

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455960	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Hays Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 Medical Pkwy San Marcos, TX 78666	

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** 42949</p> <p>Based on interview and record review, the facility failed to ensure the residents had the right to be free from abuse for two (Resident #1 and Resident #2) of four residents reviewed for abuse, in that:</p> <p>The facility failed to protect Resident #1 and Resident #2 who resided in the MCU (Memory Care Unit) from engaging in sexual activities when neither had the capacity to consent.</p> <p>An IJ was identified on 05/01/24. The IJ template was provided to the facility on [DATE] at 10:50 AM. While the IJ was removed on 05/02/24, the facility remained at a level of actual no actual harm at a scope of isolated 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 for abuse.</p> <p>Findings included:</p> <p>Review of Resident #1's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including unspecified dementia, cognitive communication deficit, Alzheimer's disease (a type of dementia that affects memory, thinking, and behavior), and hallucinations. She resided in the memory care unit.</p> <p>Review of Resident #1's quarterly MDS assessment, dated 01/24/24, reflected a BIMS of 99, indicating she was unable to complete the interview.</p> <p>Review of Resident #1's quarterly care plan, revised 01/25/24, reflected she was at risk for impaired cognitive function/dementia or impaired thought process r/t dementia with an intervention of needing supervision/assistance with all decision making. It further reflected she was an elopement risk/wanderer r/t disoriented to place with an impaired safety awareness with an intervention of documenting wandering behavior and attempted diversional interventions .</p> <p>Review of Resident #1's progress note, dated 04/14/24 at 9:23 PM and documented by LVN A , reflected the following:</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>At (6:00 PM) [CNA B] came to report that [Resident #1] was found in bed with [Resident #2] performing fellatio (oral sex). Per [CNA B] they stopped when they noticed him walking in. When I walked in [Resident #1] was sitting next to [Resident #2] fully clothed upset that we interrupted. [Resident #2] was sitting in his brief upset a well. When I spoke with [Resident #1] she kept saying it was her husband, calling him (name). It appeared consensual .</p> <p>Review of Resident #2's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke), vascular dementia (a type of dementia caused by conditions that damage blood vessels and block blood flow to the brain), frontal lobe and executive function deficit following cerebral infarction, memory deficit following cerebral infarction, and other speech and language deficits following cerebral infarction. He resided on the memory care unit.</p> <p>Review of Resident #2's admission MDS assessment, dated 04/15/24, reflected a BIMS of 10, indicating a moderate cognitive impairment.</p> <p>Review of Resident #2's admission care plan, revised 04/16/24, reflected he had impaired cognitive function/dementia or impaired thought processes r/t diagnoses of vascular dementia and history of cerebral infarction (stroke) with an intervention of him requiring the secured unit. It further reflected he had some sexual inappropriateness with another resident on 04/14/24 with an intervention of being on 1:1 with staff member at all times for safety immediately.</p> <p>Review of Resident #2's progress note, dated 04/14/24 at 9:38 PM and documented by LVN A, reflected the following:</p> <p>At (6:00 PM) [CNA B] came to report that [Resident #2] was found in bed with [Resident #1] fellatio performed to him. Per [CNA B] they stopped when they noticed him walking in. When I walked in [Resident #2] was sitting next to [Resident #1] in his brief. [Resident #1] was fully clothed and upset. [Resident #2] kept saying it was consensual .</p> <p>During an interview on 04/16/24 at 8:42 AM, the DON stated the incident between Resident #1 and #2 was not reported to HHSC because after reviewing video footage and gathering interviews it was obvious it was consensual and they were both confused. She stated there was no harm from the incident.</p> <p>During an interview on 04/16/24 at 9:35 AM, the ADM stated they went back-and-forth with whether to report the incident to HHSC or not. He stated after reviewing the video footage from multiple angles of Resident #2 pushing Resident #1 down to his room, it was obvious it was consensual as she was not fighting back. He stated although they were both confused, they were upset they were interrupted and wanted to be with each other. He stated residents had the right to engage in sexual activities.