STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455923	A. Building B. Wing	06/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood of Beeville	600 S Hillside Dr Beeville, TX 78102

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46038 Based on observation, interview and record review the facility failed to ensure residents were free from sexual abuse for 2 residents (Residents #2, and Resident #3) of 3 reviewed for abuse and neglect in that: The facility failed to supervise and protect Resident #2, who had a BIMS score of 3 (severe cognitive impairment), from harm and sexual abuse when Resident #2's family member provided video footage of Resident #3 grabbing Resident #2's breast on 11/7/23 and failed to protect vulnerable residents from harm and sexual abuse. An IJ was identified on 6/13/24. The IJ template was provided to the facility Administrator on 6/13/24 at 2:52pm. While the IJ was removed on 6/16/24 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. These deficient practices placed residents at risk of psychosocial harm and continued abuse. The findings included: 1. Record review of Resident #2's face sheet dated 6/11/24 reflected a [AGE] year-old-female who was initially admitted to the facility on [DATE]. Diagnoses included end stage renal disease (gradual loss of kidney function), congestive heart failure (impairment in the heart's ability to pump blood), Alzheimer's disease (brain disorder that destroys memory and thinking skills), dementia (general decline in cognitive abilities that affects a person's ability to perform everyday tasks), and bipolar disorder (mental illness characterized by extreme mood swings). Resident #2's MDS reflected a BIMS score of 3 (severe cognitive impairment) on 11/7/23 and a current BIMS score of 1 (severe cognitive impairment) as of 6/13/24. Resident 2's care plan initially dated 6/26/21 stated: o Resident #2 has impaired cognition R/T dementia and CVA with a BIMS score of 1. o Resident #2 has disorganized thinking and inattention (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	o Does not make needs known consistently and clearly o Psychiatric/Psychogeriatric consult as indicated. o Resident #2 is attention seeking from males (staff or residents). She at times makes inappropriate sexual comments to males. o Resident #2 has also made false accusations against staff. o Resident does perform sexual self-gratification o Resident #2 and her family have selected to have a camera in the room. Interventions include: o If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable. o Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. 2. Record review of Resident #3's face sheet dated 6/13/24 reflected a [AGE] year-old-male who was initially admitted to the facility on [DATE] with Alzheimer's disease (brain disorder that destroys memory and thinking skills), and cognitive communication deficit. Resident #3's MDS reflected Resident #3 had a BIMS score of 15 (cognitively intact). Resident #3's care plan initially dated 10/5/23 stated: o Resident #3 has impaired cognition R/T Dementia. He has poor decision-making skills. BIMS of 15. Interventions included: o Monitor/document/report PRN any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Record review of provider investigation dated 11/21/23 provided evidence video surveillance stated: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On the evening of 11/8/23 at approximately 5:00pm, Resident #2's family member went to the facility and spoke to LVN A and stated that she did not want any male residents in Resident #2's room. The family member showed LVN A, a video of an interaction between Resident #2 and Resident #3 that occured on 11/7/24. LVN A called the Administrator and informed her of Resident #2's family member's request and the video that she was shown. The Administrator called the DON and discussed the encounter between Resident #2 and Resident #3. The video revealed that Resident #2 was lying in bed wearing only a T-shirt, a brief, and had no blankets covering her. Resident #2 began to call Resident #3 into her room by waving her hand motioning Resident #3 into her room and was speaking to him in Spanish and English. Resident #2 told Resident #3 Aver, let me see, vente apa (come here daddy). Resident #2 was laughing and was cheerful as Resident #3 wheeled himself to Resident #2's bed. Resident #3 offered Resident #2 his hand. Resident #2 continued to hold Resident #3's hand with her left hand and with her right hand she appeared to be touching Resident #3's legs and trying to lift Resident #3's night gown. Resident #2 told Resident #3, [NAME] apa aver (oh daddy, let me see), estas bien bueno (you look so good). Resident #3 was seen trying to pull his gown back down over his legs. Resident #3 replied to Resident #2 and stated, [NAME] no mas que [NAME] estas (just look at how good you are). Resident #2 replied stating, que bueno apasito (so good daddy), Resident #2 and Resident #3 continued to laugh. Resident #3 touched Resident #2's breast over her gown. Resident #3 pulled away from Resident #2 and started to wheel away. As Resident #3 wheeled away, Resident #2 told Resident #3, I like it. Resident #3 turned and asked Resident #2, you like it? Resident #2 replied yes, and Resident #3 told Resident #2 he would come back later, and Resident #2 invited Resident #3 to lay down in her bed with her. Resident #2 and Resident #3 both laughed, and Resident #3 exited the room and did not return to Resident #2's room. During the incident on 11/7/23, Resident #3 was in Resident #2's room for approximately 3 to 5 minutes. In an interview and observation on 6/10/24 at 11:40am, Resident #2 was lying in bed watching TV. Resident #2 noted with a camera in the room. Resident #2 could not recall the incident and stated she did not know who Resident #3 was. In an interview on 6/10/24 at 1:35pm, Resident #2's family member stated on 11/7/23 she saw on video Resident #3 wheel himself into Resident #2's room and grab Resident #2's breast. Resident #2's family member stated, Resident #2 did not seem fearful, scared, and did not tell Resident #3 to stop. Resident #2's family member stated she asked the facility to not allow male residents into Resident #2's room as Resident #2 was flirtatious with male residents and did not feel Resident #2 