

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676048	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/23/2024
NAME OF PROVIDER OR SUPPLIER  Legend Oaks Healthcare and Rehabilitation Center G		STREET ADDRESS, CITY, STATE, ZIP CODE  1201 Fm 2685 Gladewater, TX 75647	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44128</p> <p>Based on observation, interview, and record review, the facility failed to ensure the right to be free from abuse was provided for 1 of 11 residents reviewed for abuse. (Resident #1)</p> <p>The facility failed protect Resident #1 from abuse when RN A recorded him on 07/26/24 with her personal cellphone while undressed from the waist down. RN A was laughing. RN A showed and sent the video to other staff.</p> <p>The noncompliance was identified as PNC. The Immediate Jeopardy (IJ) began on 07/26/24 and ended on 08/30/24. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place residents at risk for emotional and mental abuse.</p> <p>Findings included:</p> <p>Record review of a face sheet dated 10/22/24 revealed Resident #1 was an [AGE] year-old male and admitted on [DATE] with diagnoses including dementia, depression, and anxiety.</p> <p>Record review of a quarterly MDS dated [DATE] revealed Resident #1 was understood and usually understood others. The MDS revealed a BIMS score of 7, indicating severe cognitive impairment. The MDS indicated Resident #1 required supervision with most ADLs.</p> <p>Record review of Resident #1's physician order dated 08/23/24 indicated a verbal order was obtained to monitor for emotional distress every shift for 3 days.</p> <p>Record review of a care plan last revised on 10/12/24 revealed Resident #1 was at risk for impaired thought processes related to a history of dementia. Resident #1 needed assistance with all decision making. Resident #1 had an ADL self-care performance deficit related to decreased mobility and intermittent confusion. The care plan indicated Resident #1 had potential for a behavior problem as evidenced by inappropriate sexual behaviors. There was an intervention to provide privacy and encourage resident to remain clothed per family request.</p> <p>Record review of a Grievance Resolution Form dated 08/23/24 indicated Resident #1 was involved in a video without his knowledge. The report indicated the compliance department was involved and notified administration.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of a Progress Note dated 08/23/24 indicated, SW (Social Worker) visited with resident (Resident #1) this afternoon .SW noticed no change in his mood or behavior after he was notified of the incident. He continues to show confusion, per his usual state. He states I am OK. I am not going to let this effect my life. He is agreeable to speaking with (psych services). SW has sent in a referral for evaluation and spoke with .counselor, re: the incident. SW will continue to monitor resident and will assist further as needed. The note was signed by the Social Worker.</p> <p>Record review of Nurse's notes for Resident #1 dated 08/23/24 - 08/28/24 indicated Resident #1 was monitored for mood and distress. The notes did not indicate Resident #1 had a change in mood or emotional distress.</p> <p>Record review of an Investigation Summary and Timeline report dated 08/30/24 indicated the DON was notified of the allegation of abuse on 08/22/24 at approximately 5:00 p.m. related to the conduct of RN A. The allegation suggested that the nurse had taken an unauthorized video of a resident. RN A was immediately suspended at the time it was reported, pending investigation. During the interview process, it was confirmed that RN A had taken a video of a resident while in his room The resident was not wearing pants and his genitals were visible. The Investigation Summary and Timeline indicated that Resident #1 had been interviewed by Administrator G and had knowledge of the video at the time of the interview. The Investigation Summary and Timeline report indicated RN A was terminated in person on 08/26/24. The report indicated the police were notified and the RP requested to press charges against RN A.</p> <p>Record review of a Provider Investigation Report dated 08/23/24 indicated that on an unknown date RN A took an unauthorized video of Resident #1. The investigation findings were confirmed.</p> <p>Record review of an interview of RN A dated 08/23/24 at 9:30 a.m. indicated she had taken a video of Resident #1. She stated Resident #1 had been in his room with his roommate. She said it had been reported to her by someone in therapy that they smelled smoke in the residents' room. She said she went to the room and Resident #1 was leaning over his roommate and his genitals were rubbing on the roommate. She stated the video showed Resident #1's backside, naked from the waist down. She said she showed the video to LVN C. She said the purpose of filming the video was to show LVN C the residents behavior. She stated, .I shouldn't have done that. I should have verbally told the nurse or done a progress notes. The interview was conducted by the DON and the Clinical Resource Nurse. The interview was signed by RN A.</p> <p>On 10/22/24 at 11:30 a.m., an attempt was made to reach RN A by telephone. There was no answer. A detailed message requesting a return call was left on voicemail.</p> <p>Record review of an interview of LVN C dated 08/23/24 at 10:10 a.m. indicated that she knew about and had seen the video. She said she had seen the video. She said it was of Resident #1 walking over to his roommate. She said Resident #1 only had a shirt on. She said she just saw the back of Resident #1. She said she saw his buttocks. She said he was bending over to do something, and she could see his genitals hanging down. She said RN A had shown her from her phone. She stated RN A said, Oh my God, look what (Resident #1) did. She said RN A thought it was funny. She said she did not report the video. The interview was conducted by the DON and the Clinical Resource Nurse. The interview was signed by LVN C.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of an interview of the Transport Aide dated 08/23/24 at 10:20 a.m. indicated the Transport Aide was aware of and had seen the video. She said the video was shown to her by RN A. She said the video was of Resident #1 walking with a shirt on. She said she could see Resident #1's genitals. The interview indicated that the Transport Aide asked RN A why she had the video and RN A said something to her about when he was younger, he probably had big balls. The Transport Aide said she had seen the video weeks ago. The interview was conducted by the DON and the Clinical Resource Nurse. The interview was signed by the Transport Aide.</p> <p>During an interview on 10/22/24 at 3:34 p.m., the Transport Aide said she walked in one morning. She said RN A said to come see the video and said, it's really funny. She said she did not understand why RN A would have even filmed the video. She said she watched the video on RN A's phone, and it was never sent to her. She said she thought the video was shown to her in July 2024. She said the video was inappropriate. She said on the video she saw Resident #1 over by the air conditioner. She said RN A said, Look at his balls going back in forth, I bet when he was younger, he was bigger.</p> <p>Record review of an interview of CNA D dated 08/23/24 at 10:20 a.m. indicated CNA D was aware of the video and that she had seen the video. She said it was both shown to her and sent to her via text by RN A. She stated that on the video Resident #1 was standing by his roommate with no pants or underwear on, just a shirt. Resident #1 leaned over to help his roommate and she saw his buttocks, penis, and scrotum. She said it had been less than a month since she had seen the video. The interview was conducted by the DON and the Clinical Resource Nurse. The interview was signed by CNA D.</p> <p>Record review of an interview of LVN E dated 08/23/24 at 10:20 a.m. indicated LVN E had heard about the video but had not seen the video. He stated it had been about a month since he had heard about the video. He said he heard there was a video of Resident #1's genitalia. He said RN A had told him about the video. The interview was conducted by the DON and the Clinical Resource Nurse. The interview was signed by LVN E.</p> <p>Record review of an interview of the Staffing Coordinator dated 08/23/24 at 11:05 a.m. indicated the Staffing Coordinator became aware of the video on 08/22/24. The Staffing Coordinator stated RN A came to the office and stated that compliance had called her about a video she had taken of one of the residents and she was scared and didn't know what to do. The Staffing Coordinator indicated she had not seen the video and had only heard gossip about the video. The interview was conducted by the DON and the Clinical Resource Nurse. The interview was signed by the Staffing Coordinator. During an interview on 10/22/24 at 11:42 a.m., the Staffing Coordinator said she was in the hallway on a day in August 2024. She did not remember the date. She said RN A pulled her into the office and said compliance had reached out to her and she did not know what to do. The Staffing Coordinator said RN A was scared. The Staffing Coordinator said RN A said, I think they are calling me about the video. The Staffing Coordinator said she had heard rumors about the video but was not sure if those rumors were true. She said she has never seen the video. She said she heard there was a video out of a resident that they had at the time. She said she did not know any details. She said RN A did not tell her what was on the video or show it to her. She said she reported the incident to the DON after RN A had come into her office.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/22/24 at 11:42 a.m., the Staffing Coordinator said she was in the hallway on a day in August 2024. She did not remember the date. She said RN A pulled her into the office and said compliance had reached out to her and she did not know what to do. The Staffing Coordinator said RN A was scared. The Staffing Coordinator said RN A said, I think they are calling me about the video. The Staffing Coordinator said she had heard rumors about the video but was not sure if those rumors were true. She said she has never seen the video. She said she heard there was a video out of a resident that they had at the time. She said she did not know any details. She said RN A did not tell her what was on the video or show it to her. She said she reported the incident to the DON after RN A had come into her office.</p> <p>Record review of a telephone interview of the Treatment Nurse dated 08/23/24 at 11:15 a.m. indicated the Treatment Nurse was aware of and had seen the video. She said it was shown to her right before she went on maternity leave. She said in the video she could see Resident #1's behind and his scrotum between his legs. She said RN A had shown her the video. She said it was on RN A's phone. The Treatment Nurse said she had mentioned the video to Administrator G and ADON H. She said she may have reported it the next day but could not remember. She stated that RN A thought the video was funny and was showing staff. She said she told RN A that the video was inappropriate, and she should not be videoing the residents. The interview was conducted and signed by the DON and the Clinical Resource Nurse.</p> <p>During an interview on 10/22/2024 at 1:06 p.m., the Treatment Nurse said she went on leave in August 2024. She said it would have been the middle of August 2024. She said RN A did show her the video. She said RN A did not send her the video. She said RN A stopped her in the hall and said, Hey look at this. She said you could see Resident #1 and his roommate messing with the air conditioner. She said Resident #1 only had a shirt on. She said you could see his scrotum. She said the video was from behind and she was not sure if you could see the resident's penis. She said it did not appear Resident #1 was aware he was being videoed. She said RN A was laughing about the video. She said she told RN A it was inappropriate, and RN A said, I just thought it was funny. She said she did report it immediately to the previous ADON H that and told Administrator G the same day. She said she told Administrator G on 07/30/24 or 07/31/24. She said Administrator G told her he would address it at the next all staff meeting.</p> <p>Record review of a police Incident Report, dated 08/23/24 indicated Administrator G was the reportee. The report indicated the offense was solicitation to commit - invasive visual recording in bathroom/changing room. The report indicated RN A was the offender. The report indicated the officer spoke with Administrator G and the DON. The report indicated the DON explained that RN A recorded a patient in secret. The report indicated Resident #1 liked to walk around in the nude and RN A had secretly recorded Resident #1 and sent the video through text to RN B and made jokes about Resident #1. RN A showed her co-workers the video while making fun of Resident #1. The officer asked RN B if she still had the video and was told that she had deleted it. The report indicated on 08/27/24 It was concluded by (the facility) that (RN A) had acted inappropriately by recording (Resident #1) and was subsequently terminated for that reason. According to the interviews, (RN A) was distributing the video to other employees and making comments like, When he was younger, he probably had big balls and Look what you're missing out on. RN A herself was interviewed and stated that her reasoning for recording (Resident #1) was to provide his nurse with information on his behavior.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/22/24 at 9:28 a.m. a family member of Resident #1 said the incident of RN A videoing Resident #1 had been reported to the police. He said the investigating officer was Officer J. He said RN A took a video of Resident #1 and shared the video with her co-workers. The family member said they had not personally seen the video. The family said said Officer J had seen the video. He said Officer J had interviewed some of the facility staff at the police department and had taken several photos. The family member said one of the photos had produced the video. The family member said they did not know which one had. The family member said the facility was aware of the incident in July 2024. The family member said they were not notified of the video until the end of August 2024. The family member said Resident #1 had no memory of the incident. The family member said Resident #1 cannot even remember what he had for breakfast.</p> <p>During an interview and observation on 10/22/24 at 1:30 p.m., Officer J said nursing home staff did not report the video to the police department until a month after it was recorded. He said then the following week, Resident #1's family had reported the video to the police department. He said the first report was made on 8/23/2024. He said review of the video indicated a create date of 7/26/24. He said the police department still had custody of CNA D's and RN B's cell phones. He said they each gave consent for their phones to be searched. He said the video was eventually found on RN B's cellphone. He said on some of the photos there were text messages from the staff members and RN A discussing what Resident #1 might have looked like when he was younger. The video was observed in Officer J's office. The video showed Resident #1 from behind. Resident #1's roommate was sitting in a chair. Each resident had their backs to the camera. Resident #1 had on a polo type shirt. He was naked from the waist down. His buttocks and testicles were visible. At one point in the video, Resident #1 walked over to his roommate and bent over as if to help him with something. When the resident bent over it further exposed his testicles. In the background, there was heard a female voice laughing off and on throughout the video. At one point the female voice said, What is he doing? followed by more laughter.