</p> <p>During a telephone interview on 04/30/24 at 4:43 PM, Resident #1's FM A stated the incident that happened with Resident #1 and #2 was very upsetting. She stated that was not something Resident #1 would have wanted to have been doing if she was in her right mind. She stated the ADM told her it was consensual and she became tearful and stated, She was in a wheelchair, she did not wheel herself back there herself. How is that consensual?</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 a telephone interview on 05/01/24 at 8:53 AM, Resident #1 and #2's PPA stated both residents did not have the ability to consent and they were both in the locked dementia unit. She stated something like this happening to someone that may be able to remember could cause fear and isolation. She stated sexual assault had the most triggers for PTSD .</p> <p>During an interview on 05/01/24 at 10:07 AM, the ADON was asked how they assessed residents for the capacity to consent in sexual situations. She stated it depended how you looked at it. She stated some residents' cognitive function went in and out - one day you could have a conversation with them and the next day they were not able. She stated in that moment, Resident #1 wanted to be with Resident #2. She stated it depended on residents' cognitive function. She stated if one resident was able to consent and one was not and something like that happened, it could cause emotional trauma.</p> <p>Review of the facility's Freedom from Abuse, Neglect, and Exploitation Policy, revised 12/2023, reflected the following:</p> <p>It is the policy of this facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation, and mistreatment.</p> <p>.</p> <p>Sexual abuse is non-consensual sexual contact of any type with a resident.</p> <p>The ADM and ADON were notified on 05/01/24 at 10:50 AM that an Immediate Jeopardy had been identified due to the above failures and an IJ template was provided.</p> <p>The following POR was accepted on 05/02/24 at 12:25 PM:</p> <p>F600</p> <ol style="list-style-type: none"> 1. The Medical Director was notified of the Immediate Jeopardy on 5/1/2024 at 11:31 am. 2. Resident #1 was assessed on 5/1/2024 by ADON with no adverse effects. Resident #2 was discharged from facility on 4/23/2024. All Full-time, Part-time, PRN and agency staff will be in-serviced prior to working the floor on how to handle residents engaging in a sexual encounters. In-service includes separating residents and informing ED or DON/ADON immediately and IDT meeting will be scheduled. New staff will also be in-serviced during the orientation process prior to resident interactions. All staff currently working the floor have already been in-serviced today 5/1/2024 by RN interim DON. 3. Staff will separate residents wanting to engage in sexual encounter until the IDT process is completed and staff have been informed of IDT decision by ED or DON and plan of care is updated. These individuals will be identified based on staff interviews and observations. <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>4. Facility process for residents to have sexual encounter is for staff to inform ED or DON of residents' desire based on interviews or observed behaviors. It will then be brought to the IDT (to include, but not limited to MD, ED, DON, ADON, SW) for them to make a determination of consent and need for further interventions and care plan updates, which will be done as soon as possible but up to three days. Staff made aware on case by case basis based on IDT determination. Facility will determine if needs or choices are changed as identified during quarterly care plan reviews. Staff will be made aware based on care plan. If staff encounter a situation involving residents, they will separate the residents and inform the ED or DON/ADON.</p> <p>5. Train the trainer in-service was given by the Clinical Resource RN and was completed with interim DON and Executive Director on 5/1/24 related to resident's capacity to consent and the IDT process to determine consensual relationships of residents.</p> <p>6. Summary of IJ and corrective action to be reviewed by QAPI Committee weekly x 4 weeks or until substantial compliance established and continue monthly for 90 days to ensure ongoing compliance.</p> <p>The Surveyor monitored the POR on 05/02/24 as followed:</p> <p>During an interview on 05/02/24 at 12:28 PM, the ADM stated they had in-serviced almost 100% of their staff. They were doing in-person in-services as well as their computer-based trainings on Abuse and Neglect.