STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676096	A. Building B. Wing	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baybrooke Village Care and Rehab Center	8300 Eldorado Parkway West McKinney, TX 75070

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 Based on observation, interview, and record review, the facility failed to protect a resident's right to be free from abuse for 1 (Resident #1) of five residents reviewed for abuse. The facility failed to supervise and protect Resident #1, who did not have the ability to consent, from sexual abuse. CNA A was observed, on a camera video footage, engaging in an inappropriate, sexual oriented activity with Resident #1 on 02/02/24. The noncompliance was identified as PNC. The IJ began on 02/02/24 and ended on 02/04/24. The facility had corrected the noncompliance before the survey began on 02/05/24. This failure placed residents at risk for serious injuries, abuse, and serious psychosocial harm. Findings included: Record Review of Resident #1's Comprehensive MDS, dated [DATE], reflected she was an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety [a group of symptoms affecting memory, thinking and social abilities severely enough to interfere with daily life], elevated blood pressure, and muscle weakness. Her BIMS score not assessed related to Resident #1 never understood. Functional status reflected Resident #1 was totally dependent and required assistance of 1 to 2 staff for toileting hygiene, shower, and personal hygiene. Bladder and bowel assessment reflected Resident #1 was always incontinent of bladder and bowel. Record review of Resident #1's Care Plan reflected the following: -Resident #1 had dementia evidenced by severe cognitive impairment and inability to communicate. Interventions: Offer resident two simple choices to reduce the stress of decision making and increase resident's sense of autonomy. Initiated on 08/17/21 and last revised on 02/05/24. -Resident #1 at risk for problems with elimination (bladder and bowel). Interventions: check resident every 2 hours and assist with toileting as needed, provide peri-care after each incontinent episode. Initiated on 8/17/21 and last revised on 02/05/24. Record review of Resident #1's Order Summary for February 2024 revealed: (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Transfer to the hospital for evaluation and SANE exam with an order date of 02/03/2024. -Memantine tablet 5 mg, give 1 tablet by mouth two times a day for dementia with an order date of 08/17/2021. Review of the facility's Provider Investigation Report involving Resident #1 dated 02/04/24 reflected, .Incident date 02/02/24 at 6:50 PM revealed local PD reported that family member of roommate to Resident #1 had made an allegation of possible sexual abuse to resident #1 based on camera footage. Local PD came to the facility. Investigation initiated by PD and facility. Employee suspended. MD notified, Resident #1's family notified and came to the facility. DON assessed Resident #1 with RP present at the bedside. No destress or change in behavior noted upon assessment. Resident #1 was sent to the hospital for SANE exam, and she returned back to the facility with no new orders. Every shift observation put in place to monitor for any behavioral, cognitive changes. Resident #1 was seen by MD and Psychiatric with no new orders. Police initial request was to hold off on staff interviews until further directive. On 2/5/24 detectives arrived in the facility to continue investigation. At this time, permission was given to interview staff but advised we could not contact the accused. On 2/6/24, the PD disclosed to the Administrator that the Alleged Perpetrator had been arrested in connection with this allegation. Provider response included in-service on abuse/neglect completed, QAPI was held on 2/6/24, and resident safe survey was completed. The Investigation Summary revealed after reviewing the findings, it is summarized that the facility has confirmed that abuse occurred. Record review of a camera video footage, dated 02/02/2024 not timed, reflected CNA A removed Resident #1 brief. He moved Resident #1 to the edge of the middle of the bed. Resident #1 was lying on her back with legs extended in an upright position. CNA A was facing the resident in a standing position between the legs. CNA A was observed putting his hands on the shoulders of the resident to pull her closer to him. CNA A moved in a repetitive forward motion and the resident moving with the motion. The resident was heard making unintelligible sounds on the video. CNA A then placed the brief on the resident, repositioned her in the bed and left the room. Record review of Resident #1's nurses note dated 02/04/24 electronically signed at 08:52 AM revealed on 02/03/24 at 11:20 PM DON went to Resident #1 room with RP at the bed side. The DON did head to toe skin assessment with no open areas or concerns noted. Record review of Resident #1's pain risk assessment dated [DATE] reflected pain intensity of 0 Record review of Resident #1 medical record reflected Resident #1 was sent to the hospital on 02/03/24 at 11:45 PM Record review of Resident #1's emergency room Hospital Records, dated 02/04/24, reflected the following: [AGE] year-old female with past medical history of dementia presented to the emergency department for SANE exam. Visit Diagnosis: Abrasion of labia. Record review of Resident #1's hospital records dated 02/04/24 reflected the following: RN assisted