STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675391	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Arbor	705 Hwy 418 W Silsbee, TX 77656

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47879 Based on observation, interview and record review, the facility failed to protect a resident's right to be free from abuse for 2 of 11 residents reviewed for abuse. (Resident #1 and #2) The facility failed to protect Resident #1 from inappropriate sexual touching by Resident #2. This failure could place residents at risk of for psychosocial harm and a diminished quality of life. Findings included: 1. Record review of a face sheet dated 09/17/2024, indicated Resident #1 was a [AGE] year-old female, with an admitted [DATE] with diagnoses including Dementia (loss of cognitive functioning), Bipolar Disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs), Cirrhosis of the liver (a condition in which healthy tissue is replaced with scar tissue), anxiety disorder (persistent and excessive worry that interferes with daily activities) and depressive disorder (mental illness that negatively affects how you feel, the way you think and how you act). Record review of a quarterly MDS assessment, dated 05/26/2024, indicated Resident #1 had a BIMS score of 10 which indicated moderately impaired cognition and she sometimes makes self-understood and usually understands others. She had behaviors of inattention and disorganized thinking which fluctuates (comes and goes, changes in severity). She requires assistance with transfer, dressing, toileting, bathing and personal hygiene. Record review of a care plan initiated on 06/14/2024 indicated Resident #1 had reportable incident with another resident. Resident #1's care plan included interventions of eval and treat if showing signs of depression or anxiety and redirect as indicated. Record review of a care plan indicated on 06/18/2024 indicated Resident #1 had episodes of sexual behaviors and is at risk for further increased episodes. Resident #1's care plan included interventions of encourage to attend social activities of preference, explain procedures using terms/gestures the resident can understand, and give medications as ordered - monitor labs - report results to MD. (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 - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of a face sheet dated 09/17/2024, indicated Resident #2 was a [AGE] year-old male, readmitted [DATE] with an admitted [DATE] with diagnoses including Parkinson's disease (a disorder of the central nervous system that affects movement, including tremors), Alzheimer's disease (a progressive disease that destroys memory and other important mental function), high risk heterosexual behaviors (any sexual behavior between a male and female that puts a person at increased risk of getting or spreading a sexually transmitted infection), cognitive communication deficit (result in difficulty with thinking and how someone uses language), dementia (loss of cognitive functioning), diabetes (a chronic condition that affects the way the body processes blood sugar) and impulsiveness (tendency to act without thinking). Record review of a quarterly MDS assessment, dated 06/10/2024, indicated Resident #2 had a BIMS score of 11 which indicated moderately impaired cognition, made self-understood and able to understand others, had physical behavioral symptoms directed towards others and other behavioral symptoms not directed toward others 1 to 3 days. He had behaviors of inattention and disorganized thinking which fluctuates (comes and goes, changes in severity). He required maximal assistance with bed mobility, transfer, dressing, toileting, and bathing. Record review of a care plan initiated on 12/08/2023 and revised on 12/11/2023, indicated Resident #2 had a behavior problem related to sexual behaviors and tendencies with interventions that included administer medication as ordered and monitor/document for side effects and effectiveness, monitor behavior episodes and attempt to determine underlying cause, consider location, time of day, persons involved, and situations, document behavior and potential causes, and provide a program of activities that is of interest and accommodates residents status. Record review of a care plan initiated on 11/19/2023 and revised on 05/13/2024, indicated Resident #2 had episodes of inappropriate sexual behaviors with interventions of one on one monitoring 05/8/2024 and 06/17/2024, collect UA and transfer to behavioral hospital, encourage to attend social activities of preference, give medications as ordered - monitor labs- report to MD, monitor and chart behaviors as they