STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675884	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Teague Nursing and Rehabilitation	884 Hwy 84 W Teague, TX 75860

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview and record review the facility failed to ensure the resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 6 residents (Resident #1) reviewed for resident abuse and neglect. The facility failed to ensure Resident #1 was free from verbal sexual harassment by CNA A in November of 2025. This failure could place residents at risk of ongoing sexual harassment, psychosocial harm, fear, and decreased quality of life.Record review of Resident #1's face sheet, dated 01/20/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included unspecified injury at unspecified level of thoracic spinal cord- subsequent encounter, osteomyelitis (infection of the bone marrow), post-traumatic stress disorder (mental health condition that is caused by an extremely stressful or terrifying event), need for assistance with personal care, and muscle weakness. Record review of Resident #1's quarterly MDS assessment, dated 11/14/25, reflected a BIMS score of 15, which indicated the resident's cognition was intact. Section GG for functional abilities reflected Resident #1 was completely dependent on staff for rolling left and right, transfers, bathing/hygiene, and dressing. Record review of Resident #1's care plan, revised 01/09/26, reflected a focus on [Resident #1] has hemiplegia/ hemiparesis r/t trauma / spinal injury (chest down) with interventions that included range of motion (active or passive) with am/pm care and a focus for [Resident #1] has an ADL self-care performance deficit with interventions that included the resident requires (dependent on staff) to turn and reposition. A focus was also seen for [Resident #1] stated he is having some (minimal) emotional distress per social worker after completing an emotional distress assessment with interventions that included, [Resident #1] stated he feels safe to report any abuse to administrator or staff, counseling for social determinant of health risk, education about safety plan, and referral to social worker. Record review of Resident #1's emotional distress/ psychosocial monitoring post incident report, dated 01/08/26, reflected a positive assessment based on the following responses: If interviewable does the resident report feelings of nervousness or anxiousness related to the specific incident you are evaluating response was marked yes If the resident is interviewable do they verbalize fearfulness related to the specific incident you are evaluating response was marked yesComments based on yes responses reflected, resident would like to be informed of what is really going on. He verbalized worry that incident connected to him may sabotage his placement. Distress is minimal per resident.Document reflected it was signed 01/08/26 by the SW Record review of Resident #1's progress notes reflected a noted, dated 01/08/26, entered by the DON, Notified by social worker that resident reported some events that need to be addressed by the DON and a positive emotional distress assessment. DON speaks with resident who reports a CNA has made inappropriate remarks to him and these comments made him feel uncomfortable but scared to report them because of fear he would be removed from the facility. Resident denied any sexual contact between himself and the reported CNA and (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	states his only emotional distress is related to fear of not having a place to go if kicked out of this facility. Assured resident that he is not being removed from the facility, he is not at fault, and he should always report any inappropriate comments or actions to myself or administrator. He verbalizes understanding and states he feels better about the situation following our discussion. Record review of Resident #1's progress notes reflected a note, dated 01/09/26, entered by the ADM, Notified by DON that resident had reported to her inappropriate comments were being made by a CNA. Administrator approachedresident in his room. Resident did confirm inappropriate comments were made by a CNA. Administrator asked when this incident took place and resident responded sometime in November 2025. Administrator asked why he did not report this event then, and he responded that he feared being kicked out of the facility. Administrator assured him that any concern should be brought to the attention of the administrative personnel at anytime without fear of retaliation. Resident assured the Administrator that he would do this moving forward. Administrator did ask resident if the comments upset him and he responded no and that he was only afraid of being kicked out of the facility. Resident did not appear to be in any emotion distress at the time of this conversation. Record review of Resident #1's progress notes reflected a note, dated 01/09/26, entered by the ADON, NP notified of sexual harassment allegations and investigation concerning resident and an employee. She is advised that the resident is not physically harmed in any way, declined any sexual contact between them, and that he is reporting only emotional concerns about the facility kicking him out. She is also informed that the state is being notified as a result of the founded allegation of sexual harassment via inappropriate comments. She advises that if anything changes or the resident needs