was capable of making those decisions. Resident #2's family member stated that was the first and last incident of its kind to have happened to Resident #2. Resident #2's family member stated she had no concerns anymore about Resident #2's care at the facility and stated that Resident #3 was no longer at the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 6/10/24 at 4:04pm, the DON stated the facility was not aware of the incident until the next day after the incident occurred when Resident #2's family member came to the facility and provided video footage. The DON stated the video footage showed Resident #3 going into Resident #2's room and touching Resident #2 inappropriately. The DON stated Resident #3 was living across the hall from Resident #2. The DON stated Resident #2 called Resident #3 into her room while she was in bed by waiving to Resident #3. The DON stated Resident #3 and Resident #2 were flirting and Resident #2 was pulling up Resident #3's gown and put her hand on Resident #3's leg. The DON stated Resident #3 then touched Resident #2's upper thigh and breast over the gown. The DON stated both Resident #2 and Resident #3 had a small conversation and Resident #3 left Resident #2's room. The DON stated at no point did Resident #2 become fearful or angry about the situation as Resident #2 was laughing with Resident #3. The DON stated the Ombudsman came into the facility with Resident #2's family member and requested Resident #2 had no male visitors in her room. The DON stated on 11/15/23 per family request, Resident #2 was moved closer to the nurse's station. Initially the DON stated according to Resident #2's BIMS score of a 1 (severe cognitive impairment) Resident #2 would not be able to consent to sexual activities and/or touching. The DON then stated she did not know how to answer the question if Resident #2 was cognitively able to consent to sexual activities. The DON stated Resident #2 was able to make her own decisions on needs and Resident #2 has rights. The DON stated due to Resident #2's cognitive status, Resident #2 was unable to sign her own admissions agreement and plan of care. The DON stated since Resident #2 was unable to sign for her own plan of care, medical decisions, and had a responsible party, the DON stated, I guess she wasn't able to consent to sexual activities. In an interview on 6/11/24 at 1:27pm, the Administrator stated the facility was unaware of the incident until Resident #2's family member notified the staff about the incident the next day. The Administrator stated in the video that was provided by Resident #2's family member, Resident #2 was seen calling Resident #3 over into her room. and the family requested Resident #2 be moved to a new room closer to the nurse's station. The Administrator stated staff was educated on monitoring Resident #2 and making sure male residents did not go into Resident #2's room, but no in-service documentation was provided for surveyor review. The Administrator stated Resident #2 was not showing any signs of fear or being scared. The Administrator stated after the facility learned about the incident, the facility investigated the incident, and it was unfounded. The Administrator stated Resident #2's family was not concerned about Resident #2's safety. The Administrator stated being able to consent was based on how the resident was able to voice their needs and felt it was Resident #2's right. The Administrator would not give an answer when asked if Resident #2 was able to consent to sexual activities. In an interview on 6/11/24 at 1:51pm, LVN A stated Resident #2's family member came to the facility and showed her a video of the sexual activity between Resident #2 and Resident #3 on 11/7/23. LVN A stated the video showed Resident #2 calling over Resident #3 and Resident #2 touching his leg, holding hands, and Resident #3 grabbing Resident #2's breast over her gown. LVN A stated Resident #2 was asking Resident #3 to come lay down with her but Resident #3 ended up leaving the room and not returning. LVN A stated Resident #2 was able to voice needs at times. LVN A said she could not say if Resident #2 was able to consent to sexual activity. LVN A stated the staff were educated on monitoring Resident #2's room to make sure no other male residents went into her room but could not remember when the last abuse and neglect training was. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility did not provide a copy of Resident #2's in-service on supervison or any specific monitoring for making sure Resident #2 did not have any male visitors. In an interview on 6/12/24 at 10:06am, the SW stated due to Resident #2's low BIMS score, the SW professional opinion was Resident #2 was unable to consent to sexual activity. In a phone interview on 6/12/24 at 11:42am, Resident #2's MD stated he saw Resident #2 on a regular basis, and it was likely Resident #2 was aware of what was going on. MD stated Resident #2 was able to voice her needs and wants at times. Resident #2's MD stated it was questionable if Resident #2 was able to give consent. MD stated he was unable to say yes or no if Resident #2 could consent to sexual activity as Resident #2 had some cognitive ability but was not sure if Resident #2 was able to fully understand the effects of the situation. Record review of the Abuse, Neglect, Exploitation or Misappropriation -Reporting and Investigating policy dated 9/2022 stated: Policy Statement All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations and thoroughly investigated by facility management. Findings of all investigations are documented and reported. 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; e. Law enforcement officials; Reporting Allegations to the Administrator and Authorities 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. An IJ was identified on 6/13/24. The IJ template was provided to the facility Administator on 6/13/24 at 2:52pm. While the IJ was removed on 6/16/24 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. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of : Plan of Removal Immediate Action: Resident #3 discharged from Birchwood of Beeville on 12/1/23 at 8:24 a.m. Immediate Action: Resident #2 was assessed and found to be in no immediate physical or mental harm safety check in place 6/13/2024. Resident refused skin assessment on 6/13/24. Attempted again on 6/14/24 and completed. No signs of physical harm. Immediate Action: 26 Interview able residents have been identified and resident safe surveys were initiated on 6/13/2024. No abuse or Neglect was reported Immediate Action: On 6-13-2024 Review of the F-tag 600 Immediate Action: Medical Director notified on 6/13/24. Immediate Action: DON and the Administrator were in-serviced over the abuse and neglect policy and procedure by the Chief Operating Officer - date this was completed: 6/13/24. Immediate Action: 6-13-2024 One to one staff supervision or safety checks will be applied to any resident who alleges abuse and or causes abuse until the investigation is thoroughly completed. Safety checks mean checking the resident frequently. This is in the Policy and Procedure- Identify Sexual Abuse and Capacity to Consent section Investigation an Allegation or Suspicion of Sexual Abuse. Immediate Action: 6-13-2024 The Abuse and Neglect Policy and Procedure (identifying sexual abuse capacity) was reviewed in the facility protocol. All staff will be in-service before the start of their shift and no staff will be allowed to start work until the training has been completed. The estimated date of completion will be 6/17/2024. Immediate Action: 6-13-2024 Walkie talkies purchased to help increase communication between the staff to assist with increased resident supervision. The nurse staff: charge nurse and certified nurse aide will use radios. In place 6/14/24. There were three other residents identified as having inappropriate sexual behavior. No incidents with other residents. The three resident cognitive ability for consent is as follows: Resident with Behaviors: Resident 1- no cognitive ability for consent, care plans/care profile reviewed & updated. Resident 2- no cognitive ability for consent, care plans/care profile reviewed & updated. Resident 3- no cognitive ability for consent, care plans/care profile reviewed & updated. The Staff Development Coordinator is training the staff. Staff Development Coordinator is monitoring. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Staff Development Coordinator will oversee the training and staff's knowledge. They are going to analyze the monitoring by doing Daily monitoring. It will occur in the daily clinical meeting. Weekend supervisor would monitor during weekend. The Director of Nursing will be responsible for gathering and reviewing. It is going to be reviewed in our daily QAPI and the third Wednesday QAPI with Medical Director. Resident #2's care plan was updated, and it does include specific interventions for monitoring. Resident #2 interventions were updated in care plan. Plan of care updated for the staff to monitor the resident for noted sexual expressions frequently. One on one supervision is put in immediately. Safety checks are documented every 15 minutes for the next 72 hours. Safety check starts immediately when staff starts shift. Then the IDT team will reconvene to see if the checks need to increase or decrease. Safety check will be documented by designate staff and will be left in place until the IDT determines no longer needed. It will be documented and uploaded in Point Click Care. Resident #3 has been removed from the facility and is not a potential harm to residents. Psych services to continue monthly visits with the resident to assist with her psychosocial well-being related to her ability to have needed sexual expression. Updates made for Resident #2: has some difficulty processing information R/T CVA and Dementia AEB BIMS 1 and confusion. The resident does not have the capacity to consent to sextual contact. Intervention- Encourage the resident to continue stating thoughts even if having difficulty. Focus on a word or phrase that makes sense or responds to the feelings the resident is trying to express. A psychosocial assessment is pending date for revisit due to new psych service. The facility's process for determining whether residents have capability to give consent to sexual activities is BIMs, Resident Assessment and Care Plan, and Family Responsible Party Consent. The facility will recognize residents who lack capacity to make decisions or are making unsafe decisions by the Resident Assessment and Care Plan. Verification of the facility's Plan of Removal on 6/16/24: Reviewed the facility conducted 100% review of all residents. 4 residents were identified with inappropriate sexual behaviors. Record review of Resident #2's Care Plan revised on 06/14/2024 reflected Resident #2 was attention seeking from males (staff or residents) and at times made inappropriate sexual comments to males. Resident #2 does not have the capacity to consent to sexual contact, AEB BIMS of 1 (severe cognitive impairment). Resident #2 had also made false accusations against staff. Resident #2 does perform sexual self-gratification. Goal: Resident #2 will have fewer episodes of inappropriate behaviors by review date. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interventions: If reasonable, discuss the Resident #2's behavior. Explain/reinforce why behavior was inappropriate and/or unacceptable. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Praise any indication of the resident's, progress, or improvement in behavior. Resident #2s care plan did not reflect any updated supervision changes after the incident occured on 11/7/23. Resident #2's care plan was updated on 06/13/24 reflecting no specific supervision interventions. Record review of Resident #2' s 1:1 log sheet dated 06/15/2024 documented beginning 1:1 at 5:15PM on 06/15/2024 and maintained current during observation through review on 06/16/2024 1:15PM Record review of Resident #2's special instructions undated, reflected sexually inappropriate behaviors on electronic health record. Record review of Resident #15's Care Plan revision date on 06/13/2024 reflected, special instruction-sexually inappropriate behaviors, Resident #15 had a behavior problem R/T Dementia, Cerebral Infarction (stroke, necrotic tissue of the brain), visual disturbance AEB inappropriate verbal/physical sexual behaviors with female staff, refusing care, public sexual acts, rummaging, disruptive sounds, and wanders into other rooms. Goal: Resident #15 will have fewer episodes of behaviors by review