

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676086	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/25/2024
NAME OF PROVIDER OR SUPPLIER Goldthwaite Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1207 S Reynolds St Goldthwaite, TX 76844	

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 - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32218</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 5 of 9 residents (Residents #1, #2, #3, #4, and #5) reviewed for abuse.</p> <ol style="list-style-type: none"> The facility failed to prevent COTA D from sexually abusing Resident #1 when COTA D had intercourse with the resident in the resident's room after the resident was on the therapist's caseload. The facility failed to protect Resident #2 when COTA D removed the resident's pants for therapy treatment. The facility failed to prevent COTA D from touching Resident #4 and Resident #5's buttocks while rubbing their back during their therapy session. The facility failed to prevent COTA D from touching Resident #3's buttock and genitalia while rubbing her back during her therapy session. <p>An Immediate Jeopardy (IJ) was identified on 5/23/2024. The IJ template was provided to the facility on [DATE] at 4:43 p.m. While the IJ was removed on 5/25/2024, the facility remained out of compliance at a scope of pattern, with a potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>These failures could place residents at risk of sexual abuse from facility staff.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Record review of Resident #1's face sheet, dated 5/24/2024, reflected a [AGE] year-old female who was initially admitted to the facility on [DATE] and had diagnoses that included hypertensive heart disease with heart failure (heart problems caused by long-term heart pressure), morbid obesity due to excessive calories (weight that is 80 to 100 pounds above their ideal body weight), body mass index (a ratio of your weight to your height) of 70 or greater, type 2 diabetes mellitus (when the pancreas does not make insulin), sleep apnea (a sleep disorder in which breathing repeatedly stops and starts), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (frequent feelings of fear and worry that is intense and excessive). <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 - Some</p>	<p>Record review of Resident #1's care plan, initiated 11/22/2021, reflected the resident had a potential to exhibit withdrawal from activities and socialization due to health condition, physical, and mental limitations, problems, concerns, etc. The care plan interventions included the Social Worker providing support and verbalization of feelings, thoughts, needs, problems, and concerns.</p> <p>Record review of Resident #1's annual MDS assessment, dated 12/22/2023 reflected a BIMS score was 15, which indicated the resident was cognitively intact. Resident #1 had no mood or behavioral concerns and used a walker and wheelchair for ambulation.</p> <p>Record review of Resident #1's May 2024 Consolidated Physician Orders reflected an order, with a start date of 10/12/2023, that the resident had Occupational Therapy 4 times a week for 30 days.</p> <p>Record review of the Facility Incident Report, dated 2/29/2024, reflected Resident #1 reported to the facility during the months of September and October 2023, COTA D had gaslight me and groomed me for a relationship and she realized he had been taking advantage of her. The report reflected COTA D had intercourse with Resident #1 in the resident's room.</p> <p>Record review of the Police Report Case Identification Number 24-00293, dated 2/29/2024, reflected the police were informed by the facility of COTA D's inappropriate sexual behavior with residents.</p> <p>Record review of COTA D's personnel file revealed the COTA was hired on 5/22/2024, suspended on 2/21/2024, and his employment was terminated on 2/28/2024. The personnel file revealed COTA D was given a verbal warning on 10/12/2024 regarding following professional boundaries because of a rumor that he and Resident #1 were planning to move in together after the resident was discharged . On 1/8/2024 COTA D was given a written warning because he was not following the residents plan of care, Medicare guidelines for documentation and he was working overtime without approval. A disciplinary action form initiated 2/27/2024 and signed on 2/28/2024 revealed COTA D was terminated due to inappropriate relations and unprofessional conduct with facility a facility resident and former resident.</p> <p>During an interview on 5/22/2024 at 10:27 a.m. with the PNP she stated the SW referred Resident #1 when information came out about the resident's intimate relationship with COTA D. The PNP stated the resident was vulnerable when COTA D began taking interest in the resident. The PNP reported as their relationship progressed, COTA D told Resident #1 he could provide her a stable relationship and a home for them to live together. The PNP stated Resident #1 expressed increased depression, so she increased the resident's antidepressant dosage. The PNP stated Resident #1 scored high on her anxiety assessment, but the resident was already on an anti-anxiety medication, and the resident did not appear anxious during their meeting. The PNP reported she could not say for sure if the incident made the resident mentally upset, and because the resident was already depressed before the incident, the PNP stated it was difficult to gauge what emotional impact the incident had on the resident.</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 - Some</p>	<p>During an interview on 5/22/2024 at 11:36 a.m. with Resident #1 she stated she began receiving occupational therapy with COTA D and continued having a relationship until her surgery in November 2023. Resident #1 stated the COTA started grooming me from the beginning, telling the resident she was a beautiful woman and how great she would look when she lost weight (Resident #1 was scheduled for Lap band surgery in November 2023). Resident #1 reported when she first began working with COTA D, she was engaged to another male living in the community and the COTA was aware of their relationship. Resident #1 stated when she began having problems with her relationship with her fiancée, she would confide in COTA D, and he was supportive. Resident #1 stated she was in a vulnerable state when their romantic relationship began in September 2023. She reported COTA D was her Knight in Shining [NAME], telling her he bought a house for them to move in together and he would paint pictures of a fabulous life and how he would take care of me. Resident #1 reported at that time the COTA was taking her out to eat in the evenings at a restaurant nearby and he would take her to lunch to meet her family, who were visiting from out of town. Resident #1 stated at first COTA D did not stay when he took her to see her family, but a short time later he began joining them for lunch. Resident #1 also reported it was in September 2023 that they had intercourse in the resident's room. Resident #1 reported it was late in the evening, and COTA D checked that all the department heads left for the day. Resident #1 reported they only had intercourse one time. Resident #1 stated in November 2023, their relationship ended, however, the COTA would still kiss her and rubbed her buttocks during her cryotherapy (or cold therapy, where low temperatures are used as part of the therapy treatment to relieve muscle pain or swelling after surgery). Resident #1 reported she found out later that COTA D told her fiancée he never had any intention of the resident moving in with him, and he only said this to motivate her in therapy. The resident reported staff would see them together, but COTA D never did anything inappropriate in front of them. Resident #1 reported the Administrator had asked her in September 2023 if she and the COTA had a serious relationship and she told the Administrator they were just friends. She also reported the Administrator asked her again about a relationship between her and COTA D in November, and she told him no. The resident reported by that time it was over and she was telling the truth. Resident #1 stated only one resident asked her if she was having a relationship with COTA D. Resident #1 reported COTA D was still calling her after he no longer worked for the facility, and she told him to stop calling her and he blocked his phone number on her cell phone.</p> <p>During an interview on 5/22/2024 at 1:56 p.m. with CNA B, she stated she saw COTA D take Resident #1 to the nearby restaurant and the COTA stated they were going out to eat with her family and it was part of her therapy. The CNA stated she never saw COTA D take any other resident outside of the facility. CNA B stated she thought it was odd the COTA was taking the resident out to eat but she never told anyone. CNA B could not provide a reason why she did not tell anyone.</p> <p>During an observation and interview on 5/22/2024 at 2:55 p.m. with HA C she stated after the first State Surveyor went to the facility to investigate the incident, the CNA the resident was not herself and appeared more depressed now that she began telling others about her past relationship with COTA D.</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 - Some</p>	<p>During a telephone interview on 5/24/2024 at 3:00 p.m. with Resident #1's FEC she reported she first met COTA D in September 2023 at the facility. The FEC stated the COTA was cordial but felt conversations with the COTA were forced conversations. Resident #1's FEC stated when they ate with Resident #1 and COTA D, the COTA stated he was looking for wife-material, referring to the resident. The FEC stated at the time Resident #1 had another boyfriend who lived in the community but stated COTA D promised to move her in with him in his new home. The FEC stated they had lunch with the COTA at least 4 times. The FEC stated she recalled another incident when she saw COTA D working with another resident, the COTA helped the resident up from the chair holding her buttock instead of under the resident's arms. Resident #1's FEC stated she could not recall when this occurred, and she did not know who the resident was. The FEC did not state if she told anyone about what she witnessed.</p> <p>During an interview on 5/24/2024 at 6:15 p.m. with CNA E and CNA F both reported they saw COTA D take Resident #1 out to eat several times on weekends. They reported they told RN G the COTA was taking the resident out to dinner.</p> <p>During an interview on 5/24/2024 at 6:18 p.m. with RN G she reported she saw COTA D dressed in a suit, Resident #1 had make-up on and was wearing a dress, and the COTA took the resident out to eat. RN G stated she saw COTA take the resident out two times and she never saw the COTA enter the resident's room. RN G stated she spoke to Resident #1, and the resident was excited, and giddy that COTA D was paying attention to her. The RN stated the resident would sign herself out. RN G asked Resident #1 if there was more than a friendship between the therapist and resident, and the resident stated they were just friends. RN G stated she never told anyone because she thought administration knew he was taking her out to eat.</p> <p>During an interview on 5/22/2024 at 1:39 p.m. with the SW, she stated she was not aware of any inappropriate behavior by COTA D until after everything came out.</p> <p>2. Record review of Resident #2's face sheet dated 5/24/2024 reflected the resident was a [AGE] year-old female who was initially admitted on [DATE], and a readmitted [DATE]. Resident #2 had diagnoses which included cerebral infarction (a brain injury caused by disruption of blood flow to the brain), hemiplegia (severe or complete paralysis on one side of the body) and hemiparesis (one-sided muscle weakness because of disruptions in the brain, spinal cord, or the nerves that connect the affected muscles) following cerebral infarction affecting right dominant side, major depressive disorder major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a mental health disorder characterized by feelings of worry or fear that are strong enough to interfere with one's daily activities), and central pain syndrome (a rare neurological condition that causes chronic pain due to damage to the central nervous system).