STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675981	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mineola Heights Healthcare Centre	716 Mimosa Street Mineola, TX 75773

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** 33249 Based on observation, interview, and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 2 of 9 residents (Residents #1 and #2) reviewed for abuse. The facility failed to ensure CNA A did not sexually abuse Resident #1 during his shower earlier in the week of January 5, 2025 - January 9, 2025, when he allegedly placed his finger in his rectum. The facility failed to ensure CNA A did not sexually abuse Resident #2 during a shower provided during the period of December 28, 2024, and December 29, 2024, when he allegedly attempted to place his finger in his rectum. The noncompliance was identified as PNC. The Immediate Jeopardy (IJ) noncompliance began on 1/11/2025 and ended on 1/11/2025. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for emotional distress, fear, decreased quality of life, and further abuse. Findings included: 1)Record review of a face sheet dated 1/21/2025 indicated Resident #1 was a [AGE] year-old male, who admitted on [DATE] with the diagnosis of blindness (loss of vision), major depressive disorder (clinical depression, is a mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest in normally enjoyable activities), and intellectual disabilities (condition that limits intelligence and disrupts abilities necessary for living independently). (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
	675981	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mineola Heights Healthcare Centre	716 Mimosa Street Mineola, TX 75773

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	Record review of Resident #1's Annual MDS assessment dated [DATE] indicated Resident #1 in Section A1510 Level II Preadmission Screening and Resident Review (PASRR) conditions was marked as having an intellectual disability. The MDS indicated Resident #1 usually was understood, and usually understood others. The MDS indicated Resident #1 had a severely impaired vision (no vision or sees only light, colors or shapes; eyes do not appear to follow objects). The MDS indicated Resident #1's BIMS score was 5 indicating severe cognitive impairment. The MDS indicated Resident #1 had no physical, verbal, or other behaviors directed at others. The MDS indicated Resident #1 had rejected care 1-3 days during the assessment period. The MDS in the section F Preferences for Customary Routine and Activities Resident #1 indicated it was very important to him to him choose between a tub bath, shower, bed bath, or sponge bath. The MDS in Section GG-Functional Abilities and Goals indicated Resident #1 required substantial/maximal assistance with bathing, and partial/moderate assistance with dressing and personal hygiene. Record review of Resident #1's comprehensive care plan dated 9/24/2021 and revised on 5/06/2024 indicated Resident #1 had an ADL self-care performance deficit related to his blindness. The care plan goal was Resident #1 would maintain his current level of function. The interventions of the care plan included Resident #1 would be allowed to perform tasks as much as possible, bathing/showering, and personal hygiene he required assistance of one staff. The care plan indicated Resident #1 used antidepressant medication related to depression. The goal of this care plan was Resident #1 would be free from discomfort related to the use of antidepressant therapy. The interventions for Resident #1 included to administer the antidepressant medication, and to monitor, document, and report any adverse reactions to the antidepressant, a change in behavior/mood/cognition, social isolation, and social isolation. Record review of a hospital emergency room discharge form dated 1/11/2025 indicated Resident #1 was seen at the local emergency room and discharged on [DATE] with the primary diagnosis of sexual assault of adult. The triage notes section of the discharge form indicated Resident #1 arrived by EMS from the nursing facility. The note indicated Resident #1 arrived with complaints of sexual assault for unknown amount of time. The note indicated Resident #1 stated his caregiver had penetrated his rectum with a finger during showers. The note indicated Resident #1 indicated the last event was last week, and he had been refusing showers since then. The note indicated the family requested the transfer to the emergency room for a SANE (Sexual Assault Nurse Examination) exam. The history and physical portion of the discharge note indicated Resident #1 had intellectual disability, chronic kidney disease, and legal blindness. The history and physical noted Resident #1 had a complaint of sexual assault for an unknown period of time with a caregiver in the nursing facility that penetrated the patient's rectum on multiple occasions with his finger while the patient (Resident #1) was showering. The note indicated the patient (Resident #1) had been refusing to shower the past week and his family requested a SANE exam. The note indicated the patient (Resident #1) endorsed rectum pain, denied abdominal or leg pain, dysuria, or blood in his stool. The note indicated the family indicated even if Resident #1 had blood stool he was unable to see the stool due to his blindness. The note in the Review of Systems portion indicated in the gastrointestinal section indicated Resident #1 was positive for rectal pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675981	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mineola Heights Healthcare Centre	716 Mimosa Street Mineola, TX 75773

