STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676170	A. Building B. Wing	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Dominic Village Nursing Home	2409 E Holcombe Blvd Houston, TX 77021

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** Based on observations, interviews, and record reviews the facility failed to ensure residents were free from sexual abuse and physical abuse for three of ten residents (Resident #61, #52 and #48) reviewed for abuse. -The facility failed to have a policy and procedure in place to address the determination of capacity to consent to sexual activity for residents who lacked the cognitive ability to consent. On 2/25/25 RA A witnessed inappropriate sexual behavior between two residents who had dementia. Resident #61 had his mouth on Resident #52's breast. -The facility failed to ensure Resident #48 was free of abuse when CNA A pushed Resident #48's face into his bed railings while providing incontinence care. This failure was identified as Non-Immediate Jeopardy. An Immediate Jeopardy situation was identified on 04/30/25. The IJ template was provided to the facility on [DATE] at 05:23 PM. While the IJ was removed on 05/03/25 at 1:00 PM the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This deficient practice could place residents at risk of non-consensual sexual relations, physical pain, psychosocial distress and feeling uncomfortable. Findings include: (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the provider investigation report submitted to the state by the Administrator dated 3/04/2025 revealed in part: .Description of the Allegation: On 2/25/25 a staff member walked into the room of the listed female resident (Resident #52), observed the listed male resident (Resident #61) with his mouth on the breast of the female. The male was asked to leave the room without incident. The male resident was placed on one-to-one supervision until his transfer to a psychiatric/behavioral hospital for further evaluation/treatment. Both residents have a diagnosis of Dementia. Both residents have the capacity to be interviewed, however the female resident does not have the capacity to make informed decisions. The female resident was assessed for injuries. None were found or reported RP/Physician notified. RP reported that she did not want to send female resident to SANE-Sexual Assault Nurse Examiner. Resident is currently being followed by psychiatric services Incident reported to law enforcement .RPs, Physicians, Ombudsman notified. Staff in-serviced on Abuse. Other residents interviewed, no other incidents were reported or found. All residents are being monitored for both comfort and safety. Investigation Summary: Confirmed. Male resident placed on one to one supervision until transfer to psychiatric/behavioral hospital . Further review revealed police incident #0252699-25 and a witness statement from RA A confirming she witnessed Resident #61 in Resident #52's room with his mouth on her breast and was reported to the nurse on duty and the DON, he was asked to leave the room. The report included the facility's Abuse and Neglect policy as well as policy for Patient Care with Dignity, Respect and Safety. The report included staff in-service sign in sheet dated 2/25/25 and resident safe surveys conducted by the SW. Record review of Resident #61's face sheet dated 04/01/2025 revealed an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included dementia, cognitive communication deficit, muscle weakness and unsteady on his feet. Record review of Resident #61's admission MDS (a resident assessment tool) dated 8/13/2024 indicated he had a BIMS score of 11 out of 15 indicating moderately impaired cognition. He had no physical behavioral symptoms directed towards others. He used a walker for mobility. Record review of Resident #61's quarterly MDS dated [DATE] revealed a BIMS score of 10 out of 15 indicating moderate impaired cognition. Resident #61 had no physical behavioral symptoms directed towards others. Record review of Resident #61's undated care plan, downloaded from the electronic health records at entrance on 04/01/25, revealed the care plan did not address an inappropriate sexual incident on 2/25/2025 involving Resident #52 or sexual behaviors towards any other individuals. Record review of Resident #52's face sheet dated 04/01/2025 revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included dementia, depression, and cognitive communication deficit. Record review of Resident #52's admission MDS dated [DATE] revealed a BIMS score of 7 out of 15 indicating severe cognitive impairment. Further review of the admission MDS revealed she had no physical behavioral symptoms directed towards others. Record review of Resident #52 quarterly MDS dated [DATE] revealed a BIMS score of 6 out of 15 indicating severe cognitive impairment. Resident #52 sometimes felt lonely or isolated from others. Resident #52 had no physical behavioral symptoms directed towards others. (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 #52 undated care plan downloaded from the electronic health records