STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675438	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeshore Village Nursing and Rehabilitation	2320 Lake Shore Dr Waco, TX 76708

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46708 Based on interviews and record review, the facility failed to implement their written policies and procedures regarding prohibiting and preventing abuse for one (Resident #1) of ten residents reviewed for developing and implementing abuse and neglect policies. The facility failed to implement and utilize facility abuse, neglect, exploitation, or misappropriation - reporting and investigating policies when they did not report to local, state, and federal agencies (as required by current regulations) allegations sent by a LPN via text message to the administrator. In the text, the LPN revealed she believed that Resident #2 ejaculated on Resident #1. The facility failed to identify and assess all possible incidents of abuse and investigate and report all allegations of abuse within timeframes required by federal requirements. This failure placed residents at risk of undetected abuse, trauma, and/or decline in feelings of safety and well-being or psychosocial harm. Findings included: Review of Resident #1's face sheet dated 08/21/24 reflected a [AGE] year-old male, in the facility secured unit, who was admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis that included epileptic seizures, disorder of psychological development, cognitive communication deficit, and severe intellectual disabilities. Review of Resident #1's quarterly MDS assessment, dated 06/15/24, reflected a BIMS was not conducted because the resident was rarely/never understood, indicating a severe cognitive impairment. His cognitive skills for daily decision making were severely impaired, and he never/rarely made decisions. Section GG - functional abilities and goals was not completed with the exception of impairment on both sides both upper and lower extremities. Review of Resident #1's quarterly care plan reflected the following: A focus, revised on 11/01/19, that reflected Resident #1 had been identified as PASRR positive related to an intellectual disability and related condition of epileptic seizures. A focus revised on 08/09/23 reflected Resident #1 forgot things and had no sense of safety awareness or dignity issues with an intervention dated 10/15/22 to help Resident #1 maintain dignity. (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: 675438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeshore Village Nursing and Rehabilitation	2320 Lake Shore Dr Waco, TX 76708

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 0607

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

A focus revised on 08/09/23 reflected Resident #1 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits. Resident #1 had little or no activity involvement due to his cognitive deficits.

A focus revised on 11/05/18 of activities of daily living performance deficit related to impaired mobility and cognition.

A focus revised on 11/30/23 reflected Resident #1 was non-verbal and yell off and on throughout the day. He yelled, clapped, and swayed his head back and forth as he wandered through hallways. Resident #1 had a history of sitting in laps of other residents and staff and he frequently chewed on his hands. Due to these behaviors, he was at risk for experiencing aggressive behaviors from his peers on the unit.

A focus revised on 11/05/19 reflected Resident #1 had a communication problem related to intellectual disabilities, Aphasia (a condition in which the eye lacks a lens) with an intervention dated 11/05/18 to observe/document for physical/nonverbal indicators of discomfort or distress, and follow-up as needed.

A focus revised on 10/18/23 reflected Resident #1 received anti-anxiety medications for anxiety.

A focus revised on 11/05/19 reflected Resident #1 received antidepressant medication for behaviors and insomnia.

A focus revised on 01/09/24 reflected Resident #1 had a psychosocial well-being problem potential related to impaired cognition, severe and diagnosed intellectual and developmental disabilities.

A focus revised on 06/27/22 reflected Resident #1 had impaired visual function related to impaired vision. Admitting hospital paperwork stated he was legally blind.

A focus initiated on 08/20/24, the date the state entered the facility to investigate the complaint, revealed Resident #1 had a behavior problem r/t wipe drool and mucus on his clothing with an intervention dated 08/20/24 to clean resident hands/face and clothing as needed.

Review of Resident #2's face sheet dated 08/20/24 reflected a [AGE] year-old male, in the facility secured unit, who was admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis that included abnormal radiologic findings on diagnostic imaging of renal other diagnosis pelvis, ureter, or bladder chronic obstructive pulmonary disease with (acute) exacerbation and mild cognitive impairment of uncertain or unknown etiology.

