STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675407	A. Building B. Wing	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344 Based on interviews and record review the facility failed to immediately inform the resident representative when there was an incident that involved the resident's physical, mental, or psychosocial status for 1 resident (Resident #3) of 9 residents reviewed for notifications. The facility failed to notify Resident's #3's representative (Family Member C) that Resident #3 had been involved in an incident of inappropriate sexual behavior that occurred on 05/10/24. This failure could affect residents by causing the resident's family to be unaware of changes in residents' condition. Findings included: Record review of Resident #3's face sheet, dated 06/05/24, revealed an [AGE] year-old female was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease (memory loss), cognitive communication deficit (difficulty communicating), fracture to neck and left femur, anxiety disorder (increased worry), and major depressive disorder (increased sadness). Record review of Resident #3's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 01, which indicated the resident's cognition was severely impaired. Section B. Ability to understand others revealed that she had clear speech, sometimes could make herself understood, and sometimes could understand others. Record review of Resident #3's care plan dated 6/5/24 revealed the following: Resident #3 was dependent on staff for emotional, intellectual, physical, and social needs related to cognitive deficits. Resident #3 required assistance to ADLs related to Alzheimer's disease, had impaired cognitive function/impaired thought processes related to Alzheimer's, had a mood problem related to depression, and had the potential for psychosocial well-being related to trauma. Record review of Resident #3's progress notes revealed the following: (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024
NAME OF PROVIDER OR SUPPLIER: Ralls Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 1111 Avenue P Ralls, TX 79357	

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/11/24 at 01:27 AM LVN G documented: Male resident observed in Residents room with Penis in her hand attempting what appears to ejaculate himself. Resident Immediately stopped by staff and removed to his room. Placed on 1-1 monitoring with instructions by DON NOT to be left out of staff sight at any time. No apparent injuries noted upon physical inspection with female CNA present. DON to notify PCP & family. During an interview on 06/05/24 at 2:57 PM, LVN G stated that on 05/11/24, he was working the night shift. He said he heard a young lady yell out. He said it was the female CNA but did not know her name. He said he was on break. He said the female CNA reported that Resident #2 had a particular part of his anatomy in Resident #3's hand. LVN G stated they assisted in getting Resident #2 out of Resident #3's room. He stated when he walked in, he did not see Resident #2's penis in Resident #3's hand but did see his penis out. He said he had not seen Resident #2 do the sexual act in the past, but that Resident #2 would expose himself, and urinate on the floor. He stated that, because of the incident, he reported it to the DON and was instructed to place Resident #2 on 1:1 monitoring. He stated he would sit in the hall and ensure Resident #2 did not go into other rooms. LVN G said that Resident #3 was catatonic (immobile) and could not defend herself. During an interview on 06/05/24 at 3:49 PM, Family Member C stated she had not been notified of any incidents with Resident #2 that involved inappropriate sexual activity. During an interview on 06/06/24 at 9:47 AM, CNA H stated the incident between Resident #2 and #3 occurred on 05/10/24 around 11:00 PM. She said she was told to go and check on another resident by LVN G. While doing so, she observed Resident #2 in Resident #3's room. When she got closer, she was able to see that he had his penis out, and Resident #3's hand was cuffed under Resident #2's penis. She said Resident #2 had his hand under hers and was masturbating (rubbing it up and down). CNA H said she told Resident #2 he could not do that. CNA H said Resident #2 did not move. She said she was hesitant to physically redirect Resident #2 because Resident #2 had struck her two weeks prior. CMA H said she told Resident #2 again to stop, but this time, she placed her hands on Resident #2's shoulder, and Resident #2 jerked his shoulder back forcefully. She said she took this action from Resident #2 and needed to leave him alone. She stated that, again, because of her past experiences, she did not want to engage with Resident #2. CNA H said she yelled for help, and LVN G and CNA E assisted her. CNA H said the two male staff could get Resident #2 out of Resident #3's room without any issues. CNA H stated the administration instructed them to watch Resident #2. CNA H said all staff took turns watching Resident #2 every two hours and sat outside his door. CNA H said they told the oncoming shift what happened, and that Resident #2 was on 1:1 supervision. Before the incident on her shift, CNA H said she had not been given any specific instructions regarding Resident #2. During an interview on 06/06/24 at 12:25 PM, the DON said the potential negative outcome of not notifying the family was that the family would not be aware of what was going on with their loved one in the facility. The DON stated she was unaware that Family Member C had not been notified of the inappropriate sexual contact. She said normally, the charge nurse would have been responsible for notifying the family. She said she was unsure why LVN G had not notified the family. During an interview on 06/06/24 at 2:00 PM, Resident #3 was unable to answer any questions about being inappropriately touched. She was able to confirm she was Resident #3, but when asked more detailed questions, she blinked, and breathed at an increased pace. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Ralls Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 1111 Avenue P, Ralls, TX 79357	

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/06/24 at 1:16 PM, The ADM said she did not know a potential negative outcome for not reporting changes or incidents to family members. The ADM said the only thing she could think of was emotional affect and the family being upset. The ADM said she did expect Family Member C to be notified and was unaware of why she was not notified. The ADM stated that the nursing staff was responsible for notifying family. During an interview on 06/07/24 at 11:39 AM, Family Member C stated the facility still had not called her to notify her of the details concerning Resident #3 and inappropriate sexual contact. Family Member C said she would appreciate being informed and that it upset her not to be notified. During an interview on 06/09/24 at 1:10 PM, Family Member C stated she was notified of the inappropriate sexual incident. She said she was told the person assigned to may have forgotten. Family Member C said she was still upset about the incident and not being notified. Record review of the facility policy Abuse Investigation and Reporting, dated July 2017 revealed: Policy Statement All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Policy Interpretation and Implementation Role of the Administrator: The Administrator will keep the resident and his/her representative (sponsor) informed of the progress of the investigation. Role of the Investigator: Upon conclusion of the investigation, the investigator will record the results of the investigation on approved documentation forms and provide the completed documentation to the Administrator. Reporting All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: The Resident's Representative (Sponsor) of Record; The resident and/or representative will be notified of the outcome immediately upon conclusion of the investigation. Record review of the facility policy Resident Rights, dated December 2016 revealed: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Statement Employees shall treat all residents with kindness, respect, and dignity . Policy Interpretation and Implementation Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: o. be notified of his or her medical condition and of any changes in his or her condition;

