STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675519	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Larkspur	201 South John Redditt Drive Lufkin, TX 75904

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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 - Few Note: The nursing home is disputing this citation.	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** 43872 Based on observations, interviews, and record reviews, the facility failed to ensure residents were free from sexual abuse for 2 of 15 residents (Resident #1 and Resident #2) reviewed for abuse. 1. The facility failed to prevent sexual abuse for Resident #1 witnessed by CNA A on 06/08/2024 at approximately 2:00 p.m. to be in her room covered with a sheet and lying in bed with the Floor Tech. 2. The facility failed to prevent sexual abuse for Resident #2 that reported to CNA B on 06/08/2024 at 2:15 p. m. that the Floor Tech approximately two weeks prior had touched her hip, rubbed his penis against her while clothed, and asked if she was interested while making sexual body gestures. The noncompliance was identified as PNC. The IJ began on 06/08/2024 and ended on 06/08/2024. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for psychosocial harm, impaired quality of life in unsafe environment, and further abuse. Findings included: 1. Review of a face sheet for Resident #1, dated 06/25/2024, indicated she was a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses including: cerebral infarction (stroke), dysphagia (difficulty swallowing), UTI, mononeuropathy (nerve damage outside of brain and spinal cord), and anorexia (eating disorder). Review of Resident #1's quarterly MDS, dated [DATE], indicated she had a Brief Interview for Mental Status (BIMS) score of 08, indicating moderate impairment, and a short-term memory score of 1 indicating she had a memory problem. Resident #1's functional status indicated she was non-ambulatory and required substantial/maximal assistance with ADL's. Review of Resident #1's care plan, dated 06/25/2024, indicated she rejects care such as skin assessments and evaluation with a suspected history of personal trauma with interventions to include identifying staff that result in least resistance, talk to resident/family about reasons for refusal of care, and ensure physical and emotional safety. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of written interview statement by Social Worker with Resident #1, dated 06/08/2024, reflected the following: .Social Worker attempted to interview patient regarding reported sexual assault. Patient was unable to provide appropriate responses to questions asked. Patient is alert oriented with confusion, able to make her needs known. She requires total assistance of staff for ADL care and transfers. Review of hospital records for Resident #1, dated 06/08/2024, indicated she was sent to the ER after being found in bed with male staff member. Hospital records indicated Resident #1 reported she was sleeping and does not remember a staff member being in bed with her. Hospital records indicated Resident #1 denied pain or discomfort, and GU and skin exam were negative for abnormalities, pelvic pain, or vaginal bleeding. Review of progress notes signed by the ADON, dated 06/09/2024, indicated a head to toe assessment was completed 06/08/2024 on Resident #1 with no adverse findings. Review of progress notes signed by LVN C, dated 06/09/2024, indicated CNA A reported that staff member was found in the bed under the covers with Resident #1 at 2:10 p.m. Progress notes indicated staff member was fully dressed and immediately rolled out of the bed to his knees stating, it's not what it looks like. Progress notes indicated LVN C ensured patient safety by removing staff member from room, police interviewed resident, and resident was sent to the hospital. Review of Psychosocial Well-Being signed by the Social Worker, dated 06/12/2024, indicated Resident #1 was alert and oriented with confusion, no signs and symptoms of distress noted or verbalized, was sent to the ER for evaluation and treatment, and referral was warranted to psychology and psychiatry services. 2. Review of a face sheet for Resident #2, dated 06/25/2024, indicated she was a [AGE] year-old female, admitted on [DATE] and transferred to another nursing facility on 06/24/2024. Resident #2's face sheet indicated she had diagnoses including vascular dementia (impaired thought process due to brain damage from impaired blood flow to the brain), major depressive disorder, heart failure, and UTI. Review of Resident #2's discharge MDS, dated [DATE], indicated she had a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate impairment. Resident #2's mood indicated she had felt down, depressed, hopeless, with little interest in doing things for several days. Review of Resident #2's care plan, dated 06/25/2024, indicated she had interventions for suspected trauma to include ensure physical and emotional safety. Review of employee statement by CNA B, dated 06/08/2024, indicated the following: To whom it may concern I went to change [Resident #2] and she told me [Floor Tech], the housekeeper had got in the bed with her and was rubbing on her body with his hand and body. The resident told me that this has been going (on) 2 weeks on the weekends. Review of hospital records for Resident #2, dated 06/08/2024, reflected she was sent to the ER for complaints of being molested for 2 weeks and stated he rubbed his penis on the outside of her clothes two weeks ago. Resident #2's GU was negative for injury, bleeding, or discharge, and skin was negative for abnormalities. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of progress notes signed by LVN C, dated 06/09/2024, indicated CNA B reported Resident #2 needed to talk to the nurse at 2:13 p.m. and Resident #2 told LVN C that a short black man with thick rimmed glasses with a lazy eye went into her room two weeks ago and rubbed his stuff on her, kissed her neck, and touched her breasts and hips. Progress Notes indicated LVN C notified the DON and ED was aware at 2:17 p.m., head to toe assessment was completed with no adverse findings, police interview resident, and was sent to the hospital. Review of progress notes signed by the ADON, dated 06/09/2024, indicated a head to toe assessment was completed 06/08/2024 on Resident #2 with no adverse findings. Review of employee statement by CNA A, dated 06/08/2024, indicated the following: I [CNA A] walked in [Resident #1's] room and (saw) the housekeeper [Floor Tech] in the bed with her (and) [Resident #2] told me and [CNA B] that [Floor Tech] had been in the bed with her and rubbing on her body. Review of written interview statement by Social Worker with Resident #2, dated 06/12/2024, reflected the following: Patient stated that two weeks ago, a short black guy, who wore maroon clothing, wearing big and bulky glasses with a soft voice meandered into her room and said hi. Patient stated that she did not remember his name. She wasn't sure if he told her his name. The patient says she was lying down in bed, and he was standing by bedside moving his body suggestively. Patient told him that she was not interested. He then made a sarcastic statement voicing his opinion that it was ok. Patient stated that he touched her left hip and started moving his body so she would get the idea. He was moving suggestively his thing back and forth in front of her. Patient stated that this same type of incident has happened twice. Patient says he never got in bed or touched her in any other places. Review of provider investigation report, dated 06/13/2024, reflected the following: . Facility Investigation Findings: Confirmed . Investigation Summary Incident: Per staff member [CNA A] staff member [Floor Tech] was found in the bed with [Resident #1]. [Resident #2] reported that a man that wears thick glasses and a lazy eye rubbed his stuff on her and touched her . Summary of Assessments: Both resident[s] received a head-to-toe assessment with no adverse findings. Timeline 06/08/2024 1410 (2:10 p.m.) (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	[CNA A] Nurse Aide reported to charge nurse [LVN C], that during rounds she noted [Floor Tech] lying in bed under the covers with [Resident #1]. Per [CNA A], [Floor Tech] was fully dressed and immediately rolled out of bed to his knees stating, It's not what it looks like. Nurse assessed patient with no adverse findings. 1412 (2:12 p.m.) [LVN C] reported events to [DON]. DON called [ED] to report what was reported to her. Per our [CNA A] [Floor Tech] was following her around the building repeatedly telling her it's not what you think, and it's not what it looks like. [LVN A] was instructed to get the staff together and search the building for [Floor Tech] and get him to the front of the building and away from the resident care areas. 1415 (2:15 p.m.) [CNA B], nurse aide, reported to [LVN A], that resident [Resident #2] needed to talk to her. Stating it is the same thing going on as the other one. Per [LVN A] she went directly to the room and spoke with [Resident #2] in room [Resident #2's room] while staff searched for [Floor Tech]. 1417 (2:17 p.m.) [LVN A] reported to [DON], that resident [Resident #2] reported that a shirt black man with thick rimmed glasses with a lazy eye went into her room two weeks ago and rubbed his stuff on her, kissed her neck, and touched her breasts and hips. [DON] made [ED] aware of what was reported. [Police Department] called for an officer to come to the building. 1424 (2:24 p.m.) [LVN A] escorted [Floor Tech] to the front of the building. He was not in the resident care areas and [LVN A] stayed with him one to one until police arrived. [6:00 a.m. to 2:00 p.m.] staff were phoned to come back to the facility to give statements and provide an interview with the police. 1434 (2:34 p.m.) [Police Department] arrived and took [Floor Tech] into the conference room for questioning and instructed [LVN A] to await questioning in the chapel. 1440 (2:40 p.m.) MD made aware of incident with noted new orders to send both residents to the ER for evaluation and treatment. 1447 (2:47 p.m.) [CNA B], nurse aide arrived back to the facility for interview and statement retrieval and was asked to await questioning in the admissions office. 