Review of Resident #2's quarterly MDS assessment, dated 05/24/24, reflected a BIMS score of 9 indicating Resident #2 was cognitively moderately impaired. Section E - Behavior potential indicators of psychosis reflected delusions (misconceptions or beliefs that are firmly held, contrary to reality). Behavioral symptom - presence & frequency behavior of this type occurred 1 to 3 days revealed other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds). Functional limitation in range of motion reflected no limitations in upper extremity (shoulder, elbow, wrist, hand) or lower impairment (lower extremity hip, knee, ankle, foot) and mobility devices wheelchair.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
NAME OF PROVIDER OR SUPPLIER: Lakeshore Village Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 2320 Lake Shore Dr Waco, TX 76708	

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's quarterly care plan reflected the following: A focus, revised on 03/08/24, that reflected Resident #2 had a potential for impaired cognition related to neurological symptoms of metabolic encephalopathy (a neurological disorder that occurs when a chemical imbalance in the blood affects the brain) with intervention dated 03/08/24 to monitor/document /report to medical doctor any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status and 03/08/2024 review medications and record possible causes of cognitive deficit: new medications or dosage increases; anticholinergics, opioids, benzodiazepines, recent discontinuation, omission or decrease in dose of benzodiazepines, drug interactions, errors or adverse drug reactions, drug toxicity. A review of the care plan did not reveal a focus or interventions regarding Resident #2 bleeding when he urinates or bleeding at any other time. A record review on 08/20/24 of anonymous complaint in the Information Portal, an online system for submitting long-term care licensure applications and health care regulation Architectural Review requests, under the care areas of administration/personnel and resident/patient/client abuse. The complaint reflected, the complainant stated on 08/15/2024, or 08/16/2024, resident first name unknown (Resident #2) pulled out his penis and ejaculated on (Resident #2). The incident occurred on the facility's secured unit. Reportedly, the incident was reported by the facility's staff; however, administrator erased the report from the facility's system. The complainant would like for the facility to be investigated due to the allegations reported in this intake. Review of text message, undated, from the LPN to the administrator reflected, so I believe Resident #2 has a ejaculated on Resident #1 I am sending pictures his brief was dry inside his penis has no fluids at all bottom not penetrated sorry trying to be thorough Resident #1 has not been sleeping well for a while especially tonight. So I moved Resident #1 back with [another resident] call me back please. Review of photograph, provided to investigator by the LPN, of an incident report #831 for Resident #2 that was stricken dated 08/11/24 revealed; strike out was dated 08/12/24 strike out reason - data entry error strike out done by DON Description: Resident's roommate was in bed and was checked and changed and an unknown substance/secretion was observed on the outside of his brief. The inside of the brief was dry, and no secretions noted in brief. Resident was the only other male in the room and was observed by this LPN sitting in a chair near roommate. Roommate #1 is nonverbal. Resident unable to give description. Immediate action taken - Resident #2 was moved to another room pending outcome of incident. Administrator called and DON also notified. Injury type - no injuries observed at time of incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeshore Village Nursing and Rehabilitation	2320 Lake Shore Dr Waco, TX 76708

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/20/24 at 12:15 pm with the LPN revealed she was very upset about the whole incident because she thought there was abuse and the incident should have been investigated. She revealed it happened on 08/11/24 at around 10:00pm. She revealed the CNA was doing rounds and the CNA asked her to look at something. The CNA brought her Resident #1's adult brief. The brief had a fluid substance on it. The CNA asked the LPN what she thought it was and the LPN said both the CNA and the LPN thought the substance on the brief looked like semen. The LPN took photos asked the CNA to put it in a bag to show the DON. The LPN revealed the SC/CNA came by and they asked her what she thought the substance was and the LPN said the SC/CNA also thought it was semen. The LPN said she texted her administrator and called both the administrator and the DON and sent them photos of the substance on the brief. The brief was left in a bag for the DON to see. The LPN revealed she moved Resident #2 into a room with another roommate because she was concerned about Resident #1 being abused because of the substance found on the brief. She revealed Resident #1 is a good sleeper, but he did not sleep well that evening. She revealed the Administrator, who was the abuse and neglect coordinator, did not ever talk to her about the incident. She said the DON called her back at 6:00 am the following morning and the DON said the substance could be spit and the substance was on the outside of the brief. The LPN said that the DON said she did not think it was semen and they could not prove that it was semen and they needed to let it go. The DON told the LPN to throw the brief out. The LPN revealed she felt the situation should have been investigated. When the LPN was asked if she told the DON that she did not feel there was any abuse she said she had always felt that Resident #1 was abused and that was why she moved Resident #2 out of the room, to keep Resident #1 safe. The LPN revealed that Resident #2 had previously not displayed any sexual behaviors and Resident #1, to her knowledge, had never masturbated. The LPN revealed that the DON, struck out her incident report. The LPN revealed that when the DON struck out her incident report, she was upset because they were not going to investigate the incident. In an interview on 08/21/24 at 11:05 with SC/CNA she revealed she was not working on the secured unit on 08/11/24. She was called over (unknown who called her over) and she was asked to look at a brief. She revealed she could not specify what the substance was on the brief, but said it had a strong order and it was a clear substance, it looked more like saliva. She said the LPN and the CNA expressed concerns about interaction between Resident #2 and Resident #1 because it seemed farfetched. She had worked on the secured unit consistently and Resident #2 urinates a lot and there was blood in his urine and anything that comes out of Resident #2 had blood on it. She described the substance on the brief as clear with a strong foul order. It was not milky white, and it was bubbly and looked like it had food particles in it. She did not feel like there was abuse because Resident #1 did not seem stressed. She revealed she had worked with Resident #1 for almost three years, and he drools a lot, and he does smear it. Where it is smeared depended on where his hand landed. She did not give a written signed statement about her observation. The DON and Administrator spoke to her about it. Staff rounds every two hours, and no resident was being looked at continuously. The overnight staffing consists of one nurse and one CNA. The abuse coordinator was responsible for the investigation of any reported abuse and neglect. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
NAME OF PROVIDER OR SUPPLIER Lakeshore Village Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 Lake Shore Dr Waco, TX 76708	