occur and report progress/declines to MD. Observe for early warning signs of behaviors -approach in a calm manner, call by name, remove unwanted stimuli, provide psych consults a ordered and may have 1-2 staff members for ADL care. Record review of a care plan initiated on 06/14/2024 indicated Resident #1 had reportable incident with another resident. Resident #1's care plan included interventions of resident placed on one-on-one redirection, resident transferred to inpatient psych services for evaluation and treatment as ordered. Record review of the Provider Investigation Report dated 06/17/2024 indicated Resident #2 was witnessed touching the private area of Resident #1 while in the dining area around 11:00 a.m. The incident was witnessed by two other residents (Resident #3 and Resident #4) which alerted the staff member in the dining room and staff intervened and separated Resident #1 and Resident #2 immediately. The incident occurred on 06/17/2024 at 11:00 a.m. and was reported to the state agency on 06/17/2024. The investigation findings were confirmed, Resident #2 denied the allegations, but two other residents witnessed the incident. Resident #2 was monitored one-on-one until transferred to behavioral hospital on 06/17/2024. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's progress notes between 11/25/2023 01/29/2024 indicated the resident had inappropriate comments and/or sexual comments towards staff and inappropriate touching of staff on the following dates with the following interventions put in place: -11/25/2023 (inappropriate comments) Redirected by LVN. -11/26/2023 (inappropriate comments) Behaviors reported to MD, DON and administrator. Resident #2 monitored for ongoing behaviors. -11/30/2023 New orders were initiated to increase the resident's Aricept and start Paxil 10mg by mouth every night related to anxiety disorder. -12/5/2023 (inappropriate gestures) towards a male therapy staff who assisted the resident back to bed. -12/6/2023 An IDT meeting was conducted regarding Resident #2 exhibiting behaviors with staff. The IDT recommended to redirect resident's behaviors, approach and speak to in a calm manner. -12/09/2023 (inappropriate comments) Resident #2 requested that a CNA feed him even though the resident can feed self. The resident was being vulgar and inappropriate with the CNA. -12/12/2023 New orders were initiated for Paroxetine (generic for Paxil) 20mg 1 tablet by mouth at bedtime related to depression and sexual behaviors and Depakote 125 mg 1 tablet by mouth at bedtime related to dementia. -12/14/2023-12/20/23 - No inappropriate behaviors noted. Monitoring for behaviors continued. -12/21/2023 Increase Depakote 125 mg 2 tablets by mouth at bedtime related to dementia and sexual behaviors. -12/22/2023 - 12/25/2023 - No inappropriate behaviors noted. Monitoring for behaviors continued. -01/29/2024 (inappropriate comments and touching of a CNAs arm/hand) Behavior reported. Record review of Resident #2's psychiatric assessment note indicated on 02/01/2024 Resident #2 was seen today for a scheduled psychiatric visit. Nursing staff reported that his inappropriate behaviors of grabbing staff has improved. Assessment/Plan: continue paroxetine 20mg 1 tablet at bedtime and Depakote tablet 125mg at bedtime for depressive symptoms and improvement in sexual behaviors. Record review of Resident #2's progress notes between 02/19/2024 - 03/08/2024 indicated the resident had inappropriate verbal sexual talk and inappropriate touching of staff on the following dates with the following interventions put in place: -02/19/2024 (inappropriate touching of a housekeeper's private area) Resident behavior redirected. -02/25/2024 Resident #2's Depakote 250mg was increased to twice a day related to psychosis, dementia and other behavioral disturbances. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-02/27/2024 (inappropriate touching of CNA's arms during shower) Redirected by the CNA. -02/29/2024 (inappropriate touching of CNA's private area) The resident was redirected and told his behavior was not acceptable. Resident #2 laughed and said he did not care. -02/29/2024 A urine specimen was collected from Resident #2 to rule out a UTI related to behaviors. -03/2/2024 (inappropriate touching of a CNA's butt and slid his hands between her legs, touching her private area) The resident laughed and asked why she was upset. Behaviors reported. -03/05/2024 The charge nurse notified the SW, DON, and administrator that Resident #2 was displaying inappropriate behaviors. Resident #2 was brought to administrator's office and discussed the situation. Resident #2 said he never wanted to come to this facility