1449 (2:49 p.m.) (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Resident families notified per [Social Worker]. Family voice understanding of information given. 1450 (2:50 p.m.) Two police officers joined [CNA B] in the admissions office for questioning and statement collection. 1455 (2:55 p.m.) [CNA A], nurse aid, arrived back to facility for statement and interview and was asked to stay at the receptionist desk area and await interviewing. Four police officers question [LVN C], as to where the residents live and she escorted them to the residents rooms. Two police officers entered the room of [Resident #1] and two others entered the room of [Resident #2] to question and take statements. [Social Worker] made aware of the situation, and she reported that she was headed to the building to start life safety rounds. 1507 (3:07 p.m.) [CNA B]' interview completed, and she was asked by police to wait in the lobby until the detective arrived. 1508 (3:08 p.m.) [LVN A] was taken into the Chapel and [CNA A] was taken into the admissions office for interview and questioning by [Police Department]. Statements retrieved and staff were asked to wait for the investigator to arrive for additional questioning. Police kept all staff separate from each other. [Social Worker] at building performing life safety rounds. 1515 (3:15 p.m.) Police reported to [LVN A] that the interview was completed at this, and she was free to go back to the floor and finish her tasks. 1526 (3:26 p.m.) [DON] and [ADON] arrived at the building and spoke to police and were escorted to the admission office. An officer came into the office and gave a summary of events and allegations. In-service education started on abuse, neglect, exploitation, reportable incident protocol, accident and incidents, abuse prevention program, abuse prohibition protocol, HIPPA and privacy laws, and media policy. 1618 (4:18 p.m.) The detective arrived at the building and entered the conference room with [Floor tech]. Noted questioning started at that time. Background checks [of] 100% of employees to be completed. The detective and two police officers approached CNA A and CNA B and asked if they would be willing to testify in court as to what they saw and what happened. Noted both said yes, that they would. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	1030 (10:30 a.m.) [Medical records] requested hospital records for both patients' ER visit on 06/08/2024 be sent to facility. Awaiting records. 1400 (2:00 p.m.) Received records from hospital. 1500 (3:00 p.m.) DON placed follow up call to psych services regarding psychological evaluation on both patients 1515 (3:15 p.m.) DON placed follow up call to police department to request report. 06/14/2024 0840 (8:40 a.m.) [Psychologist] on site to evaluate both patients. Notes to be sent. Actions taken by facility: Reported to HHSC. Employee was immediately removed from the patient care area until police arrived. Police department notified. Both patients were sent to the ER for evaluation and treatment as indicated. 100% Abuse Questionnaires/safe surveys of interviewable patients. 100% head to toe assessments of non-interviewable patients. 100% rounds of all patients to ensure their safety. Request video footage from family to review incident, if available. Psychosocial assessments completed. Referrals to [psych service]. Abuse Questionnaire for 100% of staff. 100% audit of employee background checks. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	100% of interview/statements from staff members. Note any history of unusual behaviors with the suspected employee. Sex registry check on suspect. Grievances. Completion of Accident/Incident Reports. Review of employee's schedule and time punch detail. Review of employee file and prior BGC (background check}. In-service on abuse and identify sexual abuse. In-service Abuse Prohibition Protocol. In-service on Media Police and HIPPA. Notification to RPs. Physician Notification. Notification to the Ombudsman. Conclusion: After questioning the staff and alleged perpetrator, [Floor Tech] was taken to jail by police. He was terminated from [the facility] and a criminal trespass would be issued per police officer. Review of psychiatric consult by Psychologist, dated 06/14/2024, reflected the following: .[Resident #1] Diagnostic assessment was completed with (patient) indicating informed consent. (Patient) required intermittent support to remain adequately engaged. She gestured indicating she feels depressed and anxious. Patient demonstrated poor eye contact and actively turned away at one point. When psychoeducation related to sexual assault was provided. (Patient) made eye contact and asked how anyone could possibly understand how she feels. She went on to provide she worked as a nurse in the past. Patient cried and ceased to speak in an easily understandable manner, but repeated the word 'fear' and referred to difficulty with urination. Collateral information indicates patient's communication function, as demonstrated in assessment, is typical. Additionally, (patient) reportedly demonstrates periods of agitation at times. (Patient) indicated emotions including anger, fear, depression, and anxiety difficulty with reliable and consistent communication complicates assessment and treatment. Available data indicates evidence of depression, anxiety, and PTSD. Diagnostic clarity may improve over time and (diagnosis) should be updated accordingly. As {patient} demonstrates ability to communicate effectively at times, it is recommended psychotherapy services be provided to determine whether she may benefit . Review of psychiatric consult by Psychologist, dated 06/14/2024, reflected the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	.