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an Interview on 08/20/24 at 1:08 pm with the Administrator revealed he was flying back from a trip and he was half asleep and when he landed. He said the pictures of the substance on the brief and the text from the LPN stating she believed Resident #2 ejaculated on Resident #1 came over his phone. The Administrator revealed that Resident #1 slobbered and wiped his nose a lot. He revealed he gave the investigation to the DON because she was the clinical lead. He said the DON revealed to him that from a clinical standpoint she did not see any issue with the substance on the brief. She stated that because none of the staff witnessed the alleged incident happen and because the DON did not feel like the LPN was making an allegation of abuse and/or neglect, they did not report the incident. When asked if Resident #1 was assessed, the administrator said he was assessed by the LNP, and she gave the report verbally, but it was not documented. The Administrator revealed there was no documentation regarding the alleged incident except for three typed statements. One signed statement from the administrator, one typed summary of an interview with the LPN, and one typed summary of a telephone interview of the SC/CNA. The summaries of the verbal interviews with the LPN and SC/CNA were signed by the DON. The investigation also included a statement that attempts were made to reach the CNA by phone, but there were unsuccessful. The administrator confirmed that the CNA still worked at the facility PRN, but he did not know if she had been to work at the facility after the incident. When asked if he could find out if she had worked since the incident, the administrator did not inform the investigation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
NAME OF PROVIDER OR SUPPLIER: Lakeshore Village Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 2320 Lake Shore Dr Waco, TX 76708	

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/21/24 at 3:01 with the DON she revealed she received training on how to conduct abuse and neglect investigations and in this training, she was taught facilities had to report any suspicion of abuse and neglect. She stated she was aware of the facility policies and procedures. She said the LNP never said to her she felt like Resident #1 had been abused, there was no proof that Resident #2 had been on Resident #1's side of the room, no one observed him standing over Resident #1 or observed Resident #2 touching Resident #1. She revealed that Resident #2 has bladder cancer and bleed a lot when he urinated. She revealed that housekeeping had called it to her attention because Resident #2's bathroom looked like a murder scene. Because there was no blood visible in the substance on the brief, she did not feel Resident #2 ejaculated on Resident #1. She revealed that the criteria for resident-to-resident abuse was the appearance of ill outcome or resident trauma. She did not feel that Resident #1 exhibited any ill outcome or trauma. The DON revealed she had not been given the statement by CNA dated 08/11/24. The DON confirmed that the CNA still worked at the facility PRN, but she did not know if she had worked at the facility after the incident. When asked if she could find out if she had worked since the incident, the DON did not inform the investigator. When asked why the DON struck the incident report #831, she said she did not feel it was fair for that to be entered for Resident #2. The facility policy and procedures were available to her, but she did not review it before the investigation. The DON revealed she did not review the residents' medical records to determine the resident's physical and cognitive status at the time of the incident and since the incident, she did not observe the alleged victim including his interactions with staff and other residents, she did not interview the resident's representative, and she did not interview the resident's attending physician as needed to determine the resident's condition because she did not feel there was abuse. She did not interview staff members on all shifts who have had contact with the resident during the period of the alleged incident. She did not interview family members, and visitors, she did not review all events leading up to the alleged incident; and document the investigation completely and thoroughly, and she did not follow the guidelines to be used when conducting interviews when she did not obtain witness statements in writing, signed, and dated. She did not notify the ombudsman that an abuse investigation was being conducted. She did not record the findings of the investigation on approved documentation forms as outlined the facility policy. She did not provide completed documentation to the administrator and residents' representatives were not notified of the outcome immediately upon conclusion of the investigation. Review of statement by CNA dated 08/11/24 revealed that at about 10:00 pm when she went into Resident #1 and Resident #2s' room to do her rounds, Resident #2 was lying in bed with no clothes on and she told him let's get some underwear on you and some clothes. She revealed that at 1:45 am she returned to the room and checked on Resident #1 to check if his brief was wet, and she found clear white semen outside Resident #1's brief and she informed the LPN and Resident #2 was moved to another room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
NAME OF PROVIDER OR SUPPLIER Lakeshore Village Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 Lake Shore Dr Waco, TX 76708	

