for Resident #94 to be involved with any sexual activity. The RP stated Resident #94 had dementia and was incapacitated (made incapable of or unfit for normal functioning) and was not in her right mind. In an interview on 3/24/26 at 3:56 pm, the ADON stated she was at the nurse's station when CNA A started yelling out for her from the doorway of Resident #94's room. The ADON stated she went over and into Resident #94's room and saw Resident #15 with his pants up and standing next to the head of Resident #94's bed. The ADON stated CNA A informed her she saw Resident #15's penis in Resident #94's mouth. The ADON stated Resident #15 was (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	redirected out of the room, and she immediately reported the incident to the ADM and DON. The ADON stated shortly after, Resident #15 left to the day habilitation center that he attends on Mondays, Tuesdays, and Thursdays. The ADON stated Resident #15 did not have a history of any sexual behaviors with any resident. The ADON stated Resident #94 was acting normal, not fearful or crying. The ADON stated Resident #94 had no facial grimacing, and she appeared to be comfortable. The ADON stated she did not recall if a head-to-toe assessment was done for the incident, but if there was not an assessment done, it would not have hurt to have done one. The ADON stated Resident #94's FM was seen talking to LVN B the next day, and the FM did not appear to be upset. The ADON stated Resident #94's FM said something along the lines of well she's been married 3 times, what do you expect. The ADON stated she could not recall if there was an IDT meeting with the family present after the incident. The ADON stated she could not recall what the doctor stated when notified about the incident. The ADON stated she did not witness any consent between Resident #15 and Resident #94, but when she walked into the room during the incident, it appeared consensual. The ADON stated Resident #15's BIMS was a 0 and meant he had severe cognitive impairment. The ADON stated she would have to look but was pretty sure Resident #94 had severe cognitive impairment as well. The ADON could not answer if both residents could consent. The ADON stated that to get consent it would have had to have been discussed through the IDT because the residents had rights. The ADON stated she did not feel comfortable answering if both Resident #15 and Resident #94 could consent since they both had severe cognitive impairment. The ADON stated she did not witness the actual incident, but from what she was told by CNA A, both residents appeared to be consenting due to not showing any fear. In an interview on 03/25/26 at 8:31 am, CNA A stated she was collecting breakfast trays when she went to check on Resident #94 and observed Resident #15 in the room. CNA A stated she observed Resident #94 sitting up in bed and Resident #15 was positioned at the head of the bed, making thrusting movements with his pelvis. CNA A stated she asked Resident #15 what he was doing, at which time he pulled away from the bed. CNA A reported that she then observed Resident #94 with her hands raised, in a grabbing position. CNA A stated she immediately called out for the ADON, who responded to the room and removed Resident #15. CNA A stated Resident #94 indicated she was okay but was unable to explain what had occurred. CNA A reported that, to her knowledge, Resident #94's family had not provided consent for the resident to engage in any sexual activity. In an interview on 03/25/26 at 8:44 am, LVN B stated she did not witness the incident but was informed of it by the ADON. LVN B stated that upon being notified, she contacted the doctor, the PA, and called Resident #94's RP. LVN B reported that she left a message for Resident #15's RP and called Resident #94's second contact. LVN B stated that after notifying the PA, the PA reviewed Resident #15's medications and made adjustments; however, LVN B could not recall the specific changes. LVN B reported that Resident #94's RP did not return her call. LVN B stated that on the day following the incident, 03/04/26, the FM of Resident #94 came to the facility, and she informed the FM of the incident that had occurred on the previous day. LVN B stated that the FM did not appear upset regarding the situation. LVN B stated she was not aware of any consent given by Resident #94's RP to have a sexual relationship. LVN B stated she could not determine whether Resident #15 and Resident #94 were able to consent. LVN B stated that the residents had rights. LVN B stated, as far as she knew, Resident #15 did not have any prior inappropriate sexual behavior. LVN B stated she struck out the nursing note that referred to an incident on 03/02/26 because she, documented the wrong incident. Not that there were two incidents- she just documented wrong. In a phone interview on 03/25/26 at 10:49 am, the FM of Resident #94 stated she was informed about an inappropriate incident that occurred with Resident #94 but was not given details about the incident. The FM stated she assumed a male resident was just wandering in Resident #94's room and the facility was keeping them apart. The FM stated she did not give consent to Resident #94 to have any sexual activity with any resident, and stated Resident #94 did not have the cognition to consent. In a phone interview on 3/25/26 at 10:28 am, the MD stated he was notified about the incident between Resident #15 and (continued on next page)

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The ADM further stated the facility determined the incident did not constitute sexual abuse, as neither resident appeared to be in distress and neither voiced concern. The ADM stated it appeared that both residents were willing participants. Record review of the facility's undated Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Resident Property Policy reflected in part: Preface- It is the policy of this facility to encourage and support all residents, staff, families, visitors, volunteers, and resident representatives in reporting any suspected acts of abuse. Any nursing home employee or volunteer who becomes aware of abuse. shall immediately report to the Nursing Home Administrator. The Nursing Home Administrator or designee will report abuse to the state agency per State and Federal requirements. Centers for Medicaid and Medicare Services (CMS) - Definitions Definitions of Abuse and Neglect The following are the approved CMS definitions of abuse and neglect from the State Operations Manual Appendix PP effective November 28, 2016. a. Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Abuse includes verbal abuse, sexual abuse, physical abuse and mental abuse. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. ii. Sexual abuse is non-consensual sexual contact of any type with a resident. h. Immediately: means as soon as possible but ought not to exceed 24 hours after discovery of the incident, in the absence of a shorter State time frame requirement. Abuse Policy It is the policy of [Facility] that each resident will be free from Abuse. Additionally, residents will be protected from abuse, neglect, and harm while they are residing at the facility. No abuse of any type will be tolerated and residents and staff will be monitored for Protection. Objective of Abuse Policy The objective of the abuse policy is to comply with the seven-step approach to abuse and neglect detection and prevention. B. Training Components Procedure: Staff and volunteers will receive education about resident mistreatment, neglect and abuse. upon first employment and annually after that, incorporating the following elements: Training on the abuse policies and procedures, Training about challenging behaviors and how to intervene, The definition of what constitutes resident mistreatment, neglect, or abuse. Review of facility abuse policies and procedures, Annual notification of covered individuals of their obligation to comply with reporting requirements. C. Prevention The facility leadership will assess the needs of the residents in the facility to be able to identify concerns to prevent potential abuse. Procedure: 1. Resident Assessment Every resident is unique and may be subject to abuse based on a variety of circumstances, including facility physical plant, environment, the resident's health, behavior or cognitive level. b. Upon admission and periodically after that, each resident will have a safety or vulnerability assessment completed which identifies potential vulnerabilities such as cognitive, physical, psychosocial, environment and communication concerns. c. The interdisciplinary team will identify the vulnerabilities and interventions on the resident care plan. 4. Population a. The facility's population presents the following factors, (May include, but not limited to) which could result in maltreatment of residents: The assessment, planning of care and services, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents who have behaviors such as entering other residents' rooms, wandering behaviors. socially inappropriate behaviors.residents with communications disorders. b. The facility will ensure a comprehensive (continued on next page)

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	455455	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Care of Alice	218 219 N King St Alice, TX 78332

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	dementia management program to prevent resident abuse. 5. Predatory Offender Provisions When assessing a person's risk of abusing other vulnerable adults, or if a predatory offender is seeking or has been admitted to the facility: The facility must notify other residents that a predatory offender has been admitted . If it is determined that notice to a resident not be appropriate because of the resident's medical, emotional, or mental status, the resident's next of kin or emergency contact (resident representative) must be notified. D. Identification Abuse policy requirements: It is the policy of this facility that all staff monitor residents and will know how to identify potential signs and symptoms of abuse. Occurrences, patterns, and trends that may constitute abuse will be investigated. Procedure: All staff will receive education about how to identify signs and symptoms of abuse. Residents will be monitored for possible signs of abuse. E. Investigation Abuse policy requirements: It is the policy of this facility that reports of abuse (mistreatment, neglect, or abuse.) are promptly and thoroughly investigated. Procedure: The investigation is the process used to try to determine what happened. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. The information gathered is given to administration. a. Investigation of abuse: When an incident of suspected incident of abuse is reported, the Administrator or designee will investigate the incident with the assistance of appropriate personnel. The investigation will include: i. Who was involved ii. Residents' statements a. For non-verbal residents, cognitively impaired residents or residents who refuse to be interviewed, attempt to interview resident first. If unable, observe resident, complete an evaluation of resident behavior, affect, and response to interaction, and document findings. IV. Involved staff and witness statements of events. v. A description of the resident's behavior and environment at the time of the incident. vi. Injuries present including a resident assessment. vii. Observation of resident and staff behaviors during the investigation. viii. Environmental considerations. Additional Investigation Protocols i. If the alleged perpetrator is a facility resident, the staff member will immediately remove the perpetrator from the situation and another staff member will stay with the alleged perpetrator and wait for further instruction from administration, if possible. ii. Examine, assess and interview the resident and other residents potentially affected immediately to determine any injury and identify any immediate clinical interventions necessary. iii. Social Services or designee should keep in frequent contact with the resident and or resident representative. iv. If the resident could be at risk in the same environment, evaluate the situation and consider options including a room change or roommate change. v. Notification of law enforcement and or State Agency. as indicated. F. Reporting and Response Abuse Policy Requirements: It is the policy of this facility that abuse allegations are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse. are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse.to the administrator of the facility and to other officials (including to the State Survey Agency.) in accordance with State law through established procedures. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility. Definitions (in accordance to the Elder Justice Act): Covered individual: A covered individual is defined as anyone who is an owner, operat

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on interviews and record reviews 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 to local law enforcement and HHSC Complaint and Incident Intake immediately, but no later than 2 hours after the allegation was made, if the event that caused the allegation involved abuse for 2 of 6 residents (Resident #15 and Resident #94) reviewed for abuse. The facility failed to report an incident of sexual abuse that occurred on 03/03/26 to local law enforcement and to HHSC when Resident #15 was found in Resident #94's room with his penis in and or around Resident #94's mouth. An Immediate Jeopardy (IJ) was identified on 03/25/26. The IJ template was provided to the facility Administrator on 03/25/26 at 5:42 pm. While the IJ was removed on 03/27/26 at 11:11 am, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because of the facility's need to monitor and evaluate the effectiveness of the corrective systems. This failure could place residents at risk of abuse and or continued abuse and could lead to a diminished quality of life and psychosocial harm. The findings included: Record review of Resident #94's admission record reflected an [AGE] year-old female originally admitted to the facility on [DATE] and most recent admission was 01/03/24. Her diagnoses included Alzheimer's disease (progressive brain disorder that slowly destroys memory and thinking skills), dementia (loss of memory, language, problem solving and other thinking abilities which significantly impair a person's ability to perform daily activities), major depressive disorder, recurrent (persistently low or depressed mood and a loss of interest in activities that creates significant difficulty in daily life, work, and social functioning), delusional disorder (a