</p> <p>During an interview on 05/02/24 at 12:32 PM, the ADON stated Resident #2 no longer resided at their facility. She stated in-servicing started the day prior (05/01/24) with the day shift and it was continued at 10:00 PM with the night shift. She stated all staff were being in-serviced before working their shifts.</p> <p>During interviews on 05/02/24 from 12:37 PM - 1:40 PM, a HSK, three CNAs, a ST, the AD, one RN, and two LVNs (from different shifts) all stated they were in-serviced before they worked their shift on abuse, neglect, and sexual relationships between residents. All gave examples of abuse such as physical, sexual, emotional, and financial and knew their ADM was the Abuse and Neglect Coordinator. All stated residents needing to have the capacity to give consent was necessary for them to have any sort of sexual relationship or it would be considered abuse. Each staff member gave an example of when they would need to separate residents and to notify their ADM/ADON immediately such as handholding, touching, or residents expressing their desire to engage in a sexual relationship. They all knew it was a resident's right to engage in sexual acts but it would be up to the leadership team to determine if they had the capacity to consent.</p> <p>Review of the facility's QAPI agenda, dated 05/01/24, reflected the MD, ADM, DOR, MDSC, AD, SW, NP, and ADON were in attendance.</p> <p>Review of the facility's in-service entitled Abuse and Neglect, dated 05/01/24 and conducted by the ADM, reflected all staff from each shift were in-serviced on their Abuse and Neglect Policy.</p> <p>Review of the facility's in-serviced entitled How to Handle Resident Engaging in a Sexual Encounter, dated 05/01/24 and conducted by the ADM, reflected all staff from each shift were in-serviced on the following:</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>If residents are observed to be having a relationship, gently separate the two from touching and notify the ADON/Administrator immediately and the management team will have a process to meet and determine consent.</p> <p>An IJ was identified on 05/01/24. The IJ template was provided to the facility on [DATE] at 10:50 AM. While the IJ was removed on 05/02/24, the facility remained at a level of actual no actual harm at a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.</p>

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949</p> <p>Based on interview and record review the facility failed to implement their written policies and procedures regarding prohibiting and preventing abuse for two (Resident #1 and Resident #2) of four residents reviewed for developing and implementing abuse and neglect policies, in that:</p> <p>The facility failed to implement facility abuse policy when they failed to protect Resident #1 and Resident #2 who resided in the MCU (Memory Care Unit) from engaging in sexual activities when neither had the capacity to consent.</p> <p>This failure resulted in an identification of an Immediate Jeopardy (IJ) on 05/01/24 at 10:50 AM. While the IJ was removed on 05/02/24 at 1:45 PM, the facility remained at a level of actual no actual harm at a scope of isolated 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 not being protected from abuse, neglect, or exploitation.</p> <p>Findings included:</p> <p>Review of Resident #1's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including unspecified dementia, cognitive communication deficit, Alzheimer's disease (a type of dementia that affects memory, thinking, and behavior), and hallucinations. She resided in the memory care unit.</p> <p>Review of Resident #1's quarterly MDS assessment, dated 01/24/24, reflected a BIMS of 99, indicating she was unable to complete the interview.</p> <p>Review of Resident #1's quarterly care plan, revised 01/25/24, reflected she was at risk for impaired cognitive function/dementia or impaired thought process r/t dementia with an intervention of needing supervision/assistance with all decision making. It further reflected she was an elopement risk/wanderer r/t disoriented to place with an impaired safety awareness with an intervention of documenting wandering behavior and attempted diversional interventions.</p> <p>Review of Resident #1's progress note, dated 04/14/24 at 9:23 PM and documented by LVN A, reflected the following:</p> <p>At (6:00 PM) [CNA B] came to report that [Resident #1] was found in bed with [Resident #2] performing fellatio (oral sex). Per [CNA B] they stopped when they noticed him walking in. When I walked in [Resident #1] was sitting next to [Resident #2] fully clothed upset that we interrupted. [Resident #2] was sitting in his brief upset a well. When I spoke with [Resident #1] she kept saying it was her husband, calling him (name). It appeared consensual .