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 43344 Based on interviews and record review, the facility failed to ensure residents had the right to be free from sexual abuse for 3 (Resident #3, Resident #4 and Resident #6) of 9 residents reviewed for abuse. 1. The facility failed to put protective measures in place on 05/11/24 to protect Resident #4 from sexual abuse after knowing Resident #2 had displayed inappropriate sexual behavior with Resident #3. 2. The facility failed to put protective measures in place on 06/02/24 to protect Resident #3 in place from sexual abuse after knowing Resident #5 had a history of inappropriate sexual behavior. 3. The facility failed to put protective measures in place on 06/02/24 to protect Resident #6 in place from sexual abuse after knowing Resident #5 had a history of inappropriate sexual behavior. On 06/07/24 at 5:00 PM an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 06/09/24 at 3:30 PM, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure caused additional residents to be sexually abused and potentially placed other residents at risk for sexual abuse. Findings Include: 1. Findings for the facility's failure to put protective measures in place on 05/11/24 to protect Resident #4 from sexual abuse after knowing Resident #2 had displayed inappropriate sexual behavior included: Record review of Resident #2's face sheet, dated 06/05/24, revealed a [AGE] year-old-male that was readmitted to the facility on [DATE] with diagnoses that included dementia (impaired ability to remember), depressive disorder (constant feelings of sadness), mood disorder (emotional deficit), and blindness to the right eye. Record review of Resident #2's Quarterly Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 05, which indicated the resident's cognition was severely impaired. Section B Hearing, Speech, and Vision revealed that Resident #2 had clear speech, makes himself understood, and understands others. His vision is impaired, and he does not wear corrective lenses. Section E Behavior revealed that he had not had any incidents of physical or verbal behavior. Record review of Resident #2's Comprehensive Minimum Data Set, dated dated [DATE], revealed: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Section C Brief Interview for Mental Status score revealed a blank BIMS score. Section E Behavior revealed that he had had delusions, physical behaviors such as hitting, kicking, pushing, scratching, grabbing, and abusing others. Resident # 2 had exhibited verbal behaviors such as threatening others, screaming, and cursing at others. Resident #2 had other behavioral symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing, smearing food or bodily wastes, or verbal/vocal symptoms like screaming and disruptive sounds. Resident #1 exhibited wandering behavior 1-3 days. Record review of Resident #2 care plan, dated 05/01/24 revealed the following: Resident #2 wanders in other residents' rooms and gets into their beds at times and had the following interventions: Resident #2 required assistance out of rooms that were not his and staff could use snacks if needed. Resident #2 was an elopement risk/wanderer and had the following interventions: Distract Resident #2 from wandering by offering pleasant diversions. Resident #2 prefer having snacks. Followed by [name of psych care]. Notify their MD/NP of any escalation in wandering behaviors, ineffectiveness, or side effects of psychiatric medications. Monitor the resident's location throughout shifts. Document wandering behavior and attempted diversional interventions in behavior log. Resident #2 had episodes of verbal and physical aggression r/t dementia with the following interventions: Give me as many choices as possible about care and activities. Monitor for physically/verbally aggressive behavior q shift. Document observed behavior and attempted interventions in behavior log. Monitor/document/report PRN any s/sx of Resident #2 posing danger to self and others. Resident #2 had impaired visual function r/t cataracts and glaucoma. Resident #2 was blind in his right eye with the following interventions: Arrange consultation with eye care practitioner as required. Monitor/document/report PRN any s/sx of acute eye problems: Change in ability to perform ADLs, decline in mobility, sudden visual loss, pupils dilated, gray or milky, c/o halos around lights, double vision, tunnel vision, blurred or hazy vision. Place frequently used items on my left side so I may see them. Record review of Resident #2's progress notes revealed the following: Record review of on 05/11/24 at 12:12 AM LVN G documented: Data: Resident observed by CNA H reported to this nurse observed resident with pants unzipped and PENIS in Resident #3's hand. Action: Resident removed from Resident #3's room w/o incident. Resident #3 appears to have been asleep during entire incident. No physical injuries noted at this time. Response: Resident in his room and placed on 1-1 monitoring per DON instructions. Roommate moved to different room as this nurse considers this a HIGH RISK INCIDENT. DON & Administrator notified. Record review of on 05/11/24 at 03:23 PM The DON documented: Received orders from NP may administer Lorazepam 1ml now and then every 8 hours as needed. DON gave orders to charge nurse may use emergency restraint for safety of resident and others. Record review of on 05/11/24 at 05:27 PM the DON documented: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Spoke with Family Member L about incident and orders to give Lorazepam 2mg/ml injection every 8 hours as needed x 14 days. Voiced understanding and gives verbal consent at this time for medication. Also discussed that he would be going back to the behavior support center on Monday and facility would be actively looking for alternate long-term placement for resident. Voiced understanding and consents for referrals to be sent to other facilities. Record review of on 05/11/24 at 05:27 PM LVN B documented: Staff alerted this nurse that this male resident was found in female resident's bed with his hands in the female's pants. Upon entering room male resident is found in bed with female resident with his hand on resident's waist. Told resident he needed to get out of bed. RT refused and put his arm around female resident. Male resident immediately removed from female's bed and taken to his own room. Resident became aggressive with staff refusing to leave bed causing CNAs to fall. Administration notified. Physician A, the DON notified. New order for Ativan 2mg/ml injection. Injection administered. Resident continues to try to go into other female rooms. Record review on 05/31/24 at 01:07 PM The DON documented: Resident returned from behavioral center via their facility van. Notified Physician A of return and medications. Notified the NP of return and reconciled psychotropic medications. Notified family Member L of return and went over psych medications and no issues or concerns at this time. Record review of on 06/02/24 at 03:26 AM LVN M documented: Follow-up on readmission, resident continues to urinate on floor. Reminded resident to use urinal. Resident voiced understanding. Resident also continues to wander. Resident breathing even and unlabored. No complaints voiced. Record review of on 06/02/24 at 07:35 PM The DON documented: Notified by charge nurse that resident was wandering in rooms and becoming aggressive when staff was trying to redirect. Contacted the NP and new orders received to increase Seroquel to 50mg 3 times daily, Xanax 0.25mg every 6 hours as needed x 14 days, and Zyprexa 10mg IM every 12 hours as needed x 14days. Notified Family Member L of resident behavior and new orders. Voiced understanding and no issues or concerns at this time. Record review of Resident #2's monitoring sheets revealed the following: Resident #2 was monitored every 30 minutes starting 05/08/24 at 11:30 AM until 5/10/24 at 6:00 PM. (No abnormal behavior reported during this monitoring time.) No time monitoring accounted for 05/10/24 at 11:00 PM- 12:00 AM. Resident #2 was monitored on 05/11/24 from 1:00 AM-5:45 AM. (No abnormal behavior notated during this time. No time monitoring accounted for 12:00 AM-1:00 AM.) Resident #2 was monitored on 05/11/24 from 6:30 AM-4:00 PM. (No abnormal behavior notated during this time. No time monitoring accounted for 4:30 PM-6:00 PM) (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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #3's face sheet, dated 06/05/24, revealed an [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease (memory loss), cognitive communication deficit (difficulty communicating), fracture to neck and left femur, anxiety disorder (increased worry), and major depressive disorder (increased sadness). Record review of Resident #3's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 01, which indicated the resident's cognition was severely impaired. Section B. Ability to understand others revealed that she had clear speech, sometimes could make herself understood, and sometimes could understand others. Record review of Resident #3's care plan dated 6/5/24 revealed the following: Resident #3 was dependent on staff for emotional, intellectual, physical, and social needs related to cognitive deficits. Resident #3 required assistance to ADLs related to Alzheimer's disease, had impaired cognitive function/impaired thought processes related to Alzheimer's, had a mood problem related to depression, and had potential for psychosocial well-being related to trauma. Record review of Resident #3's progress notes revealed the following: 05/11/24 at 01:27 AM LVN G documented: Resident #2 observed in resident's room with Penis in her hand attempting what appears to ejaculate himself. Resident Immediately stopped by staff and removed to his room. Placed on 1-1 monitoring with instructions by DON NOT to be left out of staff sight at any time. No apparent injuries not upon physical inspection with female CNA present. DON to notify PCP & family. Record review of Resident #4's face sheet, dated 06/05/24, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnosis that included Alzheimer's disease (memory loss). Record review of Resident #4's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 03, which indicated the resident's cognition was severely impaired. Section B. Ability to understand others revealed that she had clear speech, could make herself understood, and could understand others. Record review of Resident #4's care plan dated 4/29/24 revealed the following: Resident #4 was dependent on staff for emotional, intellectual, physical, and social needs related to cognitive deficits. Resident 41 had impaired cognitive function related to Alzheimer's disease. Record review of Resident #4's progress notes revealed the following: 05/11/24 at 05:32 PM LVN B documented: Staff alerted this nurse that Resident #2 was found in female resident's bed with his hands in female's pants. Upon entering room male resident is found in bed with female resident with his hand on resident's waist. Male resident immediately removed from female's bed and taken to his own room. Female resident assessed for injury, no visible injury noted. Administration notified. DON to speak with family regarding incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/05/24 at 1:49 PM, CNA E stated that one night, when he worked the night shift (unsure of the date and exact time), Resident #2 exposed himself to Resident #3. He said he did not see it but was told by CNA H that Resident #2 had his penis in Resident #3's hand and was jerking off. He said because of that incident, Resident #2 was placed on 1:1 and was checked every 15 minutes by the night staff. He said Resident #3 was not in her right mind and would have been unable to consent. He said Resident #3 may have a BIMs score of 0. He said prior to the incident involving Resident #3, Resident #2 was not on any close monitoring. He said that when Resident #3 was in the dining room and wanted to return to his room, they would assist him, but after he was in his room, they did not do additional monitoring. During an interview on 06/05/24 at 2:57 PM, LVN G stated that on 05/11/24, he was working the night shift. He said he heard a young lady yell out. He said it was the female CNA but did not know her name. He said he was on break. He said the female CNA reported that Resident #2 had a particular part of his anatomy in Resident #3's hand. LVN G stated they assisted in getting Resident #2 out of Resident #3's room. He stated when he walked in, he did not see Resident #2's penis in Resident #3's hand but did see his penis out. He said he had not seen Resident #2 do the sexual act in the past, but that Resident #2 would expose himself and urinate on the floor. He stated that, because of the incident, he reported it to the DON and was instructed to place Resident #2 on 1:1 monitoring. He stated he would sit in the hall and ensure Resident #2 did not go into other rooms. LVN G said that Resident #3 was catatonic (immobile) and could not defend herself. LVN G did not confirm that the DON or the ADM provided specifics to what was expected regarding placing Resident #2 on 1:1 monitoring. During an interview on 06/05/24 at 4:04 PM, the ADM stated she was told but could not remember who told her that Resident #2 was standing over Resident #3 with his penis out and Resident #3's hand was on Resident #2's. The ADM stated she was not told that Resident #2 was masturbating. She said in addition to being notified about Resident #3, she was informed later that day (05/11/24) by LVN B that Resident #2 had gotten into bed with Resident #4 and had his hand near her privates. She said she had read the progress notes since the state surveyor exited on 05/09/24. She said she did not report or investigate both incidents of inappropriate sexual behavior because, in both incidents, all residents involved had dementia. The ADM stated that Resident #2 was placed on 1:1 during the second incident involving Resident #4 because Resident #2 became aggressive. The ADM stated that Resident #2 was not put on 1:1 during the first incident involving Resident #3 because he was not aggressive, and this was the first time he displayed this behavior. During an interview on 06/05/24 at 4:24 PM, the DON stated when the inappropriate sexual incidents were reported to her, she reported it to the ADM as she was the abuse coordinator. She said she had not completed any specific training with staff regarding Resident #2's behavior after the first incident. During an interview on 06/05/24 at 5:14 PM, the NP stated she was aware of and had been notified about the inappropriate sexual touching between Resident #2 and #4. She said that she had charted in her notes that the DON was concerned about the behavior of Resident #2. The NP reported that the DON reported to her that Resident #2 was found in the room of a defenseless resident (Resident #3), and he placed his penis in her hand, and was stroking his penis. The NP then said it was reported to her that Resident #2 was found in the room of another female resident on a separate incident and became combative with staff. The NP stated that she permitted the nursing staff to administer Ativan to Resident #2 during the first incident with Resident #3. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/06/24 at 5:04 AM, CNA N stated she had observed Resident #2 go into a female resident's room but always redirected him when she was on shift. She stated that when he would attempt to go into residents' rooms (male and female), she would report it to her charge nurse. She said she could not tell exact dates and times but that it had happened more than once that she had to redirect Resident #2 out of other rooms. CNA N said his behavior for wandering was constant when he was awake. During an interview on 06/06/24 at 9:47 AM, CNA H stated the incident between Resident #2 and #3 occurred on 05/10/24 around 11:00 PM. She said she was told to go and check on another resident by LVN G. While doing so, she observed Resident #2 in Resident #3's room. When she got closer, she was able to see that he had his penis out, and Resident #3's hand was cuffed under Resident #2's penis. She said Resident #2 had his hand under hers and was masturbating (rubbing it up and down). CNA H said she yelled for help, and LVN G and CNA E assisted her. CNA H said the two male staff could get Resident #2 out of Resident #3's room without any issues. CNA H stated that administration instructed them to watch Resident #2. CNA H said all staff took turns watching Resident #2 every two hours and sat outside his door. CNA H said they told the oncoming shift what happened, and that Resident #2 was on 1:1 supervision. Before the incident on her shift, CNA H said she had not been given any specific instructions regarding Resident #2. She stated that they did pass the information the following shift. CNA H said LVN G had reported the incident between Resident #2 and Resident #4. During an interview on 06/06/24 at 11:47 AM, the Dietary [NAME] stated she assisted in 1:1 monitoring with Resident #2 before the incident on 05/11/24 with Resident #3. The Dietary [NAME] stated that when she watched Resident #2, he continued to display wandering and had to be redirected. She said during her monitoring, she did observe him pull out his penis and urinate on the floor. She said this occurred while he was in his room during the night shift. The Dietary [NAME] said she suggested during the morning meeting (before the incidents on 05/11/24) that Resident #2 be moved closer to the nurses' station for better observation. The Dietary [NAME] said the ADM looked at her, looked at the whiteboard that had the room assignments, and continued the meeting. The Dietary [NAME] said she does not have the ability to change rooms for residents and that this was the duty and responsibility of the ADM and the DON. The dietary [NAME] said outside of monitoring no additional efforts were made to supervise Resident #2's behaviors. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/06/24 at 12:25 PM, the DON stated she did not see the discrepancy in the monitoring sheet that showed that Resident #2 was not monitored from the alleged time of the incident on 05/10/24 from 11:00 AM until 05/11/24 1:00 AM. She said the person in charge of staying with Resident #2 during the first incident would have been LVN G. During the second incident that involved Resident #2 and #4; she was unaware of why there was a gap in the monitoring sheet from 4:00-6:00 PM. The DON said she did not see the gap and, since she had seen it, had not followed up or questioned why there was a gap. The DON said there should have been a staff assigned 1:1 with Resident #2 on 05/11/24 and this could have prevented the incident with Resident #4. She said that once she was notified about the incident between Resident#2 and #4, she realized that there was not a 1:1 staff with Resident #2. The DON stated that normally, staff call administration when staff do not show up, and that she was unaware of why the staff did not call on 05/11/24 when the monitor tech did not show up. The DON said the only interventions that have been put in place for Resident #2 were medication adjustments and redirection from staff. She said those interventions had not been successful. The DON said no specific interventions were put in place for the night shift even though it had been identified previously that Resident #2 tended to have increased behaviors at night. The DON said it had been discussed at morning meetings that they would like to hire more staff. The DON stated that Resident #2 did exhibit wandering during the days before his inappropriate sexual behavior. The DON said inappropriate sexual behavior was new, and this was why she told LVN G to watch him. The DON said she was unsure if the oncoming shift after the first incident was notified of the 1:1 monitoring expectation and that she did not follow up to see if this was done. The DON stated she did not come up to the facility after the instructions for 1:1 was given. She said that usually, in special supervision circumstances, the ADM would come to the facility because she lives in town, and the DON does not. She said that she did not remember discussing with the ADM about the ADM coming to implement formal training for Resident #2's inappropriate sexual behavior. The DON said that regarding the incident with Resident #2, the potential negative outcome was that other incidents could also occur if this was another resident. The DON said she never expected the sexual incident because he never displayed that type of behavior. The DON said she was unaware that he had sexual tendencies. She said the system the facility had in place for monitoring was the 1:1 for the 72 hours when he returned from any behavior support. The DON said she had never observed any sexual behavior or his continued wandering behavior in person. She said all staff were responsible for keeping abuse from happening. The DON said the staff handled everything correctly regarding Resident #2 and his inappropriate sexual behavior with Resident #3 and #4. The DON said the purpose addressing resident behaviors was to protect the residents and to follow policy. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/06/24 at 1:16 PM, The ADM stated no one ever relayed to her that they considered the inappropriate sexual contact a high-risk situation. The ADM said she vaguely remembered talking about moving Resident #2's room but that the way the facility was set up had all of the females and the males together. The ADM stated moving Resident #2 would have placed him among the female residents. The ADM stated she was unaware of who monitored Resident #2 from 05/10/24 at 11:00 PM until 05/11/24 at 1:00 AM. The ADM stated she did not have the monitoring sheets and that the DON had those sheets. The ADM stated the DON was responsible for reviewing those sheets. The ADM said she sometimes reviewed them to ensure they were completed, but not regularly. The ADM said Resident #2 was not supervised because there was supposed to be a monitor tech at the facility, but they did not show up. The ADM stated that staff were trained on what to do if someone does not show up for their shift but were unaware that the staff on 05/11/24 during the day shift was aware that there was supposed to be someone for 1:1 with Resident #2. The ADM said they usually do 1:1 monitoring with any resident for 72 hours after being released from a behavior support center. She said Resident #2 was released on 05/10/24 from 1:1 supervision after being admitted back to the facility on [DATE]. The ADM stated that Resident #2 had no issues during his monitoring period. The ADM said if he had problems, staff would have reported them to her. She stated that staff had been trained to report concerns but that she did not have any written documentation to show that staff had been trained to report incidents while observing 1:1 with Resident #2. The ADM said that it was a verbal instruction given when Resident #2 was placed under 1:1 supervision on 05/11/24 after the incident with Resident #4. The ADM said no formal training was conducted. The ADM stated regarding Resident #2, the inappropriate sexual behavior was new. She said that before, Resident #2 had aggression toward staff and other residents. The ADM said she was unaware of Resident #2's tendency for sexual behavior. The ADM stated she was unaware that Resident #2 was not under 1:1 supervision when he acted inappropriately sexually against Resident #4. The system to monitor behaviors and prevent abuse specifically involved close monitoring and monitoring tech assistance. The ADM said that not addressing a resident's inappropriate sexual behavior and supervising the residents correctly could result in harm to other residents. During an interview on 06/06/24 at 2:30 PM, Resident #4 stated she kind of remembered being touched by a man. She was unable to specify a date, time, or person. During an interview on 06/06/24 at 7:26 PM, the Regional Director stated the ADM was responsible for all activities in the facility He said he would expect for the ADM and the DON to follow facility policies. During an interview on 06/07/24 at 9:00 AM, Resident #2 stated he did not touch anyone. He stated that the staff treated him well at the facility, and he was able to move around the facility without staff. He said that all the residents liked him and celebrated him. He was unable to clarify what he meant by celebrate. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/07/24 at 12:00 PM, LVN B stated that she did not observe what happened. She stated what she noted in the resident's progress notes was what she saw. She said that the medication aide notified her but that he no longer worked at the facility. LVN B said she assessed the situation and observed Resident #2's hands in Resident #4's pants. LVN B said they told Resident #2 that he needed to stop and get out. LVN B stated that when she tried to redirect Resident #2 out of the room, which was when Resident #2 became aggressive. LVN B said Resident #2 was kicking, and it was difficult because Resident #4's bed was low and on the ground. LVN B said Resident #2 was trying to kick and fight the Medication Aide. LVN B said she was upset about the incident. She said it was not passed on that he needed to be 1:1 the night before. LVN B was made aware of the incident with Resident #3, and she was told that she had to do close monitoring. She said she would set her timer and check on him every 30 minutes. She said it would have been impossible for her to sit with him 1:1, and she was the only charge nurse. LVN B said she does not know why she did not completely sign off on the monitoring form between 4:00 PM and 6:00 PM. LVN B confirmed that the initials by the 4:00-6:00 PM blank hours were hers. LVN B said on 05/11/24 during her shift (day 6:00 AM-6:00 PM), she or her staff did not sit 1:1 with Resident #2. LVN B said she would peek in on Resident #2 when she could, but she was the only nurse for all of the residents at the facility. During an interview on 06/07/24 at 12:11 PM, CNA K stated that she did physically see Resident #2's hand in Resident #4's pants. She said Resident #2's right hand was in Resident #4's brief. CNA K said Resident #2's nails were extremely long and gross. CNA K said Resident #4 was not doing anything during this incident. CNA K said Resident #4 had no emotion on her face, but her eyes were open. She said that 05/11/24 Resident #2 was all over the facility and not on special 1:1 supervision. CNA K said no monitor techs were on duty that day (05/11/24). During an interview on 06/07/24 at 12:17 PM, CNA J stated that she does not know much about the incident that occurred on 05/11/24 with Resident #2 and Resident #4. She said that the Medication Aide was the one who observed Resident #2 touching Resident #4. CNA J said they had not been notified that Resident #2 was on 1:1 and were not trained to do anything different with Resident #2. 2. Findings for the facility's failure to put protective measures in place on 06/02/24 to protect Resident #3 from sexual abuse after knowing Resident #5 had a history of inappropriate sexual behavior included: Record review of Resident #3's progress notes revealed the following: 05/11/24 at 01:27 AM LVN G documented: Resident #2 observed in resident's room with Penis in her hand attempting what appears to ejaculate himself. Resident Immediately stopped by staff and removed to his room. Placed on 1-1 monitoring with instructions by DON NOT to be left out of staff sight at any time. No apparent injuries not upon physical inspection with female CNA present. DON to notify PCP & family. Record review of Resident #5's face sheet, dated 06/09/24, revealed a [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses that included other sexual dysfunction (difficulty with sexual response), intermittent explosive disorder (impulsive and aggressive outbursts), insomnia (difficulty sleeping), age related cognitive decline, and cognitive communication deficit (difficulty communicating). Record review of Resident #5's Comprehensive Minimum Data Set, dated dated [DATE], revealed: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Section C Brief Interview for Mental Status score revealed a score of 07, which indicated the resident's cognition was severely impaired. Section B. Ability to understand others revealed that she had clear speech, could usually make herself understood, and usually understood others. Section E Behavior revealed that he had no documented behavior outside of wandering that occurred 1-3 days. Record review of Resident #5's care plan dated 6/02/24 revealed the following: Resident #5 occasionally attempted to be sexually inappropriate with staff and other residents. Resident #5 occasionally stated he was a killer and a rapist. Resident #5 had impaired cognitive function. Record review of Resident #5's progress notes revealed the following: On 06/02/24 at 02:20 PM LVN Q documented: LATE ENTRY Data: Resident #5 was kissing another resident (unidentified) on the lips. Action: Stopped the resident and sent him to his room and informed him not to be kissing other female residents. Response: WCTM this shift. 06/02/24 at 08:50 PM LVN Q documented: LATE ENTRY Data: Resident #5 was seen by a staff member touching and kissing on another resident (unidentified) in the dining room. Action: Removed the resident away from the other resident and informed him to keep his hands to himself. Response: WCTM this shift. On 06/09/24 at 02:56 PM the DON documented: Family members x 3 here to see [Resident #5]. Family would like facility to attempt referrals closer to their area. They would like referrals sent to multiple facilities. Informed Family that we would start referral process on Monday. Record review of Resident #5's monitoring sheets revealed the following: No time monitoring accounted for the following dates: 06/02/2024. Resident #5 was monitored every 15 minutes starting 06/09/24 at 12:00 AM until 11:45 PM (No abnormal behavior reported during this monitoring time). Resident #5 was monitored every 15 minutes starting 06/10/24 at 12:00 AM until 12:45 PM (No abnormal behavior reported during this monitoring time). During an interview on 06/09/24 at 11:23 AM, the DON stated as a result of the IJ, they were able to identify two other incidents that involved inappropriate sexual touching that was not investigated or reported. This occurred with Residents #5, and #3. She stated they identified the incident when they were following their removal plan and reviewing progress notes for potential residents that could be affected. The DON stated they immediately placed Resident #5 on Red supervision, notified Physician A, assessed all residents involved (Resident # 5 and #3), notified the family of both residents, and trained staff. The DON stated that she did not have details of what happened but that they had started the process of investigating. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/09/24 at 12:46 PM, the Dietary [NAME] stated she was present for the incident with Resident #5 and #4. The Dietary [NAME] said she was unsure of the date but that it happened a week before the interview. The Dietary [NAME] said the incident with Resident #4 involved Resident #5 touching and rubbing Resident #4's breast in the dining room. She said she reported this to LVN B and the ADM. She said she was unaware that anything had been done about those incidents. She said that before the IJ Resident #5 was not on any special level of supervision, but since the IJ had been placed on a special level. During an interview on 06/09/24 at 2:00 PM, Residen [TRUNCATED]

