

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455601	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024
NAME OF PROVIDER OR SUPPLIER Alvarado Ltc Partners Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 101 N Parkway Alvarado, TX 76009	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44700</p> <p>Based on observation, interview, and record review, the facility failed to ensure the residents had the right to be free from abuse for one (Resident #1) of five (5) residents reviewed for abuse, in that:</p> <p>The facility failed to prevent Resident # 1 from becoming sexually assaulted by Resident #2, who had a history of sexually inappropriate behaviors, when Resident #2 blocked Resident #1 in the shower room on 5/17/2024 and touched her breast, kissed her and masturbated in front of her.</p> <p>This failure resulted in an identification of an Immediate Jeopardy (IJ) on 05/20/2024. The IJ template was provided to the facility on [DATE] at 5:17 pm. While the IJ was removed on 05/22/2024 at 4:00 pm, the facility remained out of compliance at a scope of pattern and a severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>This failure placed residents at risk of sexual abuse with potential for injuries, trauma, and hospitalization .</p> <p>Findings included:</p> <p>Review of Resident #1's face sheet dated 5/20/2024 reflected a [AGE] year-old female admitted on [DATE] with diagnoses that included: Vascular Dementia (Memory disorder caused by circulation issues in the brain), Type 2 Diabetes Mellitus (blood sugar regulation disorder), Hypertension, Cognitive Communication Deficit (difficulty understanding and communicating), Aphasia (difficulty speaking), Dysphagia (difficulty swallowing), and Cerebrovascular Disease (brain circulation degeneration)</p> <p>Review of Resident #1's optional state assessment MDS dated [DATE] reflected a BIMS of 3 suggesting severe cognitive impairment.</p> <p>Review of Resident #1's care plan dated 4/30/2024 reflected: Resident #1 has impaired cognitive function/dementia or impaired thought processes r/t VASCULAR DEMENTIA. With intervention: o The resident needs (Specify: supervision/assistance) with all decision making. Date Initiated: 04/28/2023</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's progress notes dated 5/17/2024 at 4:38 pm by the ADON reflected: Note Text: At approximately 235 pm this resident was found in C Hall shower room with another male resident. Resident immediately removed from shower room and taken to her room. Head to toe assessment completed. No obvious injuries noted. Resident unable to give statement on what occurred in shower room due to cognitive impairment. Male resident stated he told resident to come in shower room and while in there he touched her breast outside her clothing and kissed her and started to masturbate. Abuse coordinator present and notified. Law enforcement notified and currently in building. Male resident currently on one on one pending new orders.</p> <p>Review of Resident #1's progress notes dated 5/17/2024 at 5:09 pm reflected: Resident transported to ER for exam per [city name] Police Department. Family notified</p> <p>Review of Resident #1's progress notes dated 5/17/2024 at 11:57 pm reflected: Received a phone call from [state name]Health Resource [city and state name] stating that the patient was coming back shortly. She was put on Antibiotic for 7 days for STD prophylaxis . [Preventative measures]</p> <p>Review of Resident #1's progress notes dated 5/18/2024 at 12:26 am reflected: Patient arrived to the facility via a wheelchair with one assist. No distress noted at this time vital signs are within patient parameters. New orders of Doxycycline (antibiotic) 100mg Capsule for 7 days and Metronidazole (antibiotic) 500 mg tablet for 7 days. Will continue to monitor.</p> <p>Review of Resident #2's face sheet dated 5/29/2024 reflected a [AGE] year-old male admitted on [DATE] with diagnoses that included: Cerebral Infarction (stroke), Intermittent Explosive Disorder (mood regulation disorder), Type 2 Diabetes Mellitus (blood sugar regulation disorder), Hypertension, Hemiplegia (partial paralysis), and abnormalities of gait and mobility.</p> <p>Review of Resident #2's quarterly MDS dated [DATE] reflected a BIMS of 11 suggesting a mild cognitive impairment.