</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke), vascular dementia, frontal lobe and executive function deficit following cerebral infarction , memory deficit following cerebral infarction, and other speech and language deficits following cerebral infarction. He resided on the memory care unit.</p> <p>Review of Resident #2's admission MDS assessment, dated 04/15/24, reflected a BIMS of 10, indicating a moderate cognitive impairment.</p> <p>Review of Resident #2's admission care plan, revised 04/16/24, reflected he had impaired cognitive function/dementia or impaired thought processes r/t diagnoses of vascular dementia and history of cerebral infarction with an intervention of him requiring the secured unit. It further reflected he had some sexual inappropriateness with another resident on 04/14/24 with an intervention of being on 1:1 with staff member at all times for safety immediately.</p> <p>Review of Resident #2's progress note, dated 04/14/24 at 9:38 PM and documented by LVN A, reflected the following:</p> <p>At (6:00 PM) [CNA B] came to report that [Resident #2] was found in bed with [Resident #1] fell atio performed to him. Per [CNA B] they stopped when they noticed him walking in. When I walked in [Resident #2] was sitting next to [Resident #1] in his brief. [Resident #1] was fully clothed and upset. [Resident #2] kept saying it was consensual .</p> <p>During an interview on 04/16/24 at 8:42 AM, the DON stated the incident between Resident #1 and #2 was not reported to HHSC because after reviewing video footage and gathering interviews it was obvious it was consensual and they were both confused. She stated there was no harm from the incident.</p> <p>During an interview on 04/16/24 at 9:35 AM, the ADM stated they went back-and-forth with whether to report the incident to HHSC or not. He stated after reviewing the video footage from multiple angles of Resident #2 pushing Resident #1 down to his room, it was obvious it was consensual as she was not fighting back. He stated although they were both confused, they were upset they were interrupted and wanted to be with each other. He stated residents had the right to engage in sexual activities.</p> <p>During a telephone interview on 05/01/24 at 8:53 AM, Resident #1 and #2's PPA stated both residents did not have the ability to consent and they were both in the locked dementia unit. She stated something like this happening to someone that may be able to remember could cause fear and isolation. She stated sexual assault had the most triggers for PTSD .</p> <p>During an interview on 05/01/24 at 10:07 AM, the DON was asked how they assessed residents for the capacity to consent in sexual situations. She stated it depended how you looked at it. She stated some residents' cognitive function went in and out - one day you could have a conversation with them and the next day they were not able. She stated in that moment, Resident #1 wanted to be with Resident #2. She stated it depended on residents' cognitive function. She stated if one resident was able to consent and one was not and something like that happened, it could cause emotional trauma.</p> <p>Review of the facility's Freedom from Abuse, Neglect, and Exploitation Policy, revised 12/2023, reflected the following:</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>It is the policy of this facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation, and mistreatment.</p> <p>.</p> <p>Sexual abuse is non-consensual sexual contact of any type with a resident.</p> <p>.</p> <p>Reporting/Response:</p> <p>.</p> <p>2. Allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations.</p> <p>Review of HHSC's PL 19-17, dated 07/10/19, reflected the following:</p> <p>An incident that does not result in serious bodily injury and involves abuse or neglect should be reported immediately, but not later than 24 hours after the incident occurs or is suspected.</p> <p>The ADM and ADON were notified on 05/01/24 at 10:50 AM that an Immediate Jeopardy had been identified due to the above failures and an IJ template was provided.</p> <p>The following POR was accepted on 05/02/24 at 12:25 PM:</p> <p>F607</p> <p>1. The Medical Director was notified of the Immediate Jeopardy on 5/1/2024 at 11:31 am.