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344 Based on observation, interviews and record review, the facility failed to implement their written policies and procedures to prohibit and prevent abuse and neglect for 4 (Resident #1, Resident #3, Resident #4, and Resident #6) of 9 residents reviewed for abuse and neglect. The facility failed to implement their abuse and neglect policy when: 1. The facility failed to investigate the fall incident that occurred with Resident #1 while in the care of CNA E on 05/30/24. CNA E failed to notify the nurse of the fall. Resident #1 sustained a hip fracture. 2. The facility failed to report to the state agency and investigate a sexual incident that occurred on 05/10/24 between Resident #2 and Resident #3. 3. The facility failed to report to the state agency and investigate a sexual incident that occurred on 05/11/24 between Resident #2 and Resident #4. 4. The facility failed to notify Family Member C of the inappropriate sexual incident that involved Resident #3. 5. The facility failed to report to the state agency and investigate a sexual incident that occurred on 06/02/24 between Resident #5 and Resident #3. 6. The facility failed to report to the state agency and investigate a sexual incident that occurred on 06/02/24 between Resident #5 and Resident #6. On 06/07/24 at 5:00 PM an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 06/09/24 at 3:30 PM, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. The failures placed resident at risk for continued abuse and neglect and a decline in quality of life, harm and mental anguish. Findings included: 1. Findings for fall incident that occurred on 05/30/24 with Resident #1 and CNA E included: Record review of Resident #1's face sheet, dated 06/05/24, revealed a [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (stroke), major depressive disorder, anxiety (increased feelings of fear, dread, and uneasiness), and cognitive communication deficit (difficulty understanding and communicating). (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 04, which indicated the resident's cognition was severely impaired. Section B Hearing, Speech, and Vision revealed that Resident #1 had slurred speech, could make himself understood, and usually understood others. Section GG Functional Abilities and Goals indicated the Resident #1 was dependent and this could mean that the resident did all the effort or that he required the assistance of 2 or more helpers to complete the activity of tub or shower transfer. Record review of Resident #1 Care Plan, dated 05/29/24, revealed the following: Resident #1 had an ADL self-care performance deficit r/t to limited range of motion due to CVA. Resident #1's self-performance fluctuated r/t confusion, but he usually requires assistance with ADLs. Resident #1 required 1-2 staff for showering/bath and shower/tub transfer Resident #1 required two+ person physical assists. Resident #1 used a mechanical lift for transfers with a minimum of two staff present unless transferring with therapy/ restorative. Resident #1 was at risk for falls r/t balance problem. Ensuring Resident #1 frequently used items were within reach. Resident #1 had osteoporosis and was at risk for fractures. Record review of Resident #1's progress notes revealed the following: 05/30/24 at 1:10 AM LVN F documented: Xray results show positive intertrochanteric hip fracture (upper thigh hip fracture) to left hip. Physician A notified and received orders to send [Resident #1] to ER to evaluate. Notified [Family Member A] POA. EMS here to transport resident to local hospital. Report called in to ER. ADM and DON notified as well. 05/30/24 at 1:43 AM the DON documented: 5:38 PM was notified by charge nurse that resident was c/o left hip pain. Instructed charge nurse to notify [Physician A]. Nurse received orders to obtain x-rays to left hip. Notified administrator of resident c/o left hip pain. Then instructed night nurse to notify as soon as x-ray results received. Received notification at 10:25 pm from night charge nurse that x-ray showed a left acute intertrochanteric hip fracture (upper thigh hip fracture). Immediately notified administrator of findings. 06/03/24 at 9:29 PM the LVN F documented: Resident readmitted to facility following hospitalization following fall on 5/30 resulting in intertrochanteric hip fracture (upper thigh hip fracture) to left hip. Dynamic hip screw surgery to left hip. Resident weight bearing as tolerated. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/05/24 at 12:07 PM, Family Member D stated on 05/30/24 she visited with Resident #1. She stated that he had received a shower that morning from CNA E. She said during the day, around the time they played Bingo, Resident #1 started complaining that his butt hurt. She said she thought maybe he was constipated. She said that when the CNAs (CNA J and CNA K) went to put him in bed, he started complaining of pain. She said Resident #1 pointed to his left side and said, Hurt hurt. She said she waited until the CNAs left to notify RN I to ask Resident #1 what happened because he was complaining more than earlier. Resident #1 told me that he fell in the shower that morning with CNA E. She said Resident #1 said he fell and hit his head. She said CNA E was in the room when Resident #1 fell but he did not see Resident #1 fall because his back was to Resident #1. CNA E was shutting the bathroom door when Resident #1 fell . Family Member D said she asked if Resident #1 had reported to anyone that he had fallen and if the nurse knew. She said Resident #1 said no. She said Resident #1 explained that it was an accident, that he did not want to get CNA E in trouble, and that he liked him. She said she spoke with CNA E after Resident #1's fall (unknown date and time), and he said he was sorry and acknowledged the fall. She said CNA E told her that he told the ADM and therapy. She stated she was not notified of the fall and was at the facility when CNA E showered Resident #1. She said she would have liked to have been told so that she could have had Resident #1 checked out immediately. During an interview on 06/09/24 at 12:22 PM, Resident #1 stated that he fell in the shower while showering. Resident #1 said CNA E was in the restroom, but his back was to him. Resident #1 said he fell to the floor and hit his head. Resident #1 said CNA E picked him up and put him in the wheelchair. Resident #1 said no other staff helped CNA E pick him up. Resident #1 said that a nurse did not check him. Resident #1 said no one from the administration came and talked to him about the incident. Resident #1 said he was in pain when he left the shower room but did not report it because he did not want to get CNA E in trouble. During an interview on 06/05/24 at 1:49 PM, CNA E stated the incident with Resident #1 occurred on Thursday (05/30/24). CNA E stated he had just completed Resident #1's shower. He stated Resident #1 appeared to be standing fine. He said Resident #1's leg buckled, and as Resident #1 was holding on to the grab bar, he swiveled and hit the wall. He said Resident #1 never completely hit the ground. CNA E stated he called for assistance with Resident #1. CNA E stated he called CNA J and CNA K. CNA E stated he and CNA J and CNA K finished getting Resident #1 dressed and placed Resident #1 in his wheelchair. CNA E stated he asked Resident #1 how he was doing and was told by Resident #1 that he was ok. CNA E stated he had reported what happened to the ADM and the PTA directly after the incident. CNA E stated that he reported to the ADM that the fall was not a complete fall to the ground. CNA E could not recall if he told the ADM that Resident #1 had hit the wall. He stated Resident #1 did not complain of pain or show any signs of discomfort. When he demonstrated to Family Member D what happened, CNA E stated that his head hit the wall. CNA E stated he did not have the nurse look at Resident #1 because he felt he did the correct thing when he reported the incident to the ADM. CNA E stated the ADM told him that the incident was not reportable, so he did not tell anyone else. He said although Resident #1's care plan says to use the mechanical lift, he was a physical transfer. He said the fall might have happened around 11:30 AM on 05/30/24. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/05/24 at 2:08 PM, RN I stated that he was unsure when the fall incident happened with Resident #1 but was in the middle of the week. RN I said he did not know anything about it until the end of his shift. He said CNA K came to him and alerted him that Resident #1 was in pain the same day Resident #1 fell . He said he was told by Resident #1 that he had a fall in the shower earlier that day, and he had hit his head and his hip. RN I said Resident #1 said he did not want to get CNA E in trouble. RN I said while Resident #1 was telling him, he was crying. RN I stated he notified the DON, and the DON was surprised that CNA E had not told the nursing staff anything about the incident. RN I said he was frustrated because although the incident was communicated to the PTA and the ADM, it was not communicated to him as the charge nurse, and a delay in treatment occurred. He stated that once he became aware of this, he assessed and notified Physician A. RN. I stated that x-rays were ordered, but he did not receive the results on his shift. RN I said he spoke with CNA E and inquired why he was not notified. RN I said CNA E said he could not find RN I and apologized for not reporting the incident to RN I. RN I explained that his license could be on the line and treatment for Resident #1 could be delayed. RN I said that CNA E stated he was doing therapy in the shower to promote movement, and Resident #1 gave out. RN I said that CNA E told him that Resident #1 never hit the ground, but that differed from what Resident #1 told him. He stated he was told by Resident #1 that he fell to the ground. RN I said it was vital that he was notified when fall incidents occurred so that the residents were assessed at the time of injury. RN I said during his assessment of Resident #1, he saw issues with his range of motion and the apparent pain that Resident #1 was expressing. RN I said failure to report the incident to him could compromise resident safety, and with Resident #1 hitting his head, it could have been a more significant issue. RN I said during his assessment he did not see any problems with Resident #1's mental status. RN I stated he did not talk to the PTA or the ADM about the incident as they were already gone for the day and not in the facility. During an interview on 06/05/24 at 3:10 PM, CNA J stated she was not assisting Resident #1 the day he fell . She said she and her partner (CNA K) heard the call light go off in the shower room. She said that when they saw what was happening, CNA E requested that they bring Resident #1's wheelchair. CNA J stated she did observe Resident #1, and CNA E. CNA J stated that CNA E was holding Resident #1 up. She said CNA E did not appear to need assistance. CNA J said she and her partner provided the wheelchair and walked away. She said she nor her partner provided any assistance then. CNA J stated that around 4:30-4:45 PM that same day, the call light in Resident #1's room went off, and they were told by Resident #1 and Family Member D to place Resident #1 in bed. CNA J said they (her and CNA K) transferred Resident #1, and he complained that his leg was hurting. After the transfer, CNA J said they reported the leg pain to RN I. During an interview on 06/05/24 at 3:41 PM, CNA K stated that when Resident #1 fell , she and her partner, CNA J, were not working directly with Resident #1. CNA K said she was working the floor with other residents. She said she and her partner heard the lights go off in the shower room. CNA K said CNA E asked for Resident #1's wheelchair. CNA K stated they provided him with the wheelchair and walked back out of the shower room. She said no additional assistance was provided. She said Resident #1 was being held up by CNA E. She said when she and her partner were in the restroom, CNA E did not look like he needed help. She said that the encounter was before lunch. She said that at around 4:40 PM, Resident #1's call light went off, and she and CNA J went to see what he needed. She said Resident #1 wanted to be transferred to bed, and during the transfer with her and CNA J, Resident #1 expressed that he was in pain. She stated they completed the transfer and got him comfortable. She said she and her partner immediately notified RN I. CNA K stated that RN I went to Resident #1's room, which was all she knew happened. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024
NAME OF PROVIDER OR SUPPLIER: Ralls Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 1111 Avenue P, Ralls, TX 79357	