</p> <p>Review of Resident #2's current care plan dated 5/19/2024 reflected the following problem: Behavior: Sexually inappropriate: watching porn in public areas. Date initiated 3/15/2019. Interventions were as follows:</p> <p>IF RESIDENT IS WATCHING PORN IN PUBLIC AREAS INTERVENE AND REINFORCE THAT WATCHING PORN NEEDS TO BE DONE IN HIS ROOM AND NOT IN PUBLIC AREAS FOR OTHERS TO SEE;</p> <ul style="list-style-type: none"> o Psychiatric Services consult as needed o Reinforce with staff that clear, firm limits are healthy and required when resident makes inappropriate gestures or statements; o Report incidents of target behavior to charge nurse; o Resident to be placed on secure unit due to sexual behaviors and safety; o Staff will be trained to respond, but not react to resident's behavior. <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's progress note dated 5/17/2024 at 2:45 pm by the ADON reflected: this resident was found in c hall bathroom with another female resident with door closed and was found and told staff he was masturbating in front of female resident and kissed her and touched her breast. The female resident did not show any signs of distress but is cognitively impaired and not able to consent to any of the above and was not able to give statement on event due to not remembering what happened. Immediately separated both residents, notified law enforcement, MD, both parties Family and Abuse Coordinator who is our admin. MD stated to send resident out for psych eval .</p> <p>During an interview on 5/18/2024 at 4:50 pm, the ADON stated she was working on 5/17/2024 when the incident between Resident #2 and Resident #1 occurred. She stated she had worked at the facility over a year and to her knowledge Resident #2 had never attempted to touch a female resident before. She stated he had made some inappropriate remarks to staff and female residents, but this was the first physical time. She stated Resident #2 was care planned for inappropriate sexual behavior. She stated Resident #2 had been moved to the male secure unit after the incident on 5/17/2024 pending placement at another facility.</p> <p>During an interview on 5/18/2024 at 5:06 pm, LVN A stated she was Resident #2's regular nurse and there had been an incident near the end of last year sometime between Resident #2 and another female resident. Resident #2 was found in bed in his room with a female resident that lacked the capacity to consent to that behavior .</p> <p>Review of Resident #2's progress notes from 1/1/2023 to 05/19/2024 reflected no notes related to Resident #2 being found in his bed with a female resident.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/18/2024 at 7:48 pm, CNA B stated she had been working on 5/17/2024 and found Resident #2 in the shower room with Resident #1. She stated she had seen Resident #1 in the common area by the nurses station after lunch and told her she had to go down the other hall to take care of a resident but would come get her when she got back to take her to her room to lie down. She stated she was gone about 20 mins and when she came back, Resident #1 was not in the common area. She stated she started looking all around for her in the dining room, in her bedroom, tv room but could not find her. She stated she remembered walking past the shower room and the door was shut. She stated she alerted other staff that she was looking for Resident #1 and when she came back by the nurses station, she saw the door to the shower room cracked and she could see Resident #2 looking at her. She stated she went up to the shower room door and tried to push it open, but Resident #2 had his wheelchair against the door on the inside, blocking it from being opened. She stated she was able to get her head in and could see Resident #1 next to Resident #2, and behind the door on the inside. She stated she told Resident #2 to move out of the way or I was gonna shove the door open. She stated Resident #2 moved out of the way and she grabbed her wheelchair out of the bathroom and asked her if she was ok. She stated when she put her head in the door, Resident #2 had his hand on his private area over his clothes. She stated both residents were in their wheelchairs but Resident #1 was close enough to Resident #2 that he could touch her. She stated they both had all their clothes on, and she only witnessed Resident #2's hand on his lap on top his privates . She stated her and LVN A took Resident #1 to her room because she wanted to lie down. She stated LVN A checked Resident #1 over and she nodded her head that she was ok and stated she just wanted to lie down, so they changed her and put her to bed. CNA B stated Resident #2 made inappropriate comments that were very sexual towards her and other staff when they were showering him. She stated about 6-8 months ago there was another incident with Resident #2 where she had found him in bed laying right next to a female resident with their clothes on . She reported it to LVN A at the time and the AD. She stated she did not remember reporting it to the DON or ADON, but she thought LVN might have done it. She stated she thought the incident could have been prevented because he should have been gone already after the last incident. and this was a long time coming. She stated the previous incident happened before November of 2024 sometime and they just separated the residents but kept them on the same hall. She stated they kept an eye on [Resident #2] for a while.