

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/11/2026
NAME OF PROVIDER OR SUPPLIER  Kingsville Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3130 S Brahma Blvd Kingsville, TX 78363	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record reviews, the facility failed to implement written policies and procedures to prohibit and prevent abuse, neglect, and misappropriation for 1 of 5 residents (Resident #1) reviewed for developing and implementing abuse and neglect policies and procedures. 1. The facility failed to follow their policy to report to HHSC within two hours when Resident #1 alleged Resident #2 sexually assaulted him on 02/07/26. 2. The facility failed to follow their policy to investigate an allegation of sexual abuse made by resident #1 on 02/07/26. This failure could place residents at risk for abuse/continued abuse and could lead to a diminished quality of life and psychosocial harm. Record review of Resident #1's admission record reflected an [AGE] year-old male admitted to the facility on [DATE] with hospice (end of life care). His diagnoses included chronic obstructive pulmonary disease (a progressive, incurable lung disease that causes inflammation and difficulty breathing), type 2 diabetes (chronic condition that happens when blood sugar levels are persistently high which can lead to heart disease, kidney disease, and stroke), unspecified dementia (loss of memory, language, problem solving and other thinking abilities which significantly impair a person's ability to perform daily activities), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (mental disorder characterized by excessive and persistent worry, fear, or anxiousness which significantly interferes with daily life), and cerebral infarction (stroke). Record review of Resident #1's admission MDS dated [DATE] reflected a BIMS score of 3 which indicated he had severe cognitive impairment. Record review of Resident #1's progress notes reflected the following entries: Nursing note created by LVN D on 02/07/26 at 9:48pm, effective on 02/07/26 at 8:00pm which stated, Resident was moved from [hall number] to [room number] with all meds and belongings. Nursing note created by LVN D on 02/07/26 at 10:14pm, effective 02/07/26 at 10:13pm, and struck out on 02/08/26 at 6:17am, which stated, [Hospice company] nurse just left facility. I was in room with her as she assessed resident due to report that was made today. Social service note created by the ADM on 02/09/26 at 9:18am, effective 02/08/26 at 9:16am, which was a follow up to the nursing note by LVN D effective 02/07/26 at 8:00pm, which stated, Administrator informed that room move was requested due to the hall being too loud. Also request made to have resident in a room closer to the nurse's station. Record review of HRN F's visit note report dated 02/07/26 at 9:44pm reflected the following: Reason for PRN visit: Sexual assault reported Care coordination: Indicate details/comments: Assault was reported to family member by patient, who then reported the said incident to facility and hospice. Collaboration with facility staff: Yes Staff name and title: will follow up with [ADM name] DON Identified changes and/or issues: Yes Specify changes/ issues: An outcry was made by patient to his family. Is care team coordination needed: Yes Select coordination team: Medical director, social worker, chaplain, other Specify other: Admin director Indicate what was discussed with care coordination team: Conducting an investigation regarding a sexual assault and notifying appropriate agencies. Narrative: PRN visit: Rec'd notice from admin</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The DON stated she did not feel like Resident #1 would be a reliable source because he would only say a few words. The DON stated if the facility did not report or investigate an allegation of abuse, it could potentially harm a resident because it could cause psychosocial or physical harm. The DON stated If there was a significant event, it was to be reported to the provider and documented as soon as possible, but no later than the end of the shift. In an interview on 02/10/26 at 4:14pm, the ADM stated she got a call from LVN J on 02/07/26 who told her that Resident #1's RP told her that someone touched his butt. The ADM asked if the RP was making an allegation and LVN J said no, she did not think so because she (LVN J) asked Resident #1 about it and he said no so LVN J told the RP she would let the ADM know about it. The ADM asked LVN J if the RP gave her any other context or if Resident #1 was hurt and LVN J said no. The ADM told LVN J she would call back to the nurse's station and to have the RP come talk to her. The ADM stated when she called back and the RP got on the phone with her, the ADM asked the RP if she felt like someone hurt Resident #1 or touched him inappropriately and the RP said no. The ADM stated the RP told her Resident #1 told the RP that, someone touched his [spanish slang word for anus]. The RP asked Resident #1 who did it and he did not answer her, but a few minutes later when Resident #2 yelled, Resident #1 squeezed her hand, so she assumed it was Resident #2 that had put a finger in Resident #1's anus. The ADM stated she asked the RP again if she was making an allegation and the RP told her, well, Resident #1 was very prideful, and she wanted the staff to be very careful when moving or changing him. The ADM stated the RP told her that she did not like that hallway because Resident #2 was too loud or his tv was too loud and she felt like the loudness made Resident #1 more anxious. The ADM stated she offered the RP a room change and the RP asked for a room closer to the nurse's station in a different hall and that she wanted the room changed that night. The ADM stated the RP asked about putting a camera in Resident #1's room and the ADM told her that would not be a problem. The ADM stated she spoke to LVN J again and they discussed moving Resident #1. The ADM stated she got a phone call from HRN F with [name of hospice company] at 7:40pm on 02/07/26 who said that she had been trying to call but not getting an answer at the facility to let them know she was on her way. The ADM stated she called the facility to let them know that hospice was trying to call. The ADM stated, That was pretty much all for that night. The ADM stated on Sunday morning, the RP talked to the ADM and stated she wanted to thank her for moving Resident #1 and she was not going to stay at the facility for very long. The ADM stated she did not know what time it was but on 02/09/26, the RNC went to her and told her they had an allegation of abuse, so she notified the surveyors who were on site and made a self-report. The ADM stated she spoke to HRN F and not to the HD on 02/07/26 and that she was not told why HRN F