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	Record review of the Provider Investigation Report dated 1/14/2025 indicated the state agency was notified on 1/11/2025 at 11:15 a.m., of the allegation of abuse occurring on 1/07/2025 with no time of day indicted occurring in the shower. The Provider Investigation Report indicated Resident #1 was independently ambulatory, able to be interviewed, but was unable to make decisions. The Provider Investigation Report indicated Resident #1 had a history of false allegations of embellishing tales of attention, refusing showers, and refusing medications. The Provider Investigation Report indicated the alleged perpetrator was identified by name, and was identified as CNA A. The Provider Investigation Report indicated CNA A denied the allegation. The Provider Investigation Report indicated Resident #1 was sent to the local hospital emergency room and the local police was notified with a case # 2500025. The Provider Investigation Report indicated Resident #1's physician, family member, and the ombudsman were notified. Record review of an Employee Timecard dated 1/11/2025 indicated CNA A worked on 1/01/2025 from 6:13 a.m. - 6:30 p.m., 1/02/2025 from 6:10 a.m. - 7:15 a.m., 1/06/2025 from 6:12 a.m. - 7:00 p.m., 1/07/2025 from 6:13 a.m. - 6:45 p.m., 1/10/2025 from 6:02 a.m. - 7:15 p.m., and on 1/11/2025 from 6:05 a.m. - 9:22 a.m. Record review of an undated ADL sheet indicated Resident #1 received a shower from CNA A 1/02/2025, and then again on 1/07/2025. The ADL sheet documentation had no further baths provided from 1/08/2025 - 1/21/2025. Record review of a daily staff schedule dated 1/06/2025 indicated CNA A was scheduled to work on halls 200, 300, and 400. Record review of a daily staff schedule dated 1/07/2025 indicated CNA A was scheduled to work on halls 200, 300, and 400. Record review of a daily staff schedule dated 1/10/2025 indicated CNA A was scheduled to work on halls 200, 300, and 400. Record review of a daily staff schedule dated 1/11/2025 indicated CNA A was scheduled to work with no specified halls. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675981	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mineola Heights Healthcare Centre	716 Mimosa Street Mineola, TX 75773

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	Record review of the Police Report dated 1/11/2025 at 9:43 a.m., indicated a crime/incident of aggravated sexual assault of another person was reported. The suspect was named as CNA A, and the victim was Resident #1, the reporter was LVN B. The report indicted he received the report from LVN B upon arrival that Resident #1 had identified CNA A as the individual who had inserted his finger into his rectum while taking a shower. The officer documented upon arrival at the facility, LVN B indicated she had to send CNA A home, then he was escorted to Resident #1's room. The officer wrote Resident #1 was accompanied with his family member. The officer wrote Resident #1 said yes, he wanted to make a report on a staff member. The officer wrote Resident #1 said he had a finger in my butt. The report indicated Resident #1 made a fist with his right hand and pointing his index finger straight out. The report indicated Resident #1 made a motion suggesting CNA A was inserting his finger in and out of his anus. The report indicated Resident #1 said when I take a shower, he put a finger in my butt. The officer documented when he asked Resident #1 how long this had occurred, he indicated a long time. The report indicated the family member said a couple of months ago when out of the facility Resident #1 complained his butt was sore. The report indicated Resident #1 indicated CNA A plays the music too loud in the shower too. The report indicated Resident #1 said, In the shower, he keeps the thing too loud, and when he is doing that thing in my butt with it. The report indicated the family member stated they could identify CNA A. The report indicated Resident #1 said he wanted to go to the hospital. The report indicated the officer spoke to the Administrator and gained information on CNA A. The Administrator was noted informing the officer Resident #1 had behaviors of telling falsehoods but never this severe. The report indicated LVN B indicated CNA A had played music on his phone. The officer ended the report with Resident #1 was transferred to the local hospital, but the hospital was not equipped with the specialized SANE nurse and therefore was transferred to a larger hospital. Lastly the report indicated the case was referred to the criminal investigation division for further investigation. During an observation and interview on 1/21/2025 at 10:54 a.m., Resident #1 was making his bed when the surveyor entered his dark room. Resident #1 said CNA A had given him a shower last week. Resident #1 said CNA A penetrated his rectum with CNA A's penis. Resident #1 was asked to clarify was it CNA A's penis or finger. Resident #1 again indicated he was penetrated in his rectum by CNA A's penis while he received his shower. Resident #1 also indicated the rock and roll music was too loud in the shower playing on CNA A's personal phone. Resident #1 was unable to cognitively express how the alleged actions of CNA A made him feel but said that was why he refused his next shower. During an interview on 1/21/2025 at 11:21 a.m., LVN B said Resident #1's family member came to her on Saturday 1/11/2025 and indicated Resident #1 refused his shower because he indicated CNA A's finger goes in and out of his butt when he was last showered. LVN B said she notified the Administrator immediately of the allegation, and was advised to send CNA A home immediately, to call 911 to send Resident #1 to the hospital, and then notify the local police. LVN B said she had not performed an assessment of Resident #1 prior to leaving with emergency personnel. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675981	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mineola Heights Healthcare Centre	716 Mimosa Street Mineola, TX 75773