to be seen or evaluated for any concerns related to this incident to let her know and she can get off cycle visit scheduled to address needs. Record review of the facility's self-reported 3613 and investigation packet, dated 01/13/26, reflected intake 1061475, Resident involved: Resident #1, alleged perpetrator: CNA A, how was the AP identified: by name, perpetrator: confirmed, witness name: CNA B, description of allegation: abuse- sexual harassment. Facility investigation findings: confirmed, signed by the ADM.Investigation packet included a signed statement from Resident #1, dated 01/09/26, When being questioned by social worker on 01/08/26, I expressed concerns about comments made to me by [CNA A]. She made comments about me ‘having a nice ass' and going home with her, stating her home address, and telling me ‘don't worry boo, I'll take care of you.' Another CNA, [CNA B] was present for these comments but CNA A stated [Resident #1] your only witness is [CNA B] and she gona deny it.' I did not report it at the time because I was scared of the report getting back to CNA A and it causing me to be kicked out of the facility.Investigation packet included a statement from the DON, During interview with Resident #1 regarding his alleged relationship with a CNA, he reports to DON and SW that [CNA A] made comments to him including telling him, ‘you have a nice ass for a white boy' and ‘you don't have to worry about leaving here, if you ever leave here you aren't going anywhere but to my house' in a flirting like manner and proceeded to give the resident her address. He also reports another CNA [CNA B] was present for these statements and can verify but that [CNA A] told him and [CNA B] not to say anything at the time. DON called facility 01/08/25 at 9PM and spoke to [CNA B] during her scheduled shift. [CNA B] confirms that all of these comments did take place by CNA A to Resident #1. She denied any further comments or any sexual contact to her knowledge. Record review of Associate Separation Record signed on 01/12/26 by CNA A, DON, and ADM reflected CNA A had a history of inappropriate behavior at the facility, the confirmed sexual harassment made Resident #1 feel awkward, humiliated, and embarrassed, and violated workplace rules. It reflected: Initial Conversations: August -October 2025 Multiple occasions on telephone and in person between employee, [CNA A], and DON, concerning (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	threatening comments, bullying remarks toward coworkers, and complaints about CNA A's attitude and performance from other coworkers. Nursing wide inservice education provided: October 21, 2025, signed by [CNA A]. Second Inservice provided in person to all nursing staff and verbally over phone to [CNA A] from DON November 28, 2025. Ongoing phone calls and in person conversations between employee and DON with repeated complaints about coworkers, allegations against other associates, insubordination reports, and demands for disciplinary actions to be taken against various employees based on her unfounded allegations.January 8, 2025 [CNA A] adamantly directs DON to investigate, suspend, and write up an employee based on an alleged relationship between a resident and fellow CNA. She reports that everyone, including dietary, housekeeping, and all CNA's talk about this relationship, report to her about it, and all know that this is happening. Staff was interviewed and zero employees had any prior knowledge about any relationship or talk of any resident and staff relationship. The accused resident and staff member coincide that no relationship has ever occurred or even discussed to occur. However, during the investigation, the resident reports that [CNA A] has made multiple inappropriate comments to him about taking him home and his body parts. He also states that another CNA, [CNA B], was present for these remarks. [CNA B] confirmed these comments did occur. The resident reports that these comments made by [CNA A] caused him to feel awkward, humiliated, and embarrassed. The accused CNA reports feeling repeatedly targeted and bullied based on her current and previous actions/allegations.The bullying and intimidation by [CNA A] violates 500.4 Workplace Violence Prevention Policy for Health Care Facilities -Page 77,400.24 Performance Expectations numbers 4, 5, 14, 15, 17, 18, 21, 22, and 29. The inappropriate comments violates policies including 100.16 - Non-Discrimination & Antiharassment, Sexual Harassment section - Page 13, 400.24-Performance Expectations numbers 1, 12, 15, 17, 31. In an interview on 01/20/26 at 01:40 PM with the DON, revealed she first learned of the incident concerning Resident #1 on 01/08/26 after the SW completed an emotional distress evaluation for Resident #1 that was positive. She stated Resident #1 reported to the SW that CNA A made comments about his butt. Resident #1 stated this event occurred sometime approximately in November of 2025. The DON stated she became aware at this time also CNA B was a witness to the event and attempted to reach her but could not get ahold of her; she stated CNA B had a shift later that day and was interviewed. The DON stated on the evening of 01/08/26 during the interview with CNA B, she confirmed she was in the room present for the incident when CNA A made the comment to Resident #1 of having a cute ass for a white boy and making comments of taking him home to take care of him and giving him her address. The DON stated during the interview