and would like to leave. The administrator discussed with Resident #2 about finding an alternative facility in the local area. The DON notified the VA and the SW initiated referrals to other facilities. -03/08/2024 A follow-up conversation with the NP was conducted regarding Resident #2's sexual behaviors towards female staff and the need for advanced medication management. Resident receiving psych services for behaviors without success. The resident's RP was also aware of resident's behavior and the facility's multiple attempts to manage the resident's behaviors with constant redirection, one-on-one monitoring, attempted to utilize male and female staff members to provide care, and counseling which were unsuccessful. Resident's RP was assisting with finding treatment as evidenced by reaching out to VA social services. The RP was informed of a new order for Depo Provera 150mg/1ml IM every 3 months. Record review of physician order dated 03/08/2024 Depo-testosterone inject 150 mg Intramuscular one time a day every three months starting on the 11th for 84 day(s) related to high-risk homosexual behaviors. Record review of Resident #2's progress notes between 03/11/2024 - 03/19/2024 indicated the resident had inappropriate verbal sexual talk and inappropriate touching of staff on the following dates with the following interventions put in place: -03/11/2024 Depo Provera 150mg IM administered. -03/15/2024 (inappropriate comments and gestures) Reported behavior to the charge nurse and the DON. -03/16/2024 (inappropriate gestures) Resident #2's was found lying sideways across his bed with no pants or brief on, exposing his private area. Staff redirected resident and explained to resident the gesture was inappropriate. Resident #2 laughed and stated, I know I am inappropriate, and I don't like that I do that. -03/18/2024 (inappropriate comment) The nurse explained to the resident how it was an inappropriate comment, and the resident was redirected. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-03/19/2024 (inappropriate comments and attempting to touch on the charge nurse) Resident asked a female (resident) to go to his room. The resident was not easily redirected by staff. Resident was acting sexually inappropriate with staff. The DON, SW, and RP notified. Due to resident behaviors resident was placed on one-on-one until transfer to a behavioral hospital. Resident remained on one-on-one at the nurses' station. The resident attempted to touch staff behind nurses' station, resident had to be redirected. discharged to a behavioral hospital. Record review of Resident #2's psychiatric assessment note indicated on 04/01/2024 Resident #2 was seen today for a follow-up psychiatric visit. He had a recent hospitalization at behavioral hospital for ongoing sexual behaviors towards staff. He was admitted to behavioral hospital on 03/19/2024 and readmitted back to facility on 04/08/202. Nursing Staff report that patient has an appointment with VA psychiatrist tomorrow. The note indicated the resident's medications were reviewed of what was changed at the hospital and to continue paroxetine 20mg 1 tablet at bedtime and Depakote tablet 250 mg twice a day (Patient does have room to increase this dose) for depressive symptoms and improvement in sexual behaviors. Record review of Resident #2's progress notes between 04/08/2024 -04/11/2024 indicated the resident had inappropriate verbal sexual talk and inappropriate touching of staff on the following dates with the following interventions put in place: -04/08/2024 Resident returned to facility from behavioral hospital with new medication orders for his behaviors. -04/9/2024 (inappropriate comments and gestures with student (aide)) The Administrator and ADON were notified. Police were called to and came to speak with the resident. Resident #2 made another inappropriate comment to the nurse. Nurse redirected the resident, explaining to him it was inappropriate. The police officer spoke with resident about been inappropriate. -04/11/2024 Care Conferences were held with Resident #2, key facility staff, and the resident's Psychiatrist from the VA clinic. Record review of Resident #2's psychiatric assessment note indicated on 04/18/2024 Resident #2 was seen for a scheduled follow-up appointment. The resident was being seen at request of the facility and to make appropriate medication changes. Assessment/Plan: Increase paroxetine to 40mg 1 tablet at bedtime and Depakote tablet 250 mg 1 tablet twice a day and 2 tablets at bedtime for depressive symptoms and improvement in sexual behaviors. Record review of Resident #2's progress notes between 04/19/2024 -04/11/2024 indicated the resident had inappropriate verbal sexual talk and inappropriate touching of staff on the following dates with the following interventions put in place: -04/19/2024 (inappropriate touching and kissing of CNA's arms) Another staff member stood by to assist the CNA to complete care for redirection. -04/22/2024 (inappropriate comments and touching on the CNA) Administrator made aware and spoke with resident. Resident continued to be monitored for behaviors and continued medication increase for behaviors. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-04/23/2024 Monitoring for resident behaviors and monitoring while he was up in his wheelchair. -04/25/2024 Monitoring for resident behaviors. Resident noted to have inappropriate behaviors with staff while staff assists with ADLs. Both verbal and physical. Psych services out to visit. New orders for medication management. Record review of Resident #2's psychiatric assessment note indicated on 04/25/2024 Resident #2 was being at staff request for continued unstable symptoms that have shown limited improvement. He has had recent changes in medications that have not seemed to provide much change to this. He previously spent several days at the behavioral hospital with no change upon readmission. Assessment/Plan: Decrease paroxetine to 20mg 1 tablet at bedtime and continue Depakote tablet 250 mg 1 tablet twice a day and 2 tablets at bedtime, continue Namenda 5mg 1 tablet twice daily, increase Aricept 10mg 1 tablet at bedtime, continue Rexulti 1mg 1 tablet daily (if hypersexual behaviors worsen then will discontinue) for Dementia, Depressive symptoms and improvement in sexual behaviors. Record review of Resident #2's progress notes between 04/28/2024 -04/11/2024 indicated the resident had inappropriate verbal sexual talk and inappropriate touching of staff on the following dates with the following interventions put in place: -04/28/2024 Monitoring for resident behaviors. Resident has been cooperative with care. No behaviors were noted. -04/29/2024 (inappropriate gestures) Notified administrator and administrator spoke with him. -05/01/2024 (inappropriate touching of CNA's breast and buttocks) The DON/RN, Administrator, family member was notified of the incident. The family member indicated she would come to the facility to see the resident. Psych NP at the facility and visited with the resident. Record review of Resident #2's psychiatric assessment note indicated on 05/01/2024 Resident #2 was being seen at staff request for continued unstable symptoms that have shown limited improvement. Resident #2 had ongoing inappropriate sexual behaviors towards female staff. Patient was sitting in his wheelchair in his room. When discussing his recent actions with patient, resident vehemently denied that he had touched anyone. He then demanded to know who was saying that about him. Documentation noted on 04/29 and 05/01 of continued sexually inappropriate behaviors. He flipped off two staff members and grabbed one staff members buttocks and kissed her breast. Assessment/Plan continue Depakote tablet 250 mg 1 tablet twice a day and 2 tablets at bedtime, continue Namenda 5mg 1 tablet twice daily, increase Aricept 10mg 1 tablet at bedtime, continue Rexulti 1mg 1 tablet daily (if hypersexual behaviors worsen then will discontinue) for Dementia, Depressive symptoms and improvement in sexual behaviors. Record review of Resident #2's progress notes between 05/03/2024 -05/04/2024 indicated the resident had inappropriate verbal sexual talk and inappropriate touching of staff on the following dates with the following interventions put in place: -05/03/2024 Monitoring for resident behaviors. Resident noted to have inappropriate behaviors with staff during ADL care. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-05/04/2024 (inappropriate gestures and touching on the CNA) Reported the behaviors to the CN. Staff redirected and continued to monitor behaviors. CNA who tried to get him to stop. Record review of Resident #2's progress notes dated 05/08/2024 indicated Resident #2 was placed on one-on-one monitoring after he grabbed onto a (female) resident's wheelchair and would not let go. Staff intervened immediately and removed the female resident from Resident #2's reach. Reported incident to the Administrator. He spoke with Resident #2 and the resident stayed in the DON/ADON's office while the CN called RP. No aggressive behaviors were noted; however, resident required frequent redirecting with being sexually inappropriate with staff. DON spoke with the NP regarding resident's behavior and the need to send him out for further evaluation. The resident was transferred to the