type of mental health condition in which a person can't tell what's real from what's imagined), anxiety disorder (mental disorder characterized by excessive and persistent worry, fear, or anxiousness which significantly interferes with daily life), and unspecified psychosis (psychotic symptoms not aligned with a specific psychotic disorder or mental illness). Record review of Resident #94's annual MDS dated [DATE] reflected a BIMS score of 3 which indicated she had severe cognitive impairment. Resident #94's functional abilities reflected she required partial to moderate assistance for sit to stand, sitting to lying, chair/bed to chair-transfer, toileting, bathing, and walking 10 - 50 feet. Resident #94 also had behavioral symptoms directed toward others (such as hitting, scratching, and kicking) and verbal behavioral symptoms directed toward others (such as threatening others, screaming at others, cursing at others) on 1 to 3 days of the observation period. Record review of Resident #94's care plan dated 05/16/20 reflected: Focus: I have a dx: Cognitive Communication [sic] created 11/29/20. Interventions included: Involve in activities that do not rely on communication, monitor for changes in condition, reassurance and patience when resident attempts communication, use hand gestures as needed, use short phrases that require yes or no answers. Focus: I wander in the nursing home and into other residents rooms. DX: Dementia/Alzheimer's. I am in a secured unit. Initiated on 11/29/20. Interventions included: Assist to reorientation to room and facility, assure that staff is aware that resident wanders, routine resident check Q 2Hrs and locate resident whereabouts. Focus: I have cognitive loss; moderately impaired in decisions making; short term memory loss. DX: Alzheimer's/Dementia. Interventions included: Assist in decision making by giving simple choices, assure that resident's wishes are understood by being patient, keep environment free of hazards. Initiated on 11/29/20. Record review of Resident #94's progress notes reflected: A nursing Note dated 03/03/26 at 9:29 am by LVN B stated, Male resident had been going into resident's room exposing himself and this particular incident he made physical contact with her inappropriately and was needing to be redirected. RP called and no answer, left message to call facility. A nursing note effective 03/03/26 at 1:28 pm, created 3/9/2026 (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	at 4:32 pm by the ADON stated, Charge nurse witnessed Female Resident door open calling out for the male resident previously in her room. Hey come here, come here. Female resident inviting male resident to come into her room. Redirected male resident. Record review of Resident #15's admission record reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included moderate intellectual disabilities (developmental delays resulting in an average mental age of 6 to 9 years old), other frontotemporal neurocognitive disorder (also called frontotemporal dementia or FTD- a group of progressive brain diseases that cause neurons to die in the frontal and temporal lobes, causing early-onset dementia with symptoms such as loss of empathy, social inappropriateness, and language difficulties), cognitive communication deficit (difficulty with communication), and dementia with psychotic disturbance (loss of memory, language, problem solving and other thinking abilities which significantly impair a person's ability to perform daily activities with hallucinations or delusions). Record review of Resident #15's quarterly MDS dated [DATE] reflected a BIMS of 00 (severe cognitive impairment). Resident #15's functional abilities reflected independent for, sit to stand, sit to lying, chair/bed to chair-transfer and walking 10 - 50 feet. Resident #15 required setup or clean-up assistance with toileting and supervision or touching assistance for bathing. Record review of Resident #15's care plan dated 10/22/16 and reviewed on 03/25/26 reflected: Focus: I at times exhibit inappropriate behavior of: I refuse to shower or change my clothes. I don't like brushing my teeth. I need great encouragement and assistance in doing my personal hygiene. I will steal money. I will steal sodas. Interventions included: Approach in a calm and reassuring manner, encourage involvement of families and friends, encourage socializations as tolerated, explain care procedures in simple terms, please reinforce positive behavior, report significant changes in behavior status to MD. Focus: I demonstrate socially unacceptable behavior by next review in 90 days. [sic] I will steal drinks from staff and other residents. I will steal food and candy from staff and other residents. I will make farting noises and blame other people. I will call people pigs in spanish. I will use inappropriate gestures towards staff and other residents at times. Interventions included: If behavior does continue, notify MD, family, and SW, provide privacy if needed, psychiatric evaluation if needed, remind resident that behavior is not acceptable, set limits on behavior. Focus: I have a dx: cognitive communication. Interventions included: Always face resident when speaking, monitor for changes in condition, reassurance and patience when resident attempts to communication [sic], use hand gestures as necessary, use short phrases and questions that require yes or no answers. Focus: I wander in the nursing home and into other residents rooms. DX: Dementia. I am in a secured unit. Interventions included: Assist to reorientation to room and facility, assure that staff is aware that resident wanders, encourage group activities and keep resident occupied, help resident identify there [sic] room by placing familiar items in there, provide reality orientation throughout the day, provide verbal cues and reminding often, routine resident check Q2hrs and locate resident whereabouts. Record review of Resident #15's progress notes reflected: A nursing note dated 05/21/25stated, Resident noted standing in from of another resident in room with his pants down and genitalia exposed. Nurse then redirected resident out of room and back to his room. Hall nurse attended to other resident in room. ADON notified. A nursing noted dated 05/22/25 stated, Resident cont. to enter [female resident name] room while trying to expose penis. Writer attempting to redirect resident not successful. Resident not able to remove from rm. Writer utilized w/c and escorted resident back to own rm. Notified charge nurse. A nursing note dated 06/08/25 stated, Inappropriate behavior in front of female resident. Pulled his pants down in front of female. Redirected by CNA. Resident was noted wandering around resident. Frequent monitoring of resident by staff. An interdisciplinary note dated 06/12/25 at 10:09 am stated, IDT weekly psych meeting: Resident started on Paroxetine HCl tablet 20mg. Give 1 tablet by mouth one time a day related to major depressive disorder. S/E and behavior monitoring in place as well as consent. A nursing note dated 06/13/25 at 11:08 am stated, Resident noted in female room {room number] with his hand in his pants and female resident asleep. ADON notified. Interventions: 1) 30 min checks, 2) collect UA/C&S- stat order, 3) suspenders for pants. A nursing (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	note dated 06/25/25 at 2:02 pm stated, Inappropriate