</p> <p>During an interview on 5/19/2024 at 9:19 am, LVN C stated she heard about the incident on 5/17/2024 with Resident #2 and felt it could have been prevented. She stated there was a previous incident with Resident #2 last year and if they had handled that situation better , the current incident could have been prevented. She stated she had witnessed Resident #2 talk to staff inappropriately in the past especially during his showers, but she had not witnessed any behaviors with other residents.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/19/2024 at 9:29 am, LVN A stated she had been working at the facility for 7 years and had been the weekend nurse on the hall for Residents #1 and #2 since Resident #2 was admitted last year. She stated after Resident #2 was found by CNA B in the shower room with Resident #1, they took Resident #1 to her room to assess her and make sure she was okay. Resident #1 could answer yes or no questions pretty well, but it took her a while to answer in a sentence. She stated Resident #1 denied any injury, could not remember what happened and stated she just wanted to go to bed and lie down. She stated Resident #2 had behaviors around female residents . She stated, We kind of watch him, he gets sexual in the shower. She stated, It's not every day, but they keep an eye on him around other female residents . She stated she caught Resident #2 in bed in his room with another resident last fall sometime. She stated they were both lying on top of the covers and had their clothes on but were not in there long enough to do anything. She stated the facility had talked to Resident #2 about his behaviors in the past, but the last AD decided he didn't have to go. She stated staff had refused to bathe him in the shower because of his inappropriate sexual remarks. She stated she reported it to the AD at the time but did not recall telling the DON or ADON. She stated she thought she had put a progress note in EMR but didn't remember.</p> <p>During an interview on 5/19/2024 at 11:01 am CNA D stated she had witnessed Resident #2's behavior. She stated, It starts by him fixating on a female resident. She stated Resident #2 would try to hold their hands and get close to them. She stated last week they were outside on the patio doing an activity and Resident #2 wanted her to bring Resident #1 up next to him to sit and she told him no and moved Resident #1 away from him. She stated the staff would just try to keep Resident #2 away from female residents. She stated she thought she said something to the nurse that day about the incident on the patio, but she didn't remember. She stated she felt the incident could have been prevented because we saw him grooming her. She stated Resident #2 had a history of seeking out females and was always wanting Resident #1 to sit with him or tried to come up next to her in his wheelchair. Every time they saw it they would move Resident #1 somewhere else. She stated, Everyone knew what was going on. She stated in the past she had witnessed Resident #2 grabbing another female resident's hand and putting it in his lap. She stated she believed the DON and ADON were aware of his behaviors.</p> <p>During an interview on 5/19/2024 at 11:14 pm, Resident #2 stated his room had been moved because something had happened and it was bad, bad, bad. He stated he was jacking off, kissing and titties and then he laughed. He stated it had happened in the bathroom with Resident #1 and that CNA E found them and came in the bathroom and took Resident #1 out. Resident #2 stated he was not hurt but the police came and talked to him. Resident #2 was observed in his room on the male, secure unit of the facility.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/19/2024 at 12:40 pm Resident #1's RP stated the facility called him on 5/17/2024 to tell him what had happened with Resident #1. He stated he came up to the facility and spoke to the police and Resident #1. He stated (Resident #1) had no idea what was going on and thought she had talked to the police because she left the store without paying. He stated he gave permission for them to send Resident #1 to the ED for an exam and testing. He stated once at the hospital they were able to swab Resident #1's neck and cheek, but he declined putting Resident #1 through the trauma of a SANE exam. He stated they discharged her from the ED with prescriptions for two antibiotics and she returned to the facility. He only agreed to her coming back to the facility because Resident #2 had been moved out of the general population. He stated he was told by a nurse that they found Resident #2 pleasuring himself and kissing Resident #1. The RP stated he put Resident #1 in the facility thinking she would be safe, and it made him very angry that the incident happened, that they didn't protect her. He stated fortunately with her memory issues, she didn't remember what happened but if she could, it would be a very traumatic event; it would be for anyone that experienced it and knew what was happening. He also said there was no telling what sort of trauma the event caused for her because she could not verbalize very well what happened.