at entrance on 04/01/25 revealed, Focus - Resident #52 received anti-anxiety medications daily for anxiety, date initiated 12/10/24. Interventions included: monitor/document/report PRN any adverse reactions to anti-anxiety therapy to include unexpected side effects: Mania, hostility, rage, aggressive or impulsive behavior, hallucinations. Further review revealed the care plan did not address an inappropriate sexual incident on 2/25/2025 involving Resident #61 or sexual behaviors towards any other individuals. Record review of Resident #61's progress note dated 2/25/25 at 3:16 PM and written by LVN C revealed when Resident #61 was observed with his mouth on Resident #1's chest, immediate intervention was provided to separate the residents and ensure safety. Resident #61 was redirected, and the resident was placed on one-on-one observations. Record review of the facility's one-on-one Behavior Monitoring Form dated 2/25/25 and 2/26/25 revealed Resident #61 was checked hourly after the incident starting on 2/25/25 at 3:00 PM and ending on 2/27/25 at 6:00 AM. CNA B and CNA C documented no behaviors were observed. The form was signed by the supervisor LVN C. Record review of Resident #61's Behavioral Health Diagnostic Assessment from the facility dated 03/14/2025 written by the Psychologist indicated the reason for referral was anxiety and the assessment indicated there was no sexual acting out. Record review of Resident #52's Behavioral Health Plan of Care from the facility dated 03/14/25 and written by the Psychologist indicated a primary diagnosis of adjustment disorder, anxiety, depression, and a secondary diagnosis of mild dementia with psychotic disturbance. The therapy focused on reducing symptoms of depression and anxiety. The resident was not a good historian and was occasionally confused. Further review revealed the sexual activity incident on 2/25/25 was not addressed. In an interview on 04/01/25 at 09:30 AM, RA A said back in February 2025 she walked into a resident room, and she witnessed Resident #52 and Resident #61 engaging in sexual activity. She said Resident #52 had her shirt up and Resident #61 was sucking on her breast. RA A said she tried to intervene and separate the residents but Resident #52 said she wanted Resident #61 to stay. RA A said she did not think Resident #52 was cognizant enough to give consent, so she immediately notified her nurse. In an interview on 04/01/25 at 11:45 AM, the DON stated the MDS nurse would normally be the one to update the care plan and he expected this after the incident with Residents #61 and #52. In an interview on 04/01/25 at 1:00 PM, the ADON stated the care plan should have been updated as soon as possible after the occurrence between Resident #61 and #52. The ADON stated she did not know why it was not updated but it should be as Resident #52 had behaviors and if there were specific approaches that were not reflected in the care plan, it would affect the care of the resident. The ADON stated Resident #61's care plan should also be updated for the same reason. In a telephone interview on 04/01/25 at 1:15 PM, the MDS Nurse stated she was one of the MDS nurses in charge of the long-term care residents and that the unit managers were responsible for updating care plans if behaviors for Residents #61 and #52 were involved since they were the ones who usually conduct the care conferences with the family and resident. The MDS nurse stated other responsible staff would be the SW and ADON. (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 04/01/25 at 1:45 PM, the SW stated the care plan for Resident #61 and #52 should have been updated due to behavior issues and the purpose of the care plan was to reflect everything about the resident. The SW stated the incident could happen again if the care plan was not updated. Telephone interview on 4/1/2025 at 6:58 PM, Resident #61's RP stated he was unsure about whether he was ok with Resident #61 having sexual relations and he would wait until the next care conference to discuss it with the facility. The RP said Resident #61 had some degree of Alzheimer's but was not a predator. In an observation and interview on 04/02/25 at 8:45 AM, Resident #61 was in his room lying on his bed awake and alert. Resident #61 stated he was moved to room [ROOM NUMBER] a few days ago and did not know the reason for the move. In an observation and interview on 4/16/2025 at 2:14 PM, Resident #52 denied the incident about a male resident coming into her room and sucking on her breast. She said it was a fairytale and never happened. She stated she did not recognize Resident #61's name. The resident was not in any distress. Interview on 4/16/2025 at 4:20 PM, the DON stated according to the staff he was told Resident #52 was holding her shirt up and Resident #61 had his mouth on her breast. The DON stated there were no other incidents, that that was a situation they had never faced before. The DON stated there was no real reason for Resident #61 and #52 to be able to consent since they both have dementia. Resident #61 had never done anything like that before and had