behavior at 12:29 pm in from of female resident. Redirected by staff. Constant monitoring, cont. with hourly checks. A nursing note dated 06/28/25 at 6:49 am stated, resident continues with inappropriate behaviors such as exposing his genitals to female residents several times throughout the day. he requires frequent checks and continuous redirection by staff due to this. ADON is aware. A nursing note dated 07/19/25 at 1:21 pm stated, CNA reported she witnessed resident in TV room, with penis out. Male resident hands were placed on his penis. Female resident in TV room and sitting on the chair, when CNA saw she called out for resident and male resident put his penis back in pants. Female resident turned head. Female resident removed from TV room, denies pain or distress. Male resident placed on 15 min checks, notified on call and ADON. UA orders, notified psych services, pending call back. Resident observed lying in bed, eyes closed. No distress or pain noted. A nursing note dated 07/19/25 at 2:05 pm stated, new order from psych services: increase Paxil 40mmg and one time order Ativan 0.5mg x1 dose. Oncoming nurse aware. Care endorsed. An interdisciplinary note dated 07/24/25 at 10:27 am stated, IDT weekly psych meeting: Paxil increased by psych PA. No side effects noted. Continue to monitor. A nursing note dated 07/26/25 at 7:15 am stated, Resident attempting to enter female's room. CNA redirected resident out of the room. Resident cooperative. Will continue to monitor. A nursing note dated 08/03/25 at 1:37 pm stated, Informed by housekeeper she observed resident in female's room [room number] with his pants down and female bent forward. Removed resident from room and instructed not to go into female's rooms anymore. Started on 15 min checks. ADON notified of resident's inappropriate sexual behavior. Will continue to monitor. A nursing noted dated 08/18/25 at 10:11 am stated, Notified [PA] of resident increased sexual behavior in female resident room. Pending response. A nursing note effective 03/02/26 at 10:01 am, created 03/03/26 at 9:11 am, and struck out (incorrect documentation) on 03/25/26 at 7:34 am by LVN B stated, Resident was caught by CNA after breakfast in a female resident's room with his pants down exposing himself to her and having her grab his penis. CNA intervened and redirected him and got him out of female's room. But after a while resident cont. to try and walk back towards that female's room and required constant redirection until he left to center. Cont. to monitor and redirect resident. A nursing note dated 03/03/26 at 9:11 am by LVN B stated, Resident was caught by CNA during breakfast in female resident's room with door closed and was exposing himself to her and had his penis in her mouth. CNA intervened and redirected him out of her room. Will continue to monitor. Notified psych services and RP has been notified of his behaviors. A nursing note dated 03/03/26 at 10:00 am by LVN B stated, Psych services re-evaluated his meds and n/o given. Increase back his abilify. Discontinue abilify 7.5mg QD to start 10mg QD. RP was notified. A nursing note dated 03/03/26 at 10:04 am by the ADON stated, ADON at nurse's station was called by CNA into female resident's room. Male resident had his pants up. Male resident was easily redirected out of female resident's room. Female resident was calm with no verbal refusal, no facial grimacing. Female resident had no signs of distress. Reported to ADM/DON/IDT. Will continue to monitor. A nursing note dated 03/03/26 at 8:20 pm stated, Resident continues with hypersexual behavior. Goes into females room, redirected PRN. Med as ordered. Will continue to monitor. A nursing note dated 03/14/26 at 4:35 pm stated, Resident continues going into female resident room. Redirected this shift and as needed. Will continue to monitor. In an interview on 03/24/26 at 3:30 pm, Resident #94 stated she did not have a boyfriend, and could not recall how old she was and was not able to answer if she felt fearful. In a phone interview on 03/24/26 at 3:41 pm, the RP of Resident #94 stated he would not have given consent for Resident #94 to be involved with any sexual activity. The RP stated Resident #94 had dementia and was incapacitated (made incapable of or unfit for normal functioning) and was not in her right mind. In an interview on 3/24/26 at 3:56 pm, the ADON stated she was at the nurse's station when CNA A started yelling out for her from the doorway of Resident #94's room. The ADON stated she went over and into Resident #94's room and saw Resident #15 with his pants up and standing next to the head of Resident #94's bed. The ADON stated CNA A informed her she saw Resident #15's penis in Resident #94's mouth. The ADON stated (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #15 was redirected out of the room, and she immediately reported the incident to the ADM and DON. The ADON stated shortly after, Resident #15 left to the day habilitation center that he attends on Mondays, Tuesdays, and Thursdays. The ADON stated Resident #15 did not have a history of any sexual behaviors with any resident. The ADON stated Resident #94 was acting normal, not fearful or crying. The ADON stated Resident #94 had no facial grimacing, and she appeared to be comfortable. The ADON stated she did not recall if a head-to-toe assessment was done for the incident, but if there was not an assessment done, it would not have hurt to have done one. The ADON stated Resident #94's FM was seen talking to LVN B the next day, and the FM did not appear to be upset. The ADON stated Resident #94's FM said something along the lines of well she's been married 3 times, what do you expect. The ADON stated she could not recall if there was an IDT meeting with the family present after the incident. The ADON stated she could not recall what the doctor stated when notified about the incident. The ADON stated she did not witness any consent between Resident #15 and Resident #94, but when she walked into the room during the incident, it appeared consensual. The ADON stated Resident #15's BIMS was a 0 and meant he had severe cognitive impairment. The ADON stated she would have to look but was pretty sure Resident #94 had severe cognitive impairment as well. The ADON could not answer if both residents could consent. The ADON stated that to get consent it would have had to have been discussed through the IDT because the residents had rights. The ADON stated she did not feel comfortable answering if both Resident #15 and Resident #94 could consent since they both had severe cognitive impairment. The ADON stated she did not witness the actual incident, but from what she was told by CNA A, both residents appeared to be consenting due to not showing any fear. In an interview on 03/25/26 at 8:31 am, CNA A stated she was collecting breakfast trays when she went to check on Resident #94 and observed Resident #15 in the room. CNA A stated she observed Resident #94 sitting up in bed and Resident #15 was positioned at the head of the bed, making thrusting movements with his pelvis. CNA A stated she asked Resident #15 what he was doing, at which time he pulled away from the bed. CNA A reported that she then observed Resident #94 with her hands raised, in a grabbing position. CNA A stated she immediately called out for the ADON, who responded to the room and removed Resident #15. CNA A stated