</p> <p>During an observation on 10/22/24 at 2:00 p.m., a video of RN B being interviewed by Officer J revealed RN B stated RN A had sent the video to a few people. RN B said the video was, inappropriate to say the least. RN B said RN A sent the video to her between 07/21/24 to 07/28/24. RN B said she had deleted the video from her phone after she found out that compliance had called RN A. RN B said she had deleted text messages from her phone also.</p> <p>During an interview on 10/23/24 at 8:25 a.m., RN B said she went on vacation for a whole week. She said she then tested positive for Covid and was off another week. She said texted RN A to ask what she had missed at work. She said RN A said, Hey I'm about to send you a video. She said she watched most of the video but not all of it. She said this was normal behavior for Resident #1 and she had seen this behavior daily. She said she felt the video was inappropriate. She said she thought the video was meant to be humorous. She said she thought she typed back, LOL. She said after that she did not think anything else about the video. She said she was sick, and she really did not give it much thought. She said RN A texted her and told her she had sent the video to several other people. She said she did not know the date the video was sent to her, but it was towards the end of July 2024 because she was home sick. She said Resident #1 had a shirt on and nothing below. She said he was walking away from the camera. She said that was as far as she watched. She said she could see his buttocks. She said she did not have her glasses on and did not see his testicles. She said around 8/28/24 she did have a meeting with Compliance. She said she had already deleted the video from her phone. She said now the police had her phone. She said it was sent to forensics and they found the video on the phone.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an observation on 10/22/24 at 2:10 p.m., a video of CNA D was being interviewed by Officer J. CNA D said she was shown the video in the hallway right after RN A had come out of Resident #1's room. CNA D said that at the nurse's station RN A was showing the video to LVN C, LVN E, and herself.</p> <p>During an interview on 10/22/24 at 4:20 p.m., CNA D said RN A sent the video to her the day she recorded the video. She said this date was 7/27/24 on her birthday. She said the resident's roommate was in his wheelchair over by the air conditioner. She said Resident #1 was standing over him with a polo type shirt on and was naked from the waist down. She said she could see his buttocks, testicles, and his penis. She said RN A did not tell her why she took the video. She said she could not remember the context of her conversation with RN A. She said she could not remember if she saw all of the video, but she did feel it was inappropriate. She said she did not report the video to anyone. She said she was not aware of anyone else seeing the video. She said RN A never showed the video to LVN C, LVN E, and herself at the nurse's station.</p> <p>During an interview on 10/22/24 at 2:38 p.m., LVN C said RN A just showed her the video to show her what he was doing. She said the video was just the back of Resident #1 walking over to his roommate with just a shirt on. She said you could not see his face. She said you could see his testicles from behind. She said the video was never sent to her. She said she was at her medication cart when RN A showed her the video. She said LVN E and CNA D were at the facility but were not present when she watched the video. She said the resident's behavior was not a shock to her because he did stuff like that all the time. She said the video was inappropriate and was not necessary. She said RN A was laughing and said, I can't believe this, look at him. She said she was not sure of the date the video was taken. She said she felt RN A showed it to her immediately after it was recorded. She said Resident #1 had dementia and would not remember the incident. She said one time he had even walked down the hall with only a shirt on.</p> <p>During an interview on 10/22/24 at 3:24 p.m., PTA L said she was aware RN A took a video of Resident #1. She said RN A showed her the video on her phone. She said she saw Resident #1 in his room naked from the waist down. She said he had only a shirt on. She said he was walking around the room. She said as soon as she saw it, she quit watching the video. She said she did not know if it was the day, RN A took the video. She said when RN A showed her the video she was laughing. She thought it was funny. She said Resident #1 was not aware the incident happened.</p> <p>During an interview on 10/22/24 at 3:56 p.m., Administrator G said what occurred was HR K informed him that a video was going around. He said that was either 7/31/2024 or 8/2/2024. He said he thought it was in August 2024. He said he could not remember if she gave him details of the video. He said the allegation did not hit his abuse and neglect radar. He said about two weeks later the DON was informed of the video and communicated the details the video to him and it was reported. He said RN A was suspended immediately and never brought back from suspension. He said he did send a text to the Treatment Nurse on 08/02/24. He said he did say the video was inappropriate. He said he just did not realize how bad the video was or the response would have been completely different. He said he had never seen the video. He said he left the facility sometime in August 2024. He said he was given the option to resign.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/23/24 at 4:21 p.m., the Clinical Resource Nurse said she learned of the video during one of her weekly visits. She said it was probably on 08/22/24 or 08/23/24. She said she was told there was a nurse that had taken an inappropriate video of a resident not fully dressed and that it was sent to a staff member that was not on duty that day. She said she interviewed RN A. She said RN A was off that day and she was told she had to come to the facility to be interviewed. She said RN A admitted to taking the video. She said during interview RN A said, there was no reason for taking the video. She RN A said during that interview she had shown the video to no one. The Clinical Resource Nurse said she never saw the video. She said RN A told her the video was no longer on her phone, and she had deleted the video. She said every staff member was in-serviced. She said there were some one-on-one in-services. She said these were with the people that were disciplined. She said RN A was suspended that day. She said RN A's license were referred to the state. She said if this happened to her, she would be humiliated. She said it would be humiliating regardless of her age. She said she was angry and very emotional about what happened. She said it was just disgusting. She said she had assisted with safe surveys and with Resident #1 and he had no concerns. She said she did know Administrator G had interviewed the resident. She said Administrator G told her the resident did not recall the incident. She said Administrator G was asked to resign or he would be terminated.</p> <p>Record review of a Counseling/Disciplinary Notice dated 08/22/24 indicated an allegation of abuse was identified and RN A was suspended pending investigation. RN A was notified at 5:08 p.m. by the DON.</p> <p>Record review of a Counseling/Disciplinary Notice dated 08/26/24 indicated RN A was discharged from employment and her last day worked was 08/20/24. The notice indicated, It was determined that the nurse, (RN A), was responsible for the recording and distributing inappropriate video of a resident to multiple staff members. This is against our Abuse Policy as it classifies as Mental Abuse. Staff member is to be terminated for violation of Abuse Policy. The notice was signed by Administrator G and RN A on 08/27/24.</p> <p>Record review of a Termination Form dated 08/27/24 indicated RN A was terminated with a termination date of 08/27/24 for gross misconduct. The Termination Form was signed by the DON.</p> <p>Record review of an undated Employer Report Form to the Texas Board of Nursing Regarding Violations of the Nursing Practice Act, Other Statutes, and Board Rules indicated, It was reported that (RN A) had taken inappropriate video of the resident (Resident #1) and was distributing the video to her co-workers via multimedia message. Upon investigation, it was identified that (RN A) had videoed the resident nude from the waist down while he ambulated in his room and shown multiple coworkers on her phone, as well as sent it via text message to at least 2 coworkers. Through investigation it was determined that there was no reason medical indication for the video to be taken. It has been determined through this investigation that the nurse mentally abused the resident by taking and distributing this video. CMS defines mental abuse as, abuse that is facilitated or caused by nursing home staff taking or using photographs or recording in any manner that would demean or humiliate a resident (Ref. S&amp;C16-33-NH). Employment has been terminated at this facility due to this crime.</p> <p>Record review of a Social Media facility policy dated December 2020 indicated, .An employee's use of social media, both during work time and non-work time, may subject the employee to discipline if their conduct violates company policies or law .</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Legend Oaks Healthcare and Rehabilitation Center G		STREET ADDRESS, CITY, STATE, ZIP CODE  1201 Fm 2685 Gladewater, TX 75647	
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of an Abuse: Prevention of and Prohibition Against facility policy dated 11/2017 indicated, .It is the policy of this Facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Facility staff are prohibited from taking, keeping, using or distributing photographs or video recordings of Facility residents in any manner that would demean or humiliate a resident, regardless of whether the resident provided consent and regardless of the resident's cognitive status. This includes using any type of equipment (e.g., cameras, smart phones, or other electronic devices) to take, keep, or distribute inappropriate photographs or recordings on social media. The Facility will provide oversight and monitoring to ensure that staff, who are agents of the Facility, deliver care and services in a way that promotes and respects the rights of the residents to be free from abuse, neglect, misappropriation of resident property, and exploitation .Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish .Mental Abuse includes, but is not limited to humiliation .</p> <p>The facility had corrected the noncompliance on 08/30/24 by the following:</p> <ul style="list-style-type: none"> <li>- Termination of RN A who was responsible for the abuse</li> <li>- Resignation of Administrator G who was responsible for not reporting or investigating the abuse.</li> <li>- Final Written Warnings for the failure to report alleged abuse to supervisor or abuse coordinator dated 08/23/24 were given to Transport Aide, the Staffing Coordinator, CNA D, LVN E, LVN C, and RN B. PTA L was given a Final Written Warning for the failure to report alleged abuse to supervisor or abuse coordinator on 08/29/24.</li> <li>- Safe surveys of all the residents in the facility initially and weekly for 90 Days. (on-going at the time of exit)</li> <li>- 100% staff in-service on Code of Conduct, Photographing or Videoing a resident (Abuse and Neglect), Abuse: Prevention of and Prohibition Against, and Abuse Coordinator</li> <li>- 100% staff knowledge checks on Abuse and Neglect Prevention and Reporting</li> <li>- 100% staff Abuse Prevention &amp; Reporting Skills Check</li> <li>- 100% staff on-line training on Knowing the Resident Rights, HIPPA Refresher (TO), Abuse Neglect and Exploitation, Obligation to Report Abuse</li> <li>- Psychological Services were provided to Resident #1 beginning 8/27/24</li> </ul> <p>Record review of an Ad Hoc Quality Assurance (QA) Meeting Sign-in Sheet dated 08/23/24 indicated the facility had an QA meeting addressing the incident. The QA Meeting Sign-in Sheet indicated the DON, ADON, Medical Director, Marketing Representative, Admissions Coordinator, LVN N, Maintenance Director, Activity Director MDS Nurse, Medical Records staff member, Resource Therapist, the Treatment Nurse, and Operations Manager.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review and interview of the sampled residents (Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9, Resident #10, and Resident #11) revealed they had not been abused or witnessed any abuse of other residents. They each said to their knowledge they had not been photographed or videoed by any staff members.</p> <p>All staff interviewed (RN B, LVN C, CNA D, LVN E, ADON F, HR K, PTA L, LVN O, the Staffing Coordinator, the Transport Aide, the Treatment Nurse, the Social Worker, CNA P, the Activity Director, the Dietary Manager, the Speech Therapist, Laundry Aide Q, CNA R) on 10/22/24 and 10/23/24 verbalized they had been in-serviced on Code of Conduct, Abuse/Neglect policy, Facility Staff were prohibited from taking, keeping, using or distributing photographs or video recording of facility residents, Abuse: Prevention of and Prohibition Against. Each staff member said they had taken online training of Knowing the Resident Rights, HIPPA Refresher (TO), Abuse Neglect and Exploitation, Obligation to Report Abuse. Each staff member was able to verbalize the different types of abuse. Each said they would report any abuse immediately to the abuse coordinator and during the time there was not an administrator the Abuse Coordinator was the DON. Each staff m [TRUNCATED]</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128</b></p> <p>Based on observation, interview, and record review, the facility failed to implement written policies and procedures that prohibit and prevent abuse, neglect, exploitation, or mistreatment of residents for 1 of 11 residents (Resident #1) reviewed for abuse and neglect.</p> <p>The facility failed to prevent Resident #1 from being abused when on 07/26/2024 RN A entered his room and filmed him with her cellphone. Resident #1 was naked from the waist down. RN A shared the video with other staff.</p> <p>The facility failed to protect Resident #1 from potential further abuse after the allegation. RN A was allowed to work from the date of the incident until she was suspended on 08/22/24.</p> <p>The facility staff (RN B, LVN C, CNA D, LVN E, the Staffing Coordinator, the Transport Aide, PTA L) failed to report abuse immediately to the Abuse Coordinator after they had viewed or became aware of the video.</p> <p>Facility Administrator G failed to investigate and to report an allegation of abuse to the state agency after he became aware of the video on 07/31/24.</p> <p>The noncompliance was identified as PNC. The Immediate Jeopardy (IJ) began on 07/26/24 and ended on 08/30/24. The facility had corrected the noncompliance before the survey began.</p> <p>These failures could place residents at risk for continued abuse and neglect due to inappropriate interventions and failure to report the allegations of abuse timely.</p> <p>Findings included:</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of an Abuse: Prevention of and Prohibition Against facility policy dated 11/2017 indicated, .It is the policy of this Facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Facility staff are prohibited from taking, keeping, using or distributing photographs or video recordings of Facility residents in any manner that would demean or humiliate a resident, regardless of whether the resident provided consent and regardless of the resident's cognitive status. This includes using any type of equipment (e.g., cameras, smart phones, or other electronic devices) to take, keep, or distribute inappropriate photographs or recordings on social media. The Facility will provide oversight and monitoring to ensure that staff, who are agents of the Facility, deliver care and services in a way that promotes and respects the rights of the residents to be free from abuse, neglect, misappropriation of resident property, and exploitation .Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish .Mental Abuse includes, but is not limited to humiliation .All personnel, residents, visitor, etc. are encouraged to report incidents and grievance without the fear of retribution. The Facility will act to protect and prevent abuse and neglect from occurring with the Facility by .Supervising staff to identify and correct any inappropriate or unprofessional behavior .Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur .Facility staff with knowledge of an actual or potential violation of this policy must report the violation to his or her supervisor or the Facility administrator immediately .This includes taking, keeping, using or distributing photographs or video recordings of Facility resident in any manner that would demean or humiliate a resident .with any type of device .All identified events are reported to the Administrator immediately .After receiving the allegation, and during and after the investigation, the Administrator will ensure that all residents are protected from physical and psychosocial harm .All allegations of abuse, neglect, misappropriation of resident property, and exploitation will be promptly and thoroughly investigate by the Administrator or his/her designee .Upon receiving a report or allegation of a potential violation of this policy involving the taking, keeping, using, or distributing photos or video recordings, the Administrator or his or her designee will analyze the allegations and determine whether the conduct at issue implicated resident privacy or security as protected by the Health Insurance Portability and Accountability Act (HIPPA) .The investigation will include .an interview with the person(s) reporting the incident .an interview with the resident(s) .Interviews with any witnesses to the incident, including the alleged perpetrator, as appropriate .a review of the resident's medical record .An interview with staff members (on all shifts) who may have information regarding the alleged incident .Interviews with other residents to whom the accused employee provides care or services or who may have information regarding the alleged incident .an interview with staff members (on all shifts) having contact with the accused employee and a review of all circumstance surrounding the incident .To the extent there is evidence that could be sued in a criminal investigation, staff will immediately notify the Administrator or his/her designee .The investigation, and the results of the investigation, will be documented .If an allegation of abuse .is reported, discovered or suspected, the Facility will take the following steps to protect all residents .respond immediately to protect the alleged victim and the integrity of the investigation .examine the alleged victim for any sign of injury, including a physical examination and psychosocial assessment .Increase supervision of the alleged victim and residents .make room or staffing changes .provide emotional support and counseling to the resident during and after the investigation .immediately remove the employee from the care of any resident .Suspend the employee during the pendency of the investigation . All allegations of abuse .should be reported immediately to the Administrator .Allegations of abuse .will be reported outside the Facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations .At the conclusion of the investigation, the Facility will take action, as necessary, in light of the information gathered which may include but is not limited to .</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of a face sheet dated 10/22/24 revealed Resident #1 was an [AGE] year-old male and admitted on [DATE] with diagnoses including dementia, depression, and anxiety.</p> <p>Record review of a quarterly MDS dated [DATE] revealed Resident #1 was understood and usually understood others. The MDS revealed a BIMS score of 7, indicating severe cognitive impairment. The MDS indicated Resident #1 required supervision with most ADLs.</p> <p>Record review of Resident #1's physician's orders indicated on dated 08/23/24 indicated a verbal order was obtained to monitor for emotional distress every shift for 3 days.</p> <p>Record review of a care plan last revised on 10/12/24 revealed Resident #1 was at risk for impaired thought processes related to a history of dementia. Resident #1 needed assistance with all decision making. Resident #1 had an ADL self-care performance deficit related to decreased mobility and intermittent confusion. The care plan indicated Resident #1 had potential for a behavior problem as evidenced by inappropriate sexual behaviors. There was an intervention to provide privacy and encourage resident to remain clothed per family request.</p> <p>Record review of text messages dated 08/02/24 at 6:14 p.m., indicated texts between HR K and Administrator G. The texts indicated HR K wrote, .And ANOTHER note, I don't know who, how or where it originated from but there has been a video taken of (Resident #1) with no pants on and making its way around the building. Administrator G responded, Oh no! If you're still there, will you mention to one or two of the staff at the nurse's station that any videos taken of residents against their will can give family members a foot hold to sue whoever has the video. HR K responded, I left unfortunately but I was told over the phone, not in person at the facility or I would have said just that and how it's not funny. Administrator G responded, Mmm, ok. I'll mention it to (the Treatment Nurse).</p> <p>Record review of a text message dated 08/02/24 at 6:38 p.m. to the Treatment Nurse from Administrator G indicated, Hey, I just got word that there's an inappropriate video of (Resident #1) going around the facility. Will you mention to the staff that any videos taken of residents against their will can give family members a foot hold to sue whoever has the video. It has happened to our sister facility .</p> <p>Record review of a Grievance Resolution Form dated 08/23/24 indicated Resident #1 was involved in a video without his knowledge. The report indicated the compliance department was involved and notified administration.</p> <p>Record review of a Progress Note dated 08/23/24 indicated, SW (Social Worker) visited with resident (Resident #1) this afternoon .SW noticed no change in his mood or behavior after he was notified of the incident. He continues to show confusion, per his usual state. He states I am OK. I am not going to let this effect my life. He is agreeable to speaking with (psych services). SW has sent in a referral for evaluation and spoke with .counselor, re: the incident. SW will continue to monitor resident and will assist further as needed. The note was signed by the Social Worker.</p> <p>Record review of Nurse's notes for Resident #1 dated 08/23/24 - 08/28/24 indicated Resident #1 was monitored for mood and distress. The notes did not indicate Resident #1 had a change in mood or emotional distress.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of an Investigation Summary and Timeline report dated 08/30/24 indicated the DON was notified of the allegation of abuse on 08/22/24 at approximately 5:00 p.m. related to the conduct of RN A. The allegation suggested that the nurse had taken an unauthorized video of a resident. RN A was immediately suspended at the time it was reported, pending investigation. During the interview process, it was confirmed that RN A had taken a video of a resident while in his room. The resident was not wearing pants and his genitals were visible. The Investigation Summary and Timeline indicated that Resident #1 had been interviewed by Administrator G and had knowledge of the video at the time of the interview. The Investigation Summary and Timeline report indicated RN A was terminated in person on 08/26/24. The report indicated the police were notified and the RP requested to press charges against RN A.</p> <p>Record review of a Provider Investigation Report dated 08/23/24 indicated that on an unknown date RN A took an unauthorized video of Resident #1. The investigation findings were confirmed.</p> <p>Record review of an interview of RN A dated 08/23/24 at 9:30 a.m. indicated she had taken a video of Resident #1. She stated Resident #1 had been in his room with his roommate. She said it had been reported to her by someone in therapy that they smelled smoke in the residents' room. She said she went to the room and Resident #1 was leaning over his roommate and his genitals were rubbing on the roommate. She stated the video showed Resident #1's backside, naked from the waist down. She said she showed the video to LVN C. She said the purpose of filming the video was to show LVN C the residents behavior. She stated, .I shouldn't have done that. I should have verbally told the nurse or done a progress notes. The interview was conducted by the DON and the Clinical Resource Nurse. The interview was signed by RN A.</p> <p>On 10/22/24 at 11:30 a.m., an attempt was made to reach RN A by telephone. There was no answer. A detailed message requesting a return call was left on voicemail.</p> <p>Record review of an interview of LVN C dated 08/23/24 at 10:10 a.m. indicated that she knew about and had seen the video. She said she had seen the video. She said it was of Resident #1 walking over to his roommate. She said Resident #1 only had a shirt on. She said she just saw the back of Resident #1. She said she saw his buttocks. She said he was bending over to do something, and she could see his genitals hanging down. She said RN A had shown her from her phone. She stated RN A said, Oh my God, look what (Resident #1) did. She said RN A thought it was funny. She said she did not report the video. The interview was conducted by the DON and the Clinical Resource Nurse. The interview was signed by LVN C.</p> <p>Record review of an interview of the Transport Aide dated 08/23/24 at 10:20 a.m. indicated the Transport Aide was aware of and had seen the video. She said the video was shown to her by RN A. She said the video was of Resident #1 walking with a shirt on. She said she could see Resident #1's genitals. The interview indicated that the Transport Aide asked RN A why she had the video and RN A said something to her about when he was younger, he probably had big balls. The Transport Aide said she had seen the video weeks ago. The interview indicated the Transport Aide did not report the video to anyone and when asked why she said, I know I should have. I don't know why I didn't. The interview was conducted by the DON and the Clinical Resource Nurse. The interview was signed by the Transport Aide.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/22/24 at 3:34 p.m., the Transport Aide said she walked in one morning. She said RN A said to come see the video and said, it's really funny. She said she did not understand why RN A would have even filmed the video. She said she watched the video on RN A's phone, and it was never sent to her. She said she thought the video was shown to her in July 2024. She said the video was inappropriate. She said on the video she saw Resident #1 over by the air conditioner. She said RN A said, Look at his balls going back in forth, I bet when he was younger, he was bigger.</p> <p>Record review of an interview of CNA D dated 08/23/24 at 10:20 a.m. indicated CNA D was aware of the video and that she had seen the video. She said it was both shown to her and sent to her via text by RN A. She stated that on the video Resident #1 was standing by his roommate with no pants or underwear on, just a shirt. Resident #1 leaned over to help his roommate and she saw his buttocks, penis, and scrotum. She said it had been less than a month since she had seen the video. She said she did not report the video to anyone. The interview was conducted by the DON and the Clinical Resource Nurse. The interview was signed by CNA D.</p> <p>Record review of an interview of LVN E dated 08/23/24 at 10:20 a.m. indicated LVN E had heard about the video but had not seen the video. He stated it had been about a month since he had heard about the video. He said he heard there was a video of Resident #1's genitalia. He said RN A had told him about the video. He said he thought he should have reported the video but did not report the video. The interview was conducted by the DON and the Clinical Resource Nurse. The interview was signed by LVN E.</p> <p>Record review of an interview of the Staffing Coordinator dated 08/23/24 at 11:05 a.m. indicated the Staffing Coordinator became aware of the video on 08/22/24. The Staffing Coordinator stated RN A came to the office and stated that compliance had called her about a video she had taken of one of the residents and she was scared and didn't know what to do. The Staffing Coordinator indicated she had not seen the video and had only heard gossip about the video. She said the staff that were gossiping did explain what was in the video. She said she did not report what was in the video because it was just gossip. The interview was conducted by the DON and the Clinical Resource Nurse. The interview was signed by the Staffing Coordinator.</p> <p>During an interview on 10/22/24 at 11:42 a.m., the Staffing Coordinator said she was in the hallway on a day in August 2024. She did not remember the date. She said RN A pulled her into the office and said compliance had reached out to her and she did not know what to do. The Staffing Coordinator said RN A was scared. The Staffing Coordinator said RN A said, I think they are calling me about the video. The Staffing Coordinator said she had heard rumors about the video but was not sure if those rumors were true. She said she has never seen the video. She said she heard there was a video out of a resident that they had at the time. She said she did not know any details. She said RN A did not tell her what was on the video or show it to her. She said she reported the incident to the DON after RN A had come into her office.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of a telephone interview of the Treatment Nurse dated 08/23/24 at 11:15 a.m. indicated the Treatment Nurse was aware of and had seen the video. She said it was shown to her right before she went on maternity leave. She said in the video she could see Resident #1's behind and his scrotum between his legs. She said RN A had shown her the video. She said it was on RN A's phone. The Treatment Nurse said she had mentioned the video to Administrator G and ADON H. She said she may have reported it the next day but could not remember. She stated that RN A thought the video was funny and was showing staff. She said she told RN A that the video was inappropriate, and she should not be videoing the residents. The interview was conducted and signed by the DON and the Clinical Resource Nurse.</p> <p>During an interview on 10/22/2024 at 1:06 p.m., the Treatment Nurse said she went on leave in August 2024 . She said it would have been the middle of August 2024. She said RN A did show her the video. She said RN A did not send her the video. She said RN A stopped her in the hall and said, Hey look at this. She said you could see Resident #1 and his roommate messing with the air conditioner. She said Resident #1 only had a shirt on. She said you could see his scrotum. She said the video was from behind and she was not sure if you could see the resident's penis. She said it did not appear Resident #1 was aware he was being videoed. She said RN A was laughing about the video. She said she told RN A it was inappropriate, and RN A said, I just thought it was funny. She said she did report it immediately to the previous ADON H that and told Administrator G the same day. She said she told Administrator G on 07/30/24 or 07/31/24. She said Administrator G told her he would address it at the next all staff meeting.</p> <p>Record review of a police Incident Report, dated 08/23/24 indicated Administrator G was the reportee. The report indicated the offense was solicitation to commit - invasive visual recording in bathroom/changing room. The report indicated RN A was the offender. The report indicated the officer spoke with Administrator G and the DON. The report indicated the DON explained that RN A recorded a patient in secret. The report indicated Resident #1 liked to walk around in the nude and RN A had secretly recorded Resident #1 and sent the video through text to RN B and made jokes about Resident #1. RN A showed her co-workers the video while making fun of Resident #1. The officer asked RN B if she still had the video and was told that she had deleted it. The report indicated on 08/27/24 It was concluded by (the facility) that (RN A) had acted inappropriately by recording (Resident #1) and was subsequently terminated for that reason. According to the interviews, (RN A) was distributing the video to other employees and making comments like, When he was younger, he probably had big balls and Look what you're missing out on. RN A herself was interviewed and stated that her reasoning for recording (Resident #1) was to provide his nurse with information on his behavior.</p> <p>During an interview on 10/22/24 at 9:28 a.m. a family member of Resident #1 said the incident of RN A videoing Resident #1 had been reported to the police. He said the investigating officer was Officer J. He said RN A took a video of Resident #1 and shared the video with her co-workers. The family member said they had not personally seen the video. They said Officer J had seen the video. He said Officer J had interviewed some of the facility staff at the police department and had taken several photos. The family member said one of the phones had produced the video. The family member said they did not know which one had. The family member said the facility was aware of the incident in July 2024. The family member said they were not notified of the video until the end of August 2024. The family member said Resident #1 had no memory of the incident. The family member said Resident #1 cannot even remember what he had for breakfast.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Legend Oaks Healthcare and Rehabilitation Center G		STREET ADDRESS, CITY, STATE, ZIP CODE  1201 Fm 2685 Gladewater, TX 75647	