SANE nursing in cleaning and changing Resident #1, rash visible around groin and genital area. Resident #1 seen scratching multiple times throughout process. Record review of Resident #1's hospital records dated 02/04/24 reflected Resident #1 was discharged from the hospital, on 02/04/24, back to the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 02/05/24 at 10:15 AM, the Administrator stated the DON got the call from RN E on 02/03/24 at 9:50 PM, police officer in the facility. Around 9:30 to 10 PM he was in the building. The officer told him on the phone he had evidence of sexual potential assault. By the time Administrator got to the facility CNA A had already left. The officer would not share the video with the facility. The facility requested the video from Resident #1's roommate's family member. The facility notified Resident #1's RP. They were in the facility 15 - 20 min later. The DON went with the RP to Resident#1's room. Assessment reflected redness could be from the brief. Resident#1 transferred to Baylor [NAME] & with Medical Center. The facility talked to the RP on Sunday 02/03/24, she said at the hospital they did the exam at 4:00 AM on Sunday. Resident came back the same morning. The facility received the video on 02/04/24 at 12:56 PM In an interview on 02/05/24 at 11:21 AM, Resident #1's roommate's family member stated Resident #2 called her on the phone on 02/03/24 and told her she heard, last evening, sexual comments between Resident #1 and a CNA. The family member stated she looked at the camera, she observed inappropriate act from the CNA. She stated she took the camera footage to the police station. The officer watched the camera footage with other officers, and they went to the facility. In an interview on 02/05/24 at 12:46 PM, Detective C assigned to the case requested to hold off on staff interviews until further directive. On 2/5/24 at 2:35 PM, Detective C arrived in the facility to continue investigation. At this time, permission was given to interview staff, but he advised not to contact CNA A. On 02/05/24 at 2:40 PM, attempted to interview Resident #1, she responded illogically to most questions asked of her or did not respond at all. When attempted to discuss the recent sexual abuse allegation Resident #1 responded with unmeaningful words. On 02/05/24 at 2:45 PM, RN E stated he worked on 02/03/24 from 2 PM to 10 PM. RN E stated around 9:50 PM a police officer approached him and asked him about the manager. RN E called the DON. RN E did not know why the police where in the facility, he stated couple minutes later the DON, and the Administrator came to the facility. RN E stated he was not assigned to Resident #1. In an interview on 02/07/24 at 9:00 AM, Administrator stated, on an interview on 02/06/24, Detective C told him CNA A admitted he attempted to sexually assault Resident #1. He told him CNA A was arrested on 02/05/24. On 02/07/24 at 11:06 AM attempted to call Detective C; left message. Observation on 02/07/24 at 11:25 AM with CNA F who performed incontinent care for Resident #1 revealed redness to the left inner thigh at brief lining area. In an interview on 02/07/24 at 1:12 PM, Resident #1' RP stated the police department called her and informed her CNA A was arrested on 02/05/24 because he confessed to the sexual act. Review of CNA A's timesheets reflected he worked on 02/02/24 from 1:54 PM to 10:09 PM. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1 psychiatric services note dated 02/06/24 revealed Resident #1 was seen for trauma/stressor related disorders, issues with trauma. The report stated Resident #1 was the recent victim of possible sexual assault. The report indicated Resident #1 was very confused with severe cognitive impairment. The document was signed by PA B Review CNA A's personal file reflected no barrier for employment: - Criminal history conviction name search on 12/19/22 - No search results found. - Nurse aide: NA certification status: Active. Certification number: NA0008319536. Issue date: 4/27/2005. Expiration: 6/12/2025 - Texas HHS Employability status check search results date 12/19/2022: Unemployable? NO. NAR status: Active. NAR active unemployable: NO. MAR status: Active. Incident on the EMR: NO - No result found for CNA A. Annual checklist: - Office of inspector general: 11/22/23 - DADS Employability status: 11/22/23 - DPS CCH Verification: 11/22/23 - Performance Evaluation: 11/20/23 - Compliance Code of Conduct Certification: 11/20/23 In-Services: Abuse - 10/13/23, Abuse - 12/20/22, Abuse - 12/1/23, Abuse - 1/26/24. In an interview on 02/07/24 at 1:17 PM, the Administrator revealed CNA A was suspended on 02/03/24 and terminated on 02/04/24. In an Interview on 02/07/24 at 1:25 PM, the DON stated she never got any complaint about CNA A. She stated some family members requested him to assist there loved one. She stated she watched the video, and it was disturbing. She stated all staff had been in serviced on abuse neglect before they start their shift. Review grievance log for last 3 months reflected no grievance about CNA A. An impromptu Quality Assurance and Performance Improvement was completed on 02/06/24 with the MD, Psych, Psychology, Administrator, DON, and Social Worker. Review of facility's in-services to nursing staff dated 02/03/24 to 02/05/24 reflected eleven nurses and twelve CNAs were in-serviced on Abuse and neglect reporting and prevention. (continued on next page)

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