never been a trouble resident. The DON stated that capacity to consent forms for residents with dementia may be in the facility admission Packet, it may state the RP makes the decisions and that he would have to look and see what he could find as he was not sure. Interview on 4/16/2025 at 5:18 PM, Resident #61 stated he admitted he often went by Resident #52's room to make sure she ate. He would not say what he did and began using expletives and the interview ended. Telephone interview on 4/16/25 at 5:41 PM, Resident #61's RP stated that he was not sure about consenting for him to have sexual relations because he was only his nephew. He asked the surveyor if the elderly were still having sex in the nursing home. He did not provide an answer when asked if Resident #61 could consent to sexual relations. Telephone interview on 4/17/2025 at 9:14 AM, Resident #52's RP stated she would not prevent it if Resident #52 chose to have a male resident in her room, that she would let her live out her days the way she would like to and that if a sexual interaction happened again, she would not do anything. The RP stated something like that had never happened before. The RP stated the facility had never asked for consent to have sexual relations. The RP stated Resident #52 could not make decisions for herself and that she was like a [AGE] year-old. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 4/17/2025 at 11:38 PM the Administrator stated Residents #61 and #11 had an established friendship that both families were aware of and were OK with. Resident #52 had not been deemed incompetent because she would tell him that she could make her own decisions. The Administrator stated the facility did not have consent forms for sexual activity. The Administrator stated there was no specific assessment for capacity to consent to sexual activity. The Administrator stated there was no specific policy when, how, who determined capacity to consent to sexual activity and where it would be documented. The Administrator stated we make it clear in resident rights and abuse policy we would be infringing on their rights. The Administrator stated at the time we assessed that neither resident was at risk. The Administrator stated, If it would happen again, they would be in the same situation, and he would not know how it would be addressed. The Administrator stated there were no policy revisions made after the investigation. The Administrator stated Resident #61 was moved from 400 hall to 200 hall due to the process of making a specialized are on Hall 400. On 04/17/2025 at 11:33 AM, an attempt was made to call Resident #61's physician. A voicemail and text message were sent to return Surveyor's call. No call back was received. Telephone interview on 4/17/2025 at 11:57 AM, Resident #52's Physician stated she had been notified about the incident. She stated Resident #52 did not have the capacity to consent to have sexual relations with other residents. She said at her stage of dementia, she would not understand fully what was happening. She said she was not a psychiatric doctor and not sure if she could have suffered any psycho-social harm but Resident #52 would possibly understand pain or injury. Telephone interview on 4/17/2025 at 12:27 PM, RA A stated she saw Resident #61 with Resident #52 at the entrance to Resident #52's room and noticed Resident #61 doing inappropriate things to Resident #52. RA A stated she tried to make Resident #61 leave but Resident #52 did not want him to leave. RA A called out for a nurse and nurse (unknown name) was able to get Resident #61 to leave. RA A stated she was instructed by the Administrator to sit with Resident #61. Telephone interview on 4/17/2025 at 3:00 PM, Resident #52's Psychologist stated she was not notified of the incident. Resident #52 would not have the capacity to consent to sexual relations due to her dementia worsening over the past 6 months. In a telephone interview on 04/18/25 at 1:30 PM, LVN C stated nursing staff were monitoring Resident #61 round the clock after the incident and remained by his side until he was transferred to the hospital on 2/27/25. LVN C stated Resident #61 had no behaviors and was always pleasant, friendly, and kept to himself. LVN C stated she worked quickly to get him to the behavioral hospital as soon as a bed was available. LVN C stated she had never seen sexual inappropriate behavior by Resident #61 or any resident before. LVN C confirmed she signed the one-on-one Behavior Monitoring Form dated 2/25/25 and 2/26/25. In a telephone interview on 04/18/25 at 3:50 PM, CNA C stated she observed Resident #61 every time he moved and followed him if he stepped out of the room. CNA C stated Resident #61 remained in his room and had no behaviors. CNA C stated she did sign the monitoring sheets dated 2/25/25 to 2/26/25 and confirmed her initials. (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 the facility's Abuse and Neglect Prohibition Policy and Procedure, revised 02/24/2016 read in part Policy: Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, injuries of unknown origin, and misappropriations of property .Definitions: .Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion or sexual assault .Investigation: 1. The facility will conduct an investigation on any alleged abuse/neglect, injuries of unknow origin, or misappropriation of resident property in accordance with state law . Further review of the policy did not address capacity to consent to sexual activity and how to assess capacity to consent to sexual activity. Record review of a copy of the facility's undated admission Packet revealed consent to sexual activity was not addressed. Record review of the facility's QAPI committee policy and procedure, written April 2024 revealed in part .It is the policy of the facility to establish a multi-disciplinary team whose responsibility is to monitor and evaluate systems of care, management practices, clinical care, residents' choice and quality of life to ensure our residents receive the highest quality of care possible .Our purpose entails identifying problems, initiating a plan of action to resolve problems, evaluate the results of actions taken to ensure effectiveness, review and revise action plans as necessary to obtain effectiveness and to review and revise facility policies, procedures and protocols when necessary . This failure resulted in an identification of an Immediate Jeopardy (IJ) on 04/30/25. The Administrator was informed and provided the IJ template on 04/30/25 at 5:23 PM. A Plan of Removal (POR) was requested. The following Plan of Removal submitted by the facility was accepted on 05/02/25 at 03:13 PM. Plan of Removal: Item 1 was a revised Policy and Procedure for Sexual Abuse, which was completed on 5/1/25. The revision included an assessment and process to determine a resident's capacity to consent to sexual activity. This was completed on 5/2/25. Item 2 was placing Resident #61 on one-to-one supervision until a third mental health evaluation could be completed to determine if the resident was a threat to himself or other residents. Resident #61 was also evaluated to determine capacity to consent to sexual activity. This was completed on 5/2/25. Item 3 was Resident #52 being re-evaluated for her ability to consent to sexual activity, updating care plan, and ongoing psychosocial services. This was competed on 5/2/25. Item 4 was the process for enforcement of the new policy for residents that are found to have engaged in sexual activity. This was completed on 5/1/25. Item 5 was staff in-service on revised Policy and Procedure for Sexual Abuse. No staff was permitted to work until receiving the in-service. This was completed on 5/2/25. Monitoring of Plan of Removal: (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 the facility policy titled Resident Sexual Activities dated April 2025 revealed the purpose of the policy was to establish policies and procedures for addressing both consensual /non-consensual sexual interactions involving residents, including investigation, and documentation. Procedures for the policy were: 1.Residents whose Brief Interview for Mental Status (BIMS) is 10 or below will be assessed for capacity to consent to sexual activity. 2. If the resident has demonstrated the ability to consent to sexual activity, the facility will provide adequate accommodation for space and privacy. Residents may be provided with basic education such as the use of condoms, sexually transmitted diseases etc. 3. If a resident has not demonstrated the ability to consent to a sexual activity, his/her responsible party will be notified of the sexual behavior (s) or desire to participate in one; in conjunction with the responsible party or medical power of attorney a plan to ensure the resident's safety from unwanted sexual acts(s) will be developed and implemented. 4. If a resident is a recipient of an unwanted sexual act by another resident the following steps will be taken: 1. Provide adequate monitoring for the resident until the person initiating the unwanted sexual act is either removed from the facility and or threat is neutralized. 2. If the person initiating the unwanted sexual act is a resident, this person will be placed on one-to-one monitoring until he/she is evaluated by a licensed mental health professional, discharged from the facility or deemed safe to remain in the facility, by a licensed professional. 5. When it has been determined that a sexual act between residents has occurred, all involved residents will be interviewed to determine if the act was consensual, and their response will be documented in the medical record. For residents which (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	have been determined to not have the ability to consent to a sexual activity, the party responsible or power of attorney can record the response on behalf of the resident. 6. The facility's ombudsman will continue to be notified of reportable incidents of abuse and be utilized as a resource to advocate for resident rights. 