there was no confirmed sexual contact made between Resident #1 and CNA A. The DON stated the next day on 01/09/26, she also had a conversation with CNA B on needing to report things timely and asked her why this event was not reported. She stated CNA B told her during the incident CNA A made the comment to Resident #1 and CNA B [CNA B] is the only witness and she is going to deny it. The DON said CNA B stated she took this comment from CNA A telling her not to say anything. The DON stated there was no disciplinary action against CNA B for failing to report the incident but they did 1:1 in-servicing on the importance of reporting ANE in a timely manner. The DON stated upon learning of the incident on 01/08/26, CNA A was immediately suspended pending an investigation and not allowed to work with the residents, she stated CNA A remained out of the facility until 01/12/26 when she was called back in to the facility and terminated after the investigation revealed the allegations were founded and confirmed the sexual remarks were made. The DON stated it was her expectation if staff were a witness to any sexual harassment/ ANE or if they are aware of any allegations that it needs to be reported immediately. She stated a negative outcome of not reporting timely would be physical and emotional distress. The DON stated on the Friday after (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the suspension of CNA A [01/09/26] she had a phone call with CNA A to interview her over the phone about the allegations of sexual harassment of Resident #1. The DON stated during this phone call CNA A confirmed that she had in fact made those remarks to Resident #1 about having a nice ass for a white boy and she was asked if she gave her address and said she would take care of him and CNA A confirmed that had also occurred. In an interview on 01/20/26 at 02:05 PM with CNA B, she stated she was in the room when CNA A made the comments to Resident #1 that he had a cute butt and she said she wouldn't mind taking care of him if he got out. CNA B stated at the time the comments were made they were both in Resident #1's room assisting with repositioning. CNA B stated to her knowledge there was never any sexual contact made between Resident #1 and CNA A. CNA B stated when the comments were made Resident #1 did not seem uncomfortable. CNA B stated based on what she knew now, any sexual remarks made to residents should be reported immediately. She stated she believed at the time the comments were not inappropriate since Resident #1 did not seem bothered by it. CNA B stated she was not sure of what a negative outcome would be of not reporting verbal or physical sexual abuse or harassment of a resident. CNA B stated she learned there was an investigation into the incident recently, but the comments were made approximately November/ December. CNA B stated CNA A continued to work with Resident #1 after the comments were made. She stated she did not believe CNA A made similar comments to Resident #1 again or any other resident. CNA B stated she has known CNA A for a long time and were childhood friends and that was part of her personality she had a history of inappropriate comments and behavior. CNA B stated after the investigation began, she was in-serviced on the importance of reporting timely and the ANE policy. In an interview on 01/20/26 at 02:26 PM with Resident #1, he stated the inappropriate comments from CNA A about his butt were made in November of 2025, but he didn't tell anyone until recently when reporting it to the SW. Resident #1 stated there was another staff in the room at the time the comments were made, and identified CNA B as the witness to the event. Resident #1 stated he did not report the incident at the time due to feeling like he would have retaliation from CNA A. Resident #1 stated CNA A continued to work with him after the comments were made and continued to provide care such as ADL care. Resident #1 stated this was only verbal and there was no sexual contact made by CNA A. Resident #1 stated he felt uncomfortable by the comments made and uncomfortable with CNA A continuing to provide him care afterwards saying it brought him discomfort and embarrassment. In an interview on 01/20/26 at 03:36 PM with the ADM, she stated she became aware of the incident on 01/08/26 and she stated she immediately went to speak to Resident #1 to confirm the allegations and to get him to understand and feel comfortable coming to staff in situations such as this and she did not want him to fear being placed in another facility for something that was not his fault. She stated Resident #1 reported fear of being kicked out of the facility due to the event. The ADM stated the event with Resident #1 took place approximately in November of 2025. The ADM stated she did not speak to CNA A about the incident, as the DON was handling that. She stated to her knowledge in the conversation between the DON and CNA A, CNA A did say that she said those things confirming the incident. The ADM stated she did not ask CNA B why it was not reported earlier, she had also only been interviewed by the DON who managed the clinical staff and stated to her knowledge CNA B said she did not report this sooner out of fear of retaliation from CNA A. The ADM stated CNA A had a history of saying and spreading things that are not true. The ADM stated it was her expectation any verbal or physical sexual abuse or harassment of a resident should be reported immediately by staff