</p> <p>During an interview on 5/19/2024 at 1:46 pm, MDS E stated in the past Resident #2 had behaviors of watching porn videos in the main areas, so that was included in his current care plan. She stated she had opened up the intervention on his care plan on 5/17/2024 after the incident with him in the shower room, because they discussed moving Resident #2 to the secure unit. She stated she was getting ready to leave for vacation on Friday afternoon 5/17/2024 so she just opened that current problem for inappropriate sexual behavior on his care plan since they were moving Resident #2 to the secure unit pending placement at another facility and she had forgot to change the date showing it had been updated.</p> <p>During an interview on 5/19/2024 at 2:20 pm, the ADON stated she was not aware of a previous incident last year with Resident #2 when he was found in his room in his bed with another female resident. She stated that had not been reported to her.</p> <p>During an interview on 5/20/2024 at 12:17 am, the AD stated Resident #2 would remain on the secure unit until they had a placement for him. He stated the facility NP would be seeing the resident face to face that day and the facility Medical Director was completing a desk review of Resident #2's medications. The AD stated he had been at work on 5/17/2024 and had been in his office right off the common area near the shower room. He stated he saw Residents #1 and #2 together sitting in the common area. The AD stated then staff started looking for Resident #1 and they found her in the shower room with Resident #2. The AD stated Resident #2 had Resident #1 in the shower room for less than 10 minutes. He stated they had no video cameras in the building to record what had happened. The AD stated their policy was not to keep the shower room doors locked since they were right near the nurse's desk. He stated they had not had any problems in the past that he was aware of related to Resident #2 and inappropriate sexual behaviors, but he had only been at the facility about a month.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 5/20/2024 at 12:29 pm with the AD and RGN revealed the shower room was noted to be just off the common area near the nurse's station. The shower room door was noted to have a locking mechanism on it on the inside. The AD and RGN remained inside the shower room and the Investigator locked the door from the inside and stepped outside the shower room. The door was observed to be locked and unable to be opened from the outside. It was observed there was a key slot on the outside of the door, but both the AD and the RGN denied knowing where the key was located. The RGN stated they would get the door rekeyed and start locking the shower room door. The RGN stated he had been the RGN since July of last year and was not aware of any incidents with Resident #2 watching porn or being in bed with another resident.</p> <p>During an interview on 5/20/2024 at 2:40 pm, the DON stated she was not aware of a previous incident from last year with Resident #2 where he had been found in bed in his room with another female resident. She stated the incident had not been reported to her and there was nothing in the progress notes about it for Resident #2 .</p> <p>During an interview on 5/20/2024 at 5:10 pm the RGN stated Resident #2's current care plan still had a problem on it for sexually inappropriate behavior. When asked why the area was still on the current care plan, the RGN stated he did not know. He stated he had updated Resident #2's care plan on 5/17/2024 to reflect he was being moved to the secure unit but was not sure why it did not show the revision date on the current care pan.