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/05/24 at 4:04 PM, the ADM stated she did not consider Resident #1's incident a fall because CNA E told her that Resident #1 did not fall to the ground. The ADM said CNA E told her that during a transfer, CNA E held Resident #1 up, straightened Resident #1 up, and was able to place him in his wheelchair. The ADM stated she did not talk to Resident #1 about the incident. She stated that she did not because when she was told about the incident, Resident #1 was present in the dining room. The ADM said she was unaware if the presence of CNA E could have influenced Resident #1 to speak up. She said she did not investigate the incident further after CNA E reported it. She said she later heard that CNA J and CNA K were transferring Resident #1, and Resident #1 complained of pain. She stated she was confused that Resident #1 would have been in any pain because earlier that day, he never voiced any pain concerns. The ADM said she did not know if he was in pain because she did not know how he could sit 6-7 hours in pain. She said she would have thought if he was in pain, he would have said something. She also said she did not consider it a fall because the DOR told her that if a fall occurred during restorative or therapy, it was not considered a fall. During an interview on 06/05/24 at 4:24 PM, the DON stated she received a call on 05/30/24 from RN I around 5:28 PM or 5:30 PM. RN I said Resident #1 was complaining of pain and stated he had fallen. The DON said she called CNA E, and CNA E told her Resident #1 did not fall. She said CNA E said he reported it to the ADM and the PTA directly after the incident. The DON said she was told by CNA E that Resident #1's legs buckled, and that CNA E held Resident #1 up. The DON said that she was told CNAs J and K helped CNA E with Resident #1. The DON said she interviewed CNA J and CNA K and confirmed that they observed CNA E holding Resident #1 up and that they got the wheelchair. The DON said she did not confirm if they helped with the transfer. The DON said she did not speak with Resident #1 because he had already gone to the hospital. The DON stated she had not spoken with Resident #1 since he returned from the hospital. The DON stated that she understood that since CNA E had been trained, he could transfer Resident #1 alone. During an interview on 06/06/24 at 4:56 AM, LVN F stated she worked the night shift when Resident #1 fell . She stated it was passed to her during the report that Resident #1 fell while in the shower room. LVN F said that x-rays had been ordered, and she received the report around 10:00 PM on 05/30/24 that Resident #1 had a positive fracture. LVN F stated RN I told her he was not informed about the incident when it happened. LVN F stated she spoke with Resident #1, and he was able to say to her that he had fallen in the shower, but he did not provide any additional information. During an interview on 06/06/24 at 11:00 AM, the PTA stated that on 05/30/24, CNA E approached him. The PTA said CNA E was doing restorative on Resident #1, and he slipped. The PTA said CNA E stated that he had already reported the incident to the ADM. The PTA stated that CNA E had not given him any additional information. The PTA said that when he was told about the incident, he was not told it was in the shower. The PTA stated that he had not seen Resident #1's care plan and could not verify what it entailed, but two people to transfer was for safety especially when using the mechanical lift. He stated that if the care plan stated that there needed to be two people, then there should be two people, and staff should not deviate from that. The PTA stated that therapists could transfer with one person, and sometimes, it depended on if a female or male was doing the transfer. He did not specify why gender would make a difference. The PTA said he spoke with Resident #1, and all Resident #1 kept saying was fall, fall. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Ralls Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 Avenue P Ralls, TX 79357	

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/06/24 at 12:25 PM, the DON stated she was unaware that Resident #1 had fallen in the shower. The DON said she was made aware when the nurse called about Resident #1's pain. The DON stated that the restorative aide had been trained to report the incident to therapy and the nurse (that included the DON). The DON confirmed that CNA E was a restorative aide. She said Resident #1 had improved in his health and strength. The DON said it was her understanding that Resident #1 could be transferred with one person if it was a restorative aide. The DON said that regarding the incident with Resident #1, the potential negative outcome was that similar incidents could also occur with other residents. The DON said the potential negative outcome of not reporting Resident #1's fall to the nurse staff, not following their policy, and not investigating the incident was the charge nurse would not be made aware of the incident, and there could be a negative outcome for the resident if something internally would have been wrong with the resident. The DON said she was responsible for incident/accident prevention, but the ADM was responsible for investigations and reporting. The DON said the purpose of reporting incidents and investigating incidents of alleged abuse and neglect was to protect the residents and to follow policy. The DON said the facility system to monitor was to follow their policy. The DON said she was unaware of why they did not follow the policy. During an interview on 06/06/24 at 1:16 PM, the ADM stated that not reporting falls to the nurse, investigating incidents, and/or following their facility abuse policy could cause continued harm to the residents. The ADM said she was made aware of the incident regarding Resident #1 after CNA E told her about it. The ADM said she was unaware that Resident #1 was in pain and did not interview Resident #1. She said the system was implemented to monitor that falls were reported to the appropriate people, incidents were investigated, and ANE policies were followed by training staff on the facility policy. The ADM said she did not investigate the incident because she did not consider the incident a fall since it happened with therapy. The ADM stated she expected all staff to follow the care plan. The ADM said she did not look at the care plan to confirm that CNA E's transfer was correct. During an interview on 06/06/24 at 4:00 PM, the DOR stated that she had been notified during a morning meeting that Resident #1 had a fall. The DOR said she could not remember in particular the details. The DOR said she did not remember the date of the morning meeting. The DOR said she believed it was the day after the fall incident because they typically screened every fall. The DOR said all she knew was that it had something to do with the shower and that Resident #2's knee buckled. The DOR said doing restorative in the shower was normal and that CNA E had been specifically trained to do restorative with Resident #1. The DOR said Resident #1 required two people for transfer, but a restorative could transfer Resident #2's with one person. The DOR said that because CNA E was a male, he was allowed to transfer Resident #1 with one person, but if the staff were smaller, they would recommend that the staff use two people. The DOR said nursing would ultimately make the decision. 2. Findings for sexual incident that occurred on 05/10/24 between Resident #2 and Resident #3 include: Record review of Resident #2's face sheet, dated 06/05/24, revealed a [AGE] year-old-male that was readmitted to the facility on [DATE] with diagnoses that included dementia (impaired ability to remember), depressive disorder (constant feelings of sadness), mood disorder (emotional deficit), and blindness to the right eye. Record review of Resident #2's Quarterly Minimum Data Set, dated dated [DATE], revealed: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Section C Brief Interview for Mental Status score revealed a score of 05, which indicated the resident's cognition was severely impaired. Section B Hearing, Speech, and Vision revealed that Resident #2 had clear speech, made himself understood, and understands others. His vision was impaired, and he did not wear corrective lenses. Section E Behavior revealed that he had not had any incidents of physical or verbal behaviors. Record review of Resident #2's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a blank BIMS score. Section E Behavior revealed that he had had delusions, physical behaviors such as hitting, kicking, pushing, scratching, grabbing, and abusing others. Resident #2 had exhibited verbal behaviors such as threatening others, screaming, and cursing at others. Resident #2 had other behavioral symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing, smearing food or bodily wastes, or verbal/vocal symptoms like screaming and disruptive sounds. Resident #1 exhibited wandering behavior 1-3 days. Record review of Resident #2 care plan, dated 05/01/24 revealed the following: [Resident #2] wanders in other residents' rooms and gets into their beds at times and had the following interventions: [Resident #2] required assistance out of rooms that were not his and staff could use snacks if needed. [Resident #2] was an elopement risk/wanderer and had the following interventions: Distract [Resident #2] from wandering by offering pleasant diversions. [Resident #2] prefer having snacks. Followed by [name of psych care]. Notify their MD/NP of any escalation in wandering behaviors, ineffectiveness, or side effects of psychiatric medications. Monitor the resident's location throughout shifts. Document wandering behavior and attempted diversional interventions in behavior log. [Resident #2] had episodes of verbal and physical aggression r/t dementia with the following interventions: Give me as many choices as possible about care and activities. Monitor for physically/verbally aggressive behavior q shift. Document observed behavior and attempted interventions in behavior log. Monitor/document/report PRN any s/sx of [Resident #2] posing danger to self and others. [Resident #2] had impaired visual function r/t cataracts and glaucoma. Resident #2 was blind in his right eye with the following interventions: Arrange consultation with eye care practitioner as required. Monitor/document/report PRN any s/sx of acute eye problems: Change in ability to perform ADLs, decline in mobility, sudden visual loss, pupils dilated, gray or milky, c/o halos around lights, double vision, tunnel vision, blurred or hazy vision. Place frequently used items on my left side so I may see them. Record review of Resident #2's progress notes revealed the following: Record review on 05/11/24 at 12:12 AM LVN G documented: Data: Resident observed by CNA H reported to this nurse observed resident with pants unzipped and PENIS in Resident #3's hand. Action: Resident removed from Resident #3's room w/o incident. Resident #3 appears to have been asleep during entire incident. No physical injuries noted at this time. Response: Resident in his room and placed on 1-1 monitoring per DON instructions. Roommate moved to different room as this nurse considers this a HIGH RISK INCIDENT. DON & Administrator notified. (continued on next page)

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Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review on 05/11/24 at 03:23 PM The DON documented: Received orders from NP may administer Lorazepam 1ml now and then every 8 hours as needed. DON gave orders to charge nurse may use emergency restraint for safety of resident and others. Record review on 05/11/24 at 05:27 PM the DON documented: Spoke with Family Member L about incident and orders to give Lorazepam 2mg/ml injection every 8 hours as needed x 14 days. Voiced understanding and gives verbal consent at this time for medication. Also discussed that he would be going back to the behavior support center on Monday and facility would be actively looking for alternate long-term placement for resident. Voiced understanding and consents for referrals to be sent to other facilities. Record review on 05/11/24 at 05:27 PM LVN B documented: Staff alerted this nurse that this male resident was found in female resident's bed with his hands in the female's pants. Upon entering room male resident is found in bed with female resident with his hand on resident's waist. Told resident he needed to get out of bed. RT refused and put his arm around female resident. Male resident immediately removed from female's bed and taken to his own room. Resident became aggressive with staff refusing to leave bed causing CNAs to fall. Administration notified. Physician A, the DON notified. New order for Ativan 2mg/ml injection. Injection administered. Resident continues to try to go into other female rooms. Record review on 05/31/24 at 01:07 PM The DON documented: Resident returned from behavioral center via their facility van. Notified Physician A of return and medications. Notified the NP of return and reconciled psychotropic medications. Notified family Member L of return and went over psych medications and no issues or concerns at this time. Record review on 06/02/24 at 03:26 AM LVN M documented: Follow-up on readmission, resident continues to urinate on floor. Reminded resident to use urinal. Resident voiced understanding. Resident also continues to wander. Resident breathing even and unlabored. No complaints voiced. Record review of on 06/02/24 at 07:35 PM The DON documented: Notified by charge nurse that resident was wandering in rooms and becoming aggressive when staff was trying to redirect. Contacted the NP and new orders received to increase Seroquel to 50mg 3 times daily, Xanax 0.25mg every 6 hours as needed x 14 days, and Zyprexa 10mg IM every 12 hours as needed x 14days. Notified Family Member L of resident behavior and new orders. Voiced understanding and no issues or concerns at this time. Record review of Resident #2's monitoring sheets revealed the following: Resident #2 was monitored every 30 minutes starting 05/08/24 at 11:30 AM until 5/10/24 at 6:00 PM. (No abnormal behavior reported during this monitoring time.) No time monitoring accounted for 05/10/24 at 11:00 PM- 12:00 AM. Resident #2 was monitored on 05/11/24 from 1:00 AM-5:45 AM. (No abnormal behavior notated during this time. No time monitoring accounted for 12:00 AM-1:00 AM.) Resident #2 was monitored on 05/11/24 from 6:30 AM-4:00 PM. (No abnormal behavior notated during this time. No time monitoring accounted for 4:30 PM-6:00 PM) (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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #3's face sheet, dated 06/05/24, revealed an [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease (memory loss), cognitive communication deficit (difficulty communicating), fracture to neck and left femur, anxiety disorder (increased worry), and major depressive disorder (increased sadness). Record review of Resident #3's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 01, which indicated the resident's cognition was severely impaired. Section B. Ability to understand others revealed that she had clear speech, sometimes could make herself understood, and sometimes could understand others. Record review of Resident #3's care plan dated 6/5/24 revealed the following: Resident #3 was dependent on staff for emotional, intellectual, physical, and social needs related to cognitive deficits. Resident #3 required assistance to ADLs related to Alzheimer's disease, had impaired cognitive function/impaired thought processes related to Alzheimer's, had a mood problem related to depression, and had potential for psychosocial well-being related to trauma. Record review of Resident #3's progress notes revealed the following: On 05/11/24 at 01:27 AM LVN G documented: [Resident #2] observed in resident's room with Penis in her hand attempting what appears to ejaculate himself. Resident Immediately stopped by staff and removed to his room. Placed on 1-1 monitoring with instructions by DON NOT to be left out of staff sight at any time. No apparent injuries not upon physical inspection with female CNA present. DON to notify PCP & family. During an interview on 06/05/24 at 1:49 PM, CNA E stated that one night, when he worked the night shift (unsure of the date and exact time), Resident #2 exposed himself to Resident #3. He said he did not see it but was told by CNA H that Resident #2 had his penis in Resident #3's hand and was jerking off. He said as a result of that incident, Resident #2 was placed on 1:1 and was checked every 15 minutes by the night staff. He said Resident #3 was not in her right mind and would have been unable to consent. He said Resident #3 may have a BIMs of 0 (severe cognitive impairment). He said prior to the incident involving Resident #3, Resident #2 was not on any close monitoring. He said that when Resident #3 was in the dining room and wanted to return to his room, they would assist him, but after he was in his room, they did not do additional monitoring. During an interview on 06/05/24 at 2:57 PM, LVN G stated that on 05/11/24, he was working the night shift. He said he heard a young lady yell out. He said it was the female CNA but did not know her name. He said he was on break. He said the female CNA reported that Resident #2 had a particular part of his anatomy in Resident #3's hand. LVN G stated they assisted in getting Resident #2 out of Resident #3's room. He stated when he walked in, he did not see Resident #2's penis in Resident #3's hand but did see his penis out. He said he had not seen Resident #2 do the sexual act in the past, but that Resident #2 would expose himself and urinate on the floor. He stated that, because of the incident, he reported it to the DON and was instructed to place Resident #2 on 1:1 monitoring. He stated he would sit in the hall and ensure Resident #2 did not go into other rooms. LVN G said that Resident #3 was catatonic (immobile) and could not defend herself. (continued on next page)