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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview and observation on 10/22/24 at 1:30 p.m., Officer J said nursing home staff did not report the video to the police department until a month after it was recorded. He said then the following week, Resident #1's family had reported the video to the police department. He said the first report was made on 8/23/2024. He said review of the video indicated a create date of 7/26/24. He said the police department still had custody of CNA D's and RN B's cell phones. He said they each gave consent for their phones to be searched. He said the video was eventually found on RN B's cellphone. He said on some of the phones there were text messages from the staff members and RN A discussing what Resident #1 might have looked like when he was younger. The video was observed in Officer J's office. The video showed Resident #1 from behind. Resident #1's roommate was sitting in a chair. Each resident had their backs to the camera. Resident #1 had on a polo type shirt. He was naked from the waist down. His buttocks and testicles were visible. At one point in the video, Resident #1 walked over to his roommate and bent over as if to help him with something. When the resident bent over it further exposed his testicles. In the background, there was heard a female voice laughing off and on throughout the video. At one point the female voice said, What is he doing? followed by more laughter.</p> <p>During an observation on 10/22/24 at 2:00 p.m., a video of RN B being interviewed by Officer J revealed RN B stated RN A had sent the video to a few people. RN B said the video was, inappropriate to say the least. RN B said RN A sent the video to her between 07/21/24 to 07/28/24. RN B said she had deleted the video from her phone after she found out that compliance had called RN A. RN B said she had deleted text messages from her phone also.</p> <p>During an interview on 10/23/24 at 8:25 a.m., RN B said she went on vacation for a whole week. She said she then tested positive for Covid and was off another week. She said texted RN A to ask what she had missed at work. She said RN A said, Hey I'm about to send you a video. She said she watched most of the video but not all of it. She said this was normal behavior for Resident #1 and she had seen this behavior daily. She said she felt the video was inappropriate. She said she thought the video was meant to be humorous. She said she thought she typed back, LOL. She said after that she did not think anything else about the video. She said she was sick, and she really did not give it much thought. She said RN A texted her and told her she had sent the video to several other people. She said she did not know the date the video was sent to her, but it was towards the end of July 2024 because she was home sick. She said Resident #1 had a shirt on and nothing below. She said he was walking away from the camera. She said that was as far as she watched. She said she could see his buttocks. She said she did not have her glasses on and did not see his testicles. She said around 8/28/24 she did have a meeting with Compliance. She said she had already deleted the video from her phone. She said now the police had her phone. She said it was sent to forensics and they found the video on the phone.</p> <p>During an observation on 10/22/24 at 2:10 p.m., a video of CNA D was being interviewed by Officer J. CNA D said she was shown the video in the hallway right after RN A had come out of Resident #1's room. CNA D said that at the nurse's station RN A was showing the video to LVN C, LVN E, and herself.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/22/24 at 4:20 p.m., CNA D said RN A sent the video to her the day she recorded the video. She said this date was 7/27/24 on her birthday. She said the resident's roommate was in his wheelchair over by the air conditioner. She said Resident #1 was standing over him with a polo type shirt on and was naked from the waist down. She said she could see his buttocks, testicles, and his penis. She said RN A did not tell her why she took the video. She said she could not remember the context of her conversation with RN A. She said she could not remember if she saw all of the video, but she did feel it was inappropriate. She said she did not report the video to anyone. She said she was not aware of anyone else seeing the video. She said RN A never showed the video to LVN C, LVN E, and herself at the nurse's station.</p> <p>During an interview on 10/22/24 at 2:38 p.m., LVN C said RN A just showed her the video to show her what he was doing. She said the video was just the back of Resident #1 walking over to his roommate with just a shirt on. She said you could not see his face. She said you could see his testicles from behind. She said the video was never sent to her. She said she was at her medication cart when RN A showed her the video. She said LVN E and CNA D were at the facility but were not present when she watched the video. She said the resident's behavior was not a shock to her because he did stuff like that all the time. She said the video was inappropriate and was not necessary. She said RN A was laughing and said, I can't believe this, look at him. She said she did not report the incident. She said at the time she did not think RN A was going to do anything with it. She said at the time she did not think about it reporting it. She said she was not sure of the date the video was taken. She said she felt RN A showed it to her immediately after it was recorded. She said Resident #1 had dementia and would not remember the incident. She said one time he had even walked down the hall with only a shirt on.</p> <p>During an interview on 10/22/24 at 3:24 p.m., PTA L said she was aware RN A took a video of Resident #1. She said RN A showed her the video on her phone. She said she saw Resident #1 in his room naked from the waist down. She said he had only a shirt on. She said he was walking around the room. She said as soon as she saw it, she quit watching the video. She said she did not know if it was the day, RN A took the video. She said she worked at different facilities and was not sure of the day. She said residents across the hall had complained about Resident #1 walking around naked. She said she told RN #1 about the complaint and that was when she showed her the video. She said after viewing the video she did not report it to anyone. She said she did not know why. She said the video made her uncomfortable. She said, I just didn't. I don't know why. I just didn't want that in my brain. She said when RN A showed her the video she was laughing. She thought it was funny. She said Resident #1 was not aware the incident happened.</p> <p>During an interview on 10/22/24 at 3:56 p.m., Administrator G said what occurred was HR K informed him that a video was going around. He said that was either 7/31/2024 or 8/2/2024. He said he thought it was in August 2024. He said he could not remember if she gave him details of the video. He said the allegation did not hit his abuse and neglect radar. He said about two weeks later the DON was informed of the video and communicated the details the video to him and it was reported. He said RN A was suspended immediately and never brought back from suspension. He said he did send a text to the Treatment Nurse on 08/02/24. He said he did say the video was inappropriate. He said he just did not realize how bad the video was or the response would have been completely different. He said he had never seen the video. He said he left the facility sometime in August 2024. He said he was given the option to resign.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview 10/22/24 at 4:12 p.m., the Social Worker said she was not even aware of the video until compliance got involved. She said she usually did a checkup with residents after any incident. She said she did safe surveys and there were no concerns. She said she did talk to Resident #1. She said Administrator G had just come out of his room, so the incident was fresh on Resident #1's mind. She said he did not seem upset. She said he did say, I just don't know why someone would do something like that. I'm not going to let it affect me. She said she did get an order for psychology services to check on him.</p> <p>During an interview on 10/23/24 at 8:50 a.m., ADON H said she quit working at the facility on approximately 8/12/24. She said she became aware of the video in July 2024 on a Wednesday. She said the Treatment Nurse had told her. She said she told the Treatment Nurse that she needed to report the video to the DON and Administrator G. ADON H said she reported the video to Compliance on 8/3/24 at 2:00 a.m. She said therefore she was told about the video on 7/31/24. ADON H said she never saw the video. She said the Transport Aide did tell her on 08/09/24 that she had seen the video. She said she quit working at the facility because she felt things were not being addressed. She said there were a few other reasons. She said she understood the facility did not want a tag, but they had to do the right thing. She said she knew the DON was made aware of the video on 7/31/24 and HR K told her again on 8/12/24.</p> <p>During an interview on 10/23/24 at 9:14 a.m., HR K said she found out about the video on 8/2/24. She said ADON H told her about the video. She said RN A was going around showing everyone videos of Resident #1 walking around in his room butt naked. She said she immediately texted Administrator G. She said he said he texted her back and Oh no that is really bad. The family could sue us. Could you please tell the nurse's that is not funny, and they should not be doing that? She said nothing happened after that. She said there was no investigation. She said she reported it to the DON on 8/12/24 and voiced her concerns about nothing happening. She said, and still nothing was done. She said she never saw the video. She said she was told by multiple people it did exist and what it consisted of.</p> <p>During an interview on 10/23/24 at 9:31 a.m., the DON said she first became aware of the video approximately 2 days before she reported the incident to the state. She said HR K told her but did not tell her any details about the video. She said prior to 8/21/24 she had not even heard of the video. She said she was on vacation 7/30/24 - 8/5/24. She said the video was not reported to her during that time. She said on 8/22/24 she became aware of the content of the video. She said she was told by the Staffing Coordinator. She said the Staffing Coordinator told her there was a video of Resident #1 with his genitals exposed and that RN A had taken the video. She said she suspended RN A immediately. She said she discussed the video with the Administrator G. She said he told her he had no idea about the video. She said she went back to HR K and asked her if she had reported the incident to Administrator G. She said HR K showed her a text message showing that she had reported the video to Administrator G. She said the text was dated 8/2/24. She said to her knowledge there was no investigation started by Administrator G. She said she began the investigation herself on 8/23/24. She said her investigation concluded that RN A had taken the video of Resident #1 and had shown multiple co-workers. She said RN A was terminated on 08/26/24. She said she had not seen the video. She said all staff that had knowledge of or saw the video was given final written warnings for failure to report. She said once she heard the content of the video, she felt it was abuse. She said she felt it should have been reported and investigated right from the very beginning. She said she did talk to Resident #1 about the video. She said he</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, or mistreatment are reported immediately or not later than 2 hours for 1 of 11 residents reviewed for abuse and neglect. (Resident #1)</p> <p>The facility staff (RN B, LVN C, CNA D, LVN E, the Staffing Coordinator, the Transport Aide, PTA L) failed to report abuse immediately to the Abuse Coordinator after they had viewed or became aware of video taken by RN A of Resident #1 naked from the waist down.</p> <p>Facility Administrator G failed to investigate and to report an allegation of abuse to the state agency after he became aware of the video on 07/31/24.</p> <p>The noncompliance was identified as PNC. The Immediate Jeopardy (IJ) began on 07/26/24 and ended on 08/30/24. The facility had corrected the noncompliance before the survey began.</p> <p>These failures could place residents at risk for ongoing abuse and neglect.</p> <p>Findings included:</p> <p>Record review of a face sheet dated 10/22/24 revealed Resident #1 was an [AGE] year-old male and admitted on [DATE] with diagnoses including dementia, depression, and anxiety.</p> <p>Record review of a quarterly MDS dated [DATE] revealed Resident #1 was understood and usually understood others. The MDS revealed a BIMS score of 7, indicating severe cognitive impairment. The MDS indicated Resident #1 required supervision with most ADLs.</p> <p>Record review of Resident #1's physician's orders indicated on dated 08/23/24 indicated a verbal order was obtained to monitor for emotional distress every shift for 3 days.</p> <p>Record review of a care plan last revised on 10/12/24 revealed Resident #1 was at risk for impaired thought processes related to a history of dementia. Resident #1 needed assistance with all decision making. Resident #1 had an ADL self-care performance deficit related to decreased mobility and intermittent confusion. The care plan indicated Resident #1 had potential for a behavior problem as evidenced by inappropriate sexual behaviors. There was an intervention to provide privacy and encourage resident to remain clothed per family request.