[Resident #2] Diagnostic assessment was completed with (patient) providing informed consent and participating fully in session. She responded to rating scales in a manner consistent with interview and collateral data. (Patient) acknowledged she was sexually assaulted recently and feels angry about the violation(s). (Patient declined to discuss details of the assault(s). (Patient) commented on feeling overwhelmed by the combination of recent sexual assault with existing somatic and dependence-related stressors. (Patient_ was in favor of pursuing psychotherapy services to address affective and behavioral symptoms. Initial impressions suggest (patient) is demonstration sx (symptoms) consistent with moderate anxiety disorder, mild depression, and acute PTSD. (Patient) made no requests for changes or supports at present. She reported feeling safe in the NF (Nursing Facility) . During an interview on 06/21/2024 at 3:21 p.m., the Administrator and DON said the Administrator was the abuse coordinator and that he had been employed for one week at the facility and the DON had been employed since December 2023. The Administrator said he was aware of a sexual abuse allegation that was self reported but that it occurred prior to his employment at the facility. The DON said she was aware of the sexual abuse allegation that was a self reported incident concerning the Floor Tech. The DON said there was an allegation of sexual abuse on 06/08/2024 when CNA A was making rounds in the hallway she had noticed a residents door was shut and when she opened the door the Floor Tech was in the bed with Resident #1. The DON said there was no harm to the resident noted and she was sent to the ER for an evaluation and she came back to the facility with a suggestion for UTI and no other orders. The DON said Resident #1 was evaluated by a SANE nurse and the DON had been calling the Investigator daily to get those results because the hospital would not release them since they were under investigation. The DON said there were no concerns with the Floor Tech's background history and that he had a clear record. The DON said the Floor Tech was brought to the front of the building immediately to ensure resident safety and two staff members sat with him until the police came and he was escorted off the property. The DON said he was arrested, did not know he was currently in jail but that he got bonded out on Sunday, 06/09/2024. The DON said the family was notified and was not sure if they decided to press charges. The DON said it was important residents were free from sexual abuse to ensure their well-being and safety and in response to the incident the facility completed 100% of skin assessments on residents, social life safety rounds,and in-servicing on abuse. The DON said there was one other resident, Resident #2, identified with related concerns. The DON said Resident #2 reported about 2 weeks prior the Floor Tech had came into her room and was rubbing his private area on her body and had touched and kissed her neck. The DON said Resident #2 did not mention any other times and said it only happened once. During an interview on 06/21/2024 at 4:09 p.m., the Ombudsman said she had a concern that she received a self report that a staff member was found in the bed with a resident. During an observation on 06/21/2024 at 4:28 PM, Resident #1 was laying in bed on her left side covered with sheet, bed in low position, and the door to room was open with her television on. Resident #1 did not respond to greeting or questions and appeared in no apparent distress. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 06/25/2024 at 9:30 a.m., CNA A said she had been employed at the facility since April 2024. CNA A said on 06/08/2024 around or after 1:00 p.m., she walked in the room and saw the Floor Tech lying behind Resident #1. CNA A said Resident #1 had her eyes closed facing the door, lying on her side and the Floor Tech was lying on his side behind her under the covers. CNA A said the Floor Tech appeared to have his clothes on and when he rose up he spinned the covers around and started to act like he was cleaning her bed. CNA A said she did not notice any facial grimacing on Resident #1 at the time of the incident and could see her brief was on and it appeared to be on appropriately and there were no other individuals in the room. CNA A said Resident #1's door was closed and she was a fall risk so staff leave the door open. CNA A said when the Floor Tech rose up from the bed he put his hand across her wiping the bed off and said the bed was wet and grabbed the covers off of her and