date. Interventions: Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Minimize potential for the resident's disruptive behaviors by offering tasks which divert attention. Redirect resident as needed. Record review of Resident #16's Care Plan revision date 06/13/2024 reflected, Resident #16 had impaired cognition R/T Dementia with a BIMS of 3 (severe cognitive impairment). Resident #16 had inattention and disorganized thinking. At times he would be sexually inappropriate with female staff. Goal: Would be able to communicate basic needs on a daily basis through the review date. Interventions: Administer medications as ordered. Engage in simple, structured activities that avoid overly demanding tasks. Face the resident when speaking and make eye contact. Reduce any distractions, turn off TV, radio, close door etc. Keep routine consistent & try to provide consistent care givers as much as possible in order to decrease confusion. Monitor/document /report to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Use task segmentation to support short term memory deficits. Provide 1 step directions. During an observation and interview on 06/16/2024 at 1:00PM, Resident #2 was outside in the sitting area, with RN B. Resident #2 was not displaying any signs or symptoms of distress. Resident #2 was not exhibiting any signs of fearfulness. Resident #2 stated she was not fearful of any person within the facility. Resident #2 stated when she needs assistance staff members attend to her needs. Resident #2 did not verbalize any concern regarding abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/16/2024 at 5:24PM [NAME] Resident #17 stated that the staff members are nice to her. Resident #17 she is not fearful of living at the facility, and that no one has touched her inappropriately. Resident #17 stated when she needs assistance the staff assist her. Resident #17 stated no one has ever hit, hurt, or made her feel intimidated or sad. Resident #17 does not verbalize any concerns. During an interview on 06/16/2024 at 5:28PM Resident #18 stated the staff are nice to her and treated her with respect. Resident #18 stated no one has ever touched her inappropriately and was not fearful of living at the facility. Resident #18 stated when she needs assistance, staff members do assist her. Resident #18 stated no one has ever hit, hurt, or made her feel intimidated. Resident #18 stated she was not fearful of the residents nor staff members. Resident #18 does not verbalize any concerns. Interviews beginning on 06/16/2024 at 2:11PM, RN B, RN C, RN D, LVN D, LVN E, LVN F, CNA A, CNA B, CNA C, CNA D, CNA E, CNA F, and CNA G from various shifts, were all able to state if they were to be made aware of any incident of inappropriate touching or any abuse of a resident , they would immediately stop the action and remove the aggressor to a different area of the facility. All staff stated the next step would be to implement a 1:1 on the person that was assaulted, and the aggressor and they would ask another one of their colleagues to call local law enforcement, abuse coordinator, the Administrator, followed by performing a thorough assessment of both psychological, and physical. All staff stated they would implement safety checks and keep the victim safe. Staff stated they would also use the walkie talkie system to maintain communication with their colleagues followed by documenting in a nursing note, behavioral note, and incident report under the risk management. All staff stated they were educated about sexual, physical, mental, and emotional abuse during a previous in-service on 06/13/2024. All staff were able to identify the different types and signs and symptoms of abuse. During an interview on 06/16/2024 at 4:29PM, the DON stated that for all allegations of abuse will immediately report in Tulip followed by immediately conducting the investigation process. The DON stated new implementation are paying more attention to BIMS score, and auditing special instructions- to say, inappropriate sexual behaviors. The DON stated in the MAR there was an implemented safety check order, and when the MAR pops up, the nurse would be able to document what would be the current state of each resident who was audited for inappropriate sexual behaviors. The DON stated after any allegation of abuse, a 1:1 will be implemented for both victim and perpetrator, and any aggressor would be advocated to be moved to a different behavioral facility. The DON stated for any allegation of abuse, an IDT meeting would take place, and if there was no evidence of actual abuse, the facility would remove the 1:1, but still implement a 30 minute where is your resident now check, and clinical staff will continue to monitor the victim frequently through the shift. The DON stated the facility would advocate for the perpetrator to be removed from facility and sent to another appropriate facility. The DON stated if there would be no placement for the perpetrator, the facility would maintain a 1:1 with the perpetrator and would then issue a 30-day notice of discharge due to not being able to provide 1:1 service indefinitely to meet the perpetrators needs. During an interview on 06/16/2024 at 6:25PM, the Administrator stated going forward the facility will follow its' policy and procedure regarding abuse and neglect. Record review of the facility's residents audited for wandering behaviors- reviewed no concerns noted. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's What to do if you witness or suspect sexual abuse in-service dated 06/13/2024- had 100% clinical staff in attendance. Record review of the facility's in-service dated 06/13/2024 objective of the In-service: Free of accidents/hazards/supervision/devices, facility will provide adequate supervision to prevent sexual abuse, facility will provide interventions and monitoring to ensure residents safety from sexual abuse, freedom from abuse/neglect/ Misappropriation of property/and exploitation, facility will provide an environment free from sexual abuse-had Administrator and DON in attendance. Record review of the facility's in-service dated 06/13/2024 objective of the In-service: Two-way walkie talkie's will be utilized in the facility to communicate with each other for the resident and staff safety. Please use same channel to communicate effectively to each other. Return radios to the charger ports after your shift. We must have radios on through your shift to communicate any behavior in the residents that maybe concern. If radios are not functioning, please use other means of communication such as your cell phone on the facility phone located at the nurse stations. Communication examples include telling staff of a resident that is exit seeking to keep close eye on a resident that has a change in condition to watch for, a resident having a behavior, you need assistance with a resident's care, report resident wandering in and out of rooms, any other concerns to report to other staff. - 100% clinical staff in-serviced. An IJ was identified on 6/13/24. The IJ template was provided to the facility Administrator on 6/13/24 at 2:52pm. While the IJ was removed on 6/16/24 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455923	A. Building B. Wing	06/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood of Beeville	600 S Hillside Dr Beeville, TX 78102

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46038 47371 Based on, interview and record review, the facility failed to ensure that all alleged violations involving abuse, were reported immediately, but not later than 2 hours to the State Survey Agency and other officials, for 4 residents (Resident #2, Resident #3, Resident #5, and Resident #1) of 6 residents reviewed for abuse, in that: 1. The facility did not report to the Health and Human Services Commission (HHSC)/State Survey Agency and other officials for one incident of possible sexual abuse for Resident #2 and Resident #3 on 11/08/23. 2. The facility did not report to the Health and Human Services Commission (HHSC)/State Survey Agency and other officials for one incident of an unwitnessed fall resulting in an elbow fracture for Resident #5. 4. The facility failed to report the allegation of abuse to the local law enforcement agency when they were made aware of an allegation of abuse regarding Resident #1 on 07/18/2023. These deficient practices could affect residents residing in the facility and place them at risk of further abuse and delays in having their incidents investigated timely by the facility and state agency to ensure policies and procedures were implemented for the prevention and protection of abuse. The findings included: 1. Resident #2 Record review of Resident #2's face sheet dated 6/11/24 reflected a [AGE] year-old-female who was initially admitted to the facility on [DATE]. Diagnoses included end stage renal disease (gradual loss of kidney function), congestive heart failure (impairment in the heart's ability to pump blood), Alzheimer's disease (brain disorder that destroys memory and thinking skills), dementia (general decline in cognitive abilities that affects a person's ability to perform everyday tasks), and bipolar disorder (mental illness characterized by extreme mood swings). Resident #2's MDS reflected a BIMS score of 3 (severe cognitive impairment) on 11/6/23 and a current BIMS score of 1 (severe cognitive impairment) as of 6/13/24. Resident 2's care plan initially dated 6/26/21 stated: o Resident #2 has impaired cognition R/T dementia and CVA with a BIMS score of 1. o Resident #2 has disorganized thinking and inattention o Does not make needs known consistently and clearly (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o Psychiatric/Psychogeriatric consult as indicated. o Resident #2 is attention seeking from males (staff or residents). She at times makes inappropriate sexual comments to males. o Resident #2 has also made false accusations against staff. o Resident does perform sexual self-gratification o Resident #2 and her family have selected to have a camera in the room. Interventions include: o If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable. o Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. 2. Resident #3 Record review of Resident #3's face sheet dated 6/13/24 reflected a [AGE] year-old-male who was initially admitted to the facility on [DATE] with Alzheimer's disease (brain disorder that destroys memory and thinking skills), and cognitive communication deficit. Resident #3's MDS reflected Resident #3 had a BIMS score of 15 (cognitively intact). Resident #3's care plan initially dated 10/5/23 stated: o Resident #3 has impaired cognition R/T Dementia. He has poor decision-making skills. BIMS of 15. Interventions included: o Monitor/document/report PRN any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Record of provider investigation dated 11/21/23 provided evidence video surveillance stated: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the evening of 11/8/23 at approximately 5:00pm, Resident #2's family member spoke to LVN A and stated that she did not want any male residents in Resident #2's room. The family member showed LVN A, a video of an interaction between Resident #2 and Resident #3. LVN A called the Administrator and informed her of Resident #2's family member's request and the video that she was shown. The Administrator called the DON and discussed the encounter between Resident #2 and Resident #3. The video revealed that Resident #2 was lying in bed wearing only a T-shirt, a brief, and had no blankets covering her. Resident #2 began to call Resident #3 into her room by waving her hand motioning Resident #3 into her room and was speaking to him in Spanish and English. Resident #2 told Resident #3 Aver, let me see, vente apa (come here daddy). Resident #2 was laughing and was cheerful as Resident #3 wheeled himself to Resident #2's bed. Resident #3 offered Resident #2 his hand. Resident #2 continued to hold Resident #3's hand with her left hand and with her right hand she appeared to be touching Resident #3's legs and trying to lift Resident #3's night gown. Resident #2 told Resident #3, [NAME] apa aver (oh daddy, let me see), estas bien bueno (you look so good). Resident #3 was seen trying to pull his gown back down over his legs. Resident #3 replied to Resident #2 and stated, [NAME] no mas que [NAME] estas (just look at how good you are). Resident #2 replied stating, que bueno apasito (so good daddy), Resident #2 and Resident #3 continued to laugh. Resident #3 touched Resident #2's breast over her gown. Resident #3 pulled away from Resident #2 and started to wheel away. As Resident #3 wheeled away, Resident #2 told Resident #3, I like it. Resident #3 turned and asked Resident #2, you like it? Resident #2 replied yes, and Resident #3 told Resident #2 he would come back later, and Resident #2 invited Resident #3 to lay down in her bed with her. Resident #2 and Resident #3 both laughed, and Resident #3 exited the room and did not return to Resident #2's room. The incident was not reported to HHS or local law enforcement as the Administrator felt the incident was consensual and part of resident rights. In an interview on 6/10/24 at 1:35pm, Resident #2's family member stated she saw on video Resident #3 wheel himself into Resident #2's room and grab Resident #2's breast. Resident #2's family member stated, Resident #2 did not seem fearful, scared, and did not tell Resident #3 to stop. Resident #2's family member stated she asked the facility to not allow male residents into Resident #2's room as Resident #2 was flirtatious with male residents and did not feel Resident #2 was capable of making those decisions. Resident #2's family member stated that was the first and last incident of its kind to have happened to Resident #2. Resident #2's family member stated she had no concerns anymore about Resident #2's care at the facility and stated that Resident #3 was no longer at the facility. In an interview on 6/10/24 at 4:04pm, the DON stated the facility was not aware of the incident until the next day after the incident occurred when Resident #2's family member came to the facility and provided video footage. The DON stated the video footage showed Resident #3 going into Resident #2's room and touching Resident #2 inappropriately. The DON stated Resident #3 was living across the hall from Resident #2. The DON stated Resident #2 called Resident #3 into her room while she was in bed by waiving to Resident #3. The DON stated Resident #3 and Resident #2 were flirting and Resident #2 was pulling up Resident #3's gown and put her hand on Resident #3's leg. The DON stated Resident #3 then touched Resident #2's upper thigh and breast over the gown. The DON stated both Resident #2 and Resident #3 had a small conversation and Resident #3 left Resident #2's room. The DON stated at no point did Resident #2 become fearful or angry about the situation as Resident #2 was laughing with Resident #3. The DON stated the Ombudsman came into the facility with Resident #2's family member and requested Resident #2 had no male visitors in her room. The DON stated on 11/15/23 per family request, Resident #2 was moved closer to the nurse's station. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Initially the DON stated according to Resident #2's BIMS score of a 1 (severe cognitive impairment) Resident #2 would not be able to consent to sexual activities and/or touching. The DON then stated she did not know how to answer the question if Resident #2 was cognitively able to consent to sexual activities. The DON stated Resident #2 was able to make her own decisions on needs and Resident #2 has rights. The DON stated due to Resident #2's cognitive status, Resident #2 was unable to sign her own admissions agreement and plan of care. The DON stated since Resident #2 was unable to sign for her own plan of care, medical decisions, and had a responsible party, the DON stated, I guess she wasn't able to consent to sexual activities. The DON stated the facility should make a report to the HHS within two hours for abuse and that was not done regarding the incident between Resident #2 and Resident #3. The DON stated there was no reason why the incident was not reported in the appropriate time frame. The DON stated the proper procedures would be to report the abuse to HHSC within two hours, remove the cause of abuse, and notify local law enforcement. The DON stated that the facility assumed Resident #2 lured Resident #3 into the room and did not think it was abuse at that time. The DON stated by not reporting the incident to appropriate authorities as stated in the Abuse, Neglect, and Exploitation policy, it could lead to continued sexual abuse and/or injury to the resident. The DON stated law enforcement was called but a week later and the incident was eventually reported to HHS. In an interview on 6/11/24 at 1:27pm, the Administrator stated Resident #2's family member notified the staff about the incident the next day. The Administrator stated in the video that was provided by Resident #2's family member, Resident #2 was seen calling Resident #3 over into her room. and the family requested resident be moved to a new room closer to the nurse's station. The Administrator stated staff was educated on monitoring Resident #2 and making sure male residents did not go into Resident #2's room. The Administrator stated Resident #2 was not showing any signs of fear or being scared. The Administrator stated after the facility learned about the incident, the facility investigated the incident, and it was unfounded. The Administrator stated Resident #2's family was not concerned about the Resident #2's safety and the incident was not reported to HHS due to the incident not being unwanted and felt like it was consensual interaction. The Administrator stated being able to consent was based on how the resident was able to voice their needs and felt it was Resident #2's right. The Administrator would not give an answer when asked if Resident #2 was able to consent to sexual activities. The Administrator stated the reason the incident was reported to HHS and local law enforcement was because the Ombudsman came to a care plan meeting and stated the incident needed to be reported. In a phone interview on 6/12/24 at 11:42am, Resident #2's MD stated he saw Resident #2 on a regular basis, and it was likely Resident #2 was aware of what was going on. MD stated Resident #2 was able to voice her needs and wants at times. Resident #2's MD stated it was questionable if Resident #2 was able to give consent. MD stated he was unable to say yes or no if Resident #2 could consent to sexual activity as Resident #2 had some cognitive ability but was not sure if Resident #2 was able to fully understand the effects of the situation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 6/12/24 at 10:06am, the SW stated the Ombudsman came to facility with Resident #2's family member and showed staff a video of the incident between Resident #2 and Resident #3. The SW stated the Administrator started an investigation and he interviewed Resident #2. The SW stated Resident #2 did not state she was fearful, nor did Resident #2 display signs and symptoms of being emotionally distressed. The SW stated resident had a history of flirting with men and having verbal outbursts with profane language. The SW stated Resident #2 does not target just a certain type of male but would flirt and seek attention from any male she saw. The SW stated due to Resident #2's low BIMS score, Resident #2 was unable to consent to sexual activity. 