</p> <p>During an interview on 5/21/2024 at 8:54 am, the former AD (FAD) stated he did not recall an incident from last year with Resident #2 being in bed with a female resident. He stated if there had been an incident like that he would have reported it. He stated there had been a couple incidents where he touched people - he touched other female residents by trying to hold their hands - - people that were incompetent at the time. He stated the touching incidents were a year or so ago an - he had completed a facility self-report. He stated he had had no concerns at that time with Resident #2 touching female residents in a sexual way. The FAD stated the interventions they put in place at the time were they sat down with him and told him he could not be with female resident unsupervised. He stated they thought about discharging him, but they had not seen any more behaviors at that time. He stated they had educated Resident #2 about his behaviors and tried to keep him in front of staff in the common area. He stated there was usually staff around the nurses desk in the common area and there had been no other incidents that he could recall.</p> <p>During an interview on 5/22/2024 at 3:13 pm, the AD stated everyone that worked at the facility was responsible for supervising and keeping an eye on the residents.</p> <p>Review of facility policy Preventing Resident Abuse dated June 2005 reflected: Our facility will not condone any form of resident abuse and will continually monitor our facilities policies procedures, training programs, systems, etc. to assist in preventing resident abuse. 1. The facility's goal is to achieve and maintain an abuse-free environment. 1j Assessing, care planning, and monitoring residents with needs and behaviors that may lead to conflict or neglect; 1k. assessing residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issues.1o Identifying areas within the facility that may make abuse and or neglect more likely to occur (e.g. secluded areas) and monitoring these areas regularly.</p> <p>The AD was notified on 5/20/2024 at 5:17 pm that an Immediate Jeopardy (IJ) had been identified due to the above failures and an IJ template was provided.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The following POR was accepted on 5/22/2024:</p> <p>On 5/20/24 an abbreviated survey was initiated at [facility name]. On 5/20/2024 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to resident health and safety. The notification of Immediate Jeopardy states as follows: Facility Failed to provide supervision on 5/17/2024 to prevent Resident #1 from getting Resident #2 into the shower room alone.</p> <p>All items listed will be completed by 5:00PM on 5/21/24 with continued follow-up for scheduled staff.</p> <ol style="list-style-type: none"> 1. R#2 received MD order to be placed on All Male Secure Unit Placement 2. R#1 was provided a Head-to-Toe Assessment on 5/17/24 with no injuries identified 3. Emotional Distress Assessment completed for R#1 on 5/17, 5/18, 5/19 with no issues identified 4. R#2's Care Plan was updated by MDS Nurse 5. On 5/18/24 Administrator/DON completed 100% Incident/Accident Audit on every resident in facility to ensure no incidents of sexual inappropriate behavior were documented without any interventions. No other residents were identified as having sexually inappropriate behavior. Safe surveys were completed all female residents not residing on the secure unit. 6. Administrator/DON initiated Staff in-service for ALL STAFF on 5/20/24 on Resident Accidents/Supervision, Resident Supervision/Safety, Resident Rights, and Abuse and Neglect. Administrator/DON trained by Regional Clinical Director prior to start of in-service on 5/20/2024. <p>If staff are unable to attend any of the in-services, they will be required to complete the in-service before starting their assigned shift. Any agency will be in-serviced prior to the beginning of their shift. Any new hires will be in-serviced on hire, prior to working a shift.</p> <p>The Medical Director was first made aware of the Immediate Jeopardy 5/20/24 at 7:00PM and has been involved in developing the Plan of Removal. These conversations are considered a part of the QA process. A QAPI meeting was held on 5/20/2024 with attendance of the Administrator, Director of Nursing, Assistant Director of Nursing and Regional Clinical Director.</p> <p>This plan was initially implemented 5/20/24 and will be monitored through completion by corporate and regional staff.</p> <p>Plan of Removal completion date is 5/21/24 by 5:00 pm with continuation of oncoming staff and follow up.</p> <p>A Surveyor monitored the POR on 5/22/2024 as followed:</p> <p>05/22/2024 12:16 PM Observation of shower room (room in which incident occurred) door with handle which did not lock on the inside or outside of shower room. All shampoo and any supplies needed that could contain chemicals were locked in a cabinet and no residents could access them.