behavioral hospital. Monitoring for resident behaviors continued one-on-one at the nurse's station until transport arrived. Record review of Resident #2's psychiatric assessment note indicated on 05/13/2024 Resident #2 not seen due to resident was admitted to a behavioral hospital for ongoing sexually inappropriate behaviors. Record review of Resident #2's progress notes indicated the following: -05/18/2024 Resident returned to facility. Monitoring for resident behaviors. -05/20/2024 -05/23/24 Monitoring for resident behaviors and new medication initiated for behaviors. -05/23/2024 The SW, DON, and Resident #2 had a VA virtual visit with geriatric psych to discuss his current medications, behaviors etc. Throughout the meeting, Resident #2 was cooperative. Discussed his recent visit to behavioral hospital, any possible referrals to other placing agencies that may accept Resident #2 long term due to his high sexual behaviors. VA geriatric psych states she will fax over all recommendations for Resident #2 and will follow up in a month for Resident #2. Record review of Resident #2's psychiatric assessment note indicated on 05/28/2024 Resident #2 was being seen at staff request. Resident #2 was being seen today being seen today after a recent behavioral hospital stay. He was admitted to behavioral hospital on 05/08 after being placed on one-on-one due to an incident where he held onto a female resident's chair, an unrelated incident with another male resident, and continued sexual behavior towards staff. He was discharged back to facility on 05/18/2024 with new orders for sertraline 50mg and increased Rexulti 2mg. He has not had any documented sexual behavior since return. He was noted lying in bed at visit. His speech was limited and did not answer questions. Patient was uncooperative with exam. Staff report that patient has been weak since his return from behavioral hospital. Met with VA psychiatrist, on 05/23/2024; discontinued Paxil, Rexulti, and started sertraline. Record review of Resident #2's progress notes indicated the following: -06/01/2024 Resident #2 returned to facility following an unrelated hospital stay. Monitoring for resident behaviors. -06/01-06/11/2024 No documented inappropriate behaviors. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's psychiatric assessment note indicated on 06/11/2024 Resident #2 was seen for a scheduled follow-up and medication management. He was sitting up in wheelchair in his room. He was pleasant and engaging. He states that he is fine and has been feeling okay. No behaviors noted. Assessment/Plan: Continue sertraline 50mg 1 tablet daily, continue Depakote DR 250mg 1 tablet bid and 2 tablet at bedtime, continue Namenda 5mg 1 tablet bid, continue Aricept 10 mg at bedtime for Dementia, Depressive symptoms and improvement in sexual behaviors. Record review of Resident #2's progress notes indicated the following: -06/12-06/16/2024 No documented inappropriate behaviors. Record review of Resident #2's progress notes indicated the following: -06/17/2024 The SW reported two residents witnessed Resident #2 touching another resident (Resident #1) inappropriate while sitting in the dining room. The SW reported Resident #2 denied the incident. The residents were immediately separated. Resident #2 was placed on one- on-one monitoring and the Administrator was notified, and family were notified. A Behavioral health intake for Resident #2 was called. Head to toe assessment done. Resident touching staff and grabbing staff's breast and talking about titties and how much he likes staffs. CN told Resident #2 to stop touching and he stated he liked it too much. CNA A and CNA B both had to remove Resident #2's hands from their breast and legs while providing care during a shower and when they transferred Resident #2 to a wheelchair. CN stopped Resident #2 from touching her breast and he started taking about how he really wanted to touch the CN. Resident #2 continued on one-on-one monitoring until resident was transferred to a behavioral hospital. During an observation and interview on 09/16/2024 at 03:00 p.m., Resident #2 was sitting up in his bed, eating a snack and drinking a coke. He appeared well groomed and no foul odor. He was socializing with his roommate and denies any concerns or complains. He said he was pleased with the care provided by facility staff and denied any sexual behaviors towards facility staff or other residents. During an observation and interview on 09/16/2024 at 03:30 p.m., Resident #1 was sitting in her wheelchair the dining room watching TV. She appeared well groomed and no foul odors. She was interacting with other residents and staff with no distress