</p> <p>Record review of Resident #2's annual MDS assessment, dated 5/2/2024, reflected the resident had a BIMS score of 13, which indicated the resident was cognitively intact.</p> <p>Record review of Resident #2's care plan reflected the resident was receiving pain medication therapy which included Gabapentin and Baclofen.</p> <p>Record review of Resident #2's Quarterly MDS assessment, dated 2/7/2024, reflected the resident had an occupational therapy start date of 2/1/2024.</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 - Some</p>	<p>During an interview on 5/22/2024 at 11:36 a.m. with Resident #1, she stated Resident #2 told her COTA D would take Resident #2's pants off during occupational therapy.</p> <p>During a telephone interview on 5/22/2024 at 2:20 p.m. with CNA A, she reported one day she noticed Resident #2's door was shut, and she thought that was odd because the resident always left her door open. CNA A stated she knocked, and then opened the door and saw COTA D sitting in the resident's room with his hand on the resident's leg and they were watching television. The CNA explained she saw the COTA was sitting in a chair next to the bed and the resident was in bed. CNA A stated Resident #2 was not wearing any pants and only her brief and a shirt. The CNA stated she could only see COTA D's one hand on her knee and did not know where his other hand was. CNA A stated the COTA and resident did not say anything, and she apologized and walked out. CNA A stated she thought it was a few months ago. The CNA stated she spoke to Resident #2 later and asked her if she felt uncomfortable with COTA D and she said no. The CNA stated she did not tell anyone until recently when questioned about COTA D by administrative staff.</p> <p>During an interview on 5/22/2024 at 1:56 p.m. with CNA B she stated Resident #2 told her whenever she and COTA D had a therapy session, he would take off her pants. Resident #2 told her not to tell anyone. CNA B stated when COTA D started doing therapy sessions with Resident #2 in the therapy room, the resident got made at the CNA, thinking she had told someone. The CNA stated she did not tell anyone about COTA D removing Resident #2's pants because the resident asked her not to.</p> <p>During an interview on 5/24/2024 at 11:14 a.m. with Resident #2 she reported she worked with COTA D a couple of days. The resident reported during their therapy sessions he was working with her legs. Resident #2 stated COTA D took off her pants when he was working with her. The resident stated she was wearing a brief. Resident #2 reported she did not ask the COTA why he removed her pants. Resident #2 stated the COTA would touch and rub her legs, but he never explained anything while he worked with her. Resident #2 stated, it made her feel terrible when COTA D took off her pants. Resident #2 stated on one occasion a CNA walked in when she was working with COTA D and her pants were off. The resident stated the CNA did not say anything. Resident #2 stated the COTA had not touched her anywhere else but her legs when he worked with her.</p> <p>3. Record review of Resident #3's face sheet, dated 5/24/2024, reflected the resident was a [AGE] year-old female with an original admitted [DATE], a readmitted [DATE], and a discharge date of [DATE]. Resident #3's had diagnoses which included hepatorenal syndrome (a life-threatening condition that occurs when the kidneys of someone with advanced liver disease begin to fail), hypertension (high blood pressure), (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (frequent feelings of fear and worry that is intense and excessive), and chronic pain.</p> <p>Record review of Resident #3's 5-day MDS assessment, dated 1/17/2024, reflected the resident began occupational therapy on 1/24/2024 and received therapy 4 days a week.</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 - Some</p>	<p>During an interview on 5/22/2024 at 4:46 p.m. with the Administrator he reported around mid-February, he learned a previous resident, Resident #3, was at the hospital, was being released soon, and told the facility Admissions Coordinator, who also marketed for their sister facility in town, that she would go to any other facility, just not the facility. The Administrator reported when Resident #3 stayed at the facility before she told them she was pleased with their care. The Admission Coordinator, who was also a family friend of Resident #3, reported the resident had confided in her that she did not want to return to the facility because of COTA D and he had visited her home a couple of times after she discharged, and he was handsy (touch other people in a way that is inappropriate or unwanted). The Administrator reported she assured Resident #3 that COTA D would not be providing her therapy and the Administrator then told the COTA he was suspended and sent him home. The Administrator stated after Resident #3 admitted back to the facility, she also reported COTA D gave her thong underwear one of the times he visited her home.</p> <p>During an interview on 5/24/2024 at 4:10 p.m. with the Marketing Director she reported she was a family friend of Resident #3, and the resident told her about COTA D being inappropriate with her on her previous visit. The Marketing Director stated Resident #3 initially enjoyed the attention COTA D was giving her but when the resident felt the COTA wanted more than a friendship, she felt uncomfortable.</p> <p>During an interview on 5/27/2024 at 10:01 a.m. with Resident #3, she reported while she was at the facility on her previous visit, she received occupational therapy by COTA D. Resident #3 stated when COTA D was massaging her back, he began fondling her private area and COTA D told Resident #3, I am gonna tap (slang for sexual intercourse) that one day. The resident stated she did not report it to the facility because she was afraid to. Resident #3 stated COTA D was tall at 6'4" and a big man, and she was afraid of him so when he asked for her telephone number when she was ready to discharge, she gave it to him. Resident #3 reported when she was back in the community living at her apartment COTA D called her and said he was coming over to see that her home was handicap accessible and she did not know what to say. Resident #3 stated she had gone out to eat with the COTA at that time because he insisted, she go. That was when he came into her apartment the first time, stating he needed to check that her apartment was handicap accessible. The resident stated COTA D came over to her apartment, but the resident stated she did not know how he got her address. Resident #3 stated the COTA came over to her apartment a second time and brought her a gift, thong underwear. The resident stated COTA D wanted her to wear the underwear in front of him and initially she said no but she felt intimidated because she was by herself, so she wore the underwear in front of him and then changed and told the COTA to leave. Resident #3 stated COTA D showed up a third time, wanted the resident to sit on his lap but she refused so he left. Resident #3 stated COTA D never showed up again. Resident #3 stated she did not know what to do when he wanted to come over.</p> <p>4. Record review of Resident #4's face sheet dated 5/24/2024 reflected a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #4 had diagnoses that included dementia without behavioral disturbance, congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should), hypertension (high blood pressure), and pain.</p> <p>Record review of Resident #4's Quarterly MDS assessment, dated 2/19/2024, reflected the resident had a BIMS score of 15, which indicated the resident was cognitively intact and no mood or behavioral concerns.</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 - Some</p>	<p>Record review of Resident #4's May 2024 Consolidated Physician Orders reflected the resident was discharged from occupational therapy services on 1/26/2024. Review of</p> <p>Record review of Resident #4's care plan initiated 8/11/2017 reflected the resident received pain medication which included Tramadol and gabapentin.</p> <p>During an interview on 5/23/2024 at 11:03 p.m., Resident #4 stated she received therapy at the facility, and she did not especially want it. Resident #4 stated she had a male therapist who made her feel uncomfortable. She provided COTA D's first name and gave a brief description. Resident #4 stated during a therapy session, her back was hurting and COTA D pulled her pants down a bit to put some Bio-freeze on her buttock, and she thought this was odd. The resident reported this only happened once. Resident #4 stated she told an unidentified staff member about the incident and the staff member told her to wait and see if he does it again. Resident #4 stated she did not recall who the staff member was. The resident stated the incident happened over 6 months ago in the therapy room while she was lying on the table. She did not report if anyone else was present.</p> <p>During an interview on 5/23/2024 at 12:43 p.m., the Administrator stated Resident #4 never said anything when they interviewed residents for concerns related to abuse and neglect.</p> <p>Record review of Resident #5's face sheet dated 5/24/2024 reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #5 had diagnoses which included heart failure (a chronic condition in which the heart does not pump blood as well as it should), shortness of breath (feeling you cannot get enough air into your lungs), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), diabetes mellitus without complications (when the pancreas does not make enough insulin), and unspecified pain.</p> <p>Record review of Resident #5's Quarterly MDS assessment dated [DATE] reflected the resident had a BIMS score of 15, which indicated the resident was cognitively intact.</p> <p>Record review of Resident #5's May 2024 Concentrated Physician Orders reflected the resident had an order for Lidocaine patch and gabapentin for pain and she was discharged from occupational therapy on 4/2/2024.</p> <p>Record review of Resident #5's Quarterly MDS assessment dated [DATE] reflected the resident received occupational therapy with a start date of 11/10/2023 and an end date on 1/5/2024.</p> <p>During an observation and interview on 5/24/2024 at 7:35 p.m. with Resident #5 revealed she received occupational therapy from COTA D. the Resident #5 stated while COTA D was rubbing her back, he began rubbing her buttock and intergluteal cleft (the posterior deep midline groove in the gluteal region that separates the buttocks). Resident #5 showed the region on her body where the therapist had rubbed her. The resident's voice got louder as she talked about it. Resident #5 stated it only happened one time. The resident stated she told the Administrator about it.</p> <p>During an interview on 5/24/2024 at 8:02 p.m. with the Administrator he stated they interviewed Resident #5 regarding abuse and neglect and the resident never reported COTA D touching her inappropriately. The Administrator went on to say he did not recall Resident #5 telling him about the incident and stated he would have remembered something like it.</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 - Some</p>	<p>During an interview on 5/22/2024 at 12:30 p.m. with the DOR she stated she began working at the facility PRN in June 2023, and became the DOR in July 2023. The DOR reported COTA D was already working at the facility when she started. The DOR stated she and several members of management had verbally in-serviced the COTA about following each of the residents Plan of Care that was established by the OT when the resident was evaluated. The DOR reported COTA D was reporting additional hours and provided other treatments, including taking Resident #1 out for lunch to meet with her family several times, not prescribed on the Plan of Care, which was outside his scope of practice. The DOR stated COTA D would follow the Plan of Care for a while but then would go back to providing treatment outside the COTA's scope of practice. The DOR reported Resident #1 spoke to her about going on a weekend pass to see COTA D's new house but knew the Administrator had already spoken to the COTA regarding rumors the COTA and Resident #1 had planned to live together after she discharged. The DOR stated Resident #1 later reported they were having a consensual relationship, but he was gaslighting (a form of emotional abuse that causes the victim to question their own feelings) the resident. The DOR reported sometime in August (she could not recall the date), during a weekend, she witnessed COTA D was all dressed up and pushing Resident #1 in her wheelchair out of the facility. The DOR reported she told the Administrator, and the DOR was off the clock at the time. The DOR stated COTA D was fired on 3/4/2024.