</p> <p>Record review of text messages dated 08/02/24 at 6:14 p.m., indicated texts between HR K and Administrator G. The texts indicated HR K wrote, .And ANOTHER note, I don't know who, how or where it originated from but there has been a video taken of (Resident #1) with no pants on and making its way around the building. Administrator G responded, Oh no! If you're still there, will you mention to one or two of the staff at the nurse's station that any videos taken of residents against their will can give family members a foot hold to sue whoever has the video. HR K responded, I left unfortunately but I was told over the phone, not in person at the facility or I would have said just that and how it's not funny. Administrator G responded, Mmm, ok. I'll mention it to (the Treatment Nurse).</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of a text message dated 08/02/24 at 6:38 p.m., to the Treatment Nurse from Administrator G indicated, Hey, I just got word that there's an inappropriate video of (Resident #1) going around the facility. Will you mention to the staff that any videos taken of residents against their will can give family members a foot hold to sue whoever has the video. It has happened to our sister facility .</p> <p>Record review of a Grievance Resolution Form dated 08/23/24 indicated Resident #1 was involved in a video without his knowledge. The report indicated the compliance department was involved and notified administration.</p> <p>Record review of a Progress Note dated 08/23/24 indicated, SW (Social Worker) visited with resident (Resident #1) this afternoon .SW noticed no change in his mood or behavior after he was notified of the incident. He continues to show confusion, per his usual state. He states I am OK. I am not going to let this effect my life. He is agreeable to speaking with (psych services). SW has sent in a referral for evaluation and spoke with .counselor, re: the incident. SW will continue to monitor resident and will assist further as needed. The note was signed by the Social Worker.</p> <p>Record review of Nurse's notes for Resident #1 dated 08/23/24 - 08/28/24 indicated Resident #1 was monitored for mood and distress. The notes did not indicate Resident #1 had a change in mood or emotional distress.</p> <p>Record review of an Investigation Summary and Timeline report dated 08/30/24 indicated the DON was notified of the allegation of abuse on 08/22/24 at approximately 5:00 p.m. related to the conduct of RN A. The allegation suggested that the nurse had taken an unauthorized video of a resident. RN A was immediately suspended at the time it was reported, pending investigation. During the interview process, it was confirmed that RN A had taken a video of a resident while in his room The resident was not wearing pants and his genitals were visible. The Investigation Summary and Timeline indicated that Resident #1 had been interviewed by Administrator G and had knowledge of the video at the time of the interview. The Investigation Summary and Timeline report indicated RN A was terminated in person on 08/26/24. The report indicated the police were notified and the RP requested to press charges against RN A.</p> <p>Record review of a Provider Investigation Report dated 08/23/24 indicated that on an unknown date RN A took an unauthorized video of Resident #1. The investigation findings were confirmed.</p> <p>Record review of an interview of RN A dated 08/23/24 at 9:30 a.m. indicated she had taken a video of Resident #1. She stated Resident #1 had been in his room with his roommate. She said it had been reported to her by someone in therapy that they smelled smoke in the residents' room. She said she went to the room and Resident #1 was leaning over his roommate and his genitals were rubbing on the roommate. She stated the video showed Resident #1's backside, naked from the waist down. She said she showed the video to LVN C. She said the purpose of filming the video was to show LVN C the residents behavior. She stated, .I shouldn't have done that. I should have verbally told the nurse or done a progress notes. The interview was conducted by the DON and the Clinical Resource Nurse. The interview was signed by RN A.</p> <p>On 10/22/24 at 11:30 a.m., an attempt was made to reach RN A by telephone. There was no answer. A detailed message requesting a return call was left on voicemail.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of an interview of LVN C dated 08/23/24 at 10:10 a.m. indicated that she knew about and had seen the video. She said she had seen the video. She said it was of Resident #1 walking over to his roommate. She said Resident #1 only had a shirt on. She said she just saw the back of Resident #1. She said she saw his buttocks. She said he was bending over to do something, and she could see his genitals hanging down. She said RN A had shown her from her phone. She stated RN A said, Oh my God, look what (Resident #1) did. She said RN A thought it was funny. She said she did not report the video. The interview was conducted by the DON and the Clinical Resource Nurse. The interview was signed by LVN C.</p> <p>Record review of an interview of the Transport Aide dated 08/23/24 at 10:20 a.m. indicated the Transport Aide was aware of and had seen the video. She said the video was shown to her by RN A. She said the video was of Resident #1 walking with a shirt on. She said she could see Resident #1's genitals. The interview indicated that the Transport Aide asked RN A why she had the video and RN A said something to her about when he was younger, he probably had big balls. The Transport Aide said she had seen the video weeks ago. The interview indicated the Transport Aide did not report the video to anyone and when asked why she said, I know I should have. I don't know why I didn't. The interview was conducted by the DON and the Clinical Resource Nurse. The interview was signed by the Transport Aide.</p> <p>During an interview on 10/22/24 at 3:34 p.m., the Transport Aide said she walked in one morning. She said RN A said to come see the video and said, it's really funny. She said she did not understand why RN A would have even filmed the video. She said she watched the video on RN A's phone, and it was never sent to her. She said she thought the video was shown to her in July 2024. She said the video was inappropriate. She said on the video she saw Resident #1 over by the air conditioner. She said RN A said, Look at his balls going back in forth, I bet when he was younger, he was bigger.</p> <p>Record review of an interview of CNA D dated 08/23/24 at 10:20 a.m. indicated CNA D was aware of the video and that she had seen the video. She said it was both shown to her and sent to her via text by RN A. She stated that on the video Resident #1 was standing by his roommate with no pants or underwear on, just a shirt. Resident #1 leaned over to help his roommate and she saw his buttocks, penis, and scrotum. She said it had been less than a month since she had seen the video. She said she did not report the video to anyone. The interview was conducted by the DON and the Clinical Resource Nurse. The interview was signed by CNA D.</p> <p>Record review of an interview of LVN E dated 08/23/24 at 10:20 a.m. indicated LVN E had heard about the video but had not seen the video. He stated it had been about a month since he had heard about the video. He said he heard there was a video of Resident #1's genitalia. He said RN A had told him about the video. He said he thought he should have reported the video but did not report the video. The interview was conducted by the DON and the Clinical Resource Nurse. The interview was signed by LVN E.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of an interview of the Staffing Coordinator dated 08/23/24 at 11:05 a.m. indicated the Staffing Coordinator became aware of the video on 08/22/24. The Staffing Coordinator stated RN A came to the office and stated that compliance had called her about a video she had taken of one of the residents and she was scared and didn't know what to do. The Staffing Coordinator indicated she had not seen the video and had only heard gossip about the video. She said the staff that were gossiping did explain what was in the video. She said she did not report what was in the video because it was just gossip. The interview was conducted by the DON and the Clinical Resource Nurse. The interview was signed by the Staffing Coordinator.</p> <p>During an interview on 10/22/24 at 11:42 a.m., the Staffing Coordinator said she was in the hallway on a day in August 2024. She did not remember the date. She said RN A pulled her into the office and said compliance had reached out to her and she did not know what to do. The Staffing Coordinator said RN A was scared. The Staffing Coordinator said RN A said, I think they are calling me about the video. The Staffing Coordinator said she had heard rumors about the video but was not sure if those rumors were true. She said she has never seen the video. She said she heard there was a video out of a resident that they had at the time. She said she did not know any details. She said RN A did not tell her what was on the video or show it to her. She said she reported the incident to the DON after RN A had come into her office.</p> <p>Record review of a telephone interview of the Treatment Nurse dated 08/23/24 at 11:15 a.m. indicated the Treatment Nurse was aware of and had seen the video. She said it was shown to her right before she went on maternity leave. She said in the video she could see Resident #1's behind and his scrotum between his legs. She said RN A had shown her the video. She said it was on RN A's phone. The Treatment Nurse said she had mentioned the video to Administrator G and ADON H. She said she may have reported it the next day but could not remember. She stated that RN A thought the video was funny and was showing staff. She said she told RN A that the video was inappropriate, and she should not be videoing the residents. The interview was conducted and signed by the DON and the Clinical Resource Nurse.</p> <p>During an interview on 10/22/2024 at 1:06 p.m., the Treatment Nurse said she went on leave in August 2024 . She said it would have been the middle of August 2024. She said RN A did show her the video. She said RN A did not send her the video. She said RN A stopped her in the hall and said, Hey look at this. She said you could see Resident #1 and his roommate messing with the air conditioner. She said Resident #1 only had a shirt on. She said you could see his scrotum. She said the video was from behind and she was not sure if you could see the resident's penis. She said it did not appear Resident #1 was aware he was being videoed. She said RN A was laughing about the video. She said she told RN A it was inappropriate, and RN A said, I just thought it was funny. She said she did report it immediately to the previous ADON H that and told Administrator G the same day. She said she told Administrator G on 07/30/24 or 07/31/24. She said Administrator G told her he would address it at the next all staff meeting.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Legend Oaks Healthcare and Rehabilitation Center G		STREET ADDRESS, CITY, STATE, ZIP CODE  1201 Fm 2685 Gladewater, TX 75647	
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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of a police Incident Report, dated 08/23/24 indicated Administrator G was the reportee. The report indicated the offense was solicitation to commit - invasive visual recording in bathroom/changing room. The report indicated RN A was the offender. The report indicated the officer spoke with Administrator G and the DON. The report indicated the DON explained that RN A recorded a patient in secret. The report indicated Resident #1 liked to walk around in the nude and RN A had secretly recorded Resident #1 and sent the video through text to RN B and made jokes about Resident #1. RN A showed her co-workers the video while making fun of Resident #1. The officer asked RN B if she still had the video and was told that she had deleted it. The report indicated on 08/27/24 it was concluded by (the facility) that (RN A) had acted inappropriately by recording (Resident #1) and was subsequently terminated for that reason. According to the interviews, (RN A) was distributing the video to other employees and making comments like, When he was younger, he probably had big balls and Look what you're missing out on. RN A herself was interviewed and stated that her reasoning for recording (Resident #1) was to provide his nurse with information on his behavior.</p> <p>During an interview on 10/22/24 at 9:28 a.m. a family member of Resident #1 said the incident of RN A videoing Resident #1 had been reported to the police. He said the investigating officer was Officer J. He said RN A took a video of Resident #1 and shared the video with her co-workers. The family member said they had not personally seen the video. They said Officer J had seen the video. He said Officer J had interviewed some of the facility staff at the police department and had taken several phones. The family member said one of the phones had produced the video. The family member said they did not know which one had. The family member said the facility was aware of the incident in July 2024. The family member said they were not notified of the video until the end of August 2024. The family member said Resident #1 had no memory of the incident. The family member said Resident #1 cannot even remember what he had for breakfast.</p> <p>During an interview and observation on 10/22/24 at 1:30 p.m., Officer J said nursing home staff did not report the video to the police department until a month after it was recorded. He said then the following week, Resident #1's family had reported the video to the police department. He said the first report was made on 8/23/2024. He said review of the video indicated a create date of 7/26/24. He said the police department still had custody of CNA D's and RN B's cell phones. He said they each gave consent for their phones to be searched. He said the video was eventually found on RN B's cellphone. He said on some of the phones there were text messages from the staff members and RN A discussing what Resident #1 might have looked like when he was younger. The video was observed in Officer J's office. The video showed Resident #1 from behind. Resident #1's roommate was sitting in a chair. Each resident had their backs to the camera. Resident #1 had on a polo type shirt. He was naked from the waist down. His buttocks and testicles were visible. At one point in the video, Resident #1 walked over to his roommate and bent over as if to help him with something. When the resident bent over it further exposed his testicles. In the background, there was heard a female voice laughing off and on throughout the video. At one point the female voice said, What is he doing? followed by more laughter.</p> <p>During an observation on 10/22/24 at 2:00 p.m., a video of RN B being interviewed by Officer J revealed RN B stated RN A had sent the video to a few people. RN B said the video was, inappropriate to say the least. RN B said RN A sent the video to her between 07/21/24 to 07/28/24. RN B said she had deleted the video from her phone after she found out that compliance had called RN A. RN B said she had deleted text messages from her phone also.