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Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/05/24 at 4:04 PM, the ADM stated she did not report the incident that involved inappropriate sexual contact that occurred with Residents #2 and #3 because all parties had dementia. She said she focused on if the act was willful. She said Resident #3 was asleep and did not know what was happening. She said she was told but could not remember who told her that Resident #2 was standing over Resident #3 with his penis out and Resident #3's hand was on Resident #2's penis. The ADM stated she was not told that Resident #2 was masturbating. The ADM stated that Resident #2 was not put on 1:1 during the first incident involving Resident #3 because he was not aggressive, and that was the first time he displayed this behavior. During an interview on 06/05/24 at 4:24 PM, the DON stated when the inappropriate sexual incident between Residents #2 and #3 were reported to her, she reported it to the ADM as she was the abuse coordinator. The DON stated the ADM confirmed with the Regional Director that it did not have to be reported because the residents had dementia. The DON said the Regional Director provided documentation to support the de [TRUNCATED]

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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** 43344 Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or result in serious bodily injury to the administer of the facility and to other officials including the State Survey Agency in accordance with State law through established procedures for 5 of 9 residents (Residents #2, #3, #4, #5 and #6) reviewed for abuse and neglect. 1. The facility failed to report a sexual incident which occurred on 05/10/24 between Resident #2 and Resident #3. 2. The facility failed to report a sexual incident which occurred on 05/11/24 between Resident #2 and Resident #4. 3. The facility failed to report a sexual incident which occurred on 06/02/24 between Resident #5 and Resident #3. 4. The facility failed to report a sexual incident which occurred on 06/02/24 between Resident #5 and Resident #6. These failures could place residents at risk for abuse/neglect and could lead to a diminished quality of life and psychosocial harm. Findings Include: 1. Findings for the facility failure to report a sexual incident which occurred on 05/10/24 between Resident #2 and Resident #3. Record review of Resident #2's face sheet, dated 06/05/24, revealed a [AGE] year-old-male that was readmitted to the facility on [DATE] with diagnoses that included dementia (impaired ability to remember), depressive disorder (constant feelings of sadness), mood disorder (emotional deficit), and blindness to the right eye. Record review of Resident #2's Quarterly Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 05, which indicated the resident's cognition was severely impaired. Section B Hearing, Speech, and Vision revealed that Resident #2 had clear speech, makes himself understood, and understands others. His vision is impaired, and he does not wear corrective lenses. Section E Behavior revealed that he had not had any incidents of physical or verbal behavior. Record review of Resident #2's Comprehensive Minimum Data Set, dated dated [DATE], revealed: (continued on next page)

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F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Section C Brief Interview for Mental Status score revealed a blank BIMS score. Section E Behavior revealed that he had had delusions, physical behaviors such as hitting, kicking, pushing, scratching, grabbing, and abusing others. Resident # 2 had exhibited verbal behaviors such as threatening others, screaming, and cursing at others. Resident #2 had other behavioral symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing, smearing food or bodily wastes, or verbal/vocal symptoms like screaming and disruptive sounds. Resident #1 exhibited wandering behavior 1-3 days.

Record review of Resident #2 care plan, dated 05/01/24 revealed the following:

Resident #2 wanders in other residents' rooms and gets into their beds at times and had the following interventions: Resident #2 required assistance out of rooms that were not his and staff could use snacks if needed.

Resident #2 was an elopement risk/wanderer and had the following interventions: Distract Resident #2 from wandering by offering pleasant diversions. Resident #2 prefer having snacks. Followed by [name of psych care]. Notify their MD/NP of any escalation in wandering behaviors, ineffectiveness, or side effects of psychiatric medications. Monitor the resident's location throughout shifts. Document wandering behavior and attempted diversional interventions in behavior log.

Resident #2 had episodes of verbal and physical aggression r/t dementia with the following interventions: Give me as many choices as possible about care and activities. Monitor for physically/verbally aggressive behavior q shift. Document observed behavior and attempted interventions in behavior log. Monitor/document/report PRN any s/sx of Resident #2

posing danger to self and others.

Resident #2 had impaired visual function r/t cataracts and glaucoma. Resident #2 was blind in his right eye with the following interventions: Arrange consultation with eye care practitioner as required. Monitor/document/report PRN any s/sx of acute eye problems: Change in ability to perform ADLs, decline in mobility, sudden visual loss, pupils dilated, gray or milky, c/o halos around lights, double vision, tunnel vision, blurred or hazy vision. Place frequently used items on my left side so I may see them.

Record review of Resident #2's progress notes revealed the following:

Record review of on 05/11/24 at 12:12 AM LVN G documented: Data: Resident observed by CNA H reported to this nurse observed resident with pants unzipped and PENIS in Resident #3's hand. Action: Resident removed from Resident #3's room w/o incident. Resident #3 appears to have been asleep during entire incident. No physical injuries noted at this time. Response: Resident in his room and placed on 1-1 monitoring per DON instructions. Roommate moved to different room as this nurse considers this a HIGH RISK INCIDENT. DON & Administrator notified.

Record review of on 05/11/24 at 03:23 PM The DON documented: Received orders from NP may administer Lorazepam 1ml now and then every 8 hours as needed. DON gave orders to charge nurse may use emergency restraint for safety of resident and others.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024
NAME OF PROVIDER OR SUPPLIER: Ralls Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 1111 Avenue P Ralls, TX 79357	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of on 05/11/24 at 05:27 PM the DON documented: Spoke with Family Member L about incident and orders to give Lorazepam 2mg/ml injection every 8 hours as needed x 14 days. Voiced understanding and gives verbal consent at this time for medication. Also discussed that he would be going back to the behavior support center on Monday and facility would be actively looking for alternate long-term placement for resident. Voiced understanding and consents for referrals to be sent to other facilities. Record review of on 05/11/24 at 05:27 PM LVN B documented: Staff alerted this nurse that this male resident was found in female resident's bed with his hands in the female's pants. Upon entering room male resident is found in bed with female resident with his hand on resident's waist. Told resident he needed to get out of bed. RT refused and put his arm around female resident. Male resident immediately removed from female's bed and taken to his own room. Resident became aggressive with staff refusing to leave bed causing CNAs to fall. Administration notified. Physician A, the DON notified. New order for Ativan 2mg/ml injection. Injection administered. Resident continues to try to go into other female rooms. Record review on 05/31/24 at 01:07 PM The DON documented: Resident returned from behavioral center via their facility van. Notified Physician A of return and medications. Notified the NP of return and reconciled psychotropic medications. Notified family Member L of return and went over psych medications and no issues or concerns at this time. Record review of on 06/02/24 at 03:26 AM LVN M documented: Follow-up on readmission, resident continues to urinate on floor. Reminded resident to use urinal. Resident voiced understanding. Resident also continues to wander. Resident breathing even and unlabored. No complaints voiced. Record review of on 06/02/24 at 07:35 PM The DON documented: Notified by charge nurse that resident was wandering in rooms and becoming aggressive when staff was trying to redirect. Contacted the NP and new orders received to increase Seroquel to 50mg 3 times daily, Xanax 0.25mg every 6 hours as needed x 14 days, and Zyprexa 10mg IM every 12 hours as needed x 14days. Notified Family Member L of resident behavior and new orders. Voiced understanding and no issues or concerns at this time. Record review of Resident #2's monitoring sheets revealed the following: Resident #2 was monitored every 30 minutes starting 05/08/24 at 11:30 AM until 5/10/24 at 6:00 PM. (No abnormal behavior reported during this monitoring time.) No time monitoring accounted for 05/10/24 at 11:00 PM- 12:00 AM. Resident #2 was monitored on 05/11/24 from 1:00 AM-5:45 AM. (No abnormal behavior notated during this time. No time monitoring accounted for 12:00 AM-1:00 AM.) Resident #2 was monitored on 05/11/24 from 6:30 AM-4:00 PM. (No abnormal behavior notated during this time. No time monitoring accounted for 4:30 PM-6:00 PM) Record review of Resident #3's face sheet, dated 06/05/24, revealed an [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease (memory loss), cognitive communication deficit (difficulty communicating), fracture to neck and left femur, anxiety disorder (increased worry), and major depressive disorder (increased sadness). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024
NAME OF PROVIDER OR SUPPLIER Ralls Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 Avenue P Ralls, TX 79357	

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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	Record review of Resident #3's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 01, which indicated the resident's cognition was severely impaired. Section B. Ability to understand others revealed that she had clear speech, sometimes could make herself understood, and sometimes could understand others. Record review of Resident #3's care plan dated 6/5/24 revealed the following: Resident #3 was dependent on staff for emotional, intellectual, physical, and social needs related to cognitive deficits. Resident #3 required assistance to ADLs related to Alzheimer's disease, had impaired cognitive function/impaired thought processes related to Alzheimer's, had a mood problem related to depression, and had potential for psychosocial well-being related to trauma. Record review of Resident #3's progress notes revealed the following: 05/11/24 at 01:27 AM LVN G documented: Resident #2 observed in resident's room with Penis in her hand attempting what appears to ejaculate himself. Resident Immediately stopped by staff and removed to his room. Placed on 1-1 monitoring with instructions by DON NOT to be left out of staff sight at any time. No apparent injuries not upon physical inspection with female CNA present. DON to notify PCP & family. During an interview on 06/05/24 at 1:49 PM, CNA E stated that one night, when he worked the night shift (unsure of the date and exact time), Resident #2 exposed himself to Resident #3. He said he did not see it but was told by CNA H that Resident #2 had his penis in Resident #3's hand and was jerking off. He said as a result of that incident, Resident #2 was placed on 1:1 and was checked every 15 minutes by the night staff. He said Resident #3 was not in her right mind and would have been unable to consent. He said Resident #3 may have a BIMs of 0. He said prior to the incident involving Resident #3, Resident #2 was not on any close monitoring. He said that when Resident #3 was in the dining room and wanted to return to his room, they would assist him, but after he was in his room, they did not do additional monitoring. During an interview on 06/05/24 at 2:57 PM, LVN G stated that on 05/11/24, he was working the night shift. He said he heard a young lady yell out. He said it was the female CNA but did not know her name. He said he was on break. He said the female CNA reported that Resident #2 had a particular part of his anatomy in Resident #3's hand. LVN G stated they assisted in getting Resident #2 out of Resident #3's room. He stated when he walked in, he did not see Resident #2's penis in Resident #3's hand but did see his penis out. He said he had not seen Resident #2 do the sexual act in the past, but that Resident #2 would expose himself and urinate on the floor. He stated that, because of the incident, he reported it to the DON and was instructed to place Resident #2 on 1:1 monitoring. He stated he would sit in the hall and ensure Resident #2 did not go into other rooms. LVN G said that Resident #3 was catatonic (immobile) and could not defend herself. He said he reported the incident to the DON. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024
NAME OF PROVIDER OR SUPPLIER Ralls Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 Avenue P Ralls, TX 79357	