7. The resident's care plan will be updated accordingly. Record review revealed the facility completed an assessment tool to determine a resident's capacity to consent to sexual related activities will be completed by any resident whose BIMS Score is 10 or below. The assessment tool submitted specifically addressed the residents understanding of what may be defined as a sexual activity and his/her ability to willingly consent without duress or coercion. The assessment would be administered and scored by a licensed mental health professional. A Licensed Mental Health Professional (LMHP) is a certified practitioner in the field of mental health, with the education, training, and licensure to provide a range of mental health services. Observation and record review from 5/1/25 to 5/5/25 throughout the survey revealed Resident #61 was placed on 1:1 supervision on 2-25-25 and remained on 1:1 supervision until he was sent to a behavioral health hospital on 2-27-25 for evaluation. He returned to the facility on 3-11-25 with no special instructions for supervision and returned with medications for hyper-sexual activity. Those medications were subsequently removed by his primary physician. There have been no sexual or other behaviors post interaction with Resident #52. Resident #61 was again placed on 1:1 supervision from 4/18/25 to 4/24/25 due to concerns from state surveyor. The resident was re-evaluated by a mental health professional on 4-24-25 and was subsequently able to consent to sexual related activities. His care plan was updated 4-24-25. In addition, the submitted assessment was administered to Resident #61, he had the capacity to consent to sexual activity. The resident was again placed on 1:1 supervision during the Plan of Removal and Monitoring and remained on until 5/2/25. The psychological re-assessment was completed by Psychiatric Nurse Practitioner on 5-2-25 and Resident #61 had not been found be a threat to himself, staff, or other residents. Record review revealed Resident #52 was evaluated on 5/2/25 by Psychiatric Nurse Practitioner and it was determined that she does have capacity to consent to sexual behavior. Review of staff in-service records regarding revised policy and procedure for sexual abuse was conducted on 5/3/25. Observed sign in sheets dated 5/1/25, 5/2/25, and 5/3/25 for education regarding new policy. (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 #48's face sheet, dated 04/02/25, revealed, a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #48 had diagnoses which included: type 2 diabetes, retention of urine, generalized muscle weakness, hemiplegia and hemiparesis (conditions causing weakness and paralysis on one side of the body) affecting right dominant side following a stroke (brain tissue damage caused by blocked blood flow to the brain) and morbid obesity due to excessive calories. Record review of Resident #48's MDS, dated [DATE], revealed intact cognition as indicated by a BIMS score of 15 out of 15. Resident #48 had no verbal or physical behavioral symptoms directed towards others, no rejection of care, total dependence on staff for toileting hygiene and always incontinence of bowel. Record review of Resident #48's Care Plan, completed on 02/14/25 , revealed focus- ADL self-care deficit due to right hemiplegia, interventions- toileting: total assist with 1 staff, side rails- observe for injury or entrapment related to side rail use, reposition as necessary to avoid injury. An observation and interview on 04/01/25 at 08:37 AM revealed Resident #48 in bed with no pants with an incontinence brief visible. The resident had a blanket draped over his lower abdomen to mid-thigh. Resident #48 said in the previous month (February) when CNA A was providing incontinence care she rolled him on his side and his face was pushed into the bed railing. He said he screamed at CNA A to stop, she did not apologize, and he did not know if the CNA did it intentionally. He said CNA A was typically rough and rude during incontinence care and after the incident he requested she did not provide him care any longer. Resident #48 said the incident did not make him feel bad about himself or unsafe in the facility because CNA A was suspended and then terminated after the incident. He said he did not experience pain or sustain any injuries from the incident and the rest of the facility staff were fast and helpful even when he did not request for help. In an interview on 04/01/25 at 10:55 AM, LVN A said in February of 2025, Resident #48 reported he no longer wanted CNA A to provide care to him. She said the resident reported CNA A pushed his face into the bed rails when providing incontinence care and he had to yell at CNA A to stop. She said she notified the ADON and DON of the incident immediately following the incident. LVN A said other unidentified residents complained about CNA A's care in the past due to the staff being rough/rude. In an interview on 04/01/25 at 09:25 PM, CNA A said she was terminated from the facility following the incident with Resident #48. CNA A said when she provided incontinence care to Resident #48 with an unnamed student CNA, the resident did not have any complaints and there were no issues. She said when she turned Resident #48 on his side to clean