went to put it in the laundry. CNA A said it was important to protect residents from abuse to ensure their safety and told CNA B that she had to report something to the nurse and when she saw LVN C she reported to her immediately. CNA A said CNA B was a witness that saw the Floor Tech come out of the room. CNA A said LVN C checked on Resident #1 and was calling and notifying management when the Floor Tech was following CNA A around trying to persuade her she did not see anything. CNA A said after she reported to LVN C, she entered Resident #2's room with CNA B and Resident #2 began to report a related concern of staff being inappropriate with her and described the Floor tech's appearance. CNA A said after they reported Resident #2's concern to LVN C it was the end of her shift and she had to return to the facility the same day to write a statement and the police ended up taking the Floor Tech to jail. CNA A said Resident #2 reported they had the wrong people working in this facility and that the little dark man had been rubbing on her. CNA A said Resident #2 reported to CNA B that the Floor Tech had been coming in her room touching and rubbing on her. CNA A said the Floor Tech may have done it to more but no other residents have reported any related concerns that she was aware of and had not noticed any scratches or changes in behavior such as resident being withdrawn. CNA A said Resident #1 is sometimes confused and had been acting normal with no apparent changes. CNA A said Resident #2's family came to get her. CNA A said the facility put interventions in place to prevent sexual abuse by removing the Floor Tech from resident care areas, providing in-services on abuse, and completing assessments on all residents. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 06/25/2024 at 10:09 a.m., CNA B said she had been employed since November 2015 and had received training on abuse by in-services within the last month and did not suspect abuse at this facility other than the concern with the Floor Tech. CNA B said it was important for residents to be free from abuse to ensure residents safety. CNA B said she noticed the Floor Tech seemed different that day (06/08/2024) and he had his housekeeping cart on her hall and was not cleaning. CNA B said she works with CNA A and felt that the Floor tech was watching what hall they were working on because they had just finished checking on Resident #1's hall. CNA B said they decided to check on the same hall again before ending their shift and realized Resident #1's door was shut. CNA B said they never shut Resident #1's door because she was a fall risk. CNA B said CNA A came out of the room directly across from Resident #1 and when she came out of the room she saw the door was closed and thought CNA B was in there because she was a two person assist. CNA B said CNA A went in the room, came out, and told her what she saw then notified LVN C. CNA B said she finished the room she was in and went to Resident #2's room. CNA B said at that time, Resident #2 said she needed to talk and needed her help. CNA B said she reassured Resident #2 and that she could tell her anything and Resident #2 asked if CNA B could keep a man out of her room that met Floor Tech's description as a short, bald man that wears big glasses and has one eye that is lazy. CNA B said Resident #2 told her the man keeps getting in the bed with her and he was rubbing his hand and body all over her. CNA B said Resident #2 reported the Floor Tech incident always happened on the weekend when he was working and had been going on for two weeks. CNA B said she left out of the door to confront the Floor Tech and CNA A reminded her not to get angry with him and she calmed down. CNA B said the Floor Tech was following them trying to persuade CNA B and CNA A it wasn't what they saw and they told him to leave them alone. CNA B said LVN C got him in the conference room immediately following report of the incident and was instructed she could not leave until the DON and police came. CNA B said she wrote out her statement and the police cuffed him and took him out of the door. CNA B said there was one resident, Resident #3, that reported a week before that the Floor Tech had went in her room and was standing over her bed. CNA B said the facility was thinking Resident #3 was not herself because she is sometimes confused. CNA B said she felt the facility handled the situation appropriately and that there was a sweep of the facility to check on all the residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675519	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Larkspur	201 South John Redditt Drive Lufkin, TX 75904