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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	During an interview on 06/05/24 at 4:04 PM, the ADM stated she did not report the incident that involved inappropriate sexual contact that occurred with Resident #2 and #3 because all parties had dementia. She said she focused on if the act was willful. She said Resident #3 was asleep and did not know what was happening. She said she was told but could not remember who told her that Resident #2 was standing over Resident #3 with his penis out and Resident #3's hand was on Resident #2's penis. The ADM stated she was not told that Resident #2 was masturbating. The ADM stated that Resident #2 was not put on 1:1 during the first incident involving Resident #3 because he was not aggressive, and this was the first time he displayed this behavior. During an interview on 06/05/24 at 4:24 PM, the DON stated when the inappropriate sexual incident between Residents #2 and #3 were reported to her, she reported it to the ADM as she was the abuse coordinator. The DON stated the ADM confirmed with the Regional Director that it did not have to be reported because the residents had dementia. The DON said the Regional Director provided documentation to support the decision. The DON stated she did not speak up or take any additional action to report the incidents. During an interview on 06/06/24 at 12:25 PM, the DON stated she did not want to say the wrong things and that she could not think of the potential negative outcome when it came to not reporting sexual incidents between residents, specifically the incidents that occurred between Residents #2 and #3. She said she was aware that the sexual incident had not been reported to the HHSC. The DON said the ADM told her that she did not report it based on the instruction given to her by the Regional Director. The DON said she did not observe the sexual incident between Resident #2 and #3. The DON said she was responsible for incident/accident prevention, but the ADM was responsible for reporting. The DON said the purpose of reporting incidents of alleged abuse and neglect was to protect the residents and to follow policy. The DON said the facility system to monitor was to follow their policy. The DON said she was unaware of why they did not follow the policy. The DON said the ADM was responsible for reporting and investigating the incidents. During an interview on 06/06/24 at 1:16 PM, the ADM stated she was aware that she had not reported the sexual incident between Resident #2 and #3. She said the reason she did not report the incident was because after speaking with her Regional Director, who was more experienced, they felt that it was a behavior, not intentional, and abuse did not occur. The ADM said with this being a brand-new behavior for Resident #2, she could see that she did not see anything abnormal, with the conclusion of not reporting the incident of inappropriate sexual behavior. The ADM said her gut feeling was to report the incidents. The ADM said her Regional Director told her the incidents of inappropriate sexual behavior did not have to be reported, and she did not question it. The ADM said she was responsible for reporting all appropriate incidents to HHSC. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024
NAME OF PROVIDER OR SUPPLIER Ralls Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 Avenue P Ralls, TX 79357	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/06/24 at 7:26 PM, the Regional Director stated he was notified in the middle of the night on 05/11/24 by the ADM that a resident was found in another resident's room holding his penis. The Regional Director said he was not given the details of who the resident was and the resident using another resident's hand to masturbate. The Regional Director said he was told by the ADM that there was no victim because the resident was blind, wandering, and the other resident was sleeping. The Regional Director stated again that he was not given any details at that time of which residents were involved. The Regional said he did google the flow chart from the internet and sent it to the ADM. The Regional Director said the document he provided showed a person with dementia does not have the willingness to abuse someone. The Regional Director said it was still the expectation that the incident should have been reported. The Regional Director said the purpose of reporting was to ensure no residents were in harm's way. The Regional Director said he never instructed anyone not to report any incidents. The regional director said the ADM was responsible for all activities in the facility. 2. Findings for the facility failure to report a sexual incident which occurred on 05/11/24 between Resident #2 and Resident #4. Record review of Resident #2's progress notes revealed the following: Record review of on 05/11/24 at 12:12 AM LVN G documented: Data: Resident observed by CNA H reported to this nurse observed resident with pants unzipped and PENIS in Resident #3's hand. Action: Resident removed from Resident #3's room w/o incident. Resident #3 appears to have been asleep during entire incident. No physical injuries noted at this time. Response: Resident in his room and placed on 1-1 monitoring per DON instructions. Roommate moved to different room as this nurse considers this a HIGH RISK INCIDENT. DON & Administrator notified. Record review of on 05/11/24 at 03:23 PM The DON documented: Received orders from NP may administer Lorazepam 1ml now and then every 8 hours as needed. DON gave orders to charge nurse may use emergency restraint for safety of resident and others. Record review of on 05/11/24 at 05:27 PM the DON documented: Spoke with Family Member L about incident and orders to give Lorazepam 2mg/ml injection every 8 hours as needed x 14 days. Voiced understanding and gives verbal consent at this time for medication. Also discussed that he would be going back to the behavior support center on Monday and facility would be actively looking for alternate long-term placement for resident. Voiced understanding and consents for referrals to be sent to other facilities. Record review of on 05/11/24 at 05:27 PM LVN B documented: Staff alerted this nurse that this male resident was found in female resident's bed with his hands in the female's pants. Upon entering room male resident is found in bed with female resident with his hand on resident's waist. Told resident he needed to get out of bed. RT refused and put his arm around female resident. Male resident immediately removed from female's bed and taken to his own room. Resident became aggressive with staff refusing to leave bed causing CNAs to fall. Administration notified. Physician A, the DON notified. New order for Ativan 2mg/ml injection. Injection administered. Resident continues to try to go into other female rooms. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024
NAME OF PROVIDER OR SUPPLIER Ralls Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 Avenue P Ralls, TX 79357	

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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	Record review on 05/31/24 at 01:07 PM The DON documented: Resident returned from behavioral center via their facility van. Notified Physician A of return and medications. Notified the NP of return and reconciled psychotropic medications. Notified family Member L of return and went over psych medications and no issues or concerns at this time. Record review of on 06/02/24 at 03:26 AM LVN M documented: Follow-up on readmission, resident continues to urinate on floor. Reminded resident to use urinal. Resident voiced understanding. Resident also continues to wander. Resident breathing even and unlabored. No complaints voiced. Record review of on 06/02/24 at 07:35 PM The DON documented: Notified by charge nurse that resident was wandering in rooms and becoming aggressive when staff was trying to redirect. Contacted the NP and new orders received to increase Seroquel to 50mg 3 times daily, Xanax 0.25mg every 6 hours as needed x 14 days, and Zyprexa 10mg IM every 12 hours as needed x 14days. Notified Family Member L of resident behavior and new orders. Voiced understanding and no issues or concerns at this time. Record review of Resident #2's monitoring sheets revealed the following: Resident #2 was monitored every 30 minutes starting 05/08/24 at 11:30 AM until 5/10/24 at 6:00 PM. (No abnormal behavior reported during this monitoring time.) No time monitoring accounted for 05/10/24 at 11:00 PM- 12:00 AM. Resident #2 was monitored on 05/11/24 from 1:00 AM-5:45 AM. (No abnormal behavior notated during this time. No time monitoring accounted for 12:00 AM-1:00 AM.) Resident #2 was monitored on 05/11/24 from 6:30 AM-4:00 PM. (No abnormal behavior notated during this time. No time monitoring accounted for 4:30 PM-6:00 PM) Record review of Resident #4's face sheet, dated 06/05/24, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnosis that included Alzheimer's disease (memory loss). Record review of Resident #4's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 03, which indicated the resident's cognition was severely impaired. Section B. Ability to understand others revealed that she had clear speech, could make herself understood, and could understand others. Record review of Resident #4's care plan dated 4/29/24 revealed the following: Resident #4 was dependent on staff for emotional, intellectual, physical, and social needs related to cognitive deficits. Resident 41 had impaired cognitive function related to Alzheimer's disease. Record review of Resident #4's progress notes revealed the following: 05/11/24 at 05:32 PM LVN B documented: Staff alerted this nurse that Resident #2 was found in female resident's bed with his hands in female's pants. Upon entering room male resident is found in bed with female resident with his hand on resident's waist. Male resident immediately removed from female's bed and taken to his own room. Female resident assessed for injury; no visible injury noted. Administration notified. DON to speak with family regarding incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024
NAME OF PROVIDER OR SUPPLIER: Ralls Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 1111 Avenue P, Ralls, TX 79357	

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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	During an interview on 06/05/24 at 4:04 PM, the ADM stated she did not report the incidents that involved inappropriate sexual contact that occurred with Resident #2 and #4 because all parties had dementia. She said she focused on if the act was willful. She said she was informed later that day (05/11/24) by LVN B that Resident #2 had gotten into bed with Resident #4 and had his hand near her privates. She said she had read the progress notes since the state surveyor exited on 05/09/24. She said she did not report the incident of inappropriate sexual behavior because, in the incident involving Resident #2 and #4, all residents involved had dementia. The ADM stated that Resident #2 was placed on 1:1 during the second incident involving Resident #4 because Resident #2 became aggressive. During an interview on 06/05/24 at 4:24 PM, the DON stated when the inappropriate sexual incident between Residents #2 and #4 were reported to her, she reported it to the ADM as she was the abuse coordinator. The DON stated the ADM confirmed with the Regional Director that it did not have to be reported because the residents had dementia. The DON said the Regional Director provided documentation to support the decision. The DON stated she did not speak up or take any additional action to report the incidents. During an interview on 06/06/24 at 12:25 PM, the DON stated the purpose of reporting incidents of alleged abuse and neglect was to protect the residents and to follow policy. The DON said the facility system to monitor was to follow their policy. The DON said she was unaware of why they did not follow the policy. The DON said the ADM was responsible for reporting the incidents. During an interview on 06/06/24 at 1:16 PM, the ADM did not name any potential negative outcomes for the resident during this interview. The ADM said she was aware that she had not reported the incident. She said the reason she did not report the incident was because after speaking with her Regional Director, who was more experienced, they felt that it was a behavior, not intentional, and abuse did not occur. She said that this was why she did not report the incident. The ADM said with this being a brand-new behavior for Resident #2, she could see that she did not see anything abnormal, with the conclusion of not reporting the incidents of inappropriate sexual behavior. The ADM said her gut feeling was to report the incident. The ADM said her Regional Director told her the incident of inappropriate sexual behavior did not have to be reported, and she did not question it. The ADM said she was responsible for reporting all appropriate incidents to HHSC. During an interview on 06/06/24 at 7:26 PM, the Regional Director stated it was his expectation that the incident should have been reported. The Regional Director said the purpose of reporting was to ensure no residents were in harm's way. The Regional Director said he never instructed anyone not to report any incidents. The Regional Director said the ADM was responsible for all activities in the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/07/24 at 12:00 PM, LVN B stated that she did not observe what happened between Resident #2 and Resident #4. She stated what she noted in the resident's progress notes was what she saw. She said that the medication aide notified her but that he no longer worked at the facility. LVN B said she assessed the situation and observed Resident #2's hands in Resident #4's pants. LVN B said they told Resident #2 that he needed to stop and get out. LVN B stated that when she tried to redirect Resident #2 out of the room, that was when Resident #2 became aggressive. LVN B said Resident #2 was kicking, and it was difficult because Resident #4's bed was low and on the ground. LVN B said Resident #2 was trying to kick and fight the Medication Aide. LVN B said she was upset about the incident. She said it was not passed on that he needed to be 1:1 the night before. LVN B she was instructed that she had to do close monitoring. She said she would set her time and check on him every 30 minutes. She said it would have been impossible for her to sit with him 1:1, and she was the only charge nurse. LVN B said she does not know why she did not completely sign off on the monitoring form between 4:00 PM and 6:00 PM. LVN B confirmed that the initials by the 4:00-6:00 PM blank hours were hers. LVN B said on 05/11/24 during her shift (day 6:00 AM-6:00 PM), she or her staff did not sit 1:1 with Resident #2. LVN B said she would peek in on Resident #2 when she could, but she was the only nurse for all the residents at the facility. LVN B stated she did report the inappropriate sexual incident to the DON and documented in her progress notes. 3. Findings for the facility failure to report a sexual incident which occurred on 06/02/24 between Resident #5 and Resident #3. Record review of Resident #3's progress notes revealed the following: 05/11/24 at 01:27 AM LVN G documented: Resident #2 observed in resident's room with Penis in her hand attempting what appears to ejaculate himself. Resident Immediately stopped by staff and removed to his room. Placed on 1-1 monitoring with instructions by DON NOT to be left out of staff sight at any time. No apparent injuries not upon physical inspection with female CNA present. DON to notify PCP & family. Record review of Resident #5's face sheet, dated 06/09/24, revealed a [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses that included other sexual dysfunction (difficulty with sexual response), intermittent explosive disorder (impulsive and aggressive outbursts), insomnia (difficulty sleeping), age related cognitive decline, and cognitive communication deficit (difficulty communicating). Record review of Resident #5's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 07, which indicated the resident's cognition was severely impaired. Section B. Ability to understand others revealed that she had clear speech, could usually make herself understood, and usually understood others. Section E Behavior revealed that he had no documented behavior outside of wandering that occurred 1-3 days. Record review of Resident #5's care plan dated 6/02/24 revealed the following: Resident #5 occasionally attempted to be sexually inappropriate with staff and other residents. Resident #5 occasionally stated he was a killer and a rapist. Resident #5 had impaired cognitive function. Record review of Resident #5's progress notes revealed the following: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Ralls Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 Avenue P Ralls, TX 79357	

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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	On 06/02/24 at 02:20 PM LVN Q documented: LATE ENTRY Data: Resident #5 was kissing another resident (unidentified) on the lips. Action: Stopped the resident and sent him to his room and informed him not to be kissing other female residents. Response: WCTM this shift. 06/02/24 at 08:50 PM LVN Q documented: LATE ENTRY Data: Resident #5 was seen by a staff member touching and kissing on another resident (unidentified) in the dining room. Action: Removed the resident away from the other resident and informed him to keep his hands to himself. Response: WCTM this shift. On 06/09/24 at 02:56 PM the DON documented: Family members x 3 here to see [Resident #5]. Family would like facility to attempt referrals closer to their area. They would like referrals sent to multiple facilities. Informed Family that we would start referral process on Monday. Record review of Resident #5's monitoring sheets revealed the following: Resident #5 was monitored every 15 minutes starting 06/09/24 at 12:00 AM until 11:45 PM (No abnormal behavior reported during this monitoring time). Resident #5 was monitored every 15 minutes starting 06/10/24 at 12:00 AM until 12:45 PM (No abnormal behavior reported during this monitoring time). No time monitoring accounted for the following dates: 06/02/2024. During an interview on 06/09/24 at 11:23 AM, the DON stated as a result of the IJ identified on 06/06/24, they were able to identify two other incidents that involved inappropriate sexual touching that was not reported. This occurred with Residents #5, and #3. She stated they identified the incident when they were following their removal plan and reviewing progress notes for potential residents that could be affected. The DON stated they immediately placed Resident #5 on Red supervision, notified Physician A, assessed all residents involved (Resident # 5 and #3), notified the family of both residents, and trained staff. The DON stated that she did not have details of what happened but that they had started the process of investigating. The DON stated they had reported the incident and did not know why the incidents had not been reported. During an interview on 06/09/24 at 12:46 PM, the Dietary [NAME] stated she was present for the incident with Resident #5 and #4. The Dietary [NAME] said she was unsure of the date but that it happened a week before the interview. The Dietary [NAME] said the incident with Resident #4 involved Resident #5 touching and rubbing Resident #4's breast in the dining room. She said she reported this to LVN B and the ADM. 4. Findings for the facility failure to report a sexual incident which occurred on 06/02/24 between Resident #5 and Resident #6. Record review of Resident #5's progress notes revealed the following: On 06/02/24 at 02:20 PM LVN Q documented: LATE ENTRY Data: Resident #5 was kissing another resident (unidentified) on the lips. Action: Stopped the resident and sent him to his room and informed him not to be kissing other female residents. Response: WCTM this shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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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	06/02/24 at 08:50 PM LVN Q documented: LATE ENTRY Data: Resident #5 was seen by a staff member touching and kissing on another resident (unidentified) in the dining room. Action: Removed the resident away from the other resident and informed him to keep his hands to himself. Response: WCTM this shift. On 06/09/24 at 02:56 PM the DON documented: Family members x 3 here to see [Resident #5]. Family would like facility to attempt referrals closer to their area. They would like referrals sent to multiple facilities. Informed Family that we would start referral process on Monday. Record review of Resident #5's monitoring s [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024
NAME OF PROVIDER OR SUPPLIER: Ralls Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 1111 Avenue P, Ralls, TX 79357	

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Respond appropriately to all alleged violations.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43344

Based on interview and record reviews the facility failed to have evidence that all violations, in response to abuse, neglect, exploitation or mistreatment, were thoroughly investigated for 6 of 9 residents (Residents #1, #2, #3, #4, #5 and #6) reviewed for abuse and neglect.