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/23/24 at 8:25 a.m., RN B said she went on vacation for a whole week. She said she then tested positive for Covid and was off another week. She said texted RN A to ask what she had missed at work. She said RN A said, Hey I'm about to send you a video. She said she watched most of the video but not all of it. She said this was normal behavior for Resident #1 and she had seen this behavior daily. She said she felt the video was inappropriate. She said she thought the video was meant to be humorous. She said she thought she typed back, LOL. She said after that she did not think anything else about the video. She said she was sick, and she really did not give it much thought. She said RN A texted her and told her she had sent the video to several other people. She said she did not know the date the video was sent to her, but it was towards the end of July 2024 because she was home sick. She said Resident #1 had a shirt on and nothing below. She said he was walking away from the camera. She said that was as far as she watched. She said she could see his buttocks. She said she did not have her glasses on and did not see his testicles. She said around 8/28/24 she did have a meeting with Compliance. She said she had already deleted the video from her phone. She said now the police had her phone. She said it was sent to forensics and they found the video on the phone.</p> <p>During an observation on 10/22/24 at 2:10 p.m., a video of CNA D was being interviewed by Officer J. CNA D said she was shown the video in the hallway right after RN A had come out of Resident #1's room. CNA D said that at the nurse's station RN A was showing the video to LVN C, LVN E, and herself.</p> <p>During an interview on 10/22/24 at 4:20 p.m., CNA D said RN A sent the video to her the day she recorded the video. She said this date was 7/27/24 on her birthday. She said the resident's roommate was in his wheelchair over by the air conditioner. She said Resident #1 was standing over him with a polo type shirt on and was naked from the waist down. She said she could see his buttocks, testicles, and his penis. She said RN A did not tell her why she took the video. She said she could not remember the context of her conversation with RN A. She said she could not remember if she saw all of the video, but she did feel it was inappropriate. She said she did not report the video to anyone. She said she was not aware of anyone else seeing the video. She said RN A never showed the video to LVN C, LVN E, and herself at the nurse's station.</p> <p>During an interview on 10/22/24 at 2:38 p.m., LVN C said RN A just showed her the video to show her what he was doing. She said the video was just the back of Resident #1 walking over to his roommate with just a shirt on. She said you could not see his face. She said you could see his testicles from behind. She said the video was never sent to her. She said she was at her medication cart when RN A showed her the video. She said LVN E and CNA D were at the facility but were not present when she watched the video. She said the resident's behavior was not a shock to her because he did stuff like that all the time. She said the video was inappropriate and was not necessary. She said RN A was laughing and said, I can't believe this, look at him. She said she did not report the incident. She said at the time she did not think RN A was going to do anything with it. She said at the time she did not think about it reporting it. She said she was not sure of the date the video was taken. She said she felt RN A showed it to her immediately after it was recorded. She said Resident #1 had dementia and would not remember the incident. She said one time he had even walked down the hall with only a shirt on.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/22/24 at 3:24 p.m., PTA L said she was aware RN A took a video of Resident #1. She said RN A showed her the video on her phone. She said she saw Resident #1 in his room naked from the waist down. She said he had only a shirt on. She said he was walking around the room. She said as soon as she saw it, she quit watching the video. She said she did not know if it was the day, RN A took the video. She said she worked at different facilities and was not sure of the day. She said residents across the hall had complained about Resident #1 walking around naked. She said she told RN #1 about the complaint and that was when she showed her the video. She said after viewing the video she did not report it to anyone. She said she did not know why. She said the video made her uncomfortable. She said, I just didn't. I don't know why. I just didn't want that in my brain. She said when RN A showed her the video she was laughing. She thought it was funny. She said Resident #1 was not aware the incident happened.</p> <p>During an interview on 10/22/24 at 3:56 p.m., Administrator G said what occurred was HR K informed him that a video was going around. He said that was either 7/31/2024 or 8/2/2024. He said he thought it was in August 2024. He said he could not remember if she gave him details of the video. He said the allegation did not hit his abuse and neglect radar. He said about two weeks later the DON was informed of the video and communicated the details the video to him and it was reported. He said RN A was suspended immediately and never brought back from suspension. He said he did send a text to the Treatment Nurse on 08/02/24. He said he did say the video was inappropriate. He said he just did not realize how bad the video was or the response would have been completely different. He said he had never seen the video. He said he left the facility sometime in August 2024. He said he was given the option to resign.</p> <p>During an interview 10/22/24 at 4:12 p.m., the Social Worker said she was not even aware of the video until compliance got involved. She said she usually did a checkup with residents after any incident. She said she did safe surveys and there were no concerns. She said she did talk to Resident #1. She said Administrator G had just come out of his room, so the incident was fresh on Resident #1's mind. She said he did not seem upset. She said he did say, I just don't know why someone would do something like that. I'm not going to let it affect me. She said she did get an order for psychology services to check on him.</p> <p>During an interview on 10/23/24 at 8:50 a.m., ADON H said she quit working at the facility on approximately 8/12/24. She said she became aware of the video in July 2024 on a Wednesday. She said the Treatment Nurse had told her. She said she told the Treatment Nurse that she needed to report the video to the DON and Administrator G. ADON H said she reported the video to Compliance on 8/3/24 at 2:00 a.m. She said therefore she was told about the video on 7/31/24. ADON H said she never saw the video. She said the Transport Aide did tell her on 08/09/24 that she had seen the video. She said she quit working at the facility because she felt things were not being addressed. She said there were a few other reasons. She said she understood the facility did not want a tag, but they had to do the right thing. She said she knew the DON was made aware of the video on 7/31/24 and HR K told her again on 8/12/24.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/23/24 at 9:14 a.m., HR K said she found out about the video on 8/2/24. She said ADON H told her about the video. She said RN A was going around showing everyone videos of Resident #1 walking around in his room butt naked. She said she immediately texted Administrator G. She said he said he texted her back and Oh no that is really bad. The family could sue us. Could you please tell the nurse's that is not funny, and they should not be doing that? She said nothing happened after that. She said there was no investigation. She said she reported it to the DON on 8/12/24 and voiced her concerns about nothing happening. She said, and still nothing was done. She said she never saw the video. She said she was told by multiple people it did exist and what it consisted of.</p> <p>During an interview on 10/23/24 at 9:31 a.m., the DON said she first became aware of the video approximately 2 days before she reported the incident to the state. She said HR K told her but did not tell her any details about the video. She said prior to 8/21/24 she had not even heard of the video. She said she was on vacation 7/30/24 - 8/5/24. She said the video was not reported to her during that time. She said on 8/22/24 she became aware of the content of the video. She said she was told by the Staffing Coordinator. She said the Staffing Coordinator told her there was a video of Resident #1 with his genitals exposed and that RN A had taken the video. She said she suspended RN A immediately. She said she discussed the video with the Administrator G. She said he told her he had no idea about the video. She said she went back to HR K and asked her if she had reported the incident to Administrator G. She said HR K showed her a text message showing that she had reported the video to Administrator G. She said the text was dated 8/2/24. She said to her knowledge there was no investigation started by Administrator G. She said she began the investigation herself on 8/23/24. She said her investigation concluded that RN A had taken the video of Resident #1 and had shown multiple co-workers. She said RN A was terminated on 08/26/24. She said she had not seen the video. She said all staff that had knowledge of or saw the video was given final written warnings for failure to report. She said once she heard the content of the video, she felt it was abuse. She said she felt it should have been reported and investigated right from the very beginning. She said she did talk to Resident #1 about the video. She said he did not remember the incident unless it was brought up by staff. She said she did feel like this was a dignity issue. She said he had been the mayor at one time. She said he was a photographer. She said he could not help his behavior.</p> <p>During an interview on 10/23/24 at 1:30 p.m. RN B said if this happened to herself or a family member, she would feel awful. She said, I would be so mad.</p> <p>During an interview on 10/23/24 at 2:21 p.m., a family member of Resident #1 said in the condition of dementia or Alzheimer's they would not know if this had happened to them. The family member said if they did know, they would feel it was demeaning or demoralizing and against all privacy. They said they thought the whole thing horrible. They said Resident #1 had been a very private but public person. The family member said Resident #1 was the mayor at one time. The family member said Resident #1 never discussed the birds and bees with them because he was a private person. The family member said Resident #1 would not have liked this at all.</p> <p>During an interview on 10/23/24 at 2:43 p.m., the Social Worker said if this happened to her or a family member she would be upset. She said she would probably feel embarrassed.</p> <p>During an interview on 10/23/24 at 3:00 p.m., the Treatment Nurse said this had happened to her dad she would be hell mad. She said the video was a dignity issue and abusive to the resident.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/23/24 at 3:18 p.m., CNA D if someone took a video of her or a family member naked, she would be livid. She said if it were her, she would feel humiliated.</p> <p>During an interview on 10/23/24 at 3:23 p.m., the Activity Director said if someone videoed her naked and shared it with others, she would be ashamed, mad, embarrassed and just pissed off.</p> <p>During an interview on 10/23/24 at 3:26 p.m., ADON F said she was a floor nurse when the video was taken. She said she never even heard about the video until there were in-services. She said if this happened to her or her family it would be upsetting. She said it was a modesty and dignity issue. She said it was a lack of respect.</p> <p>During an interview on 10/23/24 at 3:31 p.m., PTA L said if it happened to her, she would not like it at all. She said she would be extremely embarrassed and angry. She said she did take seriously that these are people's lives and they had feelings.</p> <p>During an interview on 10/23/24 at 3:46 p.m., LVN C said if someone took a video of her naked and shared it with other people, she would feel embarrassed and violated.</p> <p>During an interview on 10/23/24 at 4:02 p.m., LVN E said if this happened to family it would made him highly upset. He said he would be furious if it happened to him. He said it would be a total invasion of privacy.</p> <p>During an interview on 10/23/24 at 4:12 p.m., the Staffing Coordinator said if someone took a video of her naked and shared it with other people, she would feel embarrassed.</p> <p>During an interview on 10/23/24 at 4:21 p.m., the Clinical Resource Nurse said she learned of the video during one of her weekly visits. She said it was probably on 08/22/24 or 08/23/24. She said she was told there was a nurse that had taken an inappropriate video of a resident not fully dressed and that it was sent to a staff member that was not on duty that day. She said she interviewed RN A. She said RN A was off that day and she was told she had to come to the facility to be interviewed. She said RN A admitted to taking the video. She said during interview RN A said, there was no reason for taking the video. She RN A said during that interview she had shown the video to no one. The Clinical Resource Nurse said she never saw the video. She said RN A told her the video was no longer on her phone, and she had deleted the video. She said every staff member was in-serviced. She said there were some one-on-one in-services. She said these were with the people that were disciplined. She said RN A was suspended that day. She said RN A's license were referred to the state. She said if this happened to her, she would be humiliated. She said it would be humiliating regardless of her age. She said she was angry and very emotional about what happened. She said it was just disgusting. She said she had assisted with safe surveys and with Resident #1 and he had no concerns. She said she did know Administrator G had interviewed the resident. She said Administrator G told her the resident did not recall the incident. She said Administrator G was asked to resign or he would be terminated.</p> <p>During an interview on 10/23/24 at 4:45 p.m., the DON said if someone took a video of her naked and shared it with other people, she would feel absolutely disgusted, violated, and awful.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/22/24 at 4:46 p.m., Administrator M said he was not the administrator when the incident happened or when it was first reported. He said his first day was on 10/2/24. He said he would consider the video abuse. He said abuse sums it up. He said if it happened to him, he would feel terrified and abused. He said it was never something you wanted to see in your own facility.</p> <p>Record review of a Counseling/Disciplinary Notice dated 08/22/24 indicated an allegation of abuse was identified and RN A was suspended pending investigation. RN A was notified</p>