Resident #94 indicated she was okay but was unable to explain what had occurred. CNA A reported that, to her knowledge, Resident #94's family had not provided consent for the resident to engage in any sexual activity. In an interview on 03/25/26 at 8:44 am, LVN B stated she did not witness the incident but was informed of it by the ADON. LVN B stated that upon being notified, she contacted the doctor, the PA, and called Resident #94's RP. LVN B reported that she left a message for Resident #15's RP and called Resident #94's second contact. LVN B stated that after notifying the PA, the PA reviewed Resident #15's medications and made adjustments; however, LVN B could not recall the specific changes. LVN B reported that Resident #94's RP did not return her call. LVN B stated that on the day following the incident, 03/04/26, the FM of Resident #94 came to the facility, and she informed the FM of the incident that had occurred on the previous day. LVN B stated that the FM did not appear upset regarding the situation. LVN B stated she was not aware of any consent given by Resident #94's RP to have a sexual relationship. LVN B stated she could not determine whether Resident #15 and Resident #94 were able to consent. LVN B stated that the residents had rights. LVN B stated, as far as she knew, Resident #15 did not have any prior inappropriate sexual behavior. LVN B stated she struck out the nursing note that referred to an incident on 03/02/26 because she, documented the wrong incident. Not that there were two incidents- she just documented wrong. In a phone interview on 03/25/26 at 10:49 am, the FM of Resident #94 stated she was informed about an inappropriate incident that occurred with Resident #94 but was not given details about the incident. The FM stated she assumed a male resident was just wandering in Resident #94's room and the facility was keeping them apart. The FM stated she did not give consent to Resident #94 to have any sexual activity with any resident, and stated Resident #94 did not have the cognition to consent. In a phone interview on 3/25/26 at 10:28 am, the MD stated he was notified about the incident between (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	mouth. The ADM stated she immediately went to assess Resident #94, who was in bed, did not appear to be in distress, and denied that anything had occurred. The ADM stated Resident #15 also did not appear to be in distress. The ADM reported the ADON was in the process of notifying the MD, psychiatric services, and the family. The ADM stated Resident #15 had a history of exposing himself. The ADM stated she was not aware of prior incidents involving exposure to other female residents. The ADM reported staff would redirect Resident #15 away from female residents as needed. The ADM stated she believed Resident #15 and Resident #94 may have been able to consent to sexual activity but stated she was unsure how to determine whether either resident had the cognitive capacity to consent. The ADM stated the incident was not investigated as potential sexual abuse. The ADM further stated the facility determined the incident did not constitute sexual abuse, as neither resident appeared to be in distress and neither voiced concern. The ADM stated it appeared that both residents were willing participants. Record review of the facility's undated Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Resident Property Policy reflected in part: Preface- It is the policy of this facility to encourage and support all residents, staff, families, visitors, volunteers, and resident representatives in reporting any suspected acts of abuse. Any nursing home employee or volunteer who becomes aware of abuse. shall immediately report to the Nursing Home Administrator. The Nursing Home Administrator or designee will report abuse to the state agency per State and Federal requirements. Centers for Medicaid and Medicare Services (CMS) - Definitions Definitions of Abuse and Neglect The following are the approved CMS definitions of abuse and neglect from the State Operations Manual Appendix PP effective November 28, 2016. a. Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Abuse includes verbal abuse, sexual abuse, physical abuse and mental abuse. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. ii. Sexual abuse is non-consensual sexual contact of any type with a resident. h. Immediately: means as soon as possible but ought not to exceed 24 hours after discovery of the incident, in the absence of a shorter State time frame requirement. Abuse Policy It is the policy of [Facility] that each resident will be free from Abuse. Additionally, residents will be protected from abuse, neglect, and harm while they are residing at the facility. No abuse of any type will be tolerated and residents and staff will be monitored for Protection. Objective of Abuse Policy The objective of the abuse policy is to comply with the seven-step approach to abuse and neglect detection and prevention. B. Training Components Procedure: Staff and volunteers will receive education about resident mistreatment, neglect and abuse. upon first employment and annually after that, incorporating the following elements: Training on the abuse policies and procedures, The definition of what constitutes resident mistreatment, neglect, or abuse. Review of facility abuse policies and procedures, Annual notification of covered individuals of their obligation to comply with reporting requirements. Additional Investigation Protocols v. Notification of law enforcement and or State Agency. as indicated. F. Reporting and Response Abuse Policy Requirements: It is the policy of this facility that abuse allegations are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse. are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse.to the administrator of the facility and to other officials (including to the State Survey Agency.) in accordance with State law through established procedures. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility. Definitions (in accordance to the Elder Justice Act): Covered individual: A covered individual is defined as anyone who is an owner, operator, employee, manager, agent or contractor of the facility. Procedure: Internal Reporting: a. Employees must always report any abuse or suspicion of abuse immediately to the Administrator. b. The Administrator will involve key leadership personnel as necessary to assist with reporting, investigation and follow-up. c. The (continued on next page)

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	455455	A. Building B. Wing	03/27/2026