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a statement, undated, by the administrator reflected he arrived at Dallas/Fort Worth Airport on the morning of 08/11/24 to text pictures and a text message from the LPN charge nurse in the secured unit. She stated that during the night when they went to check on Resident #1 there was a clear substance on the outside of his brief. She said she thought that his roommate had ejaculated on him. She moved the roommate to another room. As I was about to get on another plane in [NAME], I called my DON to start an investigation at this. After I landed in [NAME], we spoke about where she was about the investigation. She stated the nurse did not know where it came from but did an extensive assessment of Resident #1 and said that nothing under his brief had been disturbed. Resident #1 does drool a lot and wipes [NAME] on his pants a lot during the day. This is care planned. The pictures that were sent to us showed food particles that could not come from ejaculate. The SC/CAN was working the 10:00 - 6:00 that night. She noted that a foul order was coming from the clear liquid on the top of the brief. In speaking with the DON there is not a foul order that comes from ejaculate. In interviewing the people who witnessed the clear liquid on top of the brief none of them said he was abused or neglected. The resident was not in distress physically or mentally. In reviewing the residents' files, Resident #2 has no prior history of masturbating or treating residents in a sexual manner. Resident #1 does have a large history of wiping drool on his clothing. After reviewing all the interviews and discussing it with my DON this is not a state reportable incident and is to be kept in a soft file. In an interview on 08/20/24 at 11:16 am with RN revealed she was told in report by the night LPN that when the CNA went into change Resident #1's brief, she found something particular in the brief and they, the LPN and the CNA, had suspicions that it was semen. The LPN told the RN she saved the brief with the substance and tried to call the Administrator and the DON. The RN revealed she was not aware that Resident #2 had any sexual behaviors, but they were aware that Resident #2 takes things from other residents. In an interview on 08/20/24 at 4:35 with CNA revealed she was doing her rounds and she walked in the room of Resident #1 and Resident #2 and Resident #1 was moving his head from side to side showing he was awake. She said she went to Resident #1's bed and asked if he was okay and saw he was lying in bed naked and wet, and she got him some clothes. She later came back to the room to check on Resident #1 and there was stuff on his brief. She revealed she stood there for a long time looking at it because she thought that it was semen. She revealed she called the LPN to the room, and she showed it to the LPN, and she said it was semen. They put the brief in a bag to show the Administrator and the DON. She said that the LPN called the Administrator and the DON, and they did not answer, and she moved Resident #2 to another room. The CNA revealed neither the Administrator nor the DON spoke with her about the incident. She said that the investigator was the first person to talk to her about it. She said she wrote a statement and gave it to the LPN. She revealed that Resident #1 stayed up all night and he had never stayed up all night before. She said the LPN never wavered from the idea that Resident #1 was abused, and she felt Resident #1 was safe when the LPN moved Resident #2 to another room. CNA revealed Resident #2 did not have a history of displaying any inappropriate sexual behaviors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
NAME OF PROVIDER OR SUPPLIER: Lakeshore Village Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 2320 Lake Shore Dr Waco, TX 76708	