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	During an interview on 1/21/2025 at 11:48 a.m., Resident #1's family member said she arrived for a visit with Resident #1 on 1/11/2025. The family said Resident #1 told her CNA A had touched his butthole making a moving motion and this was why he refused his shower. The family member said she went to the nurse and reported what Resident #1 had said. The family member said Resident #1 retold the same information to the local police officer, hospital staff, and the police officer who arrived at the hospital. The family member said the nurse performing the examination said Resident #1 had tearing around his anus. The family member said Resident #1 had never made any allegations in the past regarding sexual abuse, and this behavior of making this type of allegation was not his normal behavior. The family member said Resident #1's emotional behavior seemed scared to bathe. The family member indicated Resident #1 was usually very happy and cooperative. During an interview on 1/21/2025 at 11:58 a.m., CNA A said on Tuesday 1/07/2025 in the morning hours he took Resident #1 to the shower. CNA A said he provided Resident #1 with a shower and a shave that time and numerous other times. CNA A said Resident #1 could perform portions of his showers but required the physical assistance of making sweeping motions to Resident #1's buttocks and then said Resident #1 was able to perform cleansing of his genitals. CNA A said Resident #1 thanked him for the shower and shave afterwards. Therefore, he believed there were no issues. CNA A said on Saturday 1/11/2025 in the morning hours, he was providing care to another resident when he was approached by the nurse and advised he had to leave immediately there was an allegation of abuse. CNA A said after exiting the resident's room he was informed of the allegation that Resident #1 indicated in which he placed a finger in Resident #1's anus during a shower. CNA A then denied the allegations made by Resident #1. When asked about any other allegations of this nature CNA A indicated he had been named in an allegation in 2023 with the exact same allegation of putting a finger in the rectum. When asked about the findings of the previous allegations, he replied the resident was no longer residing in the facility, and the results were not confirmed because the resident did not like me. CNA A said he could not explain how two residents not knowing each other could have the exact same allegation against him. CNA A said an allegation of this type was considered sexual abuse, should be reported immediately to the abuse coordinator being the administrator immediately. CNA A said he had resigned his position as CNA on Wednesday 1/15/2025 and was not currently employed but was seeking employment elsewhere. CNA A said he had not been interviewed by the local police. 2)Record review of a face sheet dated 1/21/2025 indicated Resident #2 was a [AGE] year-old male who admitted on [DATE] and readmitted on [DATE] with the diagnoses of heart failure, and Parkinson's disease (a movement disorder of the nervous system that worsens over time). Record review of a Significant Change MDS dated [DATE] indicated Resident #2 was understood and understands others. The MDS indicated Resident #2's BIMS score was a 13 indicating he had no cognitive issues. The MDS in Section E-Behaviors there was no indications Resident #2 had any physical, verbal, or other behaviors affecting others. The MDS also indicated Resident #2 had not refused care. The MDS in Section F-Preferences for Customary Routine indicated Resident #2 said it was very important for him to choose between a tub bath, shower, bed bath, or sponge bath. The MDS indicated in Section GG-Functional Abilities and Goals indicated Resident #2 required partial to moderate assistance with shower/bathe Record review of a Comprehensive Care Plan dated 7/04/2023 and a revision date of 1/12/2024 indicated Resident #2 had an ADL self-care performance deficit related to his Parkinson's disease. The goal of the care plan was Resident #2 would maintain his current level of function. The interventions included the provision of one staff for assistance with bathing, dressing, toileting, and transfers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675981	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mineola Heights Healthcare Centre	716 Mimosa Street Mineola, TX 75773