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administrator will report to the Medical Director. External Reporting: Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located, any reasonable suspicion of a crime against any individual who is a resident of or is receiving care from the facility and each covered individual shall report immediately, but not more than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. Initial reporting of allegations: If an incident or allegation is considered reportable, the Administrator or designee will make an initial (immediate or within 24 hours) report to the State Agency. A follow-up investigation will be submitted to the State Agency within five (5) working days. Law Enforcement: All reports of suspected crime and or alleged sexual abuse must be immediately reported to local law enforcement to be investigated. Facility staff will fully cooperate with the local law enforcement designee. The Administrator or designee will inform the resident or resident's representative of the report of an incident and that an investigation is being conducted. Covered individuals are obligated to comply with reporting requirements. If uncertain whether to report an incident, call the State Agency for further direction. Informing the Resident and or Responsible Party: The Administrator or designee will inform the resident and or responsible party the results of the investigation. This was determined to be an Immediate Jeopardy (IJ) on 03/25/26 at 5:25 pm. The ADM and DON were notified on 03/25/26 at 5:42 pm. The ADM was provided with the IJ template on 03/25/26 at 5:42 pm. The following Plan of Removal submitted by the facility was accepted on 03/26/26 at 8:04 pm. Plan of Removal for Immediate Jeopardy Problem: F609 Incidents of Abuse, Neglect, and Exploitation Reportable to the Texas Health and Human Services Commission and Law Enforcement Agencies by FacilitiesIn response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to HHSC Complaint and Incident Intake, but no later than two hours after the allegation is made, if the events that cause the allegation involve abuse, or result in serious bodily injury. Interventions: On March 25, 2026, the facility reviewed the BIMS of all admitted Residents on the secured memory unit and determined there were 20 female residents with severe cognitive impairment and 16 males with severe cognitive impairment. -Verified on 03/27/26 through record review and interview with the ADM. Training: Conducted on 3/24/26: The facility Administrator and Director of Nursing were in-serviced on PL 2024-14 (Reportable Incidents). -Verified on 03/27/26 through in-service record review and interview with ADM and DON. Training: Conducted on 3/25/26: The facility Administrator and Director of Nursing were in-serviced by the Corporate Nurse on implementing the company Abuse policy, with emphasis that the policy should be followed for any type of abuse. -Verified on 03/27/26 through in-service record review and staff interviews from various shifts. Training: Conducted on 3/25/26: The facility Administrator and Director of Nursing were in-serviced by the Corporate Nurse on the reporting time frame for allegations of abuse utilizing PL 2024-14 (Reportable Incidents). -Verified on 03/27/26 through in-service record review and interviews with the Corporate Nurse, ADM, and DON. Training: Conducted on 3/25/26: The facility Administrator and Director of Nursing were in-serviced by the Corporate Nurse that all allega

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 1 resident (Resident #15) of 6 residents whose care plans were reviewed. The facility failed to ensure Resident #15's care plan addressed his history of inappropriate sexual behaviors as well as including interventions to manage those behaviors. An Immediate Jeopardy (IJ) was identified on 03/26/26. The IJ template was provided to the facility Administrator on 03/26/26 at 3:26 pm. While the IJ was removed on 03/27/26 at 11:11 am, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because of the facility's need to monitor and evaluate the effectiveness of the corrective systems. This deficient practice could place residents in the facility at risk of not being provided with the necessary care or services, and the implementation of personalized plan of care developed to address their specific needs. Findings include: Record review of Resident #15's admission record reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included moderate intellectual disabilities (developmental delays resulting in an average mental age of 6 to 9 years old), other frontotemporal neurocognitive disorder (also called frontotemporal dementia- a group of progressive brain diseases that cause neurons to die in the frontal and temporal lobes, causing early-onset dementia with symptoms such as loss of empathy, social inappropriateness, and language difficulties), cognitive communication deficit (difficulty with communication), and dementia with psychotic disturbance (loss of memory, language, problem solving and other thinking abilities which significantly impair a person's ability to perform daily activities with hallucinations or delusions). Record review of Resident #15's quarterly MDS dated [DATE] reflected a BIMS of 00 (severe cognitive impairment). Resident #15's functional abilities reflected independent for, sit to stand, sit to lying, chair/bed to chair-transfer and walking 10 - 50 feet. Resident #15 required setup or clean-up assistance with toileting and supervision or touching assistance for bathing. Resident #15 did have a behavior noted of wandering. Record review of Resident #15's care plan revised on 09/25/25 reflected did not reflect a history of inappropriate sexual behaviors. Record review of Resident #15 progress notes indicated: Resident #15's progress notes indicated he had previous inappropriate sexual behaviors on: 8/3/25- Resident #15 in female's room with his pants down with the female in the room. 7/19/25- Resident #15 was seen in T.V. room with his penis out and a female resident in the room. 6/28/25- Resident #15 exposed genitals to female residents several times 6/13/25- Resident #15 in another female resident's room with his hands in his pants while she slept. 6/8/25- Resident #15 pulled his pants down in front of a female resident. 5/22/25- Resident #15 continuously tried to enter a female resident's room with his penis exposed. 5/21/25- Resident #15 was seen standing in front of another resident's room with his pants down and his penis exposed. In an interview on 03/24/26 at 3:56 pm, the ADON stated Resident #15 did not have a prior history of inappropriate sexual behaviors with other residents. The ADON stated the MDS was responsible for care plans, and it was important to care plan resident behaviors, as care plans are individualized to address each resident's needs, including medications, behaviors, and activities of daily living. The ADON stated that if Resident #15's inappropriate sexual behaviors were not care planned, there could be an increased risk of harm to other residents related to sexual, physical, or behavioral interactions. In an interview on 03/25/26 at 10:53 am, the PA stated she was aware of Resident #15's sexual inappropriate behaviors and reported he had a history of such behaviors, which escalated following a GDR of Aripiprazole (an antipsychotic medication) from 10mg to 7.5mg on 01/22/26. In an interview on 03/26/26 at 11:05 am, the MDS stated he was responsible for care plans for all residents. The MDS stated he was not aware of any sexual behaviors for Resident #15 prior to the incident. The MDS stated if such behaviors were not care planned, staff would have clear (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	guidance on what to monitor or how to respond. The MDS reported the nursing staff discussed the incident that occurred on 03/03/26 the following day and acknowledged the behavior should have been incorporated into the care plan but was not completed. The MDS stated he knew he should have documented the incident in the care plan, but it slipped through the cracks. The MDS stated he did not have to be directly told to put updates or changes in the care plan as he was the only one to update care plans.In an interview on 03/26/26 at 12:06 pm, the DON stated Resident #15 had a history of inappropriate sexual behaviors, including exposing himself and engaging in self-stimulatory behaviors in his room. The DON stated that if such behaviors were not care planned, they could continue without appropriate monitoring and staff may not know how to appropriately supervise or intervene. The DON further stated that failure to care plan Resident #15's inappropriate sexual behaviors could lead to incidents involving other residents and result in improper care. Record review of the facilities Care Plans, Comprehensive Person-centered policy dated March 2022 reflected: Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship and between the resident's problem areas and their causes, and relevant clinical decision making. 