</p> <p>2. Resident #1 was assessed on 5/1/2024 by ADON with no adverse effects. Resident #2 was discharged from facility on 4/23/2024. All Full-time, Part-time, PRN and agency staff will be in-serviced prior to working the floor on Abuse and Neglect policy. New staff will also be in-serviced during orientation process prior to resident interactions. All Staff currently working the floor have already been in-serviced today 5/1/2024, by RN interim DON</p> <p>3. Facility process for residents to have sexual encounter is for staff to inform ED or DON of residents' desire based on interviews or observed behaviors. It will then be brought to the IDT (to include, but not limited to MD, ED, DON, ADON, SW) for them to make a determination of consent and need for further interventions and care plan updates, which will be done as soon as possible but up to three days. Staff made aware as needed on a case by case basis based on IDT determination. Facility will determine if needs or choices are changed as identified during quarterly care plan reviews. Staff will be made aware based on care plan. If staff encounter a situation involving residents, they will separate the residents and inform the ED or DON/ADON immediately and IDT meeting will be scheduled.</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>4. Train the trainer in-service was given by the Clinical Resource RN and was completed with interim DON and Executive Director on 5/1/24 related to resident's compacity to consent and the IDT process to determine consensual relationships of residents.</p> <p>5. Summary of IJ and corrective action to be reviewed by QAPI Committee weekly x 4 weeks or until substantial compliance established and continue monthly for 90 days to ensure ongoing compliance.</p> <p>The Surveyor monitored the POR on 05/02/24 as followed:</p> <p>During an interview on 05/02/24 at 12:28 PM, the ADM stated they had in-serviced almost 100% of their staff. They were doing in-person in-services as well as their computer-based trainings on Abuse and Neglect.</p> <p>During an interview on 05/02/24 at 12:32 PM, the ADON stated Resident #2 no longer resided at their facility. She stated in-servicing started the day prior (05/01/24) with the day shift and it was continued at 10:00 PM with the night shift. She stated all staff were being in-serviced before working their shifts.</p> <p>During interviews on 05/02/24 from 12:37 PM - 1:40 PM, a HSK, three CNAs, a ST, the AD, one RN, and two LVNs (from different shifts) all stated they were in-serviced before they worked their shift on abuse, neglect, and sexual relationships between residents. All gave examples of abuse such as physical, sexual, emotional, and financial and knew their ADM was the Abuse and Neglect Coordinator. All stated residents needing to have the capacity to give consent was necessary for them to have any sort of sexual relationship or it would be considered abuse. Each staff member gave an example of when they would need to separate residents and to notify their ADM/ADON immediately such as handholding, touching, or residents expressing their desire to engage in a sexual relationship. They all knew it was a resident's right to engage in sexual acts but it would be up to the leadership team to determine if they had the capacity to consent.</p> <p>Review of the facility's QAPI agenda, dated 05/01/24, reflected the MD, ADM, DOR, MDSC, AD, SW, NP, and ADON were in attendance.</p> <p>Review of the facility's in-service entitled Abuse and Neglect, dated 05/01/24 and conducted by the ADM, reflected all staff from each shift were in-serviced on their Abuse and Neglect Policy.</p> <p>Review of the facility's in-serviced entitled How to Handle Resident Engaging in a Sexual Encounter, dated 05/01/24 and conducted by the ADM, reflected all staff from each shift were in-serviced on the following:</p> <p>If residents are observed to be having a relationship, gently separate the two from touching and notify the ADON/Administrator immediately and the management team will have a process to meet and determine consent.</p> <p>While the IJ was removed on 05/02/24 at 1:45 PM, the facility remained at a level of actual no actual harm at a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949</p> <p>Based on interview and record review, the facility failed to ensure all alleged violations involving abuse or neglect were reported immediately or no later than 24 hours for two (Resident #1 and Resident #2) of four residents reviewed for abuse and neglect, in that:</p> <p>The facility failed to report to the State Agency an incident where two residents (Resident #1 and #2) who were not cognitively able to give consent were found engaging in sexual activities.</p> <p>This failure could place residents at risk of not required incidents reported as required and timely.</p> <p>Findings included:</p> <p>Review of Resident #1's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including unspecified dementia, cognitive communication deficit, Alzheimer's disease (a type of dementia that affects memory, thinking, and behavior), and hallucinations. She resided in the memory care unit.