to her or the DON. She stated it is important that the residents feel safe and that there is follow up. She stated a potential negative outcome of something like this going unreported would be that the harassment could continue to go on if unreported and fear from the resident. The ADM (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated CNA A was suspended on 01/08/26 when they learned of the incident and then terminated on 01/12/26 after the event was confirmed. She stated the facility then in-serviced CNA B one on one in a lengthy discussion on the importance of reporting events timely. In an interview on 01/21/26 at 12:17 PM with the SW, she stated she first learned of the incident involving Resident #1 after the DON went to her and instructed her she needed to complete a mental distress assessment for Resident #1. The SW stated Resident #1 reported to her, CNA A made inappropriate comments to him and asked if he was in a relationship and then said to Resident #1 if you ever get out of here come see me and provided her address. The SW stated Resident #1 was a young man and nice and it is not appropriate for her to say those things to him. The SW stated Resident #1 did have mild distress during her assessment and he did have worry there were times she was coming on to him but nothing physical ever happened, so he laughed it off as a joke. The SW stated Resident #1 expressed he did not want what happened to disrupt his placement at the facility. The SW stated she advised Resident #1 he did not do anything wrong and provided reassurance. She stated at the time Resident #1 did not have any injuries, no behavior changes. She stated it was the expectation for all staff that if they witnessed or heard of alleged abuse, sexual harassment or physical abuse that it should be reported immediately and on that shift. She stated a potential negative outcome of it going unreported would be the abuse or harassment could continue and other residents would be at risk from that employee. She went on to say that for the witness the person that did not report becomes liable as well. The SW stated CNA B stated she did not report the incident due to being threatened by CNA A. Record review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy last revised April 2021 reflected: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental or sexual, or physical abuse, and physical or chemical restraint not required to treat resident symptoms.The resident abuse, neglect and exploitation prevention program consist of a facility-wide commitment and resource allocation to support the following objectives: Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including but not necessarily limited to: facility staff. Record review of the facility's Resident Rights policy last revised February 2021 reflected: Employees shall treat all residents with kindness, respect, and dignity.Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents right to: be treated with respect, kindness, and dignity; be free from abuse, neglect, misappropriation of property and exploitation.

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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** 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, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 1 facility reviewed for abuse and neglect. The facility failed to ensure CNA B reported verbal sexual abuse, of Resident #1 by CNA A, witnessed in November 2025, to the Administrator. This failure could place residents at risk for not having incidents reported as required.Record review of Resident #1's face sheet, dated 01/20/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included unspecified injury at unspecified level of thoracic spinal cord- subsequent encounter, osteomyelitis (infection of the bone marrow), post-traumatic stress disorder (mental health condition that is caused by an extremely stressful or terrifying event), need for assistance with personal care, and muscle weakness. Record review of Resident #1's quarterly MDS assessment, dated 11/14/25, reflected a BIMS score of 15, which indicated the resident's cognition was intact. Section GG for functional abilities reflected Resident #1 was completely dependent on staff for rolling left and right, transfers, bathing/hygiene, and dressing. Record review of Resident #1's care plan, revised 01/09/26, reflected a focus on [Resident #1] has hemiplegia/ hemiparesis r/t trauma / spinal injury (chest down) with interventions that included range of motion (active or passive) with am/pm care and a focus for [Resident #1] has an ADL self-care performance deficit with interventions that included the resident requires (dependent on staff) to turn and reposition. A focus was also seen for [Resident #1] stated he is having some (minimal) emotional distress per social worker after completing an emotional distress assessment with interventions that included, [Resident #1] stated he feels safe to report any abuse to administrator or staff, counseling for social determinant of health risk, education about safety plan, and referral to social worker. Record review of Resident #1's emotional distress/ psychosocial monitoring post incident report, dated 01/08/26, reflected a positive assessment based on the following responses: If interviewable does the resident report feelings of nervousness or anxiousness related to the specific incident you are evaluating response was marked yes If the resident is interviewable do they verbalize fearfulness related to the specific incident you are evaluating response was marked yesComments based on yes responses reflected, resident would like to be informed of what is really going on. He verbalized worry that incident connected to him may sabotage his placement. Distress is minimal per resident.Document reflected it was signed 01/08/26 by the SW Record review of Resident #1's progress notes reflected a noted, dated 01/08/26, entered by the DON, Notified by social worker that resident reported some events that need to be addressed by the DON and a positive emotional distress assessment. DON speaks with resident who reports a CNA has made inappropriate remarks to him and these comments made him feel uncomfortable but scared to report them because of fear he would be removed from the facility. Resident denied any sexual contact between himself and the reported CNA and states his only emotional distress is related to fear of not having a place to go if kicked out of this facility. Assured resident that he is not being removed from the facility, he is not at fault, and he should always report (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	any inappropriate comments or actions to myself or administrator. He verbalizes understanding and states he feels better about the situation following our discussion. Record review of Resident #1's progress notes reflected a note, dated 01/09/26, entered by the ADM, Notified by DON that resident had reported to her inappropriate comments were being made by a CNA. Administrator approachedresident in his room. Resident did confirm inappropriate comments were made by a CNA. Administrator asked when this incident took place and resident responded sometime in November 2025. Administrator asked why he did not report this event then, and he responded that he feared being kicked out of the facility. Administrator assured him that any concern should be brought to the attention of the administrative personnel at anytime without fear of retaliation. Resident assured the Administrator that he would do this moving forward. Administrator did ask resident if the comments upset him and he responded no and that he was only afraid of being kicked out of the facility. Resident did not appear to be in any emotion distress at the time of this conversation. Record review of Resident #1's progress notes reflected a note, dated 01/09/26, entered by the ADON, NP notified of sexual harassment allegations and investigation concerning resident and an employee. She is advised that the resident is not physically harmed in any way, declined any sexual contact between them, and that he is reporting only emotional concerns about the facility kicking him out. She is also informed that the state is being notified as a result of the founded allegation of sexual harassment via inappropriate comments. She advises that if anything changes or the resident needs to be seen or evaluated for any concerns related to this incident to let her know and she can get off cycle visit scheduled to address needs. Record review of the facility's self-reported 3613 and investigation packet, dated 01/13/26, reflected intake 1061475, Resident involved: Resident #1, alleged perpetrator: CNA A, how was the AP identified: by name, perpetrator: confirmed, witness name: CNA B, description of allegation: abuse- sexual harassment. Facility investigation findings: confirmed, signed by the ADM.Investigation packet included a signed statement from Resident #1, dated 01/09/26, When being questioned by social worker on 01/08/26, I expressed concerns about comments made to me by [CNA A]. She made comments about me ‘having a nice ass' and going home with her, stating her home address, and telling me ‘don't worry boo, I'll take care of you.' Another CNA, [CNA B] was present for these comments but CNA A stated [Resident #1] your only witness is [CNA B] and she gona deny it.' I did not report it at the time because I was scared of the report getting back to CNA A and it causing me to be kicked out of the facility.Investigation packet included a statement from the DON, During interview with Resident #1 regarding his alleged relationship with a CNA, he reports to DON and SW that [CNA A] made comments to him including telling him, ‘you have a nice ass for a white boy' and ‘you don't have to worry about leaving here, if you ever leave here you aren't going anywhere but to my house' in a flirting like manner and proceeded to give the resident her address. He also reports another CNA [CNA B] was present for these statements and can verify but that [CNA A] told him and [CNA B] not to say anything at the time. DON called facility 01/08/25 at 9PM and spoke to [CNA B] during her scheduled shift. [CNA B] confirms that all of these comments did take place by CNA A to Resident #1. She denied any further comments or any sexual contact to her knowledge. Record review of Associate Separation Record signed on 01/12/26 by CNA A, DON, and ADM reflected CNA A had a history of inappropriate behavior at the facility, the confirmed sexual harassment made Resident #1 feel awkward, humiliated, and embarrassed, and violated workplace rules. It reflected: Initial Conversations: August -October 2025 Multiple occasions on telephone and in person between employee, [CNA A], and DON, concerning threatening comments, bullying remarks toward coworkers, and complaints about CNA A's attitude and performance from other coworkers. Nursing wide inservice