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/21/24 at 3:37 pm with the Administrator revealed he did not think there was abuse because no one told him or the DON that they felt like Resident #1 was abused. The Administrator revealed that Resident #2 had bladder cancer and because he had cancer, the substance would have been bloody if he ejaculated. Resident #2 had no history of inappropriate sexual behavior. The pictures of the substance that were sent to him looked like food particles, or saliva, or drool and no one said the roommate was actually around him and standing over him. When asked if he felt that the text that reported that one resident had ejaculated on another resident was abuse, he said it might not be abuse. He gave the example of two residents in the secured unit who slapped each with no visible injury and they weren't afraid of each other not being abuse. He felt that because there were no reported signs of Resident #1 being stressed, he did not think it was abuse. He said he discussed with corporate personnel if he should report it to HHSC, the consensus was it did not fall under a reportable incident. Collectively the people he spoke with made the decision it was not reportable to the state. Review of facility policy dated 08/2022 revealed all reports of resident abuse (including injuries of unknown origin) neglect, exploitation or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulation) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Reporting allegations of the administrator and authorities - If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are need for the protection of residents. The administrator initiates investigations. Any evidence that may be need for a criminal investigation is sealed, labeled, and protected from tampering or destruction. The administrator is responsible for keeping the resident and his/her representative (sponsor) information of the progress for the investigation. Facility policy dated 08/2022 reflected investigations may be assigned to an individual trained in reviewing, investigation, and reporting such allegation. The administrator provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation. Any evidence that may be needed for a criminal investigation is sealed, labeled, and protected from tampering or destruction. The administrator is responsible for keeping the resident and his/her representative (sponsor) informed of the progress of the investigation. The individual conducting the investigation as a minimum will: 1. Reviews the documentation and evidence; 2. Reviews the resident's medical records to determine the resident's physical and cognitive status at the time of the incident and since the incident; 3. Observes the alleged victim including his or her interactions with staff and other residents; 4. Interviews the person(s) reporting the incident; 5. Interviews any witnesses to the incident; 6. Interviews the resident (as medically appropriate) or the resident's representative; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
NAME OF PROVIDER OR SUPPLIER Lakeshore Village Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 Lake Shore Dr Waco, TX 76708	

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Interviews the resident's attending physician as needed to determine the resident's condition; 8. Interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; 9. Interviews the resident's roommate, family members, and visitors; 10. Reviews all events leading up to the alleged incident; and documents the investigation completely and thoroughly. The following guidelines are used when conducting interviews 1. Each interview is conducted separately and in a private location 2. The [purpose and confidentiality of the interview is explained thoroughly to each person involved in the interview process 3. Witness statements are obtained in writing, signed and dated. The witness may write his/her statement, or the investigator may obtain a statement. 4. The investigator notifies the ombudsman that an abuse investigation is being conducted. The ombudsman is notified of the results of the investigation as well as any corrective measure taken; 5. The investigator consults daily with the administrator concerning the progress/finding of the investigation; 6. Upon conclusion of the investigation, the investigator records the finding of the investigation on approved documentation forms and provided the completed documentation to the administrator; 7. Within 5 business day of the incident, the administrator will provide a follow-up investigation report; 8. The follow-up investigation report will provide sufficient information to describe the results of the investigation, and indicate any corrective actions taken if the allegation was verified; 9. The follow up investigation report will provide as much information as possible at the time of submission of the report; 10. The resident and/or representative are notified of the outcome immediately upon conclusion of the investigation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675438	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeshore Village Nursing and Rehabilitation	2320 Lake Shore Dr Waco, TX 76708

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 - Few	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** 46708 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made for 1 of 10 residents screened for abuse (Resident #1). The facility failed to immediately report to the State Agency (within 2 hours) an allegation sent by an LPN via text message to the administrator that she believed that Resident #2 ejaculated on Resident #1. This deficient practice delayed the investigation for the allegation and could have placed residents at risk for abuse and could have resulted in undetected abuse and/or decline in feelings of safety and well-being or psychosocial harm. Findings included: Review of Resident #1's face sheet dated 08/21/24 reflected a [AGE] year-old male, in the facility secured unit, who was admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis that included epileptic seizures, disorder of psychological development, cognitive communication deficit, and severe intellectual disabilities. Review of Resident #1's quarterly MDS assessment, dated 06/15/24, reflected a BIMS was not conducted because the resident was rarely/never understood, indicating a severe cognitive impairment. his cognitive skills for daily decision making were severely impaired, and he never/rarely made decisions. Section GG - functional abilities and goals was not completed with the exception of impairment on both sides both upper and lower extremities. Review of Resident #1's quarterly care plan reflected the following: A focus, revised on 11/01/19, that reflected Resident #1 had been identified as PASRR positive related to an intellectual disability and related condition of epileptic seizures. A focus revised on 08/09/23 reflected Resident #1 forgot things and had no sense of safety awareness or dignity issues with an intervention dated 10/15/22 to help Resident #1 maintain dignity. A focus revised on 08/09/23 reflected Resident #1 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits. Resident #1 had little or no activity involvement due to his cognitive deficits. A focus revised on 11/05/18 of activities of daily living performance deficit related to impaired mobility and cognition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
NAME OF PROVIDER OR SUPPLIER: Lakeshore Village Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 2320 Lake Shore Dr Waco, TX 76708	