</p> <p>During a telephone interview on 5/22/2024 at 3:57 a.m. with COTA D, he reported he had been a COTA for [AGE] years and began working at the facility on May 22, 2023. COTA D stated he gave statements to the licensing board and the facility should have a copy. The COTA stated he would not say any names of the residents he worked with and anything about the incidents. He stated when he was working at the facility, he would work 8, 9, or 10 hours a day. COTA D stated some residents were bedbound so therapy would begin in their room and as they progressed, they went to the gym. The COTA reported there was a restaurant about two blocks away from the facility and he would accompany the residents with their families for integration back into society and it was part of the residents' therapy treatment. COTA D stated no resident had ever been to his home. The COTA stated as part of COTA treatment they did home evaluations, home assessments, and home health. COTA D stated he did several home evaluations and house assessments during his career. The COTA reported they did not have relationships with their residents. COTA D stated sometimes residents were drawn by skilled, knowledgeable healthcare workers. COTA D stated he recalled everyone gave a resident a gift and his gift were a pair of shorts. The COTA stated the resident was female and she would wear shorts to therapy. COTA D stated that I do not have any relationship with residents. When the COTA was asked if he was working again, he stated, You do not need to worry about his personal business.</p> <p>During a telephone interview on 5/24/2024 at 2:54 p.m. with the Medical Director she reported she was made aware of the IJ. The Medical Director reported they also had a QAPI after the IJ was called. The Medical Director stated no residents were identified when she spoke to the Administrator and during QAPI. The Medical Director reported Resident #2 was one of her residents she saw at the facility and was not aware of the incident. The Medical Director noted she did have another physician that took calls for her and assisted with the residents at the facility, and he may have been informed about the incident with Resident #2. The Medical Director stated she would follow up with Resident #2 herself to see that she was doing okay.</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 - Some</p>	<p>During an interview on 5/22/2024 at 4:46 p.m. with the Administrator, he reported on 10/12/2023 he spoke to COTA D about rumors the COTA and Resident #1 were going to move in together when she was discharged . The Administrator reported COTA D denied the allegation and stated they were just friends. The Administrator reported he discussed professional boundaries with the COTA and reviewed the Code of Ethics between a therapist and resident. The Administrator also had COTA D sign a written warning letter to confirm he was instructed and understood ethical boundaries. The Administrator stated he then went to talk to Resident #1 about the rumor and at that time Resident #1 was asking about going out on pass to see COTA D's new home. The resident reported to the Administrator she and her parents were going to see COTA D's house he recently purchased. The Administrator stated he questioned Resident #1 about the rumors she was planning to move in with COTA D, and the resident denied the relationship and stated they were just friends. The Administrator reported Resident #1 never went out on pass to see the COTA's house. The Administrator stated at the time he believed COTA D was telling the truth, He was so convincing by the way he responded, and other residents reported how much they liked him. The Administrator stated the COTA was also disciplined for taking extra-long time with each treatment he was providing, running more labor hours per resident. The Administrator reported it eventually got better after several talks with COTA D.</p> <p>The Administrator reported he discovered Resident #1 and COTA D had a romantic relationship on February 29, 2024. The Administrator reported initially around mid-February, he learned a previous resident, Resident #3, was at the hospital and being released soon and told the facility Admissions Coordinator, who also marketed for their sister facility in town, that she would go to any other facility, just not to their facility. The Administrator stated when Resident #3 stayed at the facility before, she told them she was pleased with their care. The Admission Coordinator, who was also a family friend of Resident #3, reported the resident confided in her that she did not want to return to the facility because of COTA D and that he had visited her home a couple of times after she discharged , and he was handsy (touching other people in a way that is inappropriate or unwanted). The Administrator reported he assured Resident #3 that COTA D would not be providing her therapy and the Administrator then told the COTA he was suspended and sent him home. The Administrator stated after Resident #3 admitted back to the facility, she also reported COTA D had given her thong underwear one of the times he visited her home. The Administrator reported they began interviewing all residents on abuse and neglect, asking the residents if they ever had any issues with staff, and that was when Resident #1 reported she had a sexual relationship with COTA D. The Administrator also spoke to staff and learned that CNA A walked into Resident #2's room and the COTA was in the room and the resident was not wearing pants. The Administrator also reported he learned Resident #2 told CNA B that COTA D took her pants off during therapy. The Administrator reported no other residents reported an incident with COTA D. The Administrator stated he made a referral to the OT/COTA licensing board, but he did not receive copies of the COTA's statement to the board)</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 - Some</p>	<p>Record review of the facility's policy titled, Abuse/Neglect, revised 10/14/2022, reflected, Resident's should not be subject to abuse by anyone, including, but not limited to facility staff. 4. Sexual Abuse-non-consensual sexual contact of any type with a resident. C. Prevention, 3. All reports of abuse or suspicion of abuse/neglect or potential criminal behavior will be investigated as per facility policy and 5. All occurrences of potential abuse or criminal behavior will be investigated by the Abuse Preventionist and/or designee. D. Identification, Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect, or exploitation must report this to the DON, Administrator, state and /or Adult Protective Services. E. Investigation, The Administrator or Risk Management Department will be responsible for investigation and reporting cases to Health and Human Services Commission. F. Protection, The facility will take necessary measures to protect residents .during and following an abuse, neglect, and exploitation, misappropriation of residents or misappropriation of resident property investigation.</p> <p>Record review of the Occupational Therapy Code of Ethics and Ethics Standards (2010) provided by the facility, under the heading, Nonmaleficence, reflected Occupational therapy personnel shall: C. Avoid relationships that exploit the recipient of services . physically, emotionally, psychologically, financially, socially, or in any other manner that conflicts or interferes with professional judgement and objectivity, .D. Avoid engaging in any sexual relationship or [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 - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32218</p> <p>Based on observation, interview, and record review, the facility failed to follow their policies and procedures to prevent mistreatment, abuse, neglect, and exploitation of a resident, and misappropriations of residents property for 4 of 9 residents (Residents #1, #2, #3, #4, and #5) reviewed for abuse.</p> <ol style="list-style-type: none"> The facility failed to follow their policies and procedures to investigate and report to state office when they received allegations that COTA D was having a relationship Relationship with COTA D. COTA D had intercourse with Resident #1 in the resident's room after the resident was on the therapist's caseload. The facility failed to protect Resident #2 when CNA A witnessed COTA D was in the resident's room and she was not wearing pants for her therapy treatment. CNA B was also informed by the resident that COTA D removed her pants when providing therapy. The facility failed to prevent COTA D from touching Resident #4 and Resident #5's buttocks while rubbing their back during their therapy session. The facility failed to prevent COTA D from touching Resident #3's buttock and genitalia while rubbing her back during her therapy session. <p>An Immediate Jeopardy (IJ) was identified on 5/23/2024. The IJ template was provided to the facility on [DATE] at 4:43 p.m. While the IJ was removed on 5/25/2024, the facility remained out of compliance at a scope of pattern, with a potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>These failures could place residents at risk of sexual abuse from facility staff.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Record review of Resident #1's face sheet, dated 5/24/2024, reflected a [AGE] year-old female who was initially admitted to the facility on [DATE] and had diagnoses that included hypertensive heart disease with heart failure (heart problems caused by long-term heart pressure), morbid obesity due to excessive calories (weight that is 80 to 100 pounds above their ideal body weight), body mass index (a ratio of your weight to your height) of 70 or greater, type 2 diabetes mellitus (when the pancreas does not make insulin), sleep apnea (a sleep disorder in which breathing repeatedly stops and starts), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (frequent feelings of fear and worry that is intense and excessive). <p>Record review of Resident #1's care plan, initiated 11/22/2021, reflected the resident had a potential to exhibit withdrawal from activities and socialization due to health condition, physical, and mental limitations, problems, concerns, etc. The care plan interventions included the Social Worker providing support and verbalization of feelings, thoughts, needs, problems, and concerns.</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 - Some</p>	<p>Record review of Resident #1's annual MDS assessment, dated 12/22/2023 reflected a BIMS score was 15, which indicated the resident was cognitively intact. Resident #1 had no mood or behavioral concerns and used a walker and wheelchair for ambulation.</p> <p>Record review of Resident #1's May 2024 Consolidated Physician Orders reflected an order, with a start date of 10/12/2023, that the resident had Occupational Therapy 4 times a week for 30 days.</p> <p>Record review of the Facility Incident Report, dated 2/29/2024, reflected Resident #1 reported to the facility during the months of September and October 2023, COTA D had gaslight me and groomed me for a relationship and she realized he had been taking advantage of her. The report reflected COTA D had intercourse with Resident #1 in the resident's room.</p> <p>Record review of the Police Report Case Identification Number 24-00293, dated 2/29/2024, reflected the police were informed by the facility of COTA D's inappropriate sexual behavior with residents.