</p> <p>Review of Resident #1's quarterly MDS assessment, dated 01/24/24, reflected a BIMS of 99, indicating she was unable to complete the interview.</p> <p>Review of Resident #1's quarterly care plan, revised 01/25/24, reflected she was at risk for impaired cognitive function/dementia or impaired thought process r/t dementia with an intervention of needing supervision/assistance with all decision making. It further reflected she was an elopement risk/wanderer r/t disoriented to place with an impaired safety awareness with an intervention of documenting wandering behavior and attempted diversional interventions.</p> <p>Review of Resident #1's progress note, dated 04/14/24 at 9:23 PM and documented by LVN A, reflected the following:</p> <p>At (6:00 PM) [CNA B] came to report that [Resident #1] was found in bed with [Resident #2] performing fellatio (oral sex). Per [CNA B] they stopped when they noticed him walking in. When I walked in [Resident #1] was sitting next to [Resident #2] fully clothed upset that we interrupted. [Resident #2] was sitting in his brief upset a well. When I spoke with [Resident #1] she kept saying it was her husband, calling him (name). It appeared consensual .</p> <p>Review of Resident #2's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke), vascular dementia, frontal lobe and executive function deficit following cerebral infarction , memory deficit following cerebral infarction, and other speech and language deficits following cerebral infarction. He resided on the memory care unit.</p> <p>Review of Resident #2's admission MDS assessment, dated 04/15/24, reflected a BIMS of 10, indicating a moderate cognitive impairment.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455960	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Hays Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 Medical Pkwy San Marcos, TX 78666	
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's admission care plan, revised 04/16/24, reflected he had impaired cognitive function/dementia or impaired thought processes r/t diagnoses of vascular dementia and history of cerebral infarction with an intervention of him requiring the secured unit. It further reflected he had some sexual inappropriateness with another resident on 04/14/24 with an intervention of being on 1:1 with staff member at all times for safety immediately.</p> <p>Review of Resident #2's progress note, dated 04/14/24 at 9:38 PM and documented by LVN A, reflected the following:</p> <p>At (6:00 PM) [CNA B] came to report that [Resident #2] was found in bed with [Resident #1] fell atio performed to him. Per [CNA B] they stopped when they noticed him walking in. When I walked in [Resident #2] was sitting next to [Resident #1] in his brief. [Resident #1] was fully clothed and upset. [Resident #2] kept saying it was consensual .</p> <p>During an interview on 04/16/24 at 8:42 AM, the DON stated the incident between Resident #1 and #2 was not reported to HHSC because after reviewing video footage and gathering interviews it was obvious it was consensual and they were both confused. She stated there was no harm from the incident.</p> <p>During an interview on 04/16/24 at 9:35 AM, the ADM stated they went back-and-forth with whether to report the incident to HHSC or not. He stated after reviewing the video footage from multiple angles of Resident #2 pushing Resident #1 down to his room, it was obvious it was consensual as she was not fighting back. He stated although they were both confused, they were upset they were interrupted and wanted to be with each other. He stated residents had the right to engage in sexual activities.</p> <p>Review of the facility's Freedom from Abuse, Neglect, and Exploitation Policy, revised 12/2023, reflected the following:</p> <p>It is the policy of this facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation, and mistreatment.</p> <p>.</p> <p>Sexual abuse is non-consensual sexual contact of any type with a resident.</p> <p>.</p> <p>Reporting/Response:</p> <p>.</p> <p>2. Allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations.</p> <p>Review of HHSC's PL 19-17, dated 07/10/19, reflected the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455960	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Hays Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 Medical Pkwy San Marcos, TX 78666	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An incident that does not result in serious bodily injury and involves abuse or neglect should be reported immediately, but not later than 24 hours after the incident occurs or is suspected.</p>