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 06/25/2024 at 11:00 a.m., LVN C said she had been employed since January 2024. LVN C said at that the moment she did not suspect abuse and had received training on abuse by in-services with the most recent this week. LVN C said she was the charge nurse notified when the Floor Tech was found in the room with Resident #1. LVN C said CNA A notified her and she immediately went down to check on the resident and report while she had another nurse aide stay with Resident #1. LVN C said while she was reporting that incident, another aide notified her of Resident #2's similar concern. LVN C said she had that aide stay with Resident #2 and obtained the Floor Tech and notified police. LVN C said when she checked on Resident #1 she was fine and was her normal self, normally confused and disoriented with no new injuries. LVN C said Resident #1 did not know what was going on and she did not remember the Floor Tech had gotten in the bed with her. LVN C said her peri area was checked with no concerns and her diaper was fastened on all 4 contact points appropriately. LVN C said she was wearing clothes that were not disoriented at all. LVN C said Resident #2 reported that about two weeks ago, a short man with thick glasses and a lazy eye came into her room and was rubbing his junk on her and touching on her. LVN C said Resident #2 did not tell anyone and when asked why she said she was out of her mind and was not eating or drinking and had altered mental status due to a fall. LVN C said she assessed Resident #2 and she had no injuries. LVN C said Resident #2 reported she had her clothes on but he was kissing her neck and touching on her and denied that he made penetration. LVN C said Resident #2 told her he had not taken his clothes off around her and she did not say anything about her roommate. LVN C said to ensure residents were safe and free from abuse the facility did in-service training, a facility wide skin sweep, and interviews with the social worker. During an interview on 06/25/2024 at 11:38 a.m., the Social Worker said she got the report that one of the CNA's walked in the room and Floor Tech was in bed with Resident #1. The Social Worker said she interviewed the entire building that was interviewable. The Social Worker said she did have one resident, Resident #2, that stated the Floor Tech had came in her room and he was standing in front of her gesturing and saying it would be okay and rubbed her leg that occurred on two occasions and he touched her and posturing himself in front of her to put his body in her face moving his body around. The Social Worker said the facility completes background checks and checks employee history prior to hire. During an interview on 06/25/2024 at 12:00 p.m., LVN E said she had been employed off and on since 2022 and did not suspect abuse at the facility. LVN E said she received in-services on abuse and when they should report to state concerning some reportables that happened within the past couple of weeks. LVN E said it was important to ensure residents were free from abuse to ensure their safety. LVN E said she was not here when the Floor Tech was found in Resident #1's room and that no residents have reported to her of any inappropriate behavior from male staff. During an interview on 06/25/2024 at 1:54 PM, the RP said he was in the process of getting Resident #1 transferred closer to him. RP said the facility reports any problem with Resident #1 and had received a report of staff being inappropriate with Resident #1. RP said he was aware that the facility put him on administrative leave and he did not decided to press charges but has decided to move her to another facility closer to him in the central Texas area. (continued on next page)

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	675519	A. Building B. Wing	06/25/2024

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Larkspur	201 South John Redditt Drive Lufkin, TX 75904

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview and observation on 06/25/2024 at 4:35 p.m., Resident #2 was interviewed at her new nursing home facility. Resident #2 was laying in her bed. Resident #2 said she liked being in the new facility. Resident #2 said when she was at her old [facility] a short stocky black man molested her. Resident #2 said she reported the incident, and the facility fired him. Resident #2 said the man put his hands on her sides and rubbed himself on her stomach while she laid in her bed. When asked what she meant by he rubbed himself she said his penis. Resident #2 said he did not take his penis out and he did not take off her clothing. Resident #2 said when the man rubbed himself on her it made her feel sick and terribly dirty. Resident #2 said she was not physically hurt because she did not fight back. Resident #2 said she did not fight back because she wanted to get it over with. When asked if the man said anything to her, she said you mustn't tell anyone. When asked if he said anything else Resident #2 replied a bunch of stupid love stuff. Resident #2 said after the incident she stayed close to her roommate because if her roommate was around, he wouldn't bother her. Resident #2 said her roommate was usually in her room so she would stay in her room. Resident #2 said her roommate was not in her room at the time of the incident. Review of in-service signed by the Floor Tech, dated between 05/13/2024 through 05/16/2024, reflected education was provided to staff Abuse, Neglect, Reporting - Employee Investigation Questionnaires, and Employee Abuse Acknowledgement. Review of in-services dated 06/08/2024, and emp [TRUNCATED]