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128</b></p> <p>Based on observation, interview and record review, the facility failed to ensure an allegation of abuse was thoroughly investigated for 1 of 11 residents reviewed for abuse. (Resident #1)</p> <p>The facility Administrator, Administrator G, failed to investigate an incident where RN A videoed Resident #1 in his room naked from the waist down. RN A shared the video with other staff.</p> <p>The facility failed to protect Resident #1 from potential further abuse after the allegation. RN A was allowed to work from the date of the incident until she was suspended on 08/22/24.</p> <p>The noncompliance was identified as PNC. The Immediate Jeopardy (IJ) began on 07/26/24 and ended on 08/30/24. The facility had corrected the noncompliance before the survey began.</p> <p>These failures could place residents at risk for further abuse, physical or psychological harm or injury.</p> <p>Findings included:</p> <p>Record review of a face sheet dated 10/22/24 revealed Resident #1 was an [AGE] year-old male and admitted on [DATE] with diagnoses including dementia, depression, and anxiety.</p> <p>Record review of a quarterly MDS dated [DATE] revealed Resident #1 was understood and usually understood others. The MDS revealed a BIMS score of 7, indicating severe cognitive impairment. The MDS indicated Resident #1 required supervision with most ADLs.</p> <p>Record review of Resident #1's physician's orders indicated on dated 08/23/24 indicated a verbal order was obtained to monitor for emotional distress every shift for 3 days.</p> <p>Record review of a care plan last revised on 10/12/24 revealed Resident #1 was at risk for impaired thought processes related to a history of dementia. Resident #1 needed assistance with all decision making. Resident #1 had an ADL self-care performance deficit related to decreased mobility and intermittent confusion. The care plan indicated Resident #1 had potential for a behavior problem as evidenced by inappropriate sexual behaviors. There was an intervention to provide privacy and encourage resident to remain clothed per family request.</p> <p>Record review of text messages dated 08/02/24 at 6:14 p.m., indicated texts between HR K and Administrator G. The texts indicated HR K wrote, .And ANOTHER note, I don't know who, how or where it originated from but there has been a video taken of (Resident #1) with no pants on and making its way around the building. Administrator G responded, Oh no! If you're still there, will you mention to one or two of the staff at the nurse's station that any videos taken of residents against their will can give family members a foot hold to sue whoever has the video. HR K responded, I left unfortunately but I was told over the phone, not in person at the facility or I would have said just that and how it's not funny. Administrator G responded, Mmm, ok. I'll mention it to (the Treatment Nurse).</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Legend Oaks Healthcare and Rehabilitation Center G		STREET ADDRESS, CITY, STATE, ZIP CODE  1201 Fm 2685 Gladewater, TX 75647	
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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of a text message dated 08/02/24 at 6:38 p.m., to the Treatment Nurse from Administrator G indicated, Hey, I just got word that there's an inappropriate video of (Resident #1) going around the facility. Will you mention to the staff that any videos taken of residents against their will can give family members a foot hold to sue whoever has the video. It has happened to our sister facility .</p> <p>Record review of a Grievance Resolution Form dated 08/23/24 indicated Resident #1 was involved in a video without his knowledge. The report indicated the compliance department was involved and notified administration.</p> <p>Record review of a Progress Note dated 08/23/24 indicated, SW (Social Worker) visited with resident (Resident #1) this afternoon .SW noticed no change in his mood or behavior after he was notified of the incident. He continues to show confusion, per his usual state. He states I am OK. I am not going to let this effect my life. He is agreeable to speaking with (psych services). SW has sent in a referral for evaluation and spoke with .counselor, re: the incident. SW will continue to monitor resident and will assist further as needed. The note was signed by the Social Worker.</p> <p>Record review of Nurse's notes for Resident #1 dated 08/23/24 - 08/28/24 indicated Resident #1 was monitored for mood and distress. The notes did not indicate Resident #1 had a change in mood or emotional distress.</p> <p>Record review of an Investigation Summary and Timeline report dated 08/30/24 indicated the DON was notified of the allegation of abuse on 08/22/24 at approximately 5:00 p.m. related to the conduct of RN A. The allegation suggested that the nurse had taken an unauthorized video of a resident. RN A was immediately suspended at the time it was reported, pending investigation. During the interview process, it was confirmed that RN A had taken a video of a resident while in his room The resident was not wearing pants and his genitals were visible. The Investigation Summary and Timeline indicated that Resident #1 had been interviewed by Administrator G and had knowledge of the video at the time of the interview. The Investigation Summary and Timeline report indicated RN A was terminated in person on 08/26/24. The report indicated the police were notified and the RP requested to press charges against RN A.</p> <p>Record review of a Provider Investigation Report dated 08/23/24 indicated that on an unknown date RN A took an unauthorized video of Resident #1. The investigation findings were confirmed.</p> <p>Record review of an interview of RN A dated 08/23/24 at 9:30 a.m. indicated she had taken a video of Resident #1. She stated Resident #1 had been in his room with his roommate. She said it had been reported to her by someone in therapy that they smelled smoke in the residents' room. She said she went to the room and Resident #1 was leaning over his roommate and his genitals were rubbing on the roommate. She stated the video showed Resident #1's backside, naked from the waist down. She said she showed the video to LVN C. She said the purpose of filming the video was to show LVN C the residents behavior. She stated, .I shouldn't have done that. I should have verbally told the nurse or done a progress notes. The interview was conducted by the DON and the Clinical Resource Nurse. The interview was signed by RN A.</p> <p>On 10/22/24 at 11:30 a.m., an attempt was made to reach RN A by telephone. There was no answer. A detailed message requesting a return call was left on voicemail.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of an interview of LVN C dated 08/23/24 at 10:10 a.m. indicated that she knew about and had seen the video. She said she had seen the video. She said it was of Resident #1 walking over to his roommate. She said Resident #1 only had a shirt on. She said she just saw the back of Resident #1. She said she saw his buttocks. She said he was bending over to do something, and she could see his genitals hanging down. She said RN A had shown her from her phone. She stated RN A said, Oh my God, look what (Resident #1) did. She said RN A thought it was funny. She said she did not report the video. The interview was conducted by the DON and the Clinical Resource Nurse. The interview was signed by LVN C.</p> <p>Record review of an interview of the Transport Aide dated 08/23/24 at 10:20 a.m. indicated the Transport Aide was aware of and had seen the video. She said the video was shown to her by RN A. She said the video was of Resident #1 walking with a shirt on. She said she could see Resident #1's genitals. The interview indicated that the Transport Aide asked RN A why she had the video and RN A said something to her about when he was younger, he probably had big balls. The Transport Aide said she had seen the video weeks ago. The interview indicated the Transport Aide did not report the video to anyone and when asked why she said, I know I should have. I don't know why I didn't. The interview was conducted by the DON and the Clinical Resource Nurse. The interview was signed by the Transport Aide.</p> <p>During an interview on 10/22/24 at 3:34 p.m., the Transport Aide said she walked in one morning. She said RN A said to come see the video and said, it's really funny. She said she did not understand why RN A would have even filmed the video. She said she watched the video on RN A's phone, and it was never sent to her. She said she thought the video was shown to her in July 2024. She said the video was inappropriate. She said on the video she saw Resident #1 over by the air conditioner. She said RN A said, Look at his balls going back in forth, I bet when he was younger, he was bigger.</p> <p>Record review of an interview of CNA D dated 08/23/24 at 10:20 a.m. indicated CNA D was aware of the video and that she had seen the video. She said it was both shown to her and sent to her via text by RN A. She stated that on the video Resident #1 was standing by his roommate with no pants or underwear on, just a shirt. Resident #1 leaned over to help his roommate and she saw his buttocks, penis, and scrotum. She said it had been less than a month since she had seen the video. She said she did not report the video to anyone. The interview was conducted by the DON and the Clinical Resource Nurse. The interview was signed by CNA D.</p> <p>Record review of an interview of LVN E dated 08/23/24 at 10:20 a.m. indicated LVN E had heard about the video but had not seen the video. He stated it had been about a month since he had heard about the video. He said he heard there was a video of Resident #1's genitalia. He said RN A had told him about the video. He said he thought he should have reported the video but did not report the video. The interview was conducted by the DON and the Clinical Resource Nurse. The interview was signed by LVN E.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of an interview of the Staffing Coordinator dated 08/23/24 at 11:05 a.m. indicated the Staffing Coordinator became aware of the video on 08/22/24. The Staffing Coordinator stated RN A came to the office and stated that compliance had called her about a video she had taken of one of the residents and she was scared and didn't know what to do. The Staffing Coordinator indicated she had not seen the video and had only heard gossip about the video. She said the staff that were gossiping did explain what was in the video. She said she did not report what was in the video because it was just gossip. The interview was conducted by the DON and the Clinical Resource Nurse. The interview was signed by the Staffing Coordinator.</p> <p>During an interview on 10/22/24 at 11:42 a.m., the Staffing Coordinator said she was in the hallway on a day in August 2024. She did not remember the date. She said RN A pulled her into the office and said compliance had reached out to her and she did not know what to do. The Staffing Coordinator said RN A was scared. The Staffing Coordinator said RN A said, I think they are calling me about the video. The Staffing Coordinator said she had heard rumors about the video but was not sure if those rumors were true. She said she has never seen the video. She said she heard there was a video out of a resident that they had at the time. She said she did not know any details. She said RN A did not tell her what was on the video or show it to her. She said she reported the incident to the DON after RN A had come into her office.</p> <p>Record review of a telephone interview of the Treatment Nurse dated 08/23/24 at 11:15 a.m. indicated the Treatment Nurse was aware of and had seen the video. She said it was shown to her right before she went on maternity leave. She said in the video she could see Resident #1's behind and his scrotum between his legs. She said RN A had shown her the video. She said it was on RN A's phone. The Treatment Nurse said she had mentioned the video to Administrator G and ADON H. She said she may have reported it the next day but could not remember. She stated that RN A thought the video was funny and was showing staff. She said she told RN A that the video was inappropriate, and she should not be videoing the residents. The interview was conducted and signed by the DON and the Clinical Resource Nurse.</p> <p>During an interview on 10/22/2024 at 1:06 p.m., the Treatment Nurse said she went on leave in August 2024 . She said it would have been the middle of August 2024. She said RN A did show her the video. She said RN A did not send her the video. She said RN A stopped her in the hall and said, Hey look at this. She said you could see Resident #1 and his roommate messing with the air conditioner. She said Resident #1 only had a shirt on. She said you could see his scrotum. She said the video was from behind and she was not sure if you could see the resident's penis. She said it did not appear Resident #1 was aware he was being videoed. She said RN A was laughing about the video. She said she told RN A it was inappropriate, and RN A said, I just thought it was funny. She said she did report it immediately to the previous ADON H that and told Administrator G the same day. She said she told Administrator G on 07/30/24 or 07/31/24. She said Administrator G told her he would address it at the next all staff meeting.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of a police Incident Report, dated 08/23/24 indicated Administrator G was the reportee. The report indicated the offense was solicitation to commit - invasive visual recording in bathroom/changing room. The report indicated RN A was the offender. The report indicated the officer spoke with Administrator G and the DON. The report indicated the DON explained that RN A recorded a patient in secret. The report indicated Resident #1 liked to walk around in the nude and RN A had secretly recorded Resident #1 and sent the video through text to RN B and made jokes about Resident #1. RN A showed her co-workers the video while making fun of Resident #1. The officer asked RN B if she still had the video and was told that she had deleted it. The report indicated on 08/27/24 it was concluded by (the facility) that (RN A) had acted inappropriately by recording (Resident #1) and was subsequently terminated for that reason. According to the interviews, (RN A) was distributing the video to other employees and making comments like, When he was younger, he probably had big balls and Look what you're missing out on. RN A herself was interviewed and stated that her reasoning for recording (Resident #1) was to provide his nurse with information on his behavior.</p> <p>During an interview on 10/22/24 at 9:28 a.m. a family member of Resident #1 said the incident of RN A videoing Resident #1 had been reported to the police. He said the investigating officer was Officer J. He said RN A took a video of Resident #1 and shared the video with her co-workers. The family member said they had not personally seen the video. They said Officer J had seen the video. He said Officer J had interviewed some of the facility staff at the police department and had taken several phones. The family member said one of the phones had produced the video. The family member said they did not know which one had. The family member said the facility was aware of the incident in July 2024. The family member said they were not notified of the video until the end of August 2024. The family member said Resident #1 had no memory of the incident. The family member said Resident #1 cannot even remember what he had for breakfast.</p> <p>During an interview and observation on 10/22/24 at 1:30 p.m., Officer J said nursing home staff did not report the video to the police department until a month after it was recorded. He said then the following week, Resident #1's family had reported the video to the police department. He said the first report was made on 8/23/2024. He said review of the video indicated a create date of 7/26/24. He said the police department still had custody of CNA D's and RN B's cell phones. He said they each gave consent for their phones to be searched. He said the video was eventually found on RN B's cellphone. He said on some of the phones there were text messages from the staff members and RN A discussing what Resident #1 might have looked like when he was younger. The video was observed in Officer J's office. The video showed Resident #1 from behind. Resident #1's roommate was sitting in a chair. Each resident had their backs to the camera. Resident #1 had on a polo type shirt. He was naked from the waist down. His buttocks and testicles were visible. At one point in the video, Resident #1 walked over to his roommate and bent over as if to help him with something. When the resident bent over it further exposed his testicles. In the background, there was heard a female voice laughing off and on throughout the video. At one point the female voice said, What is he doing? followed by more laughter.</p> <p>During an observation on 10/22/24 at 2:00 p.m., a video of RN B being interviewed by Officer J revealed RN B stated RN A had sent the video to a few people. RN B said the video was, inappropriate to say the least. RN B said RN A sent the video to her between 07/21/24 to 07/28/24. RN B said she had deleted the video from her phone after she found out that compliance had called RN A. RN B said she had deleted text messages from her phone also.