</p> <p>Record review of COTA D's personnel file revealed the COTA was hired on 5/22/2024, suspended on 2/21/2024, and his employment was terminated on 2/28/2024. The personnel file revealed COTA D was given a verbal warning on 10/12/2024 regarding following professional boundaries because of a rumor that he and Resident #1 were planning to move in together after the resident was discharged . On 1/8/2024 COTA D was given a written warning because he was not following the residents plan of care, Medicare guidelines for documentation and he was working overtime without approval. A disciplinary action form initiated 2/27/2024 and signed on 2/28/2024 revealed COTA D was terminated due to inappropriate relations and unprofessional conduct with facility a facility resident and former resident.</p> <p>During an interview on 5/22/2024 at 10:27 a.m. with the PNP she stated the SW referred Resident #1 when information came out about the resident's intimate relationship with COTA D. The PNP stated the resident was vulnerable when COTA D began taking interest in the resident. The PNP reported as their relationship progressed, COTA D told Resident #1 he could provide her a stable relationship and a home for them to live together. The PNP stated Resident #1 expressed increased depression, so she increased the resident's antidepressant dosage. The PNP stated Resident #1 scored high on her anxiety assessment, but the resident was already on an anti-anxiety medication, and the resident did not appear anxious during their meeting. The PNP reported she could not say for sure if the incident made the resident mentally upset, and because the resident was already depressed before the incident, the PNP stated it was difficult to gauge what emotional impact the incident had on the resident.</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 - Some</p>	<p>During an interview on 5/22/2024 at 11:36 a.m. with Resident #1 she stated she began receiving occupational therapy with COTA D and continued having a relationship until her surgery in November 2023. Resident #1 stated the COTA started grooming me from the beginning, telling the resident she was a beautiful woman and how great she would look when she lost weight (Resident #1 was scheduled for Lap band surgery in November 2023). Resident #1 reported when she first began working with COTA D, she was engaged to another male living in the community and the COTA was aware of their relationship. Resident #1 stated when she began having problems with her relationship with her fiancée, she would confide in COTA D, and he was supportive. Resident #1 stated she was in a vulnerable state when their romantic relationship began in September 2023. She reported COTA D was her Knight in Shining [NAME], telling her he bought a house for them to move in together and he would paint pictures of a fabulous life and how he would take care of me. Resident #1 reported at that time the COTA was taking her out to eat in the evenings at a restaurant nearby and he would take her to lunch to meet her family, who were visiting from out of town. Resident #1 stated at first COTA D did not stay when he took her to see her family, but a short time later he began joining them for lunch. Resident #1 also reported it was in September 2023 that they had intercourse in the resident's room. Resident #1 reported it was late in the evening, and COTA D checked that all the department heads left for the day. Resident #1 reported they only had intercourse one time. Resident #1 stated in November 2023, their relationship ended, however, the COTA would still kiss her and rubbed her buttocks during her cryotherapy (or cold therapy, where low temperatures are used as part of the therapy treatment to relieve muscle pain or swelling after surgery). Resident #1 reported she found out later that COTA D told her fiancée he never had any intention of the resident moving in with him, and he only said this to motivate her in therapy. The resident reported staff would see them together, but COTA D never did anything inappropriate in front of them. Resident #1 reported the Administrator had asked her in September 2023 if she and the COTA had a serious relationship and she told the Administrator they were just friends. She also reported the Administrator asked her again about a relationship between her and COTA D in November 2023, and she told him no. The resident reported by that time it was over and she was telling the truth. Resident #1 stated only one resident asked her if she was having a relationship with COTA D. Resident #1 reported COTA D was still calling her after he no longer worked for the facility, and she told him to stop calling her and he blocked his phone number on her cell phone.</p> <p>During an interview on 5/22/2024 at 1:56 p.m. with CNA B, she stated she saw COTA D take Resident #1 to the nearby restaurant and the COTA stated they were going out to eat with her family and it was part of her therapy. The CNA stated she never saw COTA D take any other resident outside of the facility. CNA B stated she thought it was odd the COTA was taking the resident out to eat but she never told anyone. CNA B could not provide a reason why she did not tell anyone.</p> <p>During an observation and interview on 5/22/2024 at 2:55 p.m. with HA C she stated after the first State Surveyor went to the facility to investigate the incident, the CNA the resident was not herself and appeared more depressed now that she began telling others about her past relationship with COTA D.</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 - Some</p>	<p>During a telephone interview on 5/24/2024 at 3:00 p.m. with Resident #1's FEC she reported she first met COTA D in September 2023 at the facility. The FEC stated the COTA was cordial but felt conversations with the COTA were forced conversations. Resident #1's FEC stated when they ate with Resident #1 and COTA D, the COTA stated he was looking for wife-material, referring to the resident. The FEC stated at the time Resident #1 had another boyfriend who lived in the community but stated COTA D promised to move her in with him in his new home. The FEC stated they had lunch with the COTA at least 4 times. The FEC stated she recalled another incident when she saw COTA D working with another resident, the COTA helped the resident up from the chair holding her buttock instead of under the resident's arms. Resident #1's FEC stated she could not recall when this occurred, and she did not know who the resident was. The FEC did not state if she told anyone about what she witnessed.</p> <p>During an interview on 5/24/2024 at 6:15 p.m. with CNA E and CNA F both reported they saw COTA D take Resident #1 out to eat several times on weekends. They reported they told RN G the COTA was taking the resident out to dinner.</p> <p>During an interview on 5/24/2024 at 6:18 p.m. with RN G she reported she saw COTA D dressed in a suit, Resident #1 had make-up on and was wearing a dress, and the COTA took the resident out to eat. RN G stated she saw COTA take the resident out two times and she never saw the COTA enter the resident's room. RN G stated she spoke to Resident #1, and the resident was excited, and giddy that COTA D was paying attention to her. The RN stated the resident would sign herself out. RN G asked Resident #1 if there was more than a friendship between the therapist and resident, and the resident stated they were just friends. RN G stated she never told anyone because she thought administration knew he was taking her out to eat.</p> <p>During an interview on 5/22/2024 at 1:39 p.m. with the SW, she stated she was not aware of any inappropriate behavior by COTA D until after everything came out.</p> <p>2. Record review of Resident #2's face sheet dated 5/24/2024 reflected the resident was a [AGE] year-old female who was initially admitted on [DATE], and a readmitted [DATE]. Resident #2 had diagnoses which included cerebral infarction (a brain injury caused by disruption of blood flow to the brain), hemiplegia (severe or complete paralysis on one side of the body) and hemiparesis (one-sided muscle weakness because of disruptions in the brain, spinal cord, or the nerves that connect the affected muscles) following cerebral infarction affecting right dominant side, major depressive disorder major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a mental health disorder characterized by feelings of worry or fear that are strong enough to interfere with one's daily activities), and central pain syndrome (a rare neurological condition that causes chronic pain due to damage to the central nervous system).</p> <p>Record review of Resident #2's annual MDS assessment, dated 5/2/2024, reflected the resident had a BIMS score of 13, which indicated the resident was cognitively intact.</p> <p>Record review of Resident #2's care plan reflected the resident was receiving pain medication therapy which included Gabapentin and Baclofen.</p> <p>Record review of Resident #2's Quarterly MDS assessment, dated 2/7/2024, reflected the resident had an occupational therapy start date of 2/1/2024.</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 - Some</p>	<p>During an interview on 5/22/2024 at 11:36 a.m. with Resident #1, she stated Resident #2 told her COTA D would take Resident #2's pants off during occupational therapy.</p> <p>During a telephone interview on 5/22/2024 at 2:20 p.m. with CNA A, she reported one day she noticed Resident #2's door was shut, and she thought that was odd because the resident always left her door open. CNA A stated she knocked, and then opened the door and saw COTA D sitting in the resident's room with his hand on the resident's leg and they were watching television. The CNA explained she saw the COTA was sitting in a chair next to the bed and the resident was in bed. CNA A stated Resident #2 was not wearing any pants and only her brief and a shirt. The CNA stated she could only see COTA D's one hand on her knee and did not know where his other hand was. CNA A stated the COTA and resident did not say anything, and she apologized and walked out. CNA A stated she thought it was a few months ago. The CNA stated she spoke to Resident #2 later and asked her if she felt uncomfortable with COTA D and she said no. The CNA stated she did not tell anyone until recently when questioned about COTA D by administrative staff.</p> <p>During an interview on 5/22/2024 at 1:56 p.m. with CNA B she stated Resident #2 told her whenever she and COTA D had a therapy session, he would take off her pants. Resident #2 told her not to tell anyone. CNA B stated when COTA D started doing therapy sessions with Resident #2 in the therapy room, the resident got made at the CNA, thinking she had told someone. The CNA stated she did not tell anyone about COTA D removing Resident #2's pants because the resident asked her not to.</p> <p>During an interview on 5/24/2024 at 11:14 a.m. with Resident #2 she reported she worked with COTA D a couple of days. The resident reported during their therapy sessions he was working with her legs. Resident #2 stated COTA D took off her pants when he was working with her. The resident stated she was wearing a brief. Resident #2 reported she did not ask the COTA why he removed her pants. Resident #2 stated the COTA would touch and rub her legs, but he never explained anything while he worked with her. Resident #2 stated, it made her feel terrible when COTA D took off her pants. Resident #2 stated on one occasion a CNA walked in when she was working with COTA D and her pants were off. The resident stated the CNA did not say anything. Resident #2 stated the COTA had not touched her anywhere else but her legs when he worked with her.</p> <p>3. Record review of Resident #3's face sheet, dated 5/24/2024, reflected the resident was a [AGE] year-old female with an original admitted [DATE], a readmitted [DATE], and a discharge date of [DATE]. Resident #3's had diagnoses which included hepatorenal syndrome (a life-threatening condition that occurs when the kidneys of someone with advanced liver disease begin to fail), hypertension (high blood pressure), (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (frequent feelings of fear and worry that is intense and excessive), and chronic pain.