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 - Few	A focus revised on 11/30/23 reflected Resident #1 was non-verbal and yelled off and on throughout the day. He yelled, clapped, and swayed his head back and forth as he wandered through hallways. Resident #1 had a history of sitting in laps of other residents and staff and he frequently chewed on his hands. Due to these behaviors, he was at risk for experiencing aggressive behaviors from his peers on the unit. A focus revised on 11/05/19 reflected Resident #1 had a communication problem related to intellectual disabilities, Aphasia (a condition in which the eye lacks a lens) with an intervention dated 11/05/18 to observe/document for physical/nonverbal indicators of discomfort or distress, and follow-up as needed. A focus revised on 10/18/23 reflected Resident #1 received anti-anxiety medications for anxiety. A focus revised on 11/05/19 reflected Resident #1 received antidepressant medication for behaviors and insomnia. A focus revised on 01/09/24 reflected Resident #1 had a psychosocial well-being problem potential related to impaired cognition, severe and diagnosed intellectual and developmental disabilities. A focus revised on 06/27/22 reflected Resident #1 had impaired visual function related to impaired vision. Admitting hospital paperwork stated he was legally blind. A focus initiated on 08/20/24, the date the state entered the facility to investigate the complaint, revealed Resident #1 had a behavior problem r/t wipe drool and mucus on his clothing with an intervention dated 08/20/24 to clean resident hands/face and clothing as needed. Review of Resident #2's face sheet dated 08/20/24 reflected a [AGE] year-old male, in the facility secured unit, who was admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis that included abnormal radiologic findings on diagnostic imaging of renal other diagnosis pelvis, ureter, or bladder chronic obstructive pulmonary disease with (acute) exacerbation and mild cognitive impairment of uncertain or unknown etiology. Review of Resident #2's quarterly MDS assessment, dated 05/24/24, reflected a BIMS score of 9 indicating Resident #2 was cognitively moderately impaired. Section E - Behavior potential indicators of psychosis reflected delusions (misconceptions or beliefs that are firmly held, contrary to reality). Behavioral symptom - presence & frequency behavior of this type occurred 1 to 3 days revealed other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds). Functional limitation in range of motion reflected no limitations in upper extremity (shoulder, elbow, wrist, hand) or lower impairment (lower extremity hip, knee, ankle, foot) and mobility devices wheelchair. Review of Resident #2's quarterly care plan reflected the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
NAME OF PROVIDER OR SUPPLIER: Lakeshore Village Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 2320 Lake Shore Dr Waco, TX 76708	

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 - Few	A focus, revised on 03/08/24, that reflected Resident #2 had a potential for impaired cognition related to neurological symptoms of metabolic encephalopathy (a neurological disorder that occurs when a chemical imbalance in the blood affects the brain) with intervention dated 03/08/24 to monitor/document /report to medical doctor any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status and 03/08/2024 review medications and record possible causes of cognitive deficit: new medications or dosage increases; anticholinergics, opioids, benzodiazepines, recent discontinuation, omission or decrease in dose of benzodiazepines, drug interactions, errors or adverse drug reactions, drug toxicity. A review of the care plan did not reveal a focus or interventions regarding Resident #2 bleeding when he urinates or bleeding at any other time. On 08/19/24 an anonymous complaint was made through TULIP, the Texas Unified Licensure Information Portal, an online system for submitting long-term care licensure applications and health care regulation Architectural Review requests, under the care areas of administration/personnel and resident/patient/client abuse. The complaint reflected, the complainant stated on 08/15/2024, or 08/16/2024, resident first name unknown (Resident #2) pulled out his penis and ejaculated on (Resident #2). The incident occurred on the facility's secured unit. Reportedly, the incident was reported by the facility's staff; however, administrator erased the report from the facility's system. The complainant would like for the facility to be investigated due to the allegations reported in this intake. Review of text message, undated, from the LPN to the administrator reflected, so I believe Resident #2 has a ejaculated on Resident #1 I am sending pictures his brief was dry inside his penis has no fluids at all bottom not penetrated sorry trying to be thorough Resident #1 has not been sleeping well for a while especially tonight. So I moved Resident #1 back with [another resident] call me back please. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
NAME OF PROVIDER OR SUPPLIER: Lakeshore Village Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 2320 Lake Shore Dr Waco, TX 76708	