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/23/24 at 8:25 a.m., RN B said she went on vacation for a whole week. She said she then tested positive for Covid and was off another week. She said she texted RN A to ask what she had missed at work. She said RN A said, Hey I'm about to send you a video. She said she watched most of the video but not all of it. She said this was normal behavior for Resident #1 and she had seen this behavior daily. She said she felt the video was inappropriate. She said she thought the video was meant to be humorous. She said she thought she typed back, LOL. She said after that she did not think anything else about the video. She said she was sick, and she really did not give it much thought. She said RN A texted her and told her she had sent the video to several other people. She said she did not know the date the video was sent to her, but it was towards the end of July 2024 because she was home sick. She said Resident #1 had a shirt on and nothing below. She said he was walking away from the camera. She said that was as far as she watched. She said she could see his buttocks. She said she did not have her glasses on and did not see his testicles. She said around 8/28/24 she did have a meeting with Compliance. She said she had already deleted the video from her phone. She said now the police had her phone. She said it was sent to forensics and they found the video on the phone.</p> <p>During an observation on 10/22/24 at 2:10 p.m., a video of CNA D was being interviewed by Officer J. CNA D said she was shown the video in the hallway right after RN A had come out of Resident #1's room. CNA D said that at the nurse's station RN A was showing the video to LVN C, LVN E, and herself.</p> <p>During an interview on 10/22/24 at 4:20 p.m., CNA D said RN A sent the video to her the day she recorded the video. She said this date was 7/27/24 on her birthday. She said the resident's roommate was in his wheelchair over by the air conditioner. She said Resident #1 was standing over him with a polo type shirt on and was naked from the waist down. She said she could see his buttocks, testicles, and his penis. She said RN A did not tell her why she took the video. She said she could not remember the context of her conversation with RN A. She said she could not remember if she saw all of the video, but she did feel it was inappropriate. She said she did not report the video to anyone. She said she was not aware of anyone else seeing the video. She said RN A never showed the video to LVN C, LVN E, and herself at the nurse's station.</p> <p>During an interview on 10/22/24 at 2:38 p.m., LVN C said RN A just showed her the video to show her what he was doing. She said the video was just the back of Resident #1 walking over to his roommate with just a shirt on. She said you could not see his face. She said you could see his testicles from behind. She said the video was never sent to her. She said she was at her medication cart when RN A showed her the video. She said LVN E and CNA D were at the facility but were not present when she watched the video. She said the resident's behavior was not a shock to her because he did stuff like that all the time. She said the video was inappropriate and was not necessary. She said RN A was laughing and said, I can't believe this, look at him. She said she did not report the incident. She said at the time she did not think RN A was going to do anything with it. She said at the time she did not think about it reporting it. She said she was not sure of the date the video was taken. She said she felt RN A showed it to her immediately after it was recorded. She said Resident #1 had dementia and would not remember the incident. She said one time he had even walked down the hall with only a shirt on.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/22/24 at 3:24 p.m., PTA L said she was aware RN A took a video of Resident #1. She said RN A showed her the video on her phone. She said she saw Resident #1 in his room naked from the waist down. She said he had only a shirt on. She said he was walking around the room. She said as soon as she saw it, she quit watching the video. She said she did not know if it was the day, RN A took the video. She said she worked at different facilities and was not sure of the day. She said residents across the hall had complained about Resident #1 walking around naked. She said she told RN #1 about the complaint and that was when she showed her the video. She said after viewing the video she did not report it to anyone. She said she did not know why. She said the video made her uncomfortable. She said, I just didn't. I don't know why. I just didn't want that in my brain. She said when RN A showed her the video she was laughing. She thought it was funny. She said Resident #1 was not aware the incident happened.</p> <p>During an interview on 10/22/24 at 3:56 p.m., Administrator G said what occurred was HR K informed him that a video was going around. He said that was either 7/31/2024 or 8/2/2024. He said he thought it was in August 2024. He said he could not remember if she gave him details of the video. He said the allegation did not hit his abuse and neglect radar. He said about two weeks later the DON was informed of the video and communicated the details the video to him and it was reported. He said RN A was suspended immediately and never brought back from suspension. He said he did send a text to the Treatment Nurse on 08/02/24. He said he did say the video was inappropriate. He said he just did not realize how bad the video was or the response would have been completely different. He said he had never seen the video. He said he left the facility sometime in August 2024. He said he was given the option to resign.</p> <p>During an interview 10/22/24 at 4:12 p.m., the Social Worker said she was not even aware of the video until compliance got involved. She said she usually did a checkup with residents after any incident. She said she did safe surveys and there were no concerns. She said she did talk to Resident #1. She said Administrator G had just come out of his room, so the incident was fresh on Resident #1's mind. She said he did not seem upset. She said he did say, I just don't know why someone would do something like that. I'm not going to let it affect me. She said she did get an order for psychology services to check on him.</p> <p>During an interview on 10/23/24 at 8:50 a.m., ADON H said she quit working at the facility on approximately 8/12/24. She said she became aware of the video in July 2024 on a Wednesday. She said the Treatment Nurse had told her. She said she told the Treatment Nurse that she needed to report the video to the DON and Administrator G. ADON H said she reported the video to Compliance on 8/3/24 at 2:00 a.m. She said therefore she was told about the video on 7/31/24. ADON H said she never saw the video. She said the Transport Aide did tell her on 08/09/24 that she had seen the video. She said she quit working at the facility because she felt things were not being addressed. She said there were a few other reasons. She said she understood the facility did not want a tag, but they had to do the right thing. She said she knew the DON was made aware of the video on 7/31/24 and HR K told her again on 8/12/24.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/23/24 at 9:14 a.m., HR K said she found out about the video on 8/2/24. She said ADON H told her about the video. She said RN A was going around showing everyone videos of Resident #1 walking around in his room butt naked. She said she immediately texted Administrator G. She said he said he texted her back and Oh no that is really bad. The family could sue us. Could you please tell the nurse's that is not funny, and they should not be doing that? She said nothing happened after that. She said there was no investigation. She said she reported it to the DON on 8/12/24 and voiced her concerns about nothing happening. She said, and still nothing was done. She said she never saw the video. She said she was told by multiple people it did exist and what it consisted of.</p> <p>During an interview on 10/23/24 at 9:31 a.m., the DON said she first became aware of the video approximately 2 days before she reported the incident to the state. She said HR K told her but did not tell her any details about the video. She said prior to 8/21/24 she had not even heard of the video. She said she was on vacation 7/30/24 - 8/5/24. She said the video was not reported to her during that time. She said on 8/22/24 she became aware of the content of the video. She said she was told by the Staffing Coordinator. She said the Staffing Coordinator told her there was a video of Resident #1 with his genitals exposed and that RN A had taken the video. She said she suspended RN A immediately. She said she discussed the video with the Administrator G. She said he told her he had no idea about the video. She said she went back to HR K and asked her if she had reported the incident to Administrator G. She said HR K showed her a text message showing that she had reported the video to Administrator G. She said the text was dated 8/2/24. She said to her knowledge there was no investigation started by Administrator G. She said she began the investigation herself on 8/23/24. She said her investigation concluded that RN A had taken the video of Resident #1 and had shown multiple co-workers. She said RN A was terminated on 08/26/24. She said she had not seen the video. She said all staff that had knowledge of or saw the video was given final written warnings for failure to report. She said once she heard the content of the video, she felt it was abuse. She said she felt it should have been reported and investigated right from the very beginning. She said she did talk to Resident #1 about the video. She said he did not remember the incident unless it was brought up by staff. She said she did feel like this was a dignity issue. She said he had been the mayor at one time. She said he was a photographer. She said he could not help his behavior.</p> <p>During an interview on 10/23/24 at 1:30 p.m. RN B said if this happened to herself or a family member, she would feel awful. She said, I would be so mad.</p> <p>During an interview on 10/23/24 at 2:21 p.m., a family member of Resident #1 said in the condition of dementia or Alzheimer's they would not know if this had happened to them. The family member said if they did know, they would feel it was demeaning or demoralizing and against all privacy. They said they thought the whole thing horrible. They said Resident #1 had been a very private but public person. The family member said Resident #1 was the mayor at one time. The family member said Resident #1 never discussed the birds and bees with them because he was a private person. The family member said Resident #1 would not have liked this at all.</p> <p>During an interview on 10/23/24 at 2:43 p.m., the Social Worker said if this happened to her or a family member she would be upset. She said she would probably feel embarrassed.</p> <p>During an interview on 10/23/24 at 3:00 p.m., the Treatment Nurse said this had happened to her dad she would be hell mad. She said the video was a dignity issue and abusive to the resident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676048	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/23/2024
NAME OF PROVIDER OR SUPPLIER  Legend Oaks Healthcare and Rehabilitation Center G		STREET ADDRESS, CITY, STATE, ZIP CODE  1201 Fm 2685 Gladewater, TX 75647	
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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/23/24 at 3:18 p.m., CNA D if someone took a video of her or a family member naked, she would be livid. She said if it were her, she would feel humiliated.</p> <p>During an interview on 10/23/24 at 3:23 p.m., the Activity Director said if someone videoed her naked and shared it with others, she would be ashamed, mad, embarrassed and just pissed off.</p> <p>During an interview on 10/23/24 at 3:26 p.m., ADON F said she was a floor nurse when the video was taken. She said she never even heard about the video until there were in-services. She said if this happened to her or her family it would be upsetting. She said it was a modesty and dignity issue. She said it was a lack of respect.</p> <p>During an interview on 10/23/24 at 3:31 p.m., PTA L said if it happened to her, she would not like it at all. She said she would be extremely embarrassed and angry. She said she did take seriously that these are people's lives and they had feelings.</p> <p>During an interview on 10/23/24 at 3:46 p.m., LVN C said if someone took a video of her naked and shared it with other people, she would feel embarrassed and violated.</p> <p>During an interview on 10/23/24 at 4:02 p.m., LVN E said if this happened to family it would made him highly upset. He said he would be furious if it happened to him. He said it would be a total invasion of privacy.</p> <p>During an interview on 10/23/24 at 4:12 p.m., the Staffing Coordinator said if someone took a video of her naked and shared it with other people, she would feel embarrassed.</p> <p>During an interview on 10/23/24 at 4:21 p.m., the Clinical Resource Nurse said she learned of the video during one of her weekly visits. She said it was probably on 08/22/24 or 08/23/24. She said she was told there was a nurse that had taken an inappropriate video of a resident not fully dressed and that it was sent to a staff member that was not on duty that day. She said she interviewed RN A. She said RN A was off that day and she was told she had to come to the facility to be interviewed. She said RN A admitted to taking the video. She said during interview RN A said, there was no reason for taking the video. She RN A said during that interview she had shown the video to no one. The Clinical Resource Nurse said she never saw the video. She said RN A told her the video was no longer on her phone, and she had deleted the video. She said every staff member was in-serviced. She said there were some one-on-one in-services. She said these were with the people that were disciplined. She said RN A was suspended that day. She said RN A's license were referred to the state. She said if this happened to her, she would be humiliated. She said it would be humiliating regardless of her age. She said she was angry and very emotional about what happened. She said it was just disgusting. She said she had assisted with safe surveys and with Resident #1 and he had no concerns. She said she did know Administrator G had interviewed the resident. She said Administrator G told her the resident did not recall the incident. She said Administrator G was asked to resign or he would be terminated.</p> <p>During an interview on 10/23/24 at 4:45 p.m., the DON said if someone took a video of her naked and shared it with other people, she would feel absolutely disgusted, violated, and awful.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Legend Oaks Healthcare and Rehabilitation Center G		STREET ADDRESS, CITY, STATE, ZIP CODE  1201 Fm 2685 Gladewater, TX 75647	

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/22/24 at 4:46 p.m., Administrator M said he was not the administrator when the incident happened or when it was first reported. He said his first day was on 10/2/24. He said he would consider the video abuse. He said abuse sums it up. He said if it happened to him, he would feel terrified and abused. He said it was never something you wanted to see in your own facility.</p> <p>Record review of a Counseling/Disciplinary Notice dated 08/22/24 indicated an allegation of abuse was identified and RN A was suspended pending investigation. RN A was notified at 5:08 p.m. by the DON.</p> <p>Record review of a Counseling/Disciplinary Notice dated 08/ [TRUNCATED]</p>