STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676122	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Grove Nursing Home	6230 Warren St Groves, TX 77619

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47879 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse of residents are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury to HHSC for 1 of 9 residents (Resident #1) reviewed for abuse. The facility failed to report an allegation of sexual abuse within 2 hours to the State Agency when Resident #1 alleged that she had been touched inappropriately. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: Record review of a face sheet dated 07/10/2024 indicated Resident #1 was 68-years-old female, initially admitted to the facility on [DATE] with readmitted [DATE]. Her diagnoses included schizoaffective disorder, bipolar type (mental health condition with a combination of symptoms of schizophrenia and mood disorder), vitamin deficiency (condition of a long-term lack of a vitamin), obsessive-compulsive disorder (a mental health disorder characterized by repetitive actions that seem impossible to stop), hypokalemia (below normal blood potassium level), type 2 diabetes (a chronic condition that affects the way the body processes blood sugar), and insomnia (trouble falling asleep or staying asleep). Record review of a MDS assessment dated [DATE] indicated Resident #1 was usually able to make herself understood and usually understand others. She had a BIMS score of 15 (cognitively intact). Her behaviors included physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) that occurred 1 to 3 days (out of 7 days look back period). She was independent with ADLs. She was continent of bladder and bowel. (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan revision dated 06/08/2024 indicated Resident #1 was at risk for behaviors/mood pattern changes; was accusatory toward others stating they stole my money; told others she saw people, that a fatigued man came and gave me covid or that she got covid from shot, had delusions that someone came in her room/ touched her but unable to state where, had delusions about denture cream on her face that was not there etc, and called lawyers or asked to call lawyer stating the administrator was running a sex trafficking operation. Interventions included to administer medications as ordered, encourage the resident to attend activities of interest, evaluate the effectiveness of medications if there was a noted increase in mood/behaviors and notify the MD, moved rooms, interviewed resident on what happened, unable to state where she was touched, Psych consult as ordered, sent to hospital for evaluation, social services referral, send to behavioral hospital. Record review of Resident #1's care plan revision dated 06/10/2024 indicated Resident #1 had behaviors: resisted care, was at risk for her needs not being met, had a history of refusing showers, had a history of refusing psych medications, and had a history of delusions/hallucinations. Interventions included to administer medications as ordered, approach slowly and calmly, if the resident became combative staff were to leave and try to approach later-notify nurse, monitor and record behaviors, pharmacy review of medications, and psych consult as ordered. Record review of Resident #1's progress note authored by LVN A indicated that on 06/08/2024 at 7:30 a.m., that Resident approached the nurses' station and stated, I think someone came into my room last night and touched me. During an interview on 07/09/2024 at 1:00 p.m., Resident #1 said that someone came into her room on night of 06/07/2024 or early morning on 06/08/2024 and touched her. She said she had denture cream on her cheek and drainage with smell in her underwear. She was unable to give any additional details of the incident. Resident #1 denied being woke up during the night or morning from the incident and said, they gave her a shot to knock her out and take advantage of me. Resident #1 then said she spoke with a ghost lover at night but that it was not him that touched her. She said she went to the hospital for testing and was getting a lawyer to help her with the case. During an interview on 07/10/2024 at 1:30 p.m., LVN A said she recalled the incident with Resident #1 coming to the nurses' station during shift change on 06/08/2024 stating she thought someone had come into her room and touched her inappropriately. She said Resident #1 was calm and in no distress when she reported it. LVN A said she informed the resident that she needed to go to the ER for an evaluation, but the resident said she wanted to go smoke and have her coffee before she went to the ER. LVN A said Resident #1 could not give specific answers when questioned about the incident. LVN A said Resident #1 did not call for help or use her call light for assistance during the shift and the resident was sleeping during her rounds. LVN A said the information provided by Resident #1 could be a sexual assault allegation and she notified the DON and administrator/AC immediately regarding the reported incident. LVN A said she did not recall seeing any residents wandering the hall or entering Resident #1's room the night of the alleged incident. LVN A said surveillance cameras were reviewed, and no footage identified anyone other than staff doing routine rounds entering Resident #1's room during the time of the alleged incident. She said she was trained on abuse and neglect and was aware to report any allegations of abuse to the administrator/AC immediately which she did. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/10/2024 at 1:00 p.m., LVN B said she recalled the incident with Resident #1 coming to the nurses' station during shift change on 06/08/2024 and stating that she thought someone had come into her room and touched her inappropriately. She said Resident #1 was calm and in no distress and the resident requested to go smoke and have her coffee before she went to the ER. LVN B said LVN A was leaving off shift and LVN A was trying to interview Resident #1, but the resident did not give specific answers when questioned about the incident. LVN B said the DON, Administrator, and the police were notified regarding the incident. LVN B said the Administrator came to the facility and interviewed the resident prior to her being transferred to the local hospital for evaluation. LVN B said Resident #1 was transferred to a local hospital and then to another facility so a rape test and SANE exam could be performed on Resident #1. LVN B said the resident remained at the hospital for more than 24 hours but later returned to the facility and then transferred to a behavioral health facility as ordered by psych services. LVN B said she observed footage from surveillance cameras and no footage identified anyone other than staff entering Resident #1's room during the time of the alleged incident. She said she was trained on abuse and neglect and was aware to report any allegations of abuse to the administrator/AC immediately. Record review of TULIP intake for Resident #1 indicated information date received on 06/08/2024 at 5:31 p. m., read that the allegation of abuse occurred on 06/08/2024 at 8:30 a.m. (9 hours prior). Caller information indicated the reporter of the allegation was the Director of Nurses. During an interview on 07/11/2024 at 10:30 a.m., the Director of Nurses said she and the Administrator became aware of the sexual abuse allegation made by Resident #1, immediately after it was reported to LVN A on 6/08/2024. She said the Administrator/Abuse Coordinator came to the facility and they interviewed the resident (she was on speaker phone of the Administrator's cell phone). She said Resident #1 continued to allege that someone had touched her during the night but could not provide specific details or answer additional questions. The DON said the resident continued to say she slept uninterrupted through the night and had not seen or heard anything unusual during the night. The DON said Resident #1 had a history of delusions. The DON said footage from the surveillance cameras were reviewed and only staff performing routine rounds were observed entering Resident #1's room. The DON said that due to resident's delusional episodes they did not feel the allegation of sexual assault/abuse was true; however, she now realized that the allegation should have been reported to HHSC within 2 hours of the alleged incident and then investigated. The DON said her expectations were for the facility staff to report all suspicions or allegations of abuse immediately to the administrator, as the abuse coordinator. She said the timeframe for reporting allegations of abuse to the state agency was to report within 2 hours of the allegation. The DON said the incident should have been reported to the state agency within 2 hours of the allegation. Record review of the facility's undated Reporting Abuse and Neglect Policy indicated Any facility staff member who has cause to believe that the physical or mental health of a resident has been or may be adversely affect(ed) by abuse, neglect, or exploitation case(ed) by another person, is to report the abuse, neglect or exploitation immediately.3. Will ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse .