STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675975	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Creek Rehabilitation and Nursing Center	705 N Main St Lumberton, TX 77657

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety 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** 25115 Based on interviews and record review, the facility failed to ensure residents the right to be free from abuse for 1 of 16 residents (Resident #2) reviewed for abuse. The facility failed to ensure Resident #2 was free from sexual abuse on 08/28/24 and 09/02/24. An IJ was identified on 11/19/24. The IJ began on 08/28/24 and was removed on 09/04/24. While the IJ was removed on 09/04/24, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm because all staff had not been trained on monitoring behaviors after an inappropriate behavior was identified. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: Record review of Resident #1's face sheet dated 11/19/24 indicated he was a [AGE] year-old male admitted on [DATE]. His diagnoses included unspecified intracranial injury without loss of consciousness (brain injury), major depressive disorder (mental disorder), and other sequelae of non-traumatic intracerebral hemorrhage (causes of stroke). Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated he had unclear speech, was rarely/never understood, usually understood others, had severely impaired cognitive skills, and utilized a wheelchair for mobility. Record review of Resident #1's electronic care plan dated 08/23/24 did not address sexually inappropriate behaviors. Record review of Resident #1's incident report dated 08/28/24 indicated Resident #1 was noted leaning against another resident (Resident #2) with his face at breast level flicking Resident #2's breast. Resident #1 was removed from the TV room and taken to his room. MD and RP notified. DON B documented If resident is brought to common areas, resident is to be kept away from other female residents. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Record review of Resident #1's incident report dated 09/02/24 indicated Resident #1 had his hand down a female resident's pants/briefs. DON B documented Resident #1 was removed from the area and taken to his room and placed on 1 to 1. The MD, RP, and police were notified. Resident #1 had his fingers in Resident #2's brief with pinky and palm visible outside of brief. Police notified the administrator that Resident #1 had a warrant out for his arrest. Record review of the facility investigation dated 09/04/24 indicated after police notification on 09/02/24 and prior to his discharge on 09/04/24, Resident #1 was arraigned by a judge in the facility for an outstanding warrant in another county for continuous sexual abuse of a child under [AGE] years. Record review of Resident #1's progress note dated 09/04/24 at 1:00 p.m. and completed by LVN P indicated Resident #1 discharged home with Family Member R. Record review of Resident #2's face sheet dated 08/28/24 indicated she was a [AGE] year-old female admitted on [DATE]. Her diagnoses included cerebral palsy (movement disorder), anxiety disorder (feelings of fear, dread, or uneasiness), conversion disorder with seizures or convulsions (mental health issue disrupts how the brain works), epilepsy (seizure disorder), and microcephaly (small head). Record review of Resident #2's progress note dated 08/28/24 at 2:03 p.m. completed by previous DON B indicated another resident was noted flicking Resident #2's breast in the TV room. Resident #2 was removed from the TV room, a skin assessment was completed, no psychosocial harm to resident. MD was notified and responsible party was called. Record review of Resident #2's care plan dated 08/28/24 indicated there was a report of alleged inappropriate flicking of her breast by a male resident while she was watching TV, in the TV room. Interventions included staff were to monitor and ensure accused perpetrator was not in the area of Resident #2. Record review of Resident #2's progress note dated 09/02/24 at 7:35 p.m. completed by LVN S indicated Resident #2 was in her wheelchair at the nursing station with another resident's hand inside Resident #2's pants/brief. Resident #2 was taken with LVN S to be monitored. Resident #2 was assessed head to toe. ADON, DON B, RP were notified. Telemed visit completed by NP DD. Record review of Resident #2's care plan dated 09/02/24 indicated staff observed a male resident with his hand inside the top of Resident #2's pants while she was seated in her wheelchair. Interventions included monitoring for psychological distress. Record review of Resident #2's progress note dated 09/02/24 at 9:17 p.m. completed by NP DD indicated Resident #2 was awake and alert and non-verbal at baseline. Resident #2 was assessed head to toe and no visible injures or distress noted. Nursing to continue to monitor Resident #2 for any changes or signs of distress. Record review of Resident #2's progress note dated 09/03/24 at 4:30 a.m. completed by LVN EE indicated Resident #2 continued to yell in room. Resident #2 was assisted up to her wheelchair and moved to nursing station with her tablet for activities. Resident #2 was closely monitored by staff. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Village Creek Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 705 N Main St Lumberton, TX 77657	

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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	Record review of Resident #2's progress note dated 09/03/24 at 8:33 a.m. completed by DON B indicated she spoke to NP DD regarding Resident #2. Resident #2 continued to holler out but resident was at her baseline. NP DD said to continue to monitor and notify MD of any changes. Record review of Resident #2's progress note dated 09/05/24 at 1:00 a.m. completed by LVN EE indicated Resident #2 continued to scream and yell and was one on one with the nurse. Notified physician. Received one time dose of Lorazepam and new referral for psych consult. Record review of Resident #2's social service note dated 09/05/24 at 2:30 p.m. completed by the Administrator indicated a psych services referral was made. Social worker will continue Resident #2's status. Record review of Resident #2's psych evaluation dated 09/08/24 at 2:46 p.m. completed by LVN I indicated the resident was assessed by psych services and there were no new orders. Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated she was rarely/never understood, usually understood others, had severe cognitive impairment, utilized a wheelchair for mobility, and was dependent on all ADLS. During an interview on 11/19/24 at 11:45 a.m., previous Administrator C said he was standing at the nurse's station with the maintenance staff on 08/28/24 (after the lunch meal). He said he observed that Resident #1 and Resident #2 were in the TV room common area. He said Resident #1's head was near Resident #2's breast, between the breast and armpit area. He said Resident #1 was flicking with his fingers between the breast and armpit area. He said Resident #1 was removed from the common area. He said the residents were assessed and there were no injuries. He said a care plan should have been developed and implemented on 08/28/24 to prevent further inappropriate sexual behaviors from Resident #1 and to protect Resident #2. He said a second incident occurred on 09/02/24 when Resident #1 was found with his fingers inside Resident #2's pants. He said Resident #1 had been brought from his room to the TV room common area and was watching TV. He said Resident #2 was near the nurse station. He said LVN I left the nurse's station to care for another resident. He said ADON J returned to the nurse's station area and observed Resident #1 had his fingers inside of Resident #2's pants. Previous Administrator C said Resident #1 and Resident #2 were immediately separated. He said Resident #1 was placed on 1 to 1. He said the residents were assessed and there were no injuries. He said the police were notified. He said the police requested the residents' face sheets. He said he received a call within 10 minutes of providing the face sheets to the police and was informed that the police had been looking for Resident #1, for the previous 6 months, as Resident #1 had an outstanding warrant for continuous sexual abuse of a child under the age of 14. He said Resident #1 remained on 1-1 supervision until he was arraigned by a judge (while at the facility). He said Resident #1 was discharged on [DATE] with Family Member R. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675975	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER Village Creek Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 705 N Main St Lumberton, TX 77657	

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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	During an interview on 11/19/24 at 12:36 p.m., ADON J said Resident #1 was not supposed to be around Resident #2. She said she could not recall if he was not supposed to be around all females. She said she could not recall any specific training regarding Resident #1's supervision or monitoring his behavior. She said she was working on 09/02/24. She said Resident #1 repeatedly left his bed and put himself on his floor. She said staff assisted him in his wheelchair and he was brought to the TV room common area. She said Resident #1 was adjacent to the nurse's station. She said she left the nurse's station to continue her duties and when she returned to the nurse's station area, she observed Resident #1 with his fingers inside Resident #2's pants. She said the residents were immediately separated. She said Resident #1 was resistant to moving his hand out of Resident #2's pants. She said she had to physically move his hand and arm away from Resident #2. She said Resident #1 was immediately placed on 1-1 supervision until he was discharged on [DATE]. She said she did not know how Resident #1 was left unsupervised. She said there were no current residents in the facility with identified sexually inappropriate behaviors. During an interview on 11/19/24 at 12:52 p.m., CNA D said that after the incident on 08/28/24, the staff were instructed to keep Resident #1 away from female residents. She said the facility's abuse prohibition policy was reviewed and it included that if you see anything report it and separate residents immediately if the abuse was resident on resident. During an interview on 11/19/24 at 12:56 p.m., MA E said that after the incident with Resident #1 and Resident #2 on 08/28/24, staff were instructed to keep Resident #1 away from Resident #2. During an interview on 11/19/24 at 1:04 p.m., RN F said after the first incident on 08/28/24, staff were told to keep Resident #1 away from Resident #2. During an interview on 11/19/24 at 1:10 p.m., MA G said after the first incident on 08/28/24, staff were instructed to report any type of abuse witnessed and to keep Resident #1 away from Resident #2. During an interview on 11/19/24 at 1:14 p.m., Activity Director H said after the first incident on 08/28/24, staff were to report any type of abuse seen and to keep Resident #1 away from Resident #2. During an interview on 11/19/24 at 1:21 p.m., previous MDS LVN K said she thought she updated Resident #2's care plan after the first and second incidents of sexually inappropriate behavior. She said she did not know why the care plans and interventions were not updated. She said there was a risk of further incidents of inappropriate sexual behaviors if the care plans and interventions were not updated immediately. During an interview on 11/19/24 at 2:48 p.m., RDO L said staff failure to follow the facility's abuse prevention policy could place residents at risk of abuse. She said previous Administrator C and previous DON B were in-serviced on 09/02/24 on types of abuse, investigation, interventions for mitigation, inappropriate resident to resident contact to include how to intervene, and 1 to 1 supervision of alleged perpetrator. She said facility staff had not been trained on monitoring behaviors after an inappropriate behavior was identified. She said Resident #1 should have been placed on 1 to 1 supervision after the first incident of inappropriate sexual behavior on 08/28/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/20/24 at 11:54 a.m., previous Administrator C said he was aware the nurses and aides supervised Resident #2 when he was in the common areas. However, there was no formal monitoring system or interventions in place for supervision. He said staff had not been trained on monitoring behaviors after an inappropriate behavior was identified. During an interview on 11/20/24 at 2:30 p.m., CNA M said on 09/02/24 he assisted Resident #1 to his wheelchair and brought him to the TV room. He said Resident #2 was not at the nurse's station when he brought Resident #1 to the TV room. He said he went on his break and when he returned from his break, he was made aware of Resident #1's fingers being inside of Resident #2's pants. He said Resident #1 was mobile with his wheelchair. He said he was aware of the previous incident of Resident #1's sexually inappropriate behavior on 08/28/24. He said he was trained to ensure Resident #1 was kept away from female residents. He had not been trained in monitoring behaviors after an inappropriate behavior was identified. During an interview on 11/21/24 at 9:05 a.m., previous DON B said Resident #1 was supposed to be set away from any other female residents. She said she was not aware Resident #1 was mobile with his wheelchair. She said if she were aware Resident #1 was mobile with his wheelchair, he would have been on 1-1 from the date of the first incident on 08/28/24. She said there were IDT meetings and care plan conferences after the incidents on 08/28/24 and 09/02/24 at risk of harm if there were insufficient interventions in place to protect Resident #2 and other female residents from Resident #1. During an interview on 11/21/24 at 11:15 a.m., the Administrator said residents were at risk of abuse when the facility's Abuse Prohibition Policy was not implemented. She said Resident #1 should have been on 1 to 1 staffing and his behavior monitored following the first incident of inappropriate sexual behavior on 08/28/24. She said Resident #1's care plan should have been reviewed, updated, and interventions implemented to prevent further inappropriate sexual behaviors and abuse. She said there were no current residents in the facility with identified sexually inappropriate behaviors. During an interview on 11/21/24 at 1:25 p.m., LVN I said he was aware of the first incident on 08/28/24 regarding Resident #1's inappropriate sexual behavior toward Resident #2. He said he was in-serviced to keep Resident #1 away from the female residents. He had not been trained in monitoring behaviors after an inappropriate behavior was identified. He said on 09/02/24, Resident #1 was in the TV room common area. He said Resident #2 was adjacent to the nurse's station. He said he saw another resident walking on a hall that should not have been walking and he went to assist the resident to bed. He said by the time he returned to the nurse station there was a lot of commotion, and he was made aware of Resident #1's fingers being inside of Resident #2's pants. He said he was not aware Resident #1 could move his wheelchair fast enough to make it over to Resident #2. (continued on next page)

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Village Creek Rehabilitation and Nursing Center	705 N Main St Lumberton, TX 77657

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F 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Record review of the facility's Abuse Prohibition Policy revised 11/07/23 indicated each resident has the right to be free from abuse, mistreatment, neglect, corporal punishment, involuntary seclusion, and financial abuse. 5. Resident identified as exhibiting abusive behaviors will be reviewed and have their treatment plans modified as appropriate. Protection: 1. All residents will be immediately protected from harm. 4. If another resident is the alleged perpetrator, they shall immediately be assessed for treatment options. The safety and protection of other residents is the facility's primary concern. Resident to Resident incidents: The following guidelines will be implemented when resident to resident incidences occur: 1. The staff observing the incident will immediately separate the residents involved. 2. The charge nurse will assess the victim to determine any injury. 3. Physician and family of both victim and perpetrator will be notified of the incident. The abuse coordinator will be immediately contacted. 6. The interdisciplinary team will make the determination what course of action needs to be taken with the perpetrator such as, but not limited to the following: *Immediate discharge from the facility due to potential of harm to other residents. *Can the behavior be controlled by location monitoring? The facility and physician of the perpetrator will be notified of the next steps. 7. If the perpetrator is placed on location monitoring, staff will be instructed on reason for monitoring and targeted behaviors being monitored. 8. If the perpetrator is on a behavioral contract, facility staff will be in-serviced accordingly, and the resident and family will be notified of the consequences. 9. If the perpetrator continues to exhibit inappropriate behaviors/or violates the behaviors identified on the behavioral contract, staff will immediately notify the Administrator/DON. 10. The team will conduct an emergency review to determine further course of action such as immediate discharge. 11. The victim will be seen by Social Services to determine further psychological support needed as well as follow up with physician/family. 13. If the incident involves sexual behavior, the following will occur: *Determine if both the victim and perpetrator are able to make decisions. *Determine if sexual contact was consensual. *If the contact was not consensual, follow steps 1-12. 1. Sexual abuse is non-consensual sexual contact of any type with a resident Sexual abuse includes, but is not limited to: a. unwanted intimate touching of any kind especially of breasts or perineal (genital) area; .

Record review of the facility's Resident Rights policy dated 04/2017 indicated . Residents shall: . g. Be free from mental, emotional, and physical abuse and neglect, from chemical or physical restraints, and from financial exploitation and misappropriation of property; .

During interviews on 11/19/24, 11/20/24, and 11/21/24 with staff who represented all shifts, (the current Administrator, 1 ADON, 2 RNs, 5 LVNs, 8 CNAs, 4 medication aides, 1 maintenance supervisor, 1 activity director, and 1 human resource officer) were able to give examples of abuse and neglect, would report immediately to the abuse coordinator or designee, were aware there was no current resident in the facility identified with inappropriate sexual behaviors, and were aware of the facility's 1 to 1 monitoring protocol for alleged perpetrators.

Record review of the facility's in-service records dated 08/28/24 indicated Resident #1 was to be kept away from female residents.

Record review of an in-service dated 09/02/24 indicated previous Administrator C and previous DON B were in-serviced on types of abuse, investigation, interventions for mitigation, inappropriate resident to resident contact to include how to intervene, and 1 to 1 supervision of alleged perpetrator.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of in-service dated 09/02/24, 09/08/24 and 09/13/24 indicated 43 out of 53 staff indicated staff were retrained and tested on abuse and neglect prevention and reporting, inappropriate resident to resident contact, how to intervene, and 1 to 1 supervision of alleged perpetrators. The remaining staff would be trained prior to working any shift. The facility incorporated the same training into new hire orientation as of 09/02/24. An IJ was identified on 11/19/24. The IJ began on 08/28/24 and was removed on 09/04/24. While the IJ was removed on 09/04/24, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm because all staff had not been trained on monitoring behaviors after an inappropriate behavior was identified. 36214

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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 25115

Based on interviews 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 result 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 16 residents (Resident #6) reviewed for reporting allegations of neglect.

The facility failed to report an allegation of neglect within 24 hours to the State Agency when it was reported on 04/22/24 that Resident #6 only received trach care 1 time per week.

This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress.

Findings included:

Record review of Resident #6's face sheet dated 11/19/24 indicated he was a [AGE] year-old male, admitted on [DATE], and his diagnoses included quadriplegia paralysis of both arms and legs and tracheostomy (surgical opening in the neck to help air and oxygen reach the lungs).

Record review of Resident #6's quarterly MDS assessment dated [DATE] indicated he was able to make himself understood and understood others, he was cognitively intact (BIMS 14), utilized a wheelchair, was dependent for all ADLS, and received tracheostomy care and oxygen therapy.

Record review of Resident #6's care plan dated 11/21/23 indicated Resident #6 had a tracheostomy. Interventions included ensure trach ties were secured at all times, monitor and document for restlessness, agitation, confusion, increased heart rate, monitor and document level of consciousness, mental status and lethargy PRN, oxygen settings via trach at 5 L, humidified 28%, provide good oral care daily and PRN, and suction as necessary.

Record review of physician orders for Resident #6 dated 01/24/24 indicated tracheostomy suction every 4 hours and PRN.

Record review of physician orders for Resident #6 dated 01/31/24 indicated tracheostomy care every shift and PRN.

Record review of MAR/TAR for Resident #6 dated 04/2024 indicated tracheostomy care was completed as ordered.

Record review of Resident #6's nurse note dated 03/29/24 at 1:00 p.m., completed by ADON J, indicated Resident #6 discharged home with Family Member Q.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility investigation dated 05/02/24 indicated Resident #6's Family Member Q alleged on 04/22/24 that Resident #6 only received tracheostomy care 1 time per week prior to his discharge on 03/29/24. The allegation was not substantiated. During an interview on 11/20/24 at 9:49 a.m., previous Administrator C said he was the abuse coordinator (while administrator) and had received an email from the corporate office with an allegation of neglect on 04/22/24. He said he misread the email and did not notice the email included the allegation of neglect. He said when he was made aware of the allegation of neglect on 04/25/24, he reported it to HHS. He said he knew the allegation of neglect was reportable within 24 hours. He said it was his mistake. Record review of the facility's Abuse Prohibition Policy dated 05/201 and reviewed on 05/17/2025 indicated . Neglect is defined as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, mental anguish, or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, good or services that a resident(s) requires but the facility fails to provide them to the resident(s), that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress. Neglect includes cases where the facility's indifference or disregard for resident care, comfort, or safety, resulted in or could have resulted in, physical harm, pain, mental anguish, or emotional distress. Investigation . 2. The Abuse Coordinator will report such allegations to the state agency in accordance with state law. The Abuse Coordinator will report all allegations of abuse, neglect with serious bodily injury, mistreatment with serious bodily injury, exploitation with serious bodily injury, and injuries of unknown source with serious bodily injury within two hours of the allegation. The Abuse Coordinator will report all other allegations of neglect, mistreatment, exploitation, injuries of unknown source and misappropriation within 24 hours of the allegation.Reporting/Response: . 2. The facility will report all allegations and substantiated occurrences of abuse, neglect, or misappropriation of resident property to the state agency and to all other agencies as required by law and will take all necessary corrective actions depending on the results of the investigation. The Abuse Coordinator will report all allegations of abuse, neglect with serious bodily injury, mistreatment with serious bodily injury, exploitation with serious bodily injury, and injuries of unknown source with serious bodily injury immediately or within two hours of the allegation. The Abuse Coordinator will report all other allegations of neglect, mistreatment, exploitation, injuries of unknown source and misappropriation within 24 hours of the allegation. 36214

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on interviews and record review, the facility failed to develop and implement the comprehensive person-centered care plan used to maintain the resident's highest practicable physical well-being for 2 of 16 residents (Resident #1 and Resident 3) reviewed for care plans. 1. The facility failed to develop and implement interventions in the care plan to prevent Resident #1's sexual abuse of Resident #2. An IJ was identified on 11/19/24. The IJ began on 08/28/24 and was removed on 09/04/24. While the IJ was removed on 09/04/24, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm because resident care plans were not reviewed and revised. 2. The facility failed to develop and implement Resident #3's care plan and interventions to prevent Resident #3's verbal and emotional abuse of Resident #4. These failures could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: 1. Record review of Resident #1's face sheet dated 11/19/24 indicated he was a [AGE] year-old male admitted on [DATE]. His diagnoses included unspecified intracranial injury without loss of consciousness (brain injury), major depressive disorder (mental disorder), and other sequalae of non-traumatic intracerebral hemorrhage (causes of stroke). Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated he had unclear speech, was rarely/never understood, usually understood others, had severely impaired cognitive skills, and utilized a wheelchair for mobility. Record review of Resident #1's electronic care plan dated 08/23/24 did not address sexually inappropriate behaviors. Record review of Resident #1's incident report dated 08/28/24 indicated Resident #1 was noted leaning against another resident (Resident #2) with his face at breast level flicking Resident #2's breast. Resident #1 was removed from the TV room and taken to his room. MD and RP notified. DON B documented If resident is brought to common areas, resident is to be kept away from other female residents. Record review of Resident #1's incident report dated 09/02/24 indicated Resident #1 had his hand down a female resident's pants/briefs. DON B documented Resident #1 was removed from the area and taken to his room and placed on 1 to 1. The MD, RP and police were notified. Resident #1 had his fingers in Resident #2's brief with pinky and palm visible outside of brief. Police notified administrator Resident #1 had a warrant out for his arrest. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675975	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Creek Rehabilitation and Nursing Center	705 N Main St Lumberton, TX 77657

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility investigation dated 09/04/24 indicated after police notification on 09/02/24 and prior to his discharge on 09/04/24, Resident #1 was arraigned by a judge in the facility for an outstanding warrant in another county for continuous sexual abuse of a child under [AGE] years. Record review of Resident #1's progress note dated 09/04/24 at 1:00 p.m. and completed by LVN P indicated Resident #1 discharged home with his family member. 2. Record review of Resident #2's face sheet dated 08/28/24 indicated she was a [AGE] year-old female admitted on [DATE]. Her diagnoses included cerebral palsy (movement disorder), anxiety disorder (feelings of fear, dread, or uneasiness), conversion disorder with seizures or convulsions (mental health issue disrupts how the brain works), epilepsy (seizure disorder), and microcephaly (small head). Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated she was rarely/never understood, usually understood others, had severe cognitive impairment, utilized a wheelchair for mobility, and was dependent for all ADLS. Record review of Resident #2's care plan dated 08/28/24 indicated there was a report of alleged inappropriate flicking of her breast by a male resident while she was watching TV in the TV room. Interventions included staff were to monitor and ensure accused perpetrator was not in the area of Resident #2. Record review of Resident #2's care plan dated 09/02/24 indicated staff observed a male resident with his hand inside the top of Resident #2's pants while she was seated in her wheelchair. Interventions included monitoring for psychological distress. 3. Record review of Resident #3's face sheet dated 11/20/24 indicated she was a [AGE] year-old female, admitted on [DATE], and her diagnoses included persistent mood affective disorder (low mood lasting for years), major depressive disorder (persistently depressed mood), anxiety disorder, and unspecified intellectual disabilities. Record review of Resident #3's quarterly MDS assessment dated [DATE] indicated she was able to make herself understood, she understood others, was cognitively intact (BIMS score 15), and required minimal assist for some ADLS. Record review of Resident #3's electronic care plan dated 09/25/24 did not include verbal and emotional abuse of Resident #4. 4. Record review of Resident #4's face sheet dated 11/20/24 indicated he was a [AGE] year-old male admitted on [DATE] and his diagnoses included schizophrenia (mental disorder), unspecified psychosis (disconnection from reality), major depressive disorder, anxiety disorder, and unspecified intellectual disabilities. Record review of Resident #4's quarterly MDS assessment dated [DATE] indicated he was able to make himself understood and understood others, was cognitively intact (BIMS score of 13), and required supervision for some ADLS. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #4's care plan dated 10/25/23 indicated he was spiritually married to Resident #3 and they had a set of babies, and he was at risk for psychosocial issues related to his knowledge the babies were not real, and his wife believed they were real. Interventions included talking about feelings related to current personal situation, continue to go to (named provider) and speak with a counselor), and encourage Resident #4 to speak with Resident #3 about his feelings. Record review of Resident #4's care plan dated 04/01/24 indicated he was at risk for depression related to accusations and emotional manipulation. On 03/29/24, (named provider) reported Resident #4 was in emotional distress from Resident #3. Interventions included discussing concerns, fears, issues, and encouraging Resident #4 to express feelings. Record review of the facility investigation dated 04/11/24 indicated Resident #4's psych counselor alleged Resident #4 reported that Resident #3 made emotionally abusive comments towards Resident #4. Resident #3 was removed from their room. Resident #3 denied the allegations. Resident #3 and Resident #4 were in-serviced regarding emotional/verbal abuse, emotional abuse vs normal conflict, isolating others, and threatening behavior. Staff were in-serviced on abuse/neglect, emotional abuse, customer service, and resident rights. Safe surveys were completed with no concerns found. Resident #3 and Resident #4 were interviewed and said the allegations were a misunderstanding and the residents wanted to return to live in the same room. The facility continued to monitor Resident #3 and Resident #4's relationship. There were no addtional concerns noted as of 11/21/24. During an interview on 11/19/24 at 11:15 a.m., Resident #4 said he never wanted to be separated from Resident #3. He said he never felt he was abused. He said he felt safe living in the same room with Resident #3 and he wanted to move back in with Resident #3. He said they were married and he loved Resident #3. He said he received information on abuse and continued to attend day services of his choice. (continued on next page)

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	675975	A. Building B. Wing	11/21/2024

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/19/24 at 11:45 a.m., previous Administrator C said he was standing at the nurse's station with the maintenance staff on 08/28/24 (after the lunch meal). He said he observed that Resident #1 and Resident #2 were in the TV room common area. He said Resident #1's head was near Resident #2's breast, between the breast and armpit area. He said Resident #1 was flicking with his fingers between the breast and armpit area. He said Resident #1 was removed from the common area. He said the residents were assessed and there were no injuries. He said a care plan should have been developed and implemented on 08/28/24 to prevent further inappropriate sexual behaviors from Resident #1 and to protect Resident #2. He said a second incident occurred on 09/02/24 when Resident #1 was found with his fingers inside Resident #2's pants. He said Resident #1 had been brought from his room to the TV room common area and was watching TV. He said Resident #2 was near the nurse station. He said LVN I left the nurse's station to care for another resident. He said ADON J returned to the nurse's station area and observed Resident #1 had his fingers inside of Resident #2's pants. Previous Administrator C said Resident #1 and Resident #2 were immediately separated. He said Resident #1 was placed on 1 to 1. He said the residents were assessed and there were no injuries. He said the police were notified. He said the police requested the residents' face sheets. He said he received a call within 10 minutes of providing the face sheets to the police and was informed that the police had been looking for Resident #1, for the previous 6 months, as Resident #1 had an outstanding warrant for continuous sexual abuse of a child under the age of 14. He said Resident #1 remained on 1-1 supervision until he was arraigned by a judge (while at the facility). He said Resident #1 was discharged on [DATE] with Family Member R. He said he was informed by CM N of Resident #3's alleged verbal and emotional abuse of Resident #4. He said there was a care plan conference and Resident #3's care plan was supposed to be reviewed and updated to include the allegation of alleged verbal and emotional abuse. He said the previous MDS LVN K was responsible for updating resident care plans. He said he was not aware Resident #3's care plan was not updated. During an interview on 11/19/24 at 12:36 p.m., ADON J said Resident #1 was not supposed to be around Resident #2. She said she could not recall if he was not supposed to be around all females. She said she could not recall any specific training regarding Resident #1's supervision or monitoring his behavior. She said she was working on 09/02/24. She said Resident #1 repeatedly left his bed and put himself on his floor. She said staff assisted him in his wheelchair and he was brought to the TV room common area. She said Resident #1 was adjacent to the nurse's station. She said she left the nurse's station to continue her duties and when she returned to the nurse's station area, she observed Resident #1 with his fingers inside Resident #2's pants. She said the residents were immediately separated. She said Resident #1 was resistant to moving his hand out of Resident #2's pants. She said she had to physically move his hand and arm away from Resident #2. She said Resident #1 was immediately placed on 1-1 supervision until he was discharged on [DATE]. She said she did not know how Resident #1 was left unsupervised. She said there were no current residents in the facility with identified sexually inappropriate behaviors. During an interview on 11/19/24 at 1:21 p.m., previous MDS LVN K said she thought she updated Resident #2's care plan after the first and second incidents of sexually inappropriate behavior. She said she did not know why the care plans and interventions were not updated. She said there was a risk of further incidents of inappropriate sexual behaviors if the care plans and interventions were not updated immediately. She said she did not know why Resident #3's care plan was not updated after it was alleged, she verbally and emotionally abused Resident #4. She said she thought she updated the care plan and put interventions in place as required after the care conferences. (continued on next page)

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F 0656

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

During an interview on 11/20/24 at 11:54 am., CM O said Resident #3 was verbally assaultive toward Resident #4. She said Resident #4 said Resident #3 was making him stay home to take care of the baby dolls with her. She said Resident #4 indicated Resident #3 threatened Resident #4 with divorce and would throw her wedding rings at him. She said there was a care plan conference and Resident #3 understood what she was doing was not right. She said Resident #3 never said he was abused.

During an interview on 11/20/24 at 2:30 p.m., CNA M said on 09/02/24 he assisted Resident #1 to his wheelchair and brought him to the TV room. He said Resident #2 was not at the nurse's station when he brought Resident #1 to the TV room. He said he went on his break and when he returned from his break, he was made aware of Resident #1's fingers being inside of Resident #2's pants. He said Resident #1 was mobile with his wheelchair. He said he was aware of the previous incident of Resident #1's sexually inappropriate behavior on 08/28/24. He said he was trained to ensure Resident #1 was kept way from female residents. He had not been trained in monitoring behaviors after an inappropriate behavior was identified.

During an interview on 11/21/24 at 9:05 a.m., previous DON B said Resident #1 was supposed to be set away from any other female residents. She said she was not aware Resident #1 was mobile with his wheelchair. She said if she were aware Resident #1 was mobile with his wheelchair, he would have been on 1-1 from the date of the first incident on 08/28/24. She said there were IDT meetings and care plan conferences after the incident on 08/28/24 and 09/02/24 and the previous MDS LVN K was responsible for updating the resident care plans. She said she did not know why Resident #1's care plan was not updated. She said the corporate MDS supervisor was responsible for ensuring the care plans were updated as required. She said other residents were at risk of harm if there were insufficient interventions in place to protect Resident #2 and other female residents from Resident #1. She said Resident #4's care plan should have been reviewed, updated, and interventions implemented to prevent further verbal and emotional abuse of Resident #3.