10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition: b. when the desired outcome is not met This was determined to be an Immediate Jeopardy (IJ) on 03/25/26 at 5:25 pm. The ADM and DON were notified on 03/25/26 at 5:42 pm. The ADM was provided with the IJ template on 03/26/26 at 3:26 pm. The following Plan of Removal submitted by the facility was accepted on 03/26/26 at 8:04 pm. Plan of Removal for Immediate Jeopardy Problem: F656 The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights.A resident has a known history of inappropriate sexual behaviors and aggression, but the comprehensive care plan did not address the resident's inappropriate sexual behaviors or aggression which placed the resident and other residents in the facility at risk for serious physical and/or psychosocial injury, harm, impairment, or death.Interventions: On March 25, 2026, the facility reviewed the BIMS of all admitted Residents on the secured memory unit and determined there were 20 female residents with severe cognitive impairment and 16 males with severe cognitive impairment. -Verified on 03/27/26 through record review and interview with the ADM. Training: Conducted on 3/24/26: The facility Administrator and Director of Nursing were in-serviced on reportable incidents. -Verified on 03/27/26 through in-service record review and interview with ADM and DON. Training: Conducted on 3/25/26: The facility Administrator and Director of Nursing were in-serviced by the Corporate Nurse on implementing the company Abuse policy, with emphasis that the policy should be followed for any type of abuse. -Verified on 03/27/26 through in-service record review and staff interviews from various shifts. Training: Conducted on 3/25/26: The facility Administrator and Director of Nursing were in-serviced by the Corporate Nurse on the reporting timeframe for allegations of abuse utilizing PL 2024-14. -Verified on 03/27/26 through in-service record review and interviews with the Corporate Nurse, ADM, and DON. Training: Conducted on 3/25/26: The facility Administrator and Director of Nursing were in-serviced by the Corporate Nurse that all allegations of abuse must be investigated, and notification of the allegation details must be made to the Resident's Responsible Party. -Verified on 03/27/26 through in-service record review and interviews with the Corporate Nurse, ADM, and DON. Staff interviews from various shifts beginning on 03/27/26 at 8:00 am, revealed the ADM, DON, ADON, MDS, CNA A, LVN B, RNVC, LVN D, RN E, CNA F, LVN G, CNA H, CNA I, CNA J, LA, CMA K, CMA L, LVN M, LVN N, CNA O, HK, RN R, the AD, and RN T were able to identify the different types of abuse, (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	neglect and who the Abuse Coordinator was. Staff stated regardless of the resident's cognition, all suspected abuse/sexual abuse would be stopped and reported to the ADM immediately. All staff were able to identify the yellow dot program and where it would be located. All CNA's were able to state in addition to the yellow dot being located on the resident's name plate outside of their room, those residents would also be listed on their shower sheets. Training: Will be completed by 3/26/26 as follows: All staff in-servicing on: what is abuse utilizing a combined definition on reportable incidents for the THHS and CMS definitions. what is sexual abuse; and reporting of all sexual abuse and/or sexual behaviors to the Administrator. (This includes all incidents regardless of a Resident's diagnosis and/or cognitive status as the Administrator will then follow the new procedure outlined below)a Resident's cognitive status influences their ability to consent.all instances of staff encounters with Resident sexual behaviors, especially those Residents with dementia, will be stopped, Resident's separated, Resident safety ensured, and immediate report made to the Administrator. Residents will be kept separated and monitored while Administrator makes a determination on ability to consent of Resident(s).Administrator and/or Designee will ensure continuity of transfer of information to staff between shifts. going forward, any Residents with a diagnosis of dementia and an occurrence of inappropriate sexual behaviors with another Resident and place a yellow dot on the Resident's nameplate to identify to staff 1) the Resident has the diagnosis and inappropriate sexual behavior with another Resident, and 2) to be more vigilant in monitoring the Resident's location. All newly admitted Residents will be reviewed for a diagnosis of dementia and a history of inappropriate sexual behaviors; any Residents who meet these criteria will have a yellow dot added to their nameplate. In-service sign in sheets will be cross referenced with employee roster. New Procedures: Effective 3/25/26: The Administrator and DON were verbally educated that all instances of sexual activity, sexual contact, sexual behaviors, and/or sexual abuse will be called to the Corporate Nurse for review. The review will include use of Attachment 2: How to Report Abuse, Neglect, Exploitation (ANE), Other Incidents and Sexual Activity included with PL 2024-14. The review process will involve the Resident's physician, and Resident and/or the Resident's Responsible Party. The Administrator will keep a log of all reported instances along with the outcome of the call. Special emphasis will be placed on any Resident(s) with BIMS of 12 or below. Going forward, the Facility will identify Residents with a diagnosis of dementia and an occurrence of inappropriate sexual behaviors with another Resident and place a yellow dot on the Resident's nameplate to signify to staff 1) the Resident has the diagnosis and inappropriate sexual behavior with another Resident, and 2) to be more vigilant in monitoring the Resident's location. All newly admitted Residents will be reviewed for a diagnosis of dementia and a history of inappropriate sexual behaviors; any Residents who meet these criteria will have a yellow dot added to their nameplate. The DON and/or Designee will be responsible for ensuring the yellow dot is placed on the Resident's nameplate in a timely manner. Quality Assurance Performance Improvement: On March 25, 2026, the Quality Assessment and Assurance Committee members to include the Medical Director (via telephone), Administrator, Director of Nursing, Assistant Director of Nursing, Social Worker, and Corporate Nurse met to review and approve this plan. -Verified on 03/27/26 