noted. She said she did not recall being inappropriately touched by Resident #2 or any other residents or staff members. During an interview on 09/16/2024 at 04:00 p.m., Resident #3 said she witnessed Resident #2 touch Resident #1 in her private area. She said Resident #2 reached out and placed his hand on Resident #1's private area and made a rubbing movement over Resident #1's clothing. Resident #3 said she and Resident #4 hollered and told him to stop, then staff came over and removed Resident #2 from the dining area. Resident #3 said she did not hear Resident #1 telling him to stop, but he only touched the resident quickly, he stopped when we hollered at him to stop. Resident #3 said she had not been touched inappropriately by other residents and had not witnessed Resident #2 touch any other resident's inappropriately prior to this incident or since this incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/16/2024 at 04:18 p.m., Resident #4 said he witnessed Resident #2 touch Resident #1 in her private area. He said Resident #1 reached out and placed his hand on Resident #1's private area and made a rubbing movement over Resident #1's clothing. He said he and Resident #3 hollered and told him to stop, then staff came over immediately and removed Resident #2 from the dining area. Resident #4 said he did not hear Resident #1 telling him to stop, but it happened quickly and Resident #2 stopped when we hollered at him to stop. Resident #4 said he has not witnessed Resident #2 touch any other resident's inappropriately prior to this incident or since this incident. During an interview on 09/16/2024 at 04:30 p.m., the SW said she was in the dining room helping another resident when she looked up and saw two residents (Resident #3 and Resident #4) telling Resident #2 to stop and get away from Resident #1. The SW said she immediately went over to Resident #2 and separated him from Resident #1. The SW said Resident #2 was face to face with Resident #1 and both residents were in wheelchairs. She said she did not witness Resident #2 touch Resident #1 inappropriately. She said it was witnessed by two other residents. The SW said Resident #1 and Resident #2 were taken to their rooms by other staff members and she notified the CNs, DON and Administrator. The SW said she interviewed Resident #1, and she indicated Resident #2 touched her in her private/peri area but did not appear distressed or upset during the interview. The SW said she interviewed with Resident #2, and he denied touching Resident #1 inappropriately. The SW said Resident #2 was placed on one-and-one until he was transferred to behavioral hospital. She said she did safe surveys on other residents and no other residents reported any sexual abuse from staff or other residents. The SW said she did follow-up visits with Resident #1 and she reported Resident #2 had also touched her breast during the incident. The SW said Resident #1 was monitored after the incident and no signs or symptoms of emotional distress, pain or any delayed injuries noted or reported. The SW said with any suspected abuse/neglect, the resident would be protected from abuse, and the incident reported to the administrator immediately. During an interview on 09/16/2024 at 06:00 p.m., LVN E said she had been trained on abuse and neglect. She said that she had cared for Resident #2 and was aware of his sexual behaviors. She said he had not made any sexual comments to her. LVN said Resident #2 rarely got up in his wheelchair since he returned from the hospital. LVN said during shift change report she advised the CNAs to pair up when they provided care to Resident #2 and to monitor Resident #2 if he was around other residents. LVN said this nurse's station was open and nurses were able to view residents in the dining area and hallways. LVN said staff were notified and aware of Resident #2's sexual behaviors and that he was to be monitored if he was around other residents. LVN said Resident #1 did not appear to have any distress after the sexual incident with Resident #2. During an interview on 09/16/2024 at 06:30 p.m., LVN F said she was aware of Resident #2's sexual behaviors and knew he needed to be watched closely if he was in the dining area or hallway or around other residents. Record Review of facility QAPI Action Plan dated 06/17/2024 indicated the incident involving Resident to Resident abuse (Resident #1 and Resident #2) was reviewed and the following was addressed: Goal: To keep all residents ' safe from abuse/neglect. Goal Date: Ongoing (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675391	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Arbor	705 Hwy 418 W Silsbee, TX 77656