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	Record review of a shower schedule dated 12/28/2024 indicated CNA C marked Resident #2 as showered. Record review of a Daily Staffing Schedule dated 12/28/2024 indicated CNA A was scheduled to work. The Daily Staffing Schedule had CNA A handwritten in for halls 200, 300, and 400. Record review of a Safe Survey dated 1/11/2025 at 11:08 a.m., the HR/BOM asked Resident #2: *Has someone (resident or staff) touched you in a way that made you feel uncomfortable example sexually? Resident #2's answer was marked no. *Has someone (resident or staff) made sexual comments or statements to you? Resident #2's answer was marked no. *Has someone (resident or staff) shown you pictures, videos, or other materials of sexual nature? Resident #2's answer was marked no. *Does staff treat you with respect? Sometimes, depends on the person or agency was Resident #2's answer. During an interview on 1/21/2025 at 1:35 p.m., Resident #2 was asked if he had ever been abused by anyone who worked at the facility. Resident #2 said, yes I have. Resident #2 seemed hesitant to explain when asked by pausing. Although we were in his room, and privately talking he would look past me watching the door. Resident #2 said approximately 3 weeks ago, CNA A provided him with a shower, and during the shower he attempted to put his finger in his rectum. Resident #2 said when CNA A was attempting to place his finger in his rectum, he quickly moved in the shower chair, so his anus was not exposed, and Resident #2 said CNA A stopped. When asked to further explain why he failed to tell staff when the staff asked about any abuse, Resident #2 said I did not tell them the truth and I should have told them the truth, but I felt as though they would have thought I was a troublemaker. Resident #2 went on to say he felt embarrassed to talk about it and said, I felt cheap. Resident #2 agreed to tell the staff when I returned with a team member. During an interview on 1/21/2025 at 1:40 p.m., the DON entered Resident #2's room with the surveyor. Resident #2 was asked to inform the DON what he had just reported. Resident #2 then said to the DON, I should have told you when I was asked about being abused but I thought I would be making trouble for CNA A. Resident #2 informed the DON that CNA A attempted to put his finger inside his rectum during a shower approximately 3 weeks ago. Resident #2 said he could not remember the exact day it occurred. Resident #2 said on that day he had made up his mind CNA A would never provide his shower again. During a telephone interview on 1/21/2025 at 2:22 p.m., CNA A said on occasion he had cared for Resident #2. CNA A said he could not remember providing Resident #2 a shower when he was assisting CNA C on the 100-hall. CNA A again denied any forms of abuse. CNA A again had no explanation as to why 3 male residents have made the same allegation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675981	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mineola Heights Healthcare Centre	716 Mimosa Street Mineola, TX 75773