went to the facility that evening. The ADM stated she found out about the allegation early afternoon on 02/09/26. The ADM stated she was told (unknown by who) that the RP's family member reached out to HRN E directly and told her about the allegation of abuse, so HRN E talked to a CNA (hospice) and then talked to the HD. The ADM stated if they got an allegation of abuse, it was reported immediately. The ADM stated if she got an allegation of abuse, then asked the resident (or RP) about it and they said it did not occur, she would still report it, but in this case, the RP did not make an actual allegation of abuse to her. The ADM stated the RP just stated that Resident #1 was very prideful and did not like anyone to touch his butt. The ADM stated if an allegation of abuse was made it was the ADM's responsibility to report it immediately to HHSC. The ADM stated If it was not reported, the resident could be left in jeopardy, and it could result in continued abuse or abuse to others. The ADM stated, in her opinion, this was not reportable initially from the information she was given. If an allegation had been made, it would have been reported to the provider, the RP, ombudsman, and her staff immediately. In an</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>interview on 02/10/26 at 5:02pm, LVN D stated whatever happened with Resident #1 on 02/07/26 happened before she got there. LVN D stated HRN F went in to assess Resident #1 and asked LVN D to go in the room with her to do that assessment. LVN D stated she struck out her note from 02/07/26 because she did not feel comfortable using the word report because she did not what, if any, report had been made. LVN D stated HRN F stated she was there about the concern that had been made earlier. LVN D stated she did not talk to family, so she did not know what the concern was or what had been said and HRN F only said she was there to check Resident #1's bottom. LVN D stated HRN F checked Resident #1's bottom and his rectum and said it was because of whatever complaint or concern had been made that evening. LVN D stated HRN F was trying to talk to Resident #1, but he was hard to understand most of the time and HRN F could not understand him. LVN D stated HRN F just told him hi, and asked if she could check him, but he was not understandable. LVN D stated she did not remember HRN F asking any questions about why she was checking his bottom. LVN D stated LVN J told her Resident #1 had told his RP he was touched inappropriately but she did not get any details of what happened or what he said happened. LVN D stated allegations of abuse were to be reported to the administrator right away and if abuse was not reported, it could happen again or continue to happen and could lead to harm to the resident in more than one way. In a telephone interview on 02/11/26 at 8:51am, HRN F stated she was the on call nurse for the hospice company on 02/07/26. HRN F stated she got a call from the HD at 7:53pm on 02/07/26 to let her know that a complaint had come in from the RP. HRN F stated the HD told her she was going to reach out to the facility and the family but wanted her to head to the facility. HRN F stated the HD was detailed about the allegation the resident made. HRN F stated she met up with LVN D at the facility and told her exactly why she was there- which was because, Resident #1 stated another resident went into his room and put a finger in his butt. HRN F asked LVN D to accompany her into the room to assess Resident #1. HRN F stated she did not see any trauma and Resident #1 denied any accusations. HRN F stated some of Resident #1's words were clear, but some were very garbled. HRN F stated no family was at the facility when she assessed Resident #1. HRN F stated she typed up a progress note to go with the visit in her company's charting system. In an interview on 02/11/26 at 9:23am, the HD stated she spoke to the ADM on 02/07/26 and called her directly from her cell phone to the ADM's personal cell phone. The HD provided the cell phone number she called, and it was the ADM's personal cell phone number. The HD stated when she spoke to the ADM, the ADM already knew about the allegation and had already spoken to the RP, had talked to staff, and told the HD she was starting the investigation process. The HD stated to her knowledge, the RP called HRN E directly and told her what Resident #1 said and told HRN E she wanted a hospice nurse to go and assess so that it was not just a facility nurse that assessed him. The HD stated that she did not speak to the ADM again after that. In a telephone interview on 02/11/26 at 9:43am, HRN E stated a family member of Resident #1's messaged her on a social media application and asked her to call another of Resident #1's family members, ASAP. HRN E stated she called Resident #1's family member to find out what was going on HRN E stated the family member was distraught and told her it was about, Resident #1 and the facility and they needed to report the facility, and it was so awful and she couldn't speak of it. HRN E named several things that could have happened and when she said rape, the family member said, yes, that one. HRN E then told the family member she had to call her boss and report it. HRN E stated she called the HD, the HD called the RP, then HRN E was not involved with that situation anymore. HRN E stated Resident #1 always said, don't touch my [spanish slang word for anus], and when HRN E asked him what it was Resident #1 said, my ass. HRN E stated he would say it when she checked on his pressure wounds on his sacrum and gluteus and when the hospice CNA was giving him a bed bath with soap</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>and water. Record review of the facility's Abuse, Neglect and Exploitation policy dated 08/15/22 reflected in part: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Sexual Abuse is non-consensual sexual contact of any type with a resident. Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: b. Establish policies and procedures to investigate any such allegations; 2. The facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. 3. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written. The components of the facility abuse prohibition plan are discussed herein: I. Employee Training C. Training topics will include: 2. Identifying what constitutes abuse, neglect, exploitation, and misappropriation of resident property; 4. Reporting process for abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources; V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 3. Investigating different types of alleged violations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation. VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. B. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.</p>		