1. The facility failed to investigate a fall incident that occurred on 05/30/24 with Resident #1 while in the care of CNA E.

2. The facility failed to investigate a sexual incident that occurred on 05/10/24 between Resident #2 and Resident #3.

3. The facility failed to investigate a sexual incident that occurred on 05/11/24 between Resident #2 and Resident #4.

4. The facility failed to investigate a sexual incident that occurred on 06/02/24 between Resident #5 and Resident #3.

5. The facility failed to investigate a sexual incident that occurred on 06/02/24 between Resident #5 and Resident #6.

These failures could place residents at risk of incidents not being thoroughly investigated.

The findings included:

1. Findings for the facility's failure to investigate a fall incident that occurred on 05/30/24 with Resident #1 while in the care of CNA E.

Record review of Resident #1's face sheet, dated 06/05/24, revealed a [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (stroke), major depressive disorder, anxiety (increased feelings of fear, dread, and uneasiness), and cognitive communication deficit (difficulty understanding and communicating).

Record review of Resident #1's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 04, which indicated the resident's cognition was severely impaired. Section B Hearing, Speech, and Vision revealed that Resident #1 had slurred speech, could make himself understood, and usually understood others. Section GG Functional Abilities and Goals indicated the Resident #1 was dependent and this could mean that the resident did all the effort or that he required the assistance of 2 or more helpers to complete the activity of tub or shower transfer.

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Record review of Resident #1 Care Plan, dated 05/29/24, revealed the following: Resident #1 had an ADL self-care performance deficit r/t to limited range of motion due to CVA. Resident #1's self-performance fluctuate r/t confusion, but he usually requires assistance with ADLs. Resident #1 required 1-2 staff for showering/bath and shower/tub transfer Resident #1 required two+ person physical assists. Resident #1 used a mechanical lift for transfers with a minimum of two staff present unless transferring with therapy/ restorative. Resident #1 was at risk for falls r/t balance problem. Ensuring Resident #1 frequently used items were within reach. Resident #1 had osteoporosis and was at risk for fractures.

Record review of Resident #1's progress notes revealed the following:

05/30/24 at 1:10 AM LVN F documented: Xray results show positive intertrochanteric hip fracture (upper thigh hip fracture) to left hip. Physician A notified and received orders to send Resident #1 to ER to evaluate. Notified Family Member A POA. EMS here to transport resident to local hospital. Report called in to ER. ADM and DON notified as well.

05/30/24 at 1:43 AM the DON documented: 5:38 PM was notified by charge nurse that resident was c/o left hip pain. Instructed charge nurse to notify Physician A. Nurse received orders to obtain x-rays to left hip. Notified administrator of resident c/o left hip pain. Then instructed night nurse to notify as soon as x-ray results received. Received notification at 10:25 pm from night charge nurse that x-ray showed a left acute intertrochanteric hip fracture (upper thigh hip fracture). Immediately notified administrator of findings.

06/03/24 at 9:29 PM the LVN F documented: Resident readmitted to facility following hospitalization following fall on 5/30 resulting in intertrochanteric hip fracture (upper thigh hip fracture) to left hip. Dynamic hip screw surgery to left hip. Resident weight bearing as tolerated.

During an interview on 06/05/24 at 12:07 PM, Family Member D stated on 05/30/24, she visited with Resident #1. She stated that he had received a shower that morning from CNA E. She said during the day, around the time they played Bingo, Resident #1 started complaining that his butt hurt. She said she thought maybe he was constipated. She said that when the CNAs (CNA J and CNA K) went to put him in bed, he started complaining of pain. She said Resident #1 pointed to his left side and said, Hurt hurt. She said she waited until the CNAs left to notify RN I to ask Resident #1 what happened because he was complaining more than earlier. Resident #1 told me that he fell in the shower that morning with CNA E. She said Resident #1 said he fell and hit his head. She said CNA E was in the room when Resident #1 fell but he did not see Resident #1 fall because his back was to Resident #1. CNA E was shutting the bathroom door when Resident #1 fell . Family Member D said she asked if Resident #1 had reported to anyone that he had fallen and if the nurse knew. She said Resident #1 said no. She said Resident #1 explained that it was an accident, that he did not want to get CNA E in trouble, and that he liked him. She said she spoke with CNA E after Resident #1's fall (unknown date and time), and he said he was sorry and acknowledged the fall. She said CNA E told her that he told the ADM and therapy. She stated she was not notified of the fall and was at the facility when CNA showered Resident #1. She said she would have liked to have been told so that she could have had Resident #1 checked out immediately. She said no one had come to her and asked her any questions about what Resident #1 had disclosed to her.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/09/24 at 12:22 PM, Resident #1 stated that he fell in the shower while showering. Resident #1 said CNA E was in the restroom, but his back was to him. Resident #1 said he fell to the floor and hit his head. Resident #1 said CNA E picked him up and put him in the wheelchair. Resident #1 said no other staff helped CNA E to pick him up. Resident #1 said that a nurse did not check him. Resident #1 said no one from the administration came and talked to him about the incident. Resident #1 said he was in pain when he left the shower room but did not report it because he did not want to get CNA E in trouble. He said at the time of the interview no one had asked him any questions about what happened in the shower room when he fell . During an interview on 06/05/24 at 1:49 PM, CNA E stated the incident with Resident #1 occurred on Thursday (05/30/24). CNA E stated he had just completed Resident #1's shower. He stated Resident #1 appeared to be standing fine. He said Resident #1's leg buckled, and as Resident #1 was holding on to the grab bar, he swiveled and hit the wall. He said Resident #1 never completely hit the ground. CNA E stated he called for assistance with Resident #1. CNA E stated he called CNA J and CNA K. CNA E stated he and CNA J and CNA K finished getting Resident #1 dressed and placed Resident #1 in his wheelchair. CNA E stated he asked Resident #1 how he was doing and was told by Resident #1 that he was ok. CNA E stated he had reported what happened to the ADM and the PTA directly after the incident. CNA E stated that he reported to the ADM that the fall was not a complete fall to the ground. CNA E could not recall if he told the ADM that Resident #1 had hit the wall. CNA E did not disclose if the ADM had asked any additional questions about the incident. He stated Resident #1 did not complain of pain or show any signs of discomfort. When he demonstrated to Family Member D what happened, CNA E stated that his head hit the wall. CNA E stated he did not have the nurse look at Resident #1 because he felt he did the correct thing when he reported the incident to the ADM. CNA E stated the ADM told him that the incident was not reportable, so he did not tell anyone else. He said although Resident #1's care plan says to use the mechanical lift, he was a physical transfer. He said the fall might have happened around 11:30 AM on 05/30/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/05/24 at 2:08 PM, RN I stated that he was unsure when the fall incident happened with Resident #1 but was in the middle of the week. RN I said he did not know anything about it until the end of his shift. He said CNA K came to him and alerted him that Resident #1 was in pain the same day Resident #1 fell . He said he was told by Resident #1 that he had a fall in the shower earlier that day, and he had hit his head and his hip. RN I said Resident #1 said he did not want to get CNA E in trouble. RN I said while Resident #1 was telling him he was crying. RN I stated he notified the DON, and the DON was surprised that CNA E had not told the nursing staff anything about the incident. RN I said he was frustrated because although the incident was communicated to the PTA and the ADM, it was not communicated to him as the charge nurse, and a delay in treatment occurred. He stated that once he became aware of this, he assessed and notified Physician A. RN. I stated that x-rays were ordered, but he did not receive the results on his shift. RN I said he spoke with CNA E and inquired why he was not notified. RN I said CNA E said he could not find RN I and apologized for not reporting the incident to RN I. RN I explained that his license could be on the line and treatment for Resident #1 could be delayed. RN I said that CNA E stated he was doing therapy in the shower to promote movement, and Resident #1 gave out. RN I said that CNA E told him that Resident #1 never hit the ground, but this differed from what Resident #1 told him. He stated he was told by Resident #1 that he fell to the ground. RN I said it was vital that he was notified when fall incidents occurred so that the residents were assessed at the time of injury. RN I said during his assessment of Resident #1, he saw issues with his range of motion and the apparent pain that Resident #1 was expressing. RN I said failure to report the incident to him could compromise resident safety, and with Resident #1 hitting his head, it could have been a more significant issue. RN I said during his assessment he did not see any problems with Resident #1's mental status. RN I stated he did not talk to the PTA or the ADM about the incident as they were already gone for the day and not in the facility. He stated outside of him having concerns about the information not being reported to him no one asked him any additional questions about the incident between Resident #1 and CNA E. During an interview on 06/05/24 at 3:10 PM, CNA J stated she was not assisting Resident #1 the day he fell . She said she and her partner (CNA K) heard the call light go off in the shower room. She said that when they saw what was happening, CNA E requested that we bring Resident #1's wheelchair. CNA J stated she did observe Resident #1, and CNA E. CNA J stated that CNA E was holding Resident #1. CNA J said she and her partner provided the wheelchair and walked away. She said she or her partner did not provide any assistance then. CNA J stated that around 4:30-4:45 PM that same day, the call light in Resident #1's room went off, and they were told by Resident #1 and Family Member D to place Resident #1 in bed. CNA J said they (her and CNA K) transferred Resident #1, and he complained that his leg was hurting. After the transfer, CNA J said they reported the leg pain to RN I. CNA J did not disclose that any additional questions were asked of her by the ADM. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/05/24 at 3:41 PM, CNA K stated that when Resident #1 fell , she and her partner, CNA J, were not working directly with Resident #1. CNA K said she was working the floor with other residents. She said she and her partner heard the lights go off in the shower room. CNA K said CNA E asked for Resident #1's wheelchair. CNA K stated they provided him with the wheelchair and walked back out of the shower room. She said no additional assistance was provided. She said when she and her partner were in the restroom, CNA E did not look like he needed help. She said that the encounter was before lunch. She said that at around 4:40 PM, Resident #1's call light went off, and she and CNA J went to see what he needed. She said Resident #1 wanted to be transferred to bed, and during the transfer with her and CNA J, Resident #1 expressed that he was in pain. She stated they completed the transfer and got him comfortable. She said she and her partner immediately notified RN I. CNA K stated that RN I went to Resident #1's room, which was all she knew happened. CNA K did not disclose if she was asked any additional questions from the ADM about the incident with CNA E and Resident #1. During an interview on 06/05/24 at 4:04 PM, the ADM stated she did not consider Resident #1's incident a fall because CNA E told her that Resident #1 did not fall to the ground. The ADM said CNA E told her that during a transfer, CNA E held Resident #1 up, straightened Resident #1 up, and was able to place him in his wheelchair. The ADM stated she did not talk to Resident #1 about the incident. She stated that she did not because when she was told about the incident, Resident #1 was present in the dining room. The ADM said she was unaware if the presence of CNA E could have influenced Resident #1 not to speak up. She said she did not investigate the incident further after CNA E reported it. She said the only person she spoke with about the incident with Resident #1 was CNA E. She also said she did not consider it a fall because the DOR told her that if a fall occurs during restorative or therapy, it was not considered a fall . During an interview on 06/05/24 at 4:24 PM, the DON stated she received a call 05/30/24 from RN I around 5:28 PM or 5:30 PM. RN I said Resident #1 was complaining of pain and stated he had fallen. The DON said she called CNA E, and CNA E told her Resident #1 did not fall. She said CNA E said he reported it to the ADM and the PTA directly after the incident. The DON said she was told by CNA E that Resident #1's legs buckled, and that CNA E held Resident #1 up. The DON said that she was told CNA J and K helped CNA E with Resident #1. The DON said she interviewed CNA J and CNA K and confirmed that they observed CNA E holding Resident #1 up and that they got the wheelchair. The DON said she did not confirm if they helped with the transfer. The DON said she did not ask any additional or follow up questions after the CNAs confirmed that they observed CNA E holding Resident #1 up. The DON said she did not speak with Resident #1 because he had already gone to the hospital. The DON stated she had not spoken with Resident #1 since he returned from the hospital. The SON did not provide a reason why she had not spoken with Resident #1 about the incident between him and CNA E. The DON stated that she understood that since CNA E had been trained, he could transfer Resident #1 alone. (continued on next page)