education provided: October 21, 2025, signed by [CNA A]. Second (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inservice provided in person to all nursing staff and verbally over phone to [CNA A] from DON November 28, 2025. Ongoing phone calls and in person conversations between employee and DON with repeated complaints about coworkers, allegations against other associates, insubordination reports, and demands for disciplinary actions to be taken against various employees based on her unfounded allegations.January 8, 2025 [CNA A] adamantly directs DON to investigate, suspend, and write up an employee based on an alleged relationship between a resident and fellow CNA. She reports that everyone, including dietary, housekeeping, and all CNA's talk about this relationship, report to her about it, and all know that this is happening. Staff was interviewed and zero employees had any prior knowledge about any relationship or talk of any resident and staff relationship. The accused resident and staff member coincide that no relationship has ever occurred or even discussed to occur. However, during the investigation, the resident reports that [CNA A] has made multiple inappropriate comments to him about taking him home and his body parts. He also states that another CNA, [CNA B], was present for these remarks. [CNA B] confirmed these comments did occur. The resident reports that these comments made by [CNA A] caused him to feel awkward, humiliated, and embarrassed. The accused CNA reports feeling repeatedly targeted and bullied based on her current and previous actions/allegations.The bullying and intimidation by [CNA A] violates 500.4 Workplace Violence Prevention Policy for Health Care Facilities -Page 77,400.24 Performance Expectations numbers 4, 5, 14, 15, 17, 18, 21, 22, and 29. The inappropriate comments violates policies including 100.16 - Non-Discrimination & Antiharassment, Sexual Harassment section - Page 13, 400.24-Performance Expectations numbers 1, 12, 15, 17, 31. In an interview on 01/20/26 at 01:40 PM with the DON, revealed she first learned of the incident concerning Resident #1 on 01/08/26 after the SW completed an emotional distress evaluation for Resident #1 that was positive. She stated Resident #1 reported to the SW that CNA A made comments about his butt. Resident #1 stated this event occurred sometime approximately in November of 2025. The DON stated she became aware at this time also CNA B was a witness to the event and attempted to reach her but could not get ahold of her; she stated CNA B had a shift later that day and was interviewed. The DON stated on the evening of 01/08/26 during the interview with CNA B, she confirmed she was in the room present for the incident when CNA A made the comment to Resident #1 of having a cute ass for a white boy and making comments of taking him home to take care of him and giving him her address. The DON stated during the interview there was no confirmed sexual contact made between Resident #1 and CNA A. The DON stated the next day on 01/09/26, she also had a conversation with CNA B on needing to report things timely and asked her why this event was not reported. She stated CNA B told her during the incident CNA A made the comment to Resident #1 and CNA B [CNA B] is the only witness and she is going to deny it. The DON said CNA B stated she took this comment from CNA A telling her not to say anything. The DON stated there was no disciplinary action against CNA B for failing to report the incident but they did 1:1 in-servicing on the importance of reporting ANE in a timely manner. The DON stated upon learning of the incident on 01/08/26, CNA A was immediately suspended pending an investigation and not allowed to work with the residents, she stated CNA A remained out of the facility until 01/12/26 when she was called back in to the facility and terminated after the investigation revealed the allegations were founded and confirmed the sexual remarks were made. The DON stated it was her expectation if staff were a witness to any sexual harassment/ ANE or if they are aware of any allegations that it needs to be reported immediately. She stated a negative outcome of not reporting timely would be physical and emotional distress. The DON stated on the Friday after the suspension of CNA A [01/09/26] she had a phone call with CNA A to interview her over the phone about the allegations of sexual harassment of Resident #1. The DON stated during this phone call CNA A confirmed that (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675884	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Teague Nursing and Rehabilitation	884 Hwy 84 W Teague, TX 75860

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she had in fact made those remarks to Resident #1 about having a nice ass for a white boy and she was asked if she gave her address and said she would take care of him and CNA A confirmed that had also occurred. In an interview on 01/20/26 at 02:05 PM with CNA B, she stated she was in the room when CNA A made the comments to Resident #1 that he had a cute butt and she said she wouldn't mind taking care of him if he got out. CNA B stated at the time the comments were made they were both in Resident #1's room assisting with repositioning. CNA B stated to her knowledge there was never any sexual contact made between Resident #1 and CNA A. CNA B stated when the comments were made Resident #1 did not seem uncomfortable. CNA B stated based on what she knew now, any sexual