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Approaches: Keep residents separated (Resident #1 & Resident #2). --Responsible Persons: CNA/facility staff; monitoring: Nursing staff - ongoing; -Approaches: Resident #2 placed on one-on-one; --Responsible Persons: Assigned staff; monitoring: facility staff - ongoing until DC of resident to behavioral hospital; -Approaches: Monitor both residents for emotional distress, pain, and any delayed injuries; --Responsible Persons: Nursing staff; monitoring: facility staff - ongoing for 72 hours; -Approaches: Head to toe assessment completed; --Responsible person: Charge nurse; monitoring: initial ongoing for 72 hours; -Approaches: Notification to physician; --Responsible Person: Charge nurse; monitoring: initial; -Approaches: Notification to ombudsman; --Responsible Person: The Administrator; monitoring: initial; -Approaches: Notification to police; --Responsible Person: The Administrator; monitoring: initial; ----Approaches: Discharge Resident #2 to behavioral hospital -informed looking for alternate placement with discharge; --Responsible Person: DON/SW; monitoring: initial; -Approaches: Gather staff statements; --Responsible Person: DON/ADON; monitoring: initial; -Approaches: Complete safe surveys; --Responsible Person: SW; monitoring: ongoing; -Approaches: Update care plans; --Responsible Person: MDS; monitoring: ongoing; -Approaches: Complete incident on both residents; --Responsible Person: CN; monitoring: initial; -Approaches: Spoke with family member about discharge plans, family upset alleged was not told the full picture that facility was looking for alternate placement from behavioral hospital and upon return Resident #2 would go on temporary one-on-one supervision as a precaution for a few days, family member stated did not want Resident #2 returning to facility and was notifying the Ombudsman; --Responsible Person: The Administrator/SW; monitoring: ongoing; -Approaches: Resident #2 returned to the facility on one-on-one monitoring for 72 hours; looking at VA resources; --Responsible Person: Staff; monitoring: ongoing; -Approaches: Medication change and referred to psych services continue current plan of care; --Responsible Person: nursing staff; monitoring: ongoing. Record review of facility in-service dated 6/17/2024 indicated facility staff received training on abuse, neglect and exploitation policy, and all resident-to-resident sexual abuse and/or behavior must be reported to the abuse coordinator/administrator immediately, and always protect the residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's progress notes indicated the following: -06/19/2024 The SW and MDS Nurse contacted the family of Resident #2 to discuss behavioral concerns and incidents that have occurred. When speaking with them behaviors and incidents were reviewed Family Member B What has happened since he was released from the hospital? The SW attempted to explain incidents and allegations including the incident with the female resident and was interrupted by family members. Family member told the SW- I'm not sure what phone call there is to be had because you can just take him to the VA hospital and drop him off, I am on vacation with my family and trying to enjoy myself and not deal with this. The SW attempted to explain the need of assistance in finding resident safe placement and risk of safety to other residents and staff and being met with aggression from children. The Administrator was notified of the conversation and aggression from family members. VA hospital contacted and spoke with case manager on call for further assistance in finding safe placement for resident. -06/27/2024 Resident #2 returned from the Behavioral Hospital. The resident was sitting up in his wheelchair, making sexual comments towards female staff about their bodies and desire to touch them. Resident laughed when redirected. Resident being monitored by staff one-on-one for 72 hours per administration. -06/28/2024 Monitoring for resident behaviors with one-on-one monitoring after the resident returned from behavioral hospital #2 -06/30/2024 Monitoring for resident behaviors. One-on-one observations completed. No noted behaviors at this time. Record review of Resident #2's psychiatric assessment note indicated on 07/01/2024 Resident #2 was seen for evaluation following a 10-day inpatient stay for psychiatric stabilization. Collateral Information: Resident #2 recently hospitalized in behavioral health for inpatient psychiatric stabilization from 06/17/2024 - 06/27/2024, discharged [DATE]. Staff report patient's mood and behaviors had been stable since discharge [TRUNCATED]