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	During an interview on 1/21/2025 at 2:28 p.m., CNA C said she had worked with CNA A in the recent past month. CNA C said she worked on the weekend shifts. CNA C said when CNA A worked the hall with her, she would take the female residents and CNA A took the male residents. CNA C said she would complete the documentation for all the residents. CNA C said she would only document a bath if she saw CNA A taking a resident to the shower room. CNA C said she had not witnessed CNA A abusing any resident. Record review of an undated ADL sheet indicated Resident #2 showers were offered but refused on 12/23/2024, 12/25/2024, 12/27/2024, 12/30/2024, 1/1/2025, and 1/06/2025. The ADL sheet indicated Resident #2 accepted a shower on 1/03/2024. During an interview on 1/21/2025 at 3:30 p.m., the ADON said when she informed the surveyor, she completed all the staffing assignments and there was no time since October 2024 that CNA A was assigned to work with Resident #2. The ADON said she had made a mistake and CNA A had been assigned to work with Resident #2 on 12/28/2024 and 12/29/2024. During an interview on 1/21/2025 at 5:15 p.m., the Administrator said although she could not confirm the allegations of sexual abuse, she said lightening can't strike twice. The Administrator said the same allegation with three residents seemed suspicious. The Administrator said abuse was monitored daily during rounds asking questions about abuse and monitor for abuse. The Administrator said she was the abuse coordinator. The Administrator said when she became aware of the allegation, we responded appropriately to protect the residents. The Administrator said safe surveys were conducted, and there were no other residents who voiced any abuse concerns. The Administrator said although CNA A resigned his position, the termination process for CNA A was already approved. The Administrator said the risk of affecting a resident's emotional wellbeing was at risk when abuse occurred and could be harmful over time. During an interview on 1/21/2025 at 5:19 p.m., the DON said she had called CNA A and spoke to him about the allegation regarding Resident #1. The DON said she discussed with CNA A the current allegation with Resident #2 and the previous allegation with the discharged resident in 2023 whether confirmed or not was cause for alert. The DON said she randomly makes walking rounds and asked staff members the abuse questions and monitors for residents for abuse. The DON said she as well believed once the facility learned of the allegation, they acted appropriately to protect all the residents. Record review of CNA A's personnel record revealed he was hired on 5/06/2022. There were no issues noted with the criminal history checks. The personnel record included a formal termination form indicating CNA A was terminated for violating the code of conduct regarding safety health, and security, and regarding preventing abuse and neglect. Record review of an Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy dated 2001 and revised in April 2021 indicated, the 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, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The resident abuse, neglect and exploitation prevention program consists of facility-wide commitment and resource allocation to support the follow objectives: 1. Protect residents from abuse, neglect, and exploitation or misappropriation of property by anyone including but not necessarily limited to: a. facility staff . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675981	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mineola Heights Healthcare Centre	716 Mimosa Street Mineola, TX 75773

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	Record review of the Abuse and Neglect-Clinical Protocol policy dated 2005 and revised in March 2018 indicated, .3. Sexual abuse is defined as non-consensual sexual contact of any type with a resident. 4. Willful, as defined as used in the definition of abuse, means the individual must have acted deliberately, no that the individual must be intended to inflect injury or harm. The Administrator was notified of the IJ PNC on 1/21/2025 at 5:01 p.m., due to the above failures. The Administrator was provided the IJ template on 1/21/2025 at 5:01 p.m. via email. The surveyor confirmed the following actions had been implemented sufficiently to remove the immediacy by: *During a Record review on 1/21/2025 at 11:00 a.m., the Provider Investigation Report dated 1/11/2025 indicated the facility notified the family, physician, local police, and the ombudsman on 1/11/2025. *During a record review on 1/21/2025 at 11:00-12:00 Resident #1's clinical record indicated he was sent to the local hospital and a SANE exam was provided. *During an interview on 1/16/2025 at 1:18 p.m., the Victim's Advocate said Resident #1 was referred to the advocacy group for sexual crimes. *Record review of an Abuse and Neglect in-service was provided on 1/11/2025. The policy reviewed the definition of abuse and neglect as well as timeframes associated with reporting abuse and neglect to the state agency. The signature page had 32 signatures ranging from all shifts and all disciplines. *Record review of a Termination form dated 1/16/2025 for CNA A with the last day worked noted as 1/11/2025. *Record review of a Resignation letter dated 1/15/2025 for CNA A formal resignation of his role as a CNA. *Record review of a Facility counseling form indicating on 1/15/2025 CNA A was formally terminated with the criteria of not meeting job performance and or behavior expectation related abuse and neglect and violation of the code of conduct. *Review of the daily monitoring tool used for monitoring staff's knowledge of abuse and monitoring for abuse with the start date of 1/11/2025 and was current as of 1/21/2025. The monitoring tool had a staff members last name on each day. *Review of the resident safe surveys with no areas of concerns dated for 1/11/2025. *Review of Residents #1 and #2's allegations reported within the two-hour timeframe to the state agency. *Review of the police reports for Resident #1 (case# 25000025) and Resident #2 (case# 25000045). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675981	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mineola Heights Healthcare Centre	716 Mimosa Street Mineola, TX 75773

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	*Interviews with residents regarding abuse and neglect with a focus presented on sexual abuse revealed they all denied abuse with the exceptions of the above mentioned. *Interviews with staff indicated they had been in-serviced on abuse since 1/11/2025 and were able to define abuse, when to report, whom to report. The noncompliance was identified as PNC. The IJ noncompliance began on 1/11/2025 and ended on 1/11/2025. The facility had corrected the non-compliance before the survey began.