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>05/22/2024 12:22 PM Interview with Resident #2, he stated he was doing ok, and the staff were taking good care of him. He stated he felt safe in the facility, and he had been moved to the secure unit because of something bad he had done. He stated he had been jacking off, kissing, and titties. He stated that had never happened before and he was not sure if the other resident wanted to do it or not, but she was his friend and he liked her. He stated she never said no. Resident #2 was observed in secure unit in his room with call light in reach. Resident was dressed appropriately and in no sign of pain or distress.</p> <p>05/22/2024 12:26 PM Interview with Resident #1, she shook her head yes when asked if she was doing ok and if she felt safe in the facility. Resident was sitting in her wheelchair in the dining room at the table visiting her family member. Resident appeared clean and was dressed appropriately. Resident was in no sign of pain or distress and smiled when meeting and talking with surveyor.</p> <p>05/22/2024 12:28 PM Interview with FM, he stated he is doing well, and he is aware of the incident that occurred with the other resident. He stated his only concern is making sure resident is supervised correctly and that he is fine if the other resident remains in the secure unit, bit he is not sure about how he would feel if the resident was out of the secure unit. He stated resident is confused at times and she does not recall the incident.</p> <p>05/22/2024 1:15 PM Interview with MA-F she stated she had worked in the facility for about 6 years, and she worked the day shift. She stated she was in-serviced on resident accidents/supervision, resident supervision/safety, resident rights, and abuse and neglect on this past Monday and Tuesday. She stated staffing was ok. She stated she felt as though she could meet the needs of her residents. She stated she had not had any residents complain to her about any inappropriate sexual behavior from any other residents. She stated an example of abuse was cursing at a resident and she had never witnessed abuse in this facility. She stated if she suspected abuse, she would have reported it to her charge nurse and the Administrator, which was the Abuse Coordinator.</p> <p>05/22/2024 1:19 PM Interview with LVN - G, she stated she had worked in the facility for about 3 years and she worked the day shift. She stated she was in-serviced on resident accidents/supervision, resident supervision/safety, resident rights, and abuse and neglect on this past Monday, and they always have different materials for them to read. She stated staffing was generally ok and they make it work. She stated she felt as though she could meet the needs of her residents. She stated she had not had any residents complain to her about any inappropriate sexual behavior from any other residents. She stated an example of abuse was pulling a resident roughly and she had never witnessed abuse in this facility. She stated if she suspected abuse, she would have reported it to the Administrator, which was the Abuse Coordinator.</p> <p>05/22/2024 1:27 PM Interview with LVN - H, she stated she had worked in the facility for about 4 years and she worked the day shift. She stated she was in-serviced on resident accidents/supervision, resident supervision/safety, resident rights, and abuse and neglect on yesterday. She stated staffing was ok. She stated she felt as though she could meet the needs of her residents. She stated she had not had any residents complain to her about any inappropriate sexual behavior from any other residents. She stated an example of abuse was involuntarily secluding a resident and she had never witnessed abuse in this facility. She stated if she suspected abuse, she would have reported it to the Administrator, which was the Abuse Coordinator.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455601	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024
NAME OF PROVIDER OR SUPPLIER Alvarado Ltc Partners Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 101 N Parkway Alvarado, TX 76009	
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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>05/22/2024 1:30 PM Interview with CNA - I, she stated she had worked in the facility for about 4 months, and she worked the day shift. She stated she was in-serviced on resident accidents/supervision, resident supervision/safety, resident rights, and abuse and neglect today. She stated this was her first day back since the weekend and she was off on Monday and Tuesday. She stated she was in-serviced prior to getting on the floor to work. She stated staffing was ok. She stated she felt as though she could meet the needs of her residents. She stated she had not had any residents complain to her about any inappropriate sexual behavior from any other residents. She stated an example of abuse was hitting a resident and she had never witnessed abuse in this facility. She stated if she suspected abuse, she would have reported it to the Administrator, which was the Abuse Coordinator.