During an interview on 11/21/24 at 11:32 a.m., RDO L said any of the nurse staff could update resident care plans. She said previous Administrator C and previous DON B were responsible for ensuring resident care plans and interventions were updated. If care plans were not updated as required, residents were at risk of not receiving care and services required.

During an interview on 11/20/24 at 11:54 a.m., previous Administrator C said Resident #1's care plan should have been updated to keep him away from all female residents. He said Resident #3's care plan should have been reviewed, updated, and interventions implemented to prevent further verbal and emotional abuse of Resident #4.

During an interview on 11/21/24 at 11:15 a.m., the Administrator said Resident #1's care plan should have been reviewed, updated, and interventions implemented to prevent further inappropriate sexual behaviors and abuse. She said Resident #3's care plan should have been reviewed, updated, and interventions implemented to prevent further verbal and emotional abuse of Resident #4.

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/21/24 at 1:25 p.m., LVN I said he was aware of the first incident on 08/28/24 regarding Resident #1's inappropriate sexual behavior toward Resident #2. He said he was in-serviced to keep Resident #1 away from the female residents. He had not been trained in monitoring behaviors after an inappropriate behavior was identified. He said on 09/02/24, Resident #1 was in the TV room common area. He said Resident #2 was adjacent to the nurse's station. He said he saw another resident walking on a hall that should not have been walking and he went to assist the resident to bed. He said by the time he returned to the nurse station there was a lot of commotion, and he was made aware of Resident #1's fingers being inside of Resident #2's pants. He said he was not aware Resident #1 could move his wheelchair fast enough to make it over to Resident #2. Record review of the facility's Comprehensive Person-Centered Care Plan policy dated 10/2022 indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.8. Incorporate identified problem areas; . An IJ was identified on 11/19/24. The IJ began on 08/28/24 and was removed on 09/04/24. While the IJ was removed on 09/04/24, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm because resident care plans were not reviewed and revised. 36214

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 36214 Based on interviews and record review, the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 16 residents (Resident #5) reviewed for accuracy of clinical records. The facility did not ensure ADL care was documented for Resident #5 on the ADL task sheet. This failure could place residents at risk of not receiving care and services to meet their needs. Findings included: Record review of a face sheet dated 11/21/24 indicated Resident #5 was an [AGE] year-old female admitted on [DATE]. Her diagnoses included cerebral infarction (a medical condition that occurs when blood flow to the brain is disrupted, causing brain cells to die) and atherosclerotic heart disease of native coronary artery (a condition where plaque builds up in the arteries that supply blood to the heart). Record review of an admission evaluation dated 12/29/23 indicated Resident #5 was independent with bed mobility, required supervision assistance to transfer, required one-person physical assistance with dressing, personal hygiene, and toileting, and required supervision with meals for set up, cuing, and reminders of mealtimes. Record review of an ADL task sheet dated December 2023 and initialed by CNA I indicated Resident #5 was provided limited assistance with bed mobility, toileting, transferring, and partial/moderate assistance with sitting to standing and transferring to the toilet on 12/29/24 during the 2:00 p.m. to 10:00 p.m. shift. No further ADL assistance was documented for 12/30/23 or 12/31/23. Record review of a discharge MDS dated [DATE] indicated Resident #5 had a memory problem and had some difficulty in new situations, required setup/clean up assistance with eating, required partial/moderate assistance with bed mobility, and maximal assistance for sit to stand and toileting. She was always continent of bladder and always incontinent of bowel. During an interview on 11/21/24 at 8:42 a.m., the ADON said that CNAs were to document all ADL care assistance for all residents on the ADL task sheets every shift. She said CNAs complete their facility orientation and during orientation they receive sign on information for the electronic medical record. She said CNAs were then assigned with another CNA to become familiar with resident care and documentation of task sheets. She said the DON, the ADON, and the charge nurses were responsible for overseeing that CNAs charted all ADL care assistance. She reviewed Resident #5's task sheets and said the documentation of ADL assistance was not completed for 12/30/23 and 12/31/23. She said the facility policy indicated if care was not documented it was not done. She said the possible negative outcome of not documenting care given could be that residents might not receive needed care. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/24 at 11:25 a.m. CNA N said she did not remember Resident #5 but stated the task sheet indicated she had assisted her with care. She said that administration had been stressing to all CNAs the importance of documenting ADL care given on the task sheets, but missing documentation was always a problem. During an interview on 11/21/24 at 11:30 a.m., the Administrator said she expected all ADL assistance to be documented completely and accurately on the task sheets. She said possible negative outcome of inaccurate medical records could be residents not receiving services as needed. Record review of the facility policy titled Charting and Documentation last revised July 2017, indicated All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.