</p> <p>Record review of Resident #3's 5-day MDS assessment, dated 1/17/2024, reflected the resident began occupational therapy on 1/24/2024 and received therapy 4 days a week.</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 - Some</p>	<p>During an interview on 5/22/2024 at 4:46 p.m. with the Administrator he reported around mid-February, he learned a previous resident, Resident #3, was at the hospital, was being released soon, and told the facility Admissions Coordinator, who also marketed for their sister facility in town, that she would go to any other facility, just not the facility. The Administrator reported when Resident #3 stayed at the facility before she told them she was pleased with their care. The Admission Coordinator, who was also a family friend of Resident #3, reported the resident had confided in her that she did not want to return to the facility because of COTA D and he had visited her home a couple of times after she discharged, and he was handsy (touch other people in a way that is inappropriate or unwanted). The Administrator reported she assured Resident #3 that COTA D would not be providing her therapy and the Administrator then told the COTA he was suspended and sent him home. The Administrator stated after Resident #3 admitted back to the facility, she also reported COTA D gave her thong underwear one of the times he visited her home.</p> <p>During an interview on 5/24/2024 at 4:10 p.m. with the Marketing Director she reported she was a family friend of Resident #3, and the resident told her about COTA D being inappropriate with her on her previous visit. The Marketing Director stated Resident #3 initially enjoyed the attention COTA D was giving her but when the resident felt the COTA wanted more than a friendship, she felt uncomfortable.</p> <p>During an interview on 5/27/2024 at 10:01 a.m. with Resident #3, she reported while she was at the facility on her previous visit, she received occupational therapy by COTA D. Resident #3 stated when COTA D was massaging her back, he began fondling her private area and COTA D told Resident #3, I am gonna tap (slang for sexual intercourse) that one day. The resident stated she did not report it to the facility because she was afraid to. Resident #3 stated COTA D was tall at 6'4" and a big man, and she was afraid of him so when he asked for her telephone number when she was ready to discharge, she gave it to him. Resident #3 reported when she was back in the community living at her apartment COTA D called her and said he was coming over to see that her home was handicap accessible and she did not know what to say. Resident #3 stated she had gone out to eat with the COTA at that time because he insisted, she go. That was when he came into her apartment the first time, stating he needed to check that her apartment was handicap accessible. The resident stated COTA D came over to her apartment, but the resident stated she did not know how he got her address. Resident #3 stated the COTA came over to her apartment a second time and brought her a gift, thong underwear. The resident stated COTA D wanted her to wear the underwear in front of him and initially she said no but she felt intimidated because she was by herself, so she wore the underwear in front of him and then changed and told the COTA to leave. Resident #3 stated COTA D showed up a third time, wanted the resident to sit on his lap but she refused so he left. Resident #3 stated COTA D never showed up again. Resident #3 stated she did not know what to do when he wanted to come over.</p> <p>4. Record review of Resident #4's face sheet dated 5/24/2024 reflected a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #4 had diagnoses that included dementia without behavioral disturbance, congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should), hypertension (high blood pressure), and pain.</p> <p>Record review of Resident #4's Quarterly MDS assessment, dated 2/19/2024, reflected the resident had a BIMS score of 15, which indicated the resident was cognitively intact and no mood or behavioral concerns.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Goldthwaite Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1207 S Reynolds St Goldthwaite, TX 76844	
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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #4's May 2024 Consolidated Physician Orders reflected the resident was discharged from occupational therapy services on 1/26/2024. Review of</p> <p>Record review of Resident #4's care plan initiated 8/11/2017 reflected the resident received pain medication which included Tramadol and gabapentin.</p> <p>During an interview on 5/23/2024 at 11:03 p.m., Resident #4 stated she received therapy at the facility, and she did not especially want it. Resident #4 stated she had a male therapist who made her feel uncomfortable. She provided COTA D's first name and gave a brief description. Resident #4 stated during a therapy session, her back was hurting and COTA D pulled her pants down a bit to put some Bio-freeze on her buttock, and she thought this was odd. The resident reported this only happened once. Resident #4 stated she told an unidentified staff member about the incident and the staff member told her to wait and see if he does it again. Resident #4 stated she did not recall who the staff member was. The resident stated the incident happened over 6 months ago in the therapy room while she was lying on the table. She did not report if anyone else was present.</p> <p>During an interview on 5/23/2024 at 12:43 p.m., the Administrator stated Resident #4 never said anything when they interviewed residents for concerns related to abuse and neglect.</p> <p>Record review of Resident #5's face sheet dated 5/24/2024 reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #5 had diagnoses which included heart failure (a chronic condition in which the heart does not pump blood as well as it should), shortness of breath (feeling you cannot get enough air into your lungs), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), diabetes mellitus without complications (when the pancreas does not make enough insulin), and unspecified pain.</p> <p>Record review of Resident #5's Quarterly MDS assessment dated [DATE] reflected the resident had a BIMS score of 15, which indicated the resident was cognitively intact.</p> <p>Record review of Resident #5's May 2024 Concentrated Physician Orders reflected the resident had an order for Lidocaine patch and gabapentin for pain and she was discharged from occupational therapy on 4/2/2024.</p> <p>Record review of Resident #5's Quarterly MDS assessment dated [DATE] reflected the resident received occupational therapy with a start date of 11/10/2023 and an end date on 1/5/2024.</p> <p>During an observation and interview on 5/24/2024 at 7:35 p.m. with Resident #5 revealed she received occupational therapy from COTA D. the Resident #5 stated while COTA D was rubbing her back, he began rubbing her buttock and intergluteal cleft (the posterior deep midline groove in the gluteal region that separates the buttocks). Resident #5 showed the region on her body where the therapist had rubbed her. The resident's voice got louder as she talked about it. Resident #5 stated it only happened one time. The resident stated she told the Administrator about it.</p> <p>During an interview on 5/24/2024 at 8:02 p.m. with the Administrator he stated they interviewed Resident #5 regarding abuse and neglect and the resident never reported COTA D touching her inappropriately. The Administrator went on to say he did not recall Resident #5 telling him about the incident and stated he would have remembered something like it.</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 - Some</p>	<p>During an interview on 5/22/2024 at 12:30 p.m. with the DOR she stated she began working at the facility PRN in June 2023, and became the DOR in July 2023. The DOR reported COTA D was already working at the facility when she started. The DOR stated she and several members of management had verbally in-serviced the COTA about following each of the residents Plan of Care that was established by the OT when the resident was evaluated. The DOR reported COTA D was reporting additional hours and provided other treatments, including taking Resident #1 out for lunch to meet with her family several times, not prescribed on the Plan of Care, which was outside his scope of practice. The DOR stated COTA D would follow the Plan of Care for a while but then would go back to providing treatment outside the COTA's scope of practice. The DOR reported Resident #1 spoke to her about going on a weekend pass to see COTA D's new house but knew the Administrator had already spoken to the COTA regarding rumors the COTA and Resident #1 had planned to live together after she discharged. The DOR stated Resident #1 later reported they were having a consensual relationship, but he was gaslighting (a form of emotional abuse that causes the victim to question their own feelings) the resident. The DOR reported sometime in August (she could not recall the date), during a weekend, she witnessed COTA D was all dressed up and pushing Resident #1 in her wheelchair out of the facility. The DOR reported she told the Administrator, and the DOR was off the clock at the time. The DOR stated COTA D was fired on 3/4/2024.</p> <p>During a telephone interview on 5/22/2024 at 3:57 a.m. with COTA D, he reported he had been a COTA for [AGE] years and began working at the facility on May 22, 2023. COTA D stated he gave statements to the licensing board and the facility should have a copy. The COTA stated he would not say any names of the residents he worked with and anything about the incidents. He stated when he was working at the facility, he would work 8, 9, or 10 hours a day. COTA D stated some residents were bedbound so therapy would begin in their room and as they progressed, they went to the gym. The COTA reported there was a restaurant about two blocks away from the facility and he would accompany the residents with their families for integration back into society and it was part of the residents' therapy treatment. COTA D stated no resident had ever been to his home. The COTA stated as part of COTA treatment they did home evaluations, home assessments, and home health. COTA D stated he did several home evaluations and house assessments during his career. The COTA reported they did not have relationships with their residents. COTA D stated sometimes residents were drawn by skilled, knowledgeable healthcare workers. COTA D stated he recalled everyone gave a resident a gift and his gift were a pair of shorts. The COTA stated the resident was female and she would wear shorts to therapy. COTA D stated that I do not have any relationship with residents. When the COTA was asked if he was working again, he stated, You do not need to worry about his personal business.</p> <p>During a telephone interview on 5/24/2024 at 2:54 p.m. with the Medical Director she reported she was made aware of the IJ. The Medical Director reported they also had a QAPI after the IJ was called. The Medical Director stated no residents were identified when she spoke to the Administrator and during QAPI. The Medical Director reported Resident #2 was one of her residents she saw at the facility and was not aware of the incident. The Medical Director noted she did have another physician that took calls for her and assisted with the residents at the facility, and he may have been informed about the incident with Resident #2. The Medical Director stated she would follow up with Resident #2 herself to see that she was doing okay.