through in-service record review and interviews with ADM, DON, and ADON. The Administrator and/or Designee will provide a copy of the log of instances of reported sexual activity, sexual contact, sexual behaviors, and/or sexual abuse to the Corporate Nurse for a second review weekly for 2 months. -Verified on 03/27/26 through an interview with the Corporate Nurse. The results of the Administrator and/or Designee reviews will be presented to the Quality Assessment and Assurance Committee for review of trends and/or negative findings and further recommendations during the scheduled meetings for 2 months. The committee will make recommendations for further education as warranted and develop further performance improvement plans as necessary. -Verified on 03/27/26 through interview with the ADM and DON. The ADM was informed that the Immediate Jeopardy was removed on 03/27/26 at 11:11 am. The facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate administering of all drugs and biologicals) to meet the needs of each resident for one of two residents observed during medication pass. (Resident #4) The facility failed to ensure RN T did not leave a cup containing Resident #4's medications on top of the medication cart, when she went in Resident #4's room to put a gown on. This failure could place residents at risk for medication errors and receiving medications that are not prescribed for them. Findings Included: Observation of resident #4's room on 3/25/26 at 7:56 am, revealed a medication cup left in top of medication cart by RN T while she was donning (putting on protective personal equipment) gown inside room. The cup contained Levothyroxine (ordered for treatment of hypothyroidism). Record review of Resident #4's face sheet dated 3/25/26, revealed an [AGE] year-old female admitted to the facility of 6/25/21. Diagnosis included hypothyroidism (a common condition where the thyroid gland fails to produce enough thyroid hormones, slowing down the body's metabolism). Record review of Resident #4's MDS assessment, dated 12/30/25, revealed a BIMS score of 2 (severe cognitive impairment). During an interview on 3/25/26 at 8:10 a.m., RN T said she did not normally leave medications on top of the medication cart, but she forgot to take the medication into the room with her. RN T said that the negative outcome could be that any resident could grab the medication and take it. During an interview on 3/26/26 at 4:30 p.m., the DON stated medications that were scheduled to be administered should not be left unattended. The DON said the negative outcome would bet any resident or visitor could take the medication and could have an adverse reaction. Record review of facility's policy titled Administering Medications with a revised date April, 2019, revealed: No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate administering of all drugs and biologicals) to meet the needs of each resident for one of two residents observed during medication pass. (Resident #4) RN T left a cup containing Resident #4's medications on top of medication cart while she went inside the room to don gown. This failure could affect the 2 residents who received medications from RN T by placing them at risk for medication errors and receiving less than therapeutic benefits from medications. Findings Included: Observation of resident #4's room on 3/25/26 at 7:56am revealed a medication cup left in top of medication cart by RN T while she was donning gown inside room. The cup contained Levothyroxine (ordered for treatment of hypothyroidism). Record review of Resident #4's face sheet dated 3/25/26 revealed an [AGE] year-old female admitted to the facility of 6/25/21. Pertinent diagnosis include hypothyroidism (a common condition where the thyroid gland fails to produce enough thyroid hormones, slowing down the body's metabolism). Record review of Resident #4's MDS assessment, dated 12/30/25, revealed severe cognitive impairment. During an interview with RN T on 3/25/26 at 8:10 a.m. revealed she did not normally leave medications in top of medication cart, but she forgot to take the medication into the room with her. RN T said that the negative outcome could be that any resident could grab the medication and take it. During an interview on 3/26/26 at 4:30 p.m. DON stated confirmed medications scheduled to be administered should not be left unattended. DON said that the negative outcome was that any resident or visitor could take the medication and could have an adverse reaction. Record review of facility's policy titled Administering Medications with a revised date April, 2019, revealed: No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to store all drugs and biologicals in locked compartments on 2 of 8 medication carts (RN C's medication cart and the wound care cart) reviewed for storage of drugs. The facility failed to ensure RN C's medication cart located by the nurse's station in the 300 hall was locked when not in use.The facility failed to ensure the wound care cart located by room [ROOM NUMBER] was locked when not in use. This failure could place residents at risk of having access to unauthorized medications and lead to an increased risk of drug diversion, or harm due to accidental ingestion of unprescribed medications.Findings included: During an observation on 03/24/26 at 2:23 PM, a medication cart by the nurse's station in the 300 hall was unlocked and unattended. This surveyor opened all drawers having access to medications in bulk bottles and blister packs easily assessable for removal. RN C was walking from a nearby hall to the medication cart and identified herself as being responsible for the unlocked medication cart.In an interview on 03/24/26 at 2:24 PM, RN C stated she just walked away for a moment and forgot to lock the medication cart. RN C stated the cart should be locked at all times because there was medication in the cart and any resident could get into the medication cart and get medication that was not prescribed to them. RN C stated residents could have complications if a medication was taken that was not prescribed to them.During an observation on 03/25/26 at 9:20 AM, a wound care cart by room [ROOM NUMBER] was unlocked and unattended. LVN D was walking nearby and when questioned about the cart, LVN D was able to open the drawers without needing to unlock the cart. In an interview on 03/25/26 at 9:20 AM, LVN D stated the wound care cart was supposed to always be locked. LVN D stated there was no designated wound care nurse as the charge nurses were responsible for wound care. LVN D stated he did not know who used the wound care cart last. LVN D stated the cart should be locked at all times because the residents could get into the cart and get medications or supplies. LVN D stated the nurses were in charge of locking the carts. In an interview on 03/27/26 at 10:45 AM, the DON stated the medication and wound care carts should always be locked to prevent others, including residents, from getting medications and supplies. The DON stated if the carts were unlocked, then anybody could get into the carts, and they could steal medications and/or take them when not prescribed. Record review of the facility's Medication Labeling and Storage policy, dated February 2023, reflected - Policy: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. 4. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others.