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 - Few	In an interview on 08/20/24 at 12:15 pm with the LPN revealed she was very upset about the whole incident because she thought there was abuse and the incident should have been investigated. She revealed it happened on 08/11/24 at around 10:00pm. She revealed the CNA was doing rounds and the CNA asked her to look at something. The CNA brought her Resident #1's adult brief. The brief had a fluid substance on it. The CNA asked the LPN what she thought it was and the LPN said both the CNA and the LPN thought the substance on the brief looked like semen. The LPN took photos asked the CNA to put it in a bag to show the DON. The LPN revealed the SC/CNA came by and they asked her what she thought the substance was and the LPN said the SC/CNA also thought it was semen. The LPN said she texted her administrator and called both the administrator and the DON and sent them photos of the substance on the brief. The brief was left in a bag for the DON to see. The LPN revealed she moved Resident #2 into a room with another roommate because she was concerned about Resident #1 being abused because of the substance found on the brief. She revealed Resident #1 was a good sleeper, but he did not sleep well that evening. She revealed the Administrator, who was the abuse and neglect coordinator, did not ever talk to her about the incident. She said the DON called her back at 6:00 am the following morning and said the substance could be spit and the substance was on the outside of the brief. The LPN said that the DON said she did not think it was semen and they could not prove that it was semen and they needed to let it go. The DON told the LPN to throw the brief out. The LPN revealed she felt the situation should have been investigated. When the LPN was asked if she told the DON that she did not feel there was any abuse she said she had always felt that Resident #1 was abused and that is why she moved Resident #2 out of the room, to keep Resident #1 safe. The LPN revealed that Resident #2 had previously not displayed any sexual behaviors and Resident #1, to her knowledge, had never masturbated. The LPN revealed that the DON, struck out her incident report. The LPN revealed that when the DON struck out her incident report, she because upset because they were not going to investigate the incident. In an interview on 08/21/24 at 11:05 with SC/CNA she revealed she was not working on the secured unit on 08/11/24. She was called over (unknown who called her over) and she was asked to look at a brief. She revealed she could not specify what was the substance on the brief, but said it had a strong order and it was a clear substance, it looked more like saliva. She said the LPN and the CNA expressed concerns about interaction between Resident #2 and Resident #1 because it seemed farfetched. She had worked on the secured unit consistently and Resident #2 urinated a lot and there was blood in his urine and anything that comes out of Resident #2 had blood on it. She described the substance on the brief as clear with a strong foul order. It was not milky white, and it was bubbly and looked like it had food particles in it. She did not feel like there was abuse because Resident #1 did not seem stressed. She revealed she had worked with Resident #1 for almost three years, and he drooled a lot, and he did smear it. Where it was smeared depended on where his hand landed. She did not give a written signed statement about her observation. The DON and Administrator spoke to her about it. Staff rounds every two hours, and no resident was being looked at continuously. The overnight staffing consists of one nurse and one CNA. The abuse coordinator was responsible for the investigation of any reported abuse and neglect. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
NAME OF PROVIDER OR SUPPLIER: Lakeshore Village Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 2320 Lake Shore Dr Waco, TX 76708	