</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 - Some</p>	<p>During an interview on 5/22/2024 at 4:46 p.m. with the Administrator, he reported on 10/12/2023 he spoke to COTA D about rumors the COTA and Resident #1 were going to move in together when she was discharged . The Administrator reported COTA D denied the allegation and stated they were just friends. The Administrator reported he discussed professional boundaries with the COTA and reviewed the Code of Ethics between a therapist and resident. The Administrator also had COTA D sign a written warning letter to confirm he was instructed and understood ethical boundaries. The Administrator stated he then went to talk to Resident #1 about the rumor and at that time Resident #1 was asking about going out on pass to see COTA D's new home. The resident reported to the Administrator she and her parents were going to see COTA D's house he recently purchased. The Administrator stated he questioned Resident #1 about the rumors she was planning to move in with COTA D, and the resident denied the relationship and stated they were just friends. The Administrator reported Resident #1 never went out on pass to see the COTA's house. The Administrator stated at the time he believed COTA D was telling the truth, He was so convincing by the way he responded, and other residents reported how much they liked him. The Administrator stated the COTA was also disciplined for taking extra-long time with each treatment he was providing, running more labor hours per resident. The Administrator reported it eventually got better after several talks with COTA D.</p> <p>The Administrator reported he discovered Resident #1 and COTA D had a romantic relationship on February 29, 2024. The Administrator reported initially around mid-February, he learned a previous resident, Resident #3, was at the hospital and being released soon and told the facility Admissions Coordinator, who also marketed for their sister facility in town, that she would go to any other facility, just not to their facility. The Administrator stated when Resident #3 stayed at the facility before, she told them she was pleased with their care. The Admission Coordinator, who was also a family friend of Resident #3, reported the resident confided in her that she did not want to return to the facility because of COTA D and that he had visited her home a couple of times after she discharged , and he was handsy (touching other people in a way that is inappropriate or unwanted). The Administrator reported he assured Resident #3 that COTA D would not be providing her therapy and the Administrator then told the COTA he was suspended and sent him home. The Administrator stated after Resident #3 admitted back to the facility, she also reported COTA D had given her thong underwear one of the times he visited her home. The Administrator reported they began interviewing all residents on abuse and neglect, asking the residents if they ever had any issues with staff, and that was when Resident #1 reported she had a sexual relationship with COTA D. The Administrator also spoke to staff and learned that CNA A walked into Resident #2's room and the COTA was in the room and the resident was not wearing pants. The Administrator also reported he learned Resident #2 told CNA B that COTA D took her pants off during therapy. The Administrator reported no other residents reported an incident with COTA D. The Administrator stated he made a referral to the OT/COTA licensing board, but he did not receive copies of the COTA's statement to the board)</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 - Some</p>	<p>Record review of the facility's policy titled, Abuse/Neglect, revised 10/14/2022, reflected, Resident's should not be subject to abuse by anyone, including, but not limited to facility staff. 4. Sexual Abuse-non-consensual sexual contact of any type with a resident. C. Prevention, 3. All reports of abuse or suspicion of abuse/neglect or potential criminal behavior will be investigated as per facility policy and 5. All occurrences of potential abuse or criminal behavior will be investigated by the Abuse Preventionist and/or designee. D. Identification, Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect, or exploitation must report this to the DON, Administrator, state and /or Adult Protective Services. E. Investigation, The Administrator or Risk Management Department will be responsible for investigation and reporting cases to Health and Human Services Commission. F. Protection, The facility will take necessary measures to protect residents .during and following an abuse, neglect, and exploitation, misappropriation of residents or misappropriation of resident property investigation.</p> <p>Record review of the Occupational Therapy Code of Ethics and Ethics Standards (2010) provided by the facility, under the heading, Nonmaleficence, reflected Occupational thera[TRUNCATED]</p>

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32218</p> <p>Based on observation, interview and record review the facility failed to administer in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practical physical, mental, and psychological well-being of each resident in that:</p> <p>The facility failed to ensure that residents were free from abuse for 5 (Residents #1, 2, 3, 4, 5)) of 9 residents reviewed for abuse.</p> <p>The facility failed to follow their policy and procedure for investigating allegations of abuse. The Administrator was first alerted that COTA D and Resident #1 were having a relationship beyond resident and therapist on 10/ 2024 but failed to further investigate and report the allegation.</p> <p>The facility failed to implement interventions to ensure Resident #1 was safe after receiving an allegation that COTA D was having a relationship beyond therapist and resident.</p> <p>An Immediate Jeopardy (IJ) was identified on 5/23/2024. The IJ template was provided to the facility on [DATE] at 4:43 p.m. While the IJ was removed on 5/25/2024, the facility remained out of compliance at a scope of pattern, with a potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>These failures could place residents at risk of sexual abuse from facility staff.</p> <p>Findings include:</p> <p>1. Record review of Resident #1's face sheet, dated 5/24/2024, reflected a [AGE] year-old female who was initially admitted to the facility on [DATE] and had diagnoses that included hypertensive heart disease with heart failure (heart problems caused by long-term heart pressure), morbid obesity due to excessive calories (weight that is 80 to 100 pounds above their ideal body weight), body mass index (a ratio of your weight to your height) of 70 or greater, type 2 diabetes mellitus (when the pancreas does not make insulin), sleep apnea (a sleep disorder in which breathing repeatedly stops and starts), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (frequent feelings of fear and worry that is intense and excessive).</p> <p>Record review of Resident #1's care plan, initiated 11/22/2021, reflected the resident had a potential to exhibit withdrawal from activities and socialization due to health condition, physical, and mental limitations, problems, concerns, etc. The care plan interventions included the Social Worker providing support and verbalization of feelings, thoughts, needs, problems, and concerns.</p> <p>Record review of Resident #1's annual MDS assessment, dated 12/22/2023 reflected a BIMS score was 15, which indicated the resident was cognitively intact. Resident #1 had no mood or behavioral concerns and used a walker and wheelchair for ambulation.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #1's May 2024 Consolidated Physician Orders reflected an order, with a start date of 10/12/2023, that the resident had Occupational Therapy 4 times a week for 30 days.</p> <p>Record review of the Facility Incident Report, dated 2/29/2024, reflected Resident #1 reported to the facility during the months of September and October 2023, COTA D had gaslight me and groomed me for a relationship and she realized he had been taking advantage of her. The report reflected COTA D had intercourse with Resident #1 in the resident's room.</p> <p>Record review of the Police Report Case Identification Number 24-00293, dated 2/29/2024, reflected the police were informed by the facility of COTA D's inappropriate sexual behavior with residents.</p> <p>Record review of COTA D's personnel file revealed the COTA was hired on 5/22/2024, suspended on 2/21/2024, and his employment was terminated on 2/28/2024. The personnel file revealed COTA D was given a verbal warning on 10/12/2024 regarding following professional boundaries because of a rumor that he and Resident #1 were planning to move in together after the resident was discharged . On 1/8/2024 COTA D was given a written warning because he was not following the residents plan of care, Medicare guidelines for documentation and he was working overtime without approval. A disciplinary action form initiated 2/27/2024 and signed on 2/28/2024 revealed COTA D was terminated due to inappropriate relations and unprofessional conduct with facility a facility resident and former resident.</p> <p>During an interview on 5/22/2024 at 10:27 a.m. with the PNP she stated the SW referred Resident #1 when information came out about the resident's intimate relationship with COTA D. The PNP stated the resident was vulnerable when COTA D began taking interest in the resident. The PNP reported as their relationship progressed, COTA D told Resident #1 he could provide her a stable relationship and a home for them to live together. The PNP stated Resident #1 expressed increased depression, so she increased the resident's antidepressant dosage. The PNP stated Resident #1 scored high on her anxiety assessment, but the resident was already on an anti-anxiety medication, and the resident did not appear anxious during their meeting. The PNP reported she could not say for sure if the incident made the resident mentally upset, and because the resident was already depressed before the incident, the PNP stated it was difficult to gauge what emotional impact the incident had on the resident.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/22/2024 at 11:36 a.m. with Resident #1 she stated she began receiving occupational therapy with COTA D and continued having a relationship until her surgery in November 2023. Resident #1 stated the COTA started grooming me from the beginning, telling the resident she was a beautiful woman and how great she would look when she lost weight (Resident #1 was scheduled for Lap band surgery in November 2023). Resident #1 reported when she first began working with COTA D, she was engaged to another male living in the community and the COTA was aware of their relationship. Resident #1 stated when she began having problems with her relationship with her fiancée, she would confide in COTA D, and he was supportive. Resident #1 stated she was in a vulnerable state when their romantic relationship began in September 2023. She reported COTA D was her Knight in Shining [NAME], telling her he bought a house for them to move in together and he would paint pictures of a fabulous life and how he would take care of me. Resident #1 reported at that time the COTA was taking her out to eat in the evenings at a restaurant nearby and he would take her to lunch to meet her family, who were visiting from out of town. Resident #1 stated at first COTA D did not stay when he took her to see her family, but a short time later he began joining them for lunch. Resident #1 also reported it was in September 2023 that they had intercourse in the resident's room. Resident #1 reported it was late in the evening, and COTA D checked that all the department heads left for the day. Resident #1 reported they only had intercourse one time. Resident #1 stated in November 2023, their relationship ended, however, the COTA would still kiss her and rubbed her buttocks during her cryotherapy (or cold therapy, where low temperatures are used as part of the therapy treatment to relieve muscle pain or swelling after surgery). Resident #1 reported she found out later that COTA D told her fiancée he never had any intention of the resident moving in with him, and he only said this to motivate her in therapy. The resident reported staff would see them together, but COTA D never did anything inappropriate in front of them. Resident #1 reported the Administrator had asked her in September 2023 if she and the COTA had a serious relationship and she told the Administrator they were just friends. She also reported the Administrator asked her again about a relationship between her and COTA D in November 2023, and she told him no. The resident reported by that time it was over and she was telling the truth. Resident #1 stated only one resident asked her if she was having a relationship with COTA D. Resident #1 reported COTA D was still calling her after he no longer worked for the facility, and she told him to stop calling her and he blocked his phone number on her cell phone.