</p> <p>05/22/2024 1:35 PM Interview with AD and RGN, they stated they had in-serviced staff regarding resident accidents/supervision, resident supervision/safety, resident rights, and abuse and neglect. They stated there may be some staff that have not been in-serviced as of yet, but they will not be allowed to work until they have received the in-services. They stated 85% of staff have been in-service so far and there were only a few staff that had not been in-serviced yet. They stated the RN weekend supervisor was the one responsible for ensuring staff on the weekends have been in-serviced prior to working. They stated staffing was adequate to meet the resident's needs. They stated they felt as though their staff could meet the needs of their residents. They stated they were not aware of any residents that had complained about any inappropriate sexual behavior from any other residents. They stated an example of abuse was sexual a resident and they had never witnessed abuse in this facility. They stated if staff suspected abuse, they should have reported it immediately to Administrator which was the Abuse Coordinator. They stated Resident #2 would remain in the secure unit unless they had to staff available to perform one on one supervision. They stated they are actively trying to have resident placed at a different facility which is more suitable for him, but each facility has denied resident admitting so far and they may also suggest family taking him home.</p> <p>05/22/2024 2:17 PM Interview with LVN - J, she stated she had worked in the facility for about 2 months, and she worked the 2-10 shift. She stated she was in-serviced on resident accidents/supervision, resident supervision/safety, resident rights, and abuse and neglect on Monday. She stated she was in-serviced prior to getting on the floor to work. She stated staffing was good. She stated she felt as though she could meet the needs of her residents. She stated she had not had any residents complain to her about any inappropriate sexual behavior from any other residents. She stated an example of abuse was cussing at a resident and she had never witnessed abuse in this facility. She stated if she suspected abuse, she would have reported it to the Administrator, which was the Abuse Coordinator.</p> <p>05/22/2024 2:22 PM Interview with MA- K, he stated he had worked in the facility for about a year and a half, and he worked the 2-10 shift. He stated he was in-serviced on resident accidents/supervision, resident supervision/safety, resident rights, and abuse and neglect on Monday and Tuesday. He stated he was in-serviced prior to getting on the floor to work. He stated staffing was decent. He stated he felt as though he could meet the needs of his residents. He stated he had not had any residents complain to him about any inappropriate sexual behavior from any other residents. He stated an example of abuse was a resident-to-resident altercation and he had never witnessed abuse in this facility. He stated if he suspected abuse, he would have called and reported it to the Administrator, which was the Abuse Coordinator.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Alvarado Ltc Partners Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 101 N Parkway Alvarado, TX 76009	
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>05/22/2024 Reviewed in-servicing which includes attendance forms with staff signatures dated 05/20/2024 given by the RGN for DON and AD over accidents and incidents, abuse and neglect, safety and supervision of residents, and resident rights. Reviewed in-servicing which includes attendance forms with staff signatures dated 05/20/2024 given by the DON over accidents and incidents, abuse and neglect, safety and supervision of residents, and resident rights.</p> <p>05/22/2024 Reviewed documentation on QAPI meeting held 05/20/2024 regarding prevent reoccurrence and continued safety for all residents in which the DON and Administrator both attended.</p> <p>05/22/2024 Reviewed documentation for 100% incident/accident audit performed for every resident in facility.</p> <p>05/22/2024 Reviewed safe surveys dated 05/19/24 - 05/20/24 performed on female resident which resided outside of secure unit.</p> <p>05/22/2024 Reviewed incident quiz given to staff and resident abuse questionnaires given to residents.</p> <p>On 5/22/2024 at 4:00 pm, the AD was informed the immediacy was removed. The IJ template was provided to the facility on [DATE] at 5:17 pm. While the IJ was removed on 05/22/2024 at 4:00 pm, the facili [TRUNCATED]</p>		