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Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/06/24 at 11:00 AM, the PTA stated that on 05/30/24, CNA E approached him. The PTA said CNA E was doing restorative on Resident #1, and he slipped. CNA E stated that he had already reported the incident to the ADM. The PTA stated that CNA E had not given him any additional information. The PTA said that when he was told about the incident, he was not told it was in the shower. The PTA stated that he had not seen Resident #1's care plan and could not verify what it entailed, but two people to transfer was for safety especially when using the mechanical lift. He stated that if the care plan stated that there needs to be two people, then there should be two people, and staff should not deviate from that. The PTA stated that therapists could transfer with one person, and sometimes, it depends on a female or male was doing the transfer. The PTA said he spoke with Resident #1, and all Resident #1 kept saying was fall, fall. The PTA did not disclose if the ADM had spoken with him about the incident between Resident #1 and CNA E. During an interview on 06/06/24 at 12:25 PM, the DON stated she was unaware that Resident #1 had fallen in the shower. The DON said she was made aware when the nurse called about Resident #1's pain. The DON stated that the restorative Aide had been trained to report the incident to therapy and the nurse (that included the DON). The DON said that regarding the incident with Resident #1, the potential negative outcome was that similar incidents could also occur with other residents. The DON said the potential negative outcome of not investigating Resident #1's fall was the facility staff would not be following their policy, and there could be a negative outcome for the resident if something internally would have been wrong with the resident. The DON said she was responsible for incident/accident prevention, but the ADM was responsible for investigating incidents. The DON said the purpose of reporting incidents and investigating incidents of alleged abuse and neglect was to protect the residents and to follow policy. The DON said the facility system to monitor was to follow their policy. The DON said she was unaware of why they did not follow the policy. The DON said the ADM was responsible for investigating the incidents. During an interview on 06/06/24 at 1:16 PM, The ADM stated that not investigating incidents could cause continued harm to the residents. The ADM said she was made aware of the incident regarding Resident #1 after CNA E told her about it. The ADM said she was unaware that Resident #1 was in pain and admitted that she did not interview Resident #1. She said the system to monitor investigations was to monitor that falls and to ensure falls were investigated, and ANE policies were followed by training staff on the facility policy. The ADM said she did not investigate the incident because she did not consider the incident a fall since it happened with therapy. 2. Findings for the facility's failure to investigate a sexual incident that occurred on 05/10/24 between Resident #2 and Resident #3 included: Record review of Resident #2's face sheet, dated 06/05/24, revealed a [AGE] year-old-male that was readmitted to the facility on [DATE] with diagnoses that included dementia (impaired ability to remember), depressive disorder (constant feelings of sadness), mood disorder (emotional deficit), and blindness to the right eye. Record review of Resident #2's Quarterly Minimum Data Set, dated dated [DATE], revealed: (continued on next page)

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Section C Brief Interview for Mental Status score revealed a score of 05, which indicated the resident's cognition was severely impaired. Section B Hearing, Speech, and Vision revealed that Resident #2 had clear speech, makes himself understood, and understands others. His vision is impaired, and he does not wear corrective lenses. Section E Behavior revealed that he had not had any incidents of physical or verbal behavior.

Record review of Resident #2's Comprehensive Minimum Data Set, dated dated [DATE], revealed:

Section C Brief Interview for Mental Status score revealed a blank BIMS score. Section E Behavior revealed that he had had delusions, physical behaviors such as hitting, kicking, pushing, scratching, grabbing, and abusing others. Resident # 2 had exhibited verbal behaviors such as threatening others, screaming, and cursing at others. Resident #2 had other behavioral symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing, smearing food or bodily wastes, or verbal/vocal symptoms like screaming and disruptive sounds. Resident #1 exhibited wandering behavior 1-3 days.

Record review of Resident #2 care plan, dated 05/01/24 revealed the following:

Resident #2 wanders in other residents' rooms and gets into their beds at times and had the following interventions: Resident #2 required assistance out of rooms that were not his and staff could use snacks if needed.

Resident #2 was an elopement risk/wanderer and had the following interventions: Distract Resident #2 from wandering by offering pleasant diversions. Resident #2 prefer having snacks. Followed by [name of psych care]. Notify their MD/NP of any escalation in wandering behaviors, ineffectiveness, or side effects of psychiatric medications. Monitor the resident's location throughout shifts. Document wandering behavior and attempted diversional interventions in behavior log.

Resident #2 had episodes of verbal and physical aggression r/t dementia with the following interventions: Give me as many choices as possible about care and activities. Monitor for physically/verbally aggressive behavior q shift. Document observed behavior and attempted interventions in behavior log. Monitor/document/report PRN any s/sx of Resident #2

posing danger to self and others.

Resident #2 had impaired visual function r/t cataracts and glaucoma. Resident #2 was blind in his right eye with the following interventions: Arrange consultation with eye care practitioner as required. Monitor/document/report PRN any s/sx of acute eye problems: Change in ability to perform ADLs, decline in mobility, sudden visual loss, pupils dilated, gray or milky, c/o halos around lights, double vision, tunnel vision, blurred or hazy vision. Place frequently used items on my left side so I may see them.

Record review of Resident #2's progress notes revealed the following:

(continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of on 05/11/24 at 12:12 AM LVN G documented: Data: Resident observed by CNA H reported to this nurse observed resident with pants unzipped and PENIS in Resident #3's hand. Action: Resident removed from Resident #3's room w/o incident. Resident #3 appears to have been asleep during entire incident. No physical injuries noted at this time. Response: Resident in his room and placed on 1-1 monitoring per DON instructions. Roommate moved to different room as this nurse considers this a HIGH RISK INCIDENT. DON & Administrator notified. Record review of on 05/11/24 at 03:23 PM The DON documented: Received orders from NP may administer Lorazepam 1ml now and then every 8 hours as needed. DON gave orders to charge nurse may use emergency restraint for safety of resident and others. Record review of on 05/11/24 at 05:27 PM the DON documented: Spoke with Family Member L about incident and orders to give Lorazepam 2mg/ml injection every 8 hours as needed x 14 days. Voiced understanding and gives verbal consent at this time for medication. Also discussed that he would be going back to the behavior support center on Monday and facility would be actively looking for alternate long-term placement for resident. Voiced understanding and consents for referrals to be sent to other facilities. Record review of on 05/11/24 at 05:27 PM LVN B documented: Staff alerted this nurse that this male resident was found in female resident's bed with his hands in the female's pants. Upon entering room male resident is found in bed with female resident with his hand on resident's waist. Told resident he needed to get out of bed. RT refused and put his arm around female resident. Male resident immediately removed from female's bed and taken to his own room. Resident became aggressive with staff refusing to leave bed causing CNAs to fall. Administration notified. Physician A, the DON notified. New order for Ativan 2mg/ml injection. Injection administered. Resident continues to try to go into other female rooms. Record review on 05/31/24 at 01:07 PM The DON documented: Resident returned from behavioral center via their facility van. Notified Physician A of return and medications. Notified the NP of return and reconciled psychotropic medications. Notified family Member L of return and went over psych medications and no issues or concerns at this time. Record review of on 06/02/24 at 03:26 AM LVN M documented: Follow-up on readmission, resident continues to urinate on floor. Reminded resident to use urinal. Resident voiced understanding. Resident also continues to wander. Resident breathing even and unlabored. No complaints voiced. Record review of on 06/02/24 at 07:35 PM The DON documented: Notified by charge nurse that resident was wandering in rooms and becoming aggressive when staff was trying to redirect. Contacted the NP and new orders received to increase Seroquel to 50mg 3 times daily, Xanax 0.25mg every 6 hours as needed x 14 days, and Zyprexa 10mg IM every 12 hours as needed x 14days. Notified Family Member L of resident behavior and new orders. Voiced understanding and no issues or concerns at this time. Record review of Resident #2's monitoring sheets revealed the following: Resident #2 was monitored every 30 minutes starting 05/08/24 at 11:30 AM until 5/10/24 at 6:00 PM. (No abnormal behavior reported during this monitoring time.) No time monitoring accounted for 05/10/24 at 11:00 PM- 12:00 AM. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2 was monitored on 05/11/24 from 1:00 AM-5:45 AM. (No abnormal behavior notated during this time. No time monitoring accounted for 12:00 AM-1:00 AM.) Resident #2 was monitored on 05/11/24 from 6:30 AM-4:00 PM. (No abnormal behavior notated during this time. No time monitoring accounted for 4:30 PM-6:00 PM) Record review of Resident #3's face sheet, dated 06/05/24, revealed an [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease (memory loss), cognitive communication deficit (difficulty communicating), fracture to neck and left femur, anxiety disorder (increased worry), and major depressive disorder (increased sadness). Record review of Resident #3's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 01, which indicated the resident's cognition was severely impaired. Section B. Ability to understand others revealed that she had clear speech, sometimes could make herself understood, and sometimes could understand others. Record review of Resident #3's care plan dated 6/5/24 revealed the following: Resident #3 was dependent on staff for emotional, intellectual, physical, and social needs related to cognitive deficits. Resident #3 required assistance to ADLs related to Alzheimer's disease, had impaired cognitive function/impaired thought processes related to Alzheimer's, had a mood problem related to depression, and had potential for psychosocial well-being related to trauma. Record review of Resident #3's progress notes revealed the following: 05/11/24 at 01:27 AM LVN G documented: Resident #2 observed in resident's room with Penis in her hand attempting what appears to ejaculate himself. Resident Immediately stopped by staff and removed to his room. Placed on 1-1 monitoring with instructions by DON NOT to be left out of staff sight at any time. No apparent injuries not upon physical inspection with female CNA present. DON to notify PCP & family. During an interview on 06/05/24 at 1:49 PM, CNA E stated that one night, when he worked the night shift (unsure of the date and exact time), Resident #2 exposed himself to Resident #3. He said he did not see it but was told by CNA H that Resident #2 had his penis in Resident #3's hand and was jerking off. He said as a result of that incident, Resident #2 was placed on 1:1 and was checked every 15 minutes by the night staff. He said Resident #3 was not in her right mind and would have been unable to consent. He said Resident #3 may have a BIMs of 0. He said prior to the incident involving Resident #3, Resident #2 was not on any close monitoring. He said that when Resident #3 was in the dining room and wanted to return to his room, they would assist him, but after he was in his room, they did not do additional monitoring. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024
NAME OF PROVIDER OR SUPPLIER Ralls Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 Avenue P Ralls, TX 79357	

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/05/24 at 2:57 PM, LVN G stated that on 05/11/24, he was working the night shift. He said he heard a young lady yell out. He said it was the female CNA but did not know her name. He said he was on break. He said the female CNA reported that Resident #2 had a particular part of his anatomy in Resident #3's hand. LVN G stated they assisted in getting Resident #2 out of Resident #3's room. He stated when he walked in, he did not see Resident #2's penis in Resident #3's hand but did see his penis out. He said he had not seen Resident #2 do the sexual act in the past, but that Resident #2 would expose himself and urinate on the floor. He stated that, because of the incident, he reported it to the DON and was instructed to place Resident #2 on 1:1 monitoring. He stated he would sit in the hall and ensure Resident #2 did not go into other rooms. LVN G said that Resident #3 was catatonic (immobile) and could not defend herself. He said he reported the incident to the DON. During an interview on 06/05/24 at 4:04 PM, the ADM stated she did not report the incident that involved inappropriate sexual contact that occurred with Resident #2 and #3 because all parties had dementia. She said she focused on if the act was willful. She said Resident #3 was asleep and did not know what was happening. She said she was told but could not remember who told her that Resident #2 was standing over Resident #3 with his penis out and Resident #3's hand was on Resident #2's penis. The ADM stated she was not told that Resident #2 was masturbating. The ADM stated that Resident #2 was not put on 1:1 during the first incident involving Resident #3 because he was not aggressive, and this was the first time he displayed this behavior. During an interview on 06/05/24 at 4:24 PM, the DON stated when the inappropriate sexual incident between Residents #2 and #3 were reported to her, she reported it to the ADM as she was the abuse coordinator. The DON stated the ADM confirmed with the Regional Director that it did not have to be reported because the residents had dementia. The DON said the Regional Director provided documentation to support the decision. The DON stated she did not speak up or take any additional action to investigate the incidents after being told it did not need to be reported. During an interview on 06/06/24 at 12:25 PM, the DON stated she did not want to say the wrong things and that she could not think of the potential negative outcome when it came to not investigating sexual incidents between residents, specifically the incidents that occurred between Residents #2 and #3. She said she was aware that the sexual incident had not been reported to the HHSC. The DON said the ADM told her that she did not report it based on the instruction given to her by the Regional Director. The DON said she did not observe the sexual incident between Resident #2 and #3. The DON said she was responsible for incident/accident prevention, but the ADM was responsible for investigating. The DON said the purpose of investigating incidents of alleged abuse and neglect was to protect the residents and to follow policy. The DON said the facility system to monitor was to follow their policy. The DON said she was unaware of why they did not follow the policy. The DON said the ADM was responsible for investigating the incidents and she did not have a specific reason why the incident was not investigated by the ADM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/06/24 at 1:16 PM, the ADM stated she was aware that she had not reported the sexual incident between Resident #2 and #3. She said the reason she did not report the incident was because after speaking with her Regional Director, who was more experienced, they felt that it was a behavior, not intentional, and abuse did not occur. The ADM said with this being a brand-new behavior for Resident #2, she could see that she did not see anything abnormal, with the conclusion of not reporting the incident of inappropriate sexual behavior. The ADM said her gut feeling was to report the incidents. The ADM said her Regional Director told her the incidents of inappropriate sexual behavior did not have to be reported, and she did not question it. She said because she was instructed not report the incident, she did not take any additional action to investigate. The ADM said she was responsible for inves [TRUNCATED]