</p> <p>During an interview on 5/22/2024 at 1:56 p.m. with CNA B, she stated she saw COTA D take Resident #1 to the nearby restaurant and the COTA stated they were going out to eat with her family and it was part of her therapy. The CNA stated she never saw COTA D take any other resident outside of the facility. CNA B stated she thought it was odd the COTA was taking the resident out to eat but she never told anyone. CNA B could not provide a reason why she did not tell anyone.</p> <p>During an observation and interview on 5/22/2024 at 2:55 p.m. with HA C she stated after the first State Surveyor went to the facility to investigate the incident, the CNA the resident was not herself and appeared more depressed now that she began telling others about her past relationship with COTA D.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During a telephone interview on 5/24/2024 at 3:00 p.m. with Resident #1's FEC she reported she first met COTA D in September 2023 at the facility. The FEC stated the COTA was cordial but felt conversations with the COTA were forced conversations. Resident #1's FEC stated when they ate with Resident #1 and COTA D, the COTA stated he was looking for wife-material, referring to the resident. The FEC stated at the time Resident #1 had another boyfriend who lived in the community but stated COTA D promised to move her in with him in his new home. The FEC stated they had lunch with the COTA at least 4 times. The FEC stated she recalled another incident when she saw COTA D working with another resident, the COTA helped the resident up from the chair holding her buttock instead of under the resident's arms. Resident #1's FEC stated she could not recall when this occurred, and she did not know who the resident was. The FEC did not state if she told anyone about what she witnessed.</p> <p>During an interview on 5/24/2024 at 6:15 p.m. with CNA E and CNA F both reported they saw COTA D take Resident #1 out to eat several times on weekends. They reported they told RN G the COTA was taking the resident out to dinner.</p> <p>During an interview on 5/24/2024 at 6:18 p.m. with RN G she reported she saw COTA D dressed in a suit, Resident #1 had make-up on and was wearing a dress, and the COTA took the resident out to eat. RN G stated she saw COTA take the resident out two times and she never saw the COTA enter the resident's room. RN G stated she spoke to Resident #1, and the resident was excited, and giddy that COTA D was paying attention to her. The RN stated the resident would sign herself out. RN G asked Resident #1 if there was more than a friendship between the therapist and resident, and the resident stated they were just friends. RN G stated she never told anyone because she thought administration knew he was taking her out to eat.</p> <p>During an interview on 5/22/2024 at 1:39 p.m. with the SW, she stated she was not aware of any inappropriate behavior by COTA D until after everything came out.</p> <p>2. Record review of Resident #2's face sheet dated 5/24/2024 reflected the resident was a [AGE] year-old female who was initially admitted on [DATE], and a readmitted [DATE]. Resident #2 had diagnoses which included cerebral infarction (a brain injury caused by disruption of blood flow to the brain), hemiplegia (severe or complete paralysis on one side of the body) and hemiparesis (one-sided muscle weakness because of disruptions in the brain, spinal cord, or the nerves that connect the affected muscles) following cerebral infarction affecting right dominant side, major depressive disorder major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a mental health disorder characterized by feelings of worry or fear that are strong enough to interfere with one's daily activities), and central pain syndrome (a rare neurological condition that causes chronic pain due to damage to the central nervous system).</p> <p>Record review of Resident #2's annual MDS assessment, dated 5/2/2024, reflected the resident had a BIMS score of 13, which indicated the resident was cognitively intact.</p> <p>Record review of Resident #2's care plan reflected the resident was receiving pain medication therapy which included Gabapentin and Baclofen.</p> <p>Record review of Resident #2's Quarterly MDS assessment, dated 2/7/2024, reflected the resident had an occupational therapy start date of 2/1/2024.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Goldthwaite Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1207 S Reynolds St Goldthwaite, TX 76844	
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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/22/2024 at 11:36 a.m. with Resident #1, she stated Resident #2 told her COTA D would take Resident #2's pants off during occupational therapy.</p> <p>During a telephone interview on 5/22/2024 at 2:20 p.m. with CNA A, she reported one day she noticed Resident #2's door was shut, and she thought that was odd because the resident always left her door open. CNA A stated she knocked, and then opened the door and saw COTA D sitting in the resident's room with his hand on the resident's leg and they were watching television. The CNA explained she saw the COTA was sitting in a chair next to the bed and the resident was in bed. CNA A stated Resident #2 was not wearing any pants and only her brief and a shirt. The CNA stated she could only see COTA D's one hand on her knee and did not know where his other hand was. CNA A stated the COTA and resident did not say anything, and she apologized and walked out. CNA A stated she thought it was a few months ago. The CNA stated she spoke to Resident #2 later and asked her if she felt uncomfortable with COTA D and she said no. The CNA stated she did not tell anyone until recently when questioned about COTA D by administrative staff.</p> <p>During an interview on 5/22/2024 at 1:56 p.m. with CNA B she stated Resident #2 told her whenever she and COTA D had a therapy session, he would take off her pants. Resident #2 told her not to tell anyone. CNA B stated when COTA D started doing therapy sessions with Resident #2 in the therapy room, the resident got made at the CNA, thinking she had told someone. The CNA stated she did not tell anyone about COTA D removing Resident #2's pants because the resident asked her not to.</p> <p>During an interview on 5/24/2024 at 11:14 a.m. with Resident #2 she reported she worked with COTA D a couple of days. The resident reported during their therapy sessions he was working with her legs. Resident #2 stated COTA D took off her pants when he was working with her. The resident stated she was wearing a brief. Resident #2 reported she did not ask the COTA why he removed her pants. Resident #2 stated the COTA would touch and rub her legs, but he never explained anything while he worked with her. Resident #2 stated, it made her feel terrible when COTA D took off her pants. Resident #2 stated on one occasion a CNA walked in when she was working with COTA D and her pants were off. The resident stated the CNA did not say anything. Resident #2 stated the COTA had not touched her anywhere else but her legs when he worked with her.</p> <p>3. Record review of Resident #3's face sheet, dated 5/24/2024, reflected the resident was a [AGE] year-old female with an original admitted [DATE], a readmitted [DATE], and a discharge date of [DATE]. Resident #3's had diagnoses which included hepatorenal syndrome (a life-threatening condition that occurs when the kidneys of someone with advanced liver disease begin to fail), hypertension (high blood pressure), (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (frequent feelings of fear and worry that is intense and excessive), and chronic pain.</p> <p>Record review of Resident #3's 5-day MDS assessment, dated 1/17/2024, reflected the resident began occupational therapy on 1/24/2024 and received therapy 4 days a week.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/22/2024 at 4:46 p.m. with the Administrator he reported around mid-February, he learned a previous resident, Resident #3, was at the hospital, was being released soon, and told the facility Admissions Coordinator, who also marketed for their sister facility in town, that she would go to any other facility, just not the facility. The Administrator reported when Resident #3 stayed at the facility before she told them she was pleased with their care. The Admission Coordinator, who was also a family friend of Resident #3, reported the resident had confided in her that she did not want to return to the facility because of COTA D and he had visited her home a couple of times after she discharged, and he was handsy (touch other people in a way that is inappropriate or unwanted). The Administrator reported she assured Resident #3 that COTA D would not be providing her therapy and the Administrator then told the COTA he was suspended and sent him home. The Administrator stated after Resident #3 admitted back to the facility, she also reported COTA D gave her thong underwear one of the times he visited her home.</p> <p>During an interview on 5/24/2024 at 4:10 p.m. with the Marketing Director she reported she was a family friend of Resident #3, and the resident told her about COTA D being inappropriate with her on her previous visit. The Marketing Director stated Resident #3 initially enjoyed the attention COTA D was giving her but when the resident felt the COTA wanted more than a friendship, she felt uncomfortable.</p> <p>During an interview on 5/27/2024 at 10:01 a.m. with Resident #3, she reported while she was at the facility on her previous visit, she received occupational therapy by COTA D. Resident #3 stated when COTA D was massaging her back, he began fondling her private area and COTA D told Resident #3, I am gonna tap (slang for sexual intercourse) that one day. The resident stated she did not report it to the facility because she was afraid to. Resident #3 stated COTA D was tall at 6'4" and a big man, and she was afraid of him so when he asked for her telephone number when she was ready to discharge, she gave it to him. Resident #3 reported when she was back in the community living at her apartment COTA D called her and said he was coming over to see that her home was handicap accessible and she did not know what to say. Resident #3 stated she had gone out to eat with the COTA at that time because he insisted, she go. That was when he came into her apartment the first time, stating he needed to check that her apartment was handicap accessible. The resident stated COTA D came over to her apartment, but the resident stated she did not know how he got her address. Resident #3 stated the COTA came over to her apartment a second time and brought her a gift, thong underwear. The resident stated COTA D wanted her to wear the underwear in front of him and initially she said no but she felt intimidated because she was by herself, so she wore the underwear in front of him and then changed and told the COTA to leave. Resident #3 stated COTA D showed up a third time, wanted the resident to sit on his lap but she refused so he left. Resident #3 stated COTA D never showed up again. Resident #3 stated she did not know what to do when he wanted to come over.</p> <p>4. Record review of Resident #4's face sheet dated 5/24/2024 reflected a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #4 had diagnoses that included dementia without behavioral disturbance, congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should), hypertension (high blood pressure), and pain.</p> <p>Record review of Resident #4's Quarterly MDS assessment, dated 2/19/2024, reflected the resident had a BIMS score of 15, which indicated the resident was cognitively intact and no mood or behavioral concerns.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #4's May 2024 Consolidated Physician Orders reflected the resident was discharged from occupational therapy services on 1/26/2024. Review of</p> <p>Record review of Resident #4's care plan initiated 8/11/2017 reflected the resident received pain medication which included Tramadol and gabapentin.