3. Resident #5 Record review of Resident #5's face sheet dated 06/10/2024 reflected an [AGE] year-old male with an original admitted [DATE]. Pertinent diagnoses include Dementia (mental decline that affects the quality of daily living), Major Depressive Disorder (mental disorder characterized by a depressed mood, low self-esteem, and a loss of interest in normally enjoyable activities), and Chronic Pain. Record review of Resident #5's MDS dated [DATE] reflected a BIMS score of 5 (Severe Cognitive Impairment). Record review of Resident #5's comprehensive care plan dated 03/24/2024 indicated a problem with falls, stating he had a history of falls prior to admission with additional falls since admission. Interventions used in preventing injuries from falls included anticipating the needs of Resident #5, encouraging Resident #5 to use the call light, keeping the call light within reach, ensuring Resident #5 is wearing appropriate footwear, keeping furniture in a locked position, and keeping needed items within reach. Record review of Resident #5's progress note dated 12/24/2023 at 6:45 AM written by LVN G revealed that an unnamed CNA found Resident #5 sitting on the floor of his room. LVN G entered the room and noted the patient was sitting up against the bed on his bottom, alert and talking. Resident #5 was assessed with no injuries noted. Resident #5 stated he was trying to transfer from his bed to his wheelchair but did not lock his wheelchair. Resident #5 stated that his wheelchair started to roll away from him and he sat down on the floor. Resident #5 denied pain or discomfort at this time. Record review of Resident #5's progress note dated 12/27/2023 at 9:34 AM written by the DON revealed that Resident #5 had a visit from a veteran's affairs nurse and a social worker. Resident #5 reported at that time that his left elbow was hurting since his fall on Sunday (12/24/2023). Record review of Resident #5's x-ray results dated 12/27/2023 at 7:46 PM revealed that Resident #5 had an acute radial head fracture (a break to the radius bone in the forearm just below the elbow joint) on his left elbow. In an interview with LVN H on 06/11/2024 at 11:23 AM, LVN H stated that Resident #5 was a fall risk. LVN H stated that in the case of an unwitnessed fall, he would check for injuries before assisting the patient up, complete a head-to-toe assessment, check vitals, ask about any specific pain, and apprise the family, DON, and medical director of the unwitnessed fall. (continued on next page)

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	455923	A. Building B. Wing	06/16/2024

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Resident #5 on 06/11/2024 at 11:31 AM, Resident #5 stated that he did not remember experiencing a fall on 12/24/2023. He also stated that he feels like he gets treated well at the facility and could not come up with any complaints. He stated that he has pain all over, but especially in his back. He stated that he gets medication for his pain which helps him a lot. He stated that he never tries to hide his pain from any of the nurses. In an interview with the Administrator on 06/11/2024 at 2:30 PM, the Administrator stated that it is a group decision between her, the DON, an ADON if present, and potentially others on whether to report an incident to HHS or not. The Administrator stated they have an algorithm they use to help make these decisions. The Administrator stated that the resident does not get a vote when deciding if incidents should be reported to HHS. The Administrator stated either her or the DON file reports in TULIP. The Administrator stated that falls with no witnesses that result in a fracture should be reported to HHS. The Administrator stated that if the fracture was found several days after the suspected fall, then she would report it as an injury of unknown origin because she could not be certain if the fall caused the injury or not. In an interview with the DON on 06/11/2024 at 4:11 PM, the DON stated that in response to a fall, nurses will do an assessment before helping the resident get up. The DON stated that nurses conduct a 72 hour follow-up to ensure the mental status of the resident has not changed and what the resident's pain level is. The DON stated that the family and medical director are notified as well. The DON stated that any unwitnessed fall with major injuries is always reported in TULIP. The DON stated that in the instance an injury was found several days after a fall, and the injury could not be traced directly back to the fall, then it would be reported in TULIP as an injury of unknown origin. In an interview with LVN G on 06/12/2024 at 3:48 PM, LVN G stated that the fall Resident #5 experienced on 12/24/2023 was not witnessed. LVN G stated she was present the day Resident #5 had his fall on 12/24/2023. LVN G stated she was informed by a CNA of Resident #5's fall and proceeded to go through her procedure of assessing the resident, including checking for any injuries and asking about pain level immediately after the incident was brought to her attention. LVN G stated that no injuries were noted at the time of her initial assessment. 4. Resident #1 Record review of Resident #1's Face Sheet dated 06/11/2024 documented a [AGE] year-old female resident originally admitted to the facility on [DATE] and was readmitted on [DATE]. Her diagnoses were: vascular dementia (cognition impairment), cognitive communication deficit, muscle wasting, and atrophy, syncope (fainting or passing out), and collapse. Record review of Resident #1's Quarterly Minimum Data Set, dated dated dated [DATE] noted the following: Brief interview of mental status summary score of 8- (severe cognitive impairment). MDS coded Resident#1 to need total dependence for toilet use, transfers, and bed mobility. Functional Status: required substantial/maximal assistance for toileting, transfers, and bed mobility, as well as setup or clean-up assistance for eating. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident#1's Care Plan revision date 06/03/2024 revealed [Resident #1] has impaired cognition related to Dementia AEB BIMS of 8 which would be indicative of moderate cognitive impairment. She has a HX of hallucinations & delusions. HX of false allegations. Goal: Will be able to communicate basic needs on a daily basis through the review date. Interventions: engage in simple, structured activities that avoid overly demanding tasks. Face the resident when speaking and make eye contact. Reduce any distractions turn off TV, radio, close door etc. Keep routine consistent & try to provide consistent care givers as much as possible in order to decrease confusion. Monitor/document /report to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status, understands consistent, simple, directive sentences. Provide with necessary cues - stop and return if agitated, use task segmentation to support short term memory deficits. Provide 1 step directions. Record review of Resident #4's Progress note dated 07/18/2023 at 12:17PM, RN A documented during a care plan meeting, resident reported approximately 2 weeks ago she was going to her room and recalls the linen and trash barrels were in front of her closed door, she moved them to enter her room. She opened the door and then quickly closed it, when she thought she saw staff member lying over roommate in bed. She told her [family member] and at that time [family member] present during meeting & verified her telling him that day. He said he didn't say anything because he didn't believe it happened. He said [Resident #4] sometimes sees things that aren't really there. Administrator & DON, ADON were immediately called into the meeting for further interview. During an interview on 06/10/2024 at 4:31PM the DON stated on 07/18/2023, after Resident #4's care plan meeting, she was made aware of the allegation made by Resident #4 stating Resident#4 verbalized witnessing an unknown CNA on top of Resident #1. The DON stated she, in conjunction with the Administrator began the investigation into the allegation of potential abuse. The DON stated Resident #1 had a history of being a poor historian, due to her cognitive impairment related to dementia. The DON stated she interviewed Resident #1, and Resident #1 responded with denying allegation of abuse, as well as denied allegations of any person on top of her or her bed. The DON stated as part of the facility's policy and procedures the normal course of action for any allegation of abuse, would be to notify Administrator followed by the proper agencies including the local police department. The DON stated, when asked if the facility notified the local police department of this allegation of abuse, the facility did not notify the local authorities due to them concluding the allegation of abuse was unfounded. The DON stated if a resident expresses fearfulness or if there were any findings that would conclude abuse then the facility would notify the local authorities, but in this case did not. The DON stated consequences for not following the facility's policy and procedure, of notifying the local law enforcement regarding abuse, could cause the victim to continually be exposed to the potential abusive perpetrator. The DON stated, when asked how the facility ruled out abuse, the DON said due to the lack of evidentiary support to substantiate the allegation of abuse and the environmental safety resident surveys, the facility could not substantiate the allegation of abuse. The DON reiterated the reason the facility did not notify the local law enforcement regarding the allegation of abuse was that there was not enough evidence to conclude abuse. The DON stated due to Resident #1's history of verbalizing false allegations, this situation the facility will still look into the allegation and follow the abuse policy and procedure process, but certain situations necessitate calling the police immediately, this incident did not. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/12/24 at 4:15 PM the Administrator stated, Resident #1 never gets out of bed, and felt the most likely scenario was a CNA reaching over the resident. The Administrator stated she began the investigation promptly. The Administrator stated the facility did not notify local law enforcement on this investigation due to the conclusion that the accusation and evidence of the allegation were inconclusive. The Administrator stated if somebody said they were raped then she would call the police immediately in that situation before completing her own investigation. The Administrator stated she would not treat complaints differently from residents who have a history of making false accusations or psychiatric disorders. The Administrator stated after gathering evidence, a clinical team meeting was held and attempted to determine what happened for this allegation of abuse. When the Administrator was asked why the local law enforcement agency were not notified of the allegation of abuse, she did not respond with a reasoning as to why the facility did not follow their policy and procedure regarding allegations of abuse. Record review of the facility's provider investigation report dated 07/21/2023, revealed incident category: abuse; description of the allegation: [Resident #4] reported during a care plan meeting on 07/18/2023 that two weeks ago she saw a female CNA on top her roommate (Resident #1). Record review of the Abuse, Neglect, Exploitation or Misappropriation -Reporting and Investigating dated 9/2022 stated: Policy Statement All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations and thoroughly investigated by facility management. Findings of all investigations are documented and reported. 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; e. Law enforcement officials; Reporting Allegations to the Administrator and Authorities 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. 50039 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Evidence for tag placed under [NAME], [NAME] 609 - Reporting of Alleged Violations - E