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 - Few	In an interview on 08/20/24 at 1:08 pm with the administrator revealed he was flying back from Vancouver, and he was half asleep and when he landed, he said the pictures of the substance on the brief and the text from the LPN stating she believed Resident #2 ejaculated on Resident #1 came over his phone. The Administrator revealed that Resident #1 slobbered and wiped his nose a lot. He revealed he gave the investigation to the DON because she was the clinical lead. He said the DON revealed to him that from a clinical standpoint she did not see any issue with the substance on the brief and because none of the staff witnessed the alleged incident happen and because the DON did not feel like the LPN was making an allegation of abuse and/or neglect, they did not report the incident. In an interview on 08/21/24 at 3:01 with the DON she revealed she received training on how to do abuse and neglect investigation and in this training, she was taught facilities had to report any suspicion of abuse and neglect and she was aware of the facility policies and procedures. The facility policy and procedure were available to her, but she did not review it before the investigation. She said the LNP never said to her she felt like Resident #1 had been abused, there was no proof that Resident #2 had been on Resident #1's side of the room, no one observed him standing over Resident #1 or observed Resident #2 touching Resident #1. She revealed that Resident #2 has bladder cancer and bleed a lot when he urinated. She revealed that housekeeping had called it to her attention because Resident #2's bathroom looks like a murder scene. Because there was no blood visible in the substance on the brief, she did not feel Resident #2 ejaculated on Resident #1. She revealed that the criteria for resident-to-resident abuse is the appearance of ill outcome or resident trauma. She did not feel that Resident #1 exhibited any ill outcome or trauma. Review of photograph, provided to investigator by the LPN, of an incident report #831 for Resident #2 that was stricken dated 08/11/24 revealed; strike out was dated 08/12/24 strike out reason - data entry error strike out done by DON Description: Resident's roommate was in bed and was checked and changed and an unknown substance/secretion was observed on the outside of his brief. The inside of the brief was dry, and no secretions noted in brief. Resident was the only other male in the room and was observed by this LPN sitting in a chair near roommate. Roommate #1 is nonverbal. Resident unable to give description. Immediate action taken - Resident #2 was moved to another room pending outcome of incident. Administrator called and DON also notified. Injury type - no injuries observed at time of incident. Review of statement by CNA dated 08/11/24 revealed that at about 10:00 pm when she went into Resident #1 and Resident #2s' room to do her rounds, Resident #2 was lying in bed with no clothes on and she told him let's get some underwear on you and some clothes. She revealed that at 1:45 am she returned to the room and checked on Resident #1 to check if his brief was wet, and she found clear white semen outside Resident #1's brief and she informed the LPN and Resident #2 was moved to another room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeshore Village Nursing and Rehabilitation	2320 Lake Shore Dr Waco, TX 76708

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 - Few	In an interview on 08/20/24 at 11:16 am with RN revealed she was told in report by the night LPN that when the CNA went into change Resident #1's brief, she found something particular in the brief and they, the LPN and the CAN, had suspicions that it was [NAME]. The LPN told the RN she saved the brief with the substance and tried to call the Administrator and the DON. The RN revealed she was not aware that Resident #2 had any sexual behaviors, but they are aware that Resident #2 takes things from other residents. In an interview on 08/20/24 at 4:35 with CNA revealed she was doing her rounds and she walked in the room of Resident #1 and Resident #2 and Resident #1 was moving his head from side to side showing he was awake. She said she went to Resident #1's bed and asked if he was okay and saw he was lying in bed naked and wet, and she got him some clothes. She later came back to the room to check on Resident #1 and there was stuff on his brief. She revealed she stood there for a long time looking at it because she thought that it was semen. She revealed she called the LPN to the room, and she showed it to the LPN, and she said it was semen. They put the brief in a bag to show the Administrator and the DON. She said that the LPN called the Administrator and the DON, and they did not answer, and she moved Resident #2 to another room. The CNA revealed neither the Administrator nor the DON spoke with her about the incident. She said that the investigator was the first person to talk to her about it. She said she wrote a statement and gave it to the LPN. She revealed that Resident #1 stayed up all night and he had never stayed up all night before. She said the LPN never wavered from the idea that Resident #1 was abused, and she felt Resident #1 was safe when the LPN moved Resident #2 to another room. CNA revealed Resident #2 did not have a history of displaying any inappropriate sexual behaviors. In an interview on 08/21/24 at 3:37 pm with the administrator revealed he did not think there was abuse because no one told him or the DON that they felt like Resident #1 was abused. The Administrator revealed that Resident #2 had bladder cancer and because he had cancer, the substance would have been bloody if he ejaculated. Resident #2 had no history of inappropriate sexual behavior. The pictures of the substance that were sent to him looked like food particles, or saliva, or drool and no one said the roommate was actually around him and standing over him. When asked if he felt that the text that reported that one resident had ejaculated on another resident was abuse, he said it might not be abuse. He gave the example of two residents in the secured unit who slapped each with no visible injury and they aren't afraid of each other not being abuse. He felt that because there were no reported signs of Resident #1 being stressed, he did not think it was abuse. He said he discussed with corporate personnel if he should report it to HHSC, the consensus was it did not fall under a reportable incident. Collectively the people he spoke with made the decision it was not reportable to the state. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeshore Village Nursing and Rehabilitation	2320 Lake Shore Dr Waco, TX 76708

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 - Few	Review of facility policy dated 08/2022 revealed all reports of resident abuse (including injuries of unknown origin) neglect, exploitation or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulation) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Reporting allegations of the administrator and authorities - If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are need for the protection of residents. The administrator initiates investigations. Any evidence that may be need for a criminal investigation is sealed, labeled, and protected from tampering or destruction. The administrator is responsible for keeping the resident and his/her representative (sponsor) information of the progress for the investigation.