</p> <p>During an interview on 5/23/2024 at 11:03 p.m., Resident #4 stated she received therapy at the facility, and she did not especially want it. Resident #4 stated she had a male therapist who made her feel uncomfortable. She provided COTA D's first name and gave a brief description. Resident #4 stated during a therapy session, her back was hurting and COTA D pulled her pants down a bit to put some Bio-freeze on her buttock, and she thought this was odd. The resident reported this only happened once. Resident #4 stated she told an unidentified staff member about the incident and the staff member told her to wait and see if he does it again. Resident #4 stated she did not recall who the staff member was. The resident stated the incident happened over 6 months ago in the therapy room while she was lying on the table. She did not report if anyone else was present.</p> <p>During an interview on 5/23/2024 at 12:43 p.m., the Administrator stated Resident #4 never said anything when they interviewed residents for concerns related to abuse and neglect.</p> <p>5. Record review of Resident #5's face sheet dated 5/24/2024 reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #5 had diagnoses which included heart failure (a chronic condition in which the heart does not pump blood as well as it should), shortness of breath (feeling you cannot get enough air into your lungs), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), diabetes mellitus without complications (when the pancreas does not make enough insulin), and unspecified pain.</p> <p>Record review of Resident #5's Quarterly MDS assessment dated [DATE] reflected the resident had a BIMS score of 15, which indicated the resident was cognitively intact.</p> <p>Record review of Resident #5's May 2024 Concentrated Physician Orders reflected the resident had an order for Lidocaine patch and gabapentin for pain and she was discharged from occupational therapy on 4/2/2024.</p> <p>Record review of Resident #5's Quarterly MDS assessment dated [DATE] reflected the resident received occupational therapy with a start date of 11/10/2023 and an end date on 1/5/2024.</p> <p>During an observation and interview on 5/24/2024 at 7:35 p.m. with Resident #5 revealed she received occupational therapy from COTA D. the Resident #5 stated while COTA D was rubbing her back, he began rubbing her buttock and intergluteal cleft (the posterior deep midline groove in the gluteal region that separates the buttocks). Resident #5 showed the region on her body where the therapist had rubbed her. The resident's voice got louder as she talked about it. Resident #5 stated it only happened one time. The resident stated she told the Administrator about it.</p> <p>During an interview on 5/24/2024 at 8:02 p.m. with the Administrator he stated they interviewed Resident #5 regarding abuse and neglect and the resident never reported COTA D touching her inappropriately. The Administrator went on to say he did not recall Resident #5 telling him about the incident and stated he would have remembered something like it.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/22/2024 at 12:30 p.m. with the DOR she stated she began working at the facility PRN in June 2023, and became the DOR in July 2023. The DOR reported COTA D was already working at the facility when she started. The DOR stated she and several members of management had verbally in-serviced the COTA about following each of the residents Plan of Care that was established by the OT when the resident was evaluated. The DOR reported COTA D was reporting additional hours and provided other treatments, including taking Resident #1 out for lunch to meet with her family several times, not prescribed on the Plan of Care, which was outside his scope of practice. The DOR stated COTA D would follow the Plan of Care for a while but then would go back to providing treatment outside the COTA's scope of practice. The DOR reported Resident #1 spoke to her about going on a weekend pass to see COTA D's new house but knew the Administrator had already spoken to the COTA regarding rumors the COTA and Resident #1 had planned to live together after she discharged. The DOR stated Resident #1 later reported they were having a consensual relationship, but he was gaslighting (a form of emotional abuse that causes the victim to question their own feelings) the resident. The DOR reported sometime in August (she could not recall the date), during a weekend, she witnessed COTA D was all dressed up and pushing Resident #1 in her wheelchair out of the facility. The DOR reported she told the Administrator, and the DOR was off the clock at the time. The DOR stated COTA D was fired on 3/4/2024.</p> <p>During a telephone interview on 5/22/2024 at 3:57 a.m. with COTA D, he reported he had been a COTA for [AGE] years and began working at the facility on May 22, 2023. COTA D stated he gave statements to the licensing board and the facility should have a copy. The COTA stated he would not say any names of the residents he worked with and anything about the incidents. He stated when he was working at the facility, he would work 8, 9, or 10 hours a day. COTA D stated some residents were bedbound so therapy would begin in their room and as they progressed, they went to the gym. The COTA reported there was a restaurant about two blocks away from the facility and he would accompany the residents with their families for integration back into society and it was part of the residents' therapy treatment. COTA D stated no resident had ever been to his home. The COTA stated as part of COTA treatment they did home evaluations, home assessments, and home health. COTA D stated he did several home evaluations and house assessments during his career. The COTA reported they did not have relationships with their residents. COTA D stated sometimes residents were drawn by skilled, knowledgeable healthcare workers. COTA D stated he recalled everyone gave a resident a gift and his gift were a pair of shorts. The COTA stated the resident was female and she would wear shorts to therapy. COTA D stated that I do not have any relationship with residents. When the COTA was asked if he was working again, he stated, You do not need to worry about his personal business.</p> <p>During a telephone interview on 5/24/2024 at 2:54 p.m. with the Medical Director she reported she was made aware of the IJ. The Medical Director reported they also had a QAPI after the IJ was called. The Medical Director stated no residents were identified when she spoke to the Administrator and during QAPI. The Medical Director reported Resident #2 was one of her residents she saw at the facility and was not aware of the incident. The Medical Director noted she did have another physician that took calls for her and assisted with the residents at the facility, and he may have been informed about the incident with Resident #2. The Medical Director stated she would follow up with Resident #2 herself to see that she was doing okay.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/22/2024 at 4:46 p.m. with the Administrator, he reported on 10/12/2023 he spoke to COTA D about rumors the COTA and Resident #1 were going to move in together when she was discharged . The Administrator reported COTA D denied the allegation and stated they were just friends. The Administrator reported he discussed professional boundaries with the COTA and reviewed the Code of Ethics between a therapist and resident. The Administrator also had COTA D sign a written warning letter to confirm he was instructed and understood ethical boundaries. The Administrator stated he then went to talk to Resident #1 about the rumor and at that time Resident #1 was asking about going out on pass to see COTA D's new home. The resident reported to the Administrator she and her parents were going to see COTA D's house he recently purchased. The Administrator stated he questioned Resident #1 about the rumors she was planning to move in with COTA D, and the resident denied the relationship and stated they were just friends. The Administrator reported Resident #1 never went out on pass to see the COTA's house. The Administrator stated at the time he believed COTA D was telling the truth, He was so convincing by the way he responded, and other residents reported how much they liked him. The Administrator stated the COTA was also disciplined for taking extra-long time with each treatment he was providing, running more labor hours per resident. The Administrator reported it eventually got better after several talks with COTA D.</p> <p>The Administrator reported he discovered Resident #1 and COTA D had a romantic relationship on February 29, 2024. The Administrator reported initially around mid-February, he learned a previous resident, Resident #3, was at the hospital and being released soon and told the facility Admissions Coordinator, who also marketed for their sister facility in town, that she would go to any other facility, just not to their facility. The Administrator stated when Resident #3 stayed at the facility before, she told them she was pleased with their care. The Admission Coordinator, who was also a family friend of Resident #3, reported the resident confided in her that she did not want to return to the facility because of COTA D and that he had visited her home a couple of times after she discharged , and he was handsy (touching other people in a way that is inappropriate or unwanted). The Administrator reported he assured Resident #3 that COTA D would not be providing her therapy and the Administrator then told the COTA he was suspended and sent him home. The Administrator stated after Resident #3 admitted back to the facility, she also reported COTA D had given her thong underwear one of the times he visited her home. The Administrator reported they began interviewing all residents on abuse and neglect, asking the residents if they ever had any issues with staff, and that was when Resident #1 reported she had a sexual relationship with COTA D. The Administrator also spoke to staff and learned that CNA A walked into Resident #2's room and the COTA was in the room and the resident was not wearing pants. The Administrator also reported he learned Resident #2 told CNA B that COTA D took her pants off during therapy. The Administrator reported no other residents reported an incident with COTA D. The Administrator stated he made a referral to the OT/COTA licensing board, but he did not receive copies of the COTA's statement to the board)</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of the facility's policy titled, Abuse/Neglect, revised 10/14/2022, reflected, Resident's should not be subject to abuse by anyone, including, but not limited to facility staff. 4. Sexual Abuse-non-consensual sexual contact of any type with a resident. C. Prevention, 3. All reports of abuse or suspicion of abuse/neglect or potential criminal behavior will be investigated as per facility policy and 5. All occurrences of potential abuse or criminal behavior will be investigated by the Abuse Preventionist and/or designee. D. Identification, Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect, or exploitation must report this to the DON, Administrator, state and /or Adult Protective Services. E. Investigation, The Administrator or Risk Management Department will be responsible for investigation and reporting cases to Health and Human Services Commission. F. Protection, The facility will take necessary measures to protect residents .during and following an abuse, neglect, and exploitation, misappropriation of residents or misappropriation of resident property investigation.</p> <p>Record review of the Occupational Therapy Code of Ethics and Ethics Standards (2010) provided by the facility, under the heading, Nonmaleficence, reflected Occupational therapy personnel shall: C. Avoid relationships that exploit the recipient of services . physically, emotionally, psychologically, financially, socially, or in any other manner that conflicts or interferes with professional judgement and objectivity, .D. Avoid engaging in any sexual re[TRUNCATED]</p>