remarks made to residents should be reported immediately. She stated she believed at the time the comments were not inappropriate since Resident #1 did not seem bothered by it. CNA B stated she was not sure of what a negative outcome would be of not reporting verbal or physical sexual abuse or harassment of a resident. CNA B stated she learned there was an investigation into the incident recently, but the comments were made approximately November/ December. CNA B stated CNA A continued to work with Resident #1 after the comments were made. She stated she did not believe CNA A made similar comments to Resident #1 again or any other resident. CNA B stated she has known CNA A for a long time and were childhood friends and that was part of her personality she had a history of inappropriate comments and behavior. CNA B stated after the investigation began, she was in-serviced on the importance of reporting timely and the ANE policy. In an interview on 01/20/26 at 02:26 PM with Resident #1, he stated the inappropriate comments from CNA A about his butt were made in November of 2025, but he didn't tell anyone until recently when reporting it to the SW. Resident #1 stated there was another staff in the room at the time the comments were made, and identified CNA B as the witness to the event. Resident #1 stated he did not report the incident at the time due to feeling like he would have retaliation from CNA A. Resident #1 stated CNA A continued to work with him after the comments were made and continued to provide care such as ADL care. Resident #1 stated this was only verbal and there was no sexual contact made by CNA A. Resident #1 stated he felt uncomfortable by the comments made and uncomfortable with CNA A continuing to provide him care afterwards saying it brought him discomfort and embarrassment. In an interview on 01/20/26 at 03:36 PM with the ADM, she stated she became aware of the incident on 01/08/26 and she stated she immediately went to speak to Resident #1 to confirm the allegations and to get him to understand and feel comfortable coming to staff in situations such as this and she did not want him to fear being placed in another facility for something that was not his fault. She stated Resident #1 reported fear of being kicked out of the facility due to the event. The ADM stated the event with Resident #1 took place approximately in November of 2025. The ADM stated she did not speak to CNA A about the incident, as the DON was handling that. She stated to her knowledge in the conversation between the DON and CNA A, CNA A did say that she said those things confirming the incident. The ADM stated she did not ask CNA B why it was not reported earlier, she had also only been interviewed by the DON who managed the clinical staff and stated to her knowledge CNA B said she did not report this sooner out of fear of retaliation from CNA A. The ADM stated CNA A had a history of saying and spreading things that are not true. The ADM stated it was her expectation any verbal or physical sexual abuse or harassment of a resident should be reported immediately by staff to her or the DON. She stated it is important that the residents feel safe and that there is follow up. She stated a potential negative outcome of something like this going unreported would be that the harassment could continue to go on if unreported and fear from the resident. The ADM stated CNA A was suspended on 01/08/26 when they learned of the incident and then terminated on 01/12/26 after the event was confirmed. She stated the facility then in-serviced CNA B one on one in a lengthy (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discussion on the importance of reporting events timely. In an interview on 01/21/26 at 12:17 PM with the SW, she stated she first learned of the incident involving Resident #1 after the DON went to her and instructed her she needed to complete a mental distress assessment for Resident #1. The SW stated Resident #1 reported to her, CNA A made inappropriate comments to him and asked if he was in a relationship and then said to Resident #1 if you ever get out of here come see me and provided her address. The SW stated Resident #1 was a young man and nice and it is not appropriate for her to say those things to him. The SW stated Resident #1 did have mild distress during her assessment and he did have worry there were times she was coming on to him but nothing physical ever happened, so he laughed it off as a joke. The SW stated Resident #1 expressed he did not want what happened to disrupt his placement at the facility. The SW stated she advised Resident #1 he did not do anything wrong and provided reassurance. She stated at the time Resident #1 did not have any injuries, no behavior changes. She stated it was the expectation for all staff that if they witnessed or heard of alleged abuse, sexual harassment or physical abuse that it should be reported immediately and on that shift. She stated a potential negative outcome of it going unreported would be the abuse or harassment could continue and other residents would be at risk from that employee. She went on to say that for the witness the person that did not report becomes liable as well. The SW stated CNA B stated she did not report the incident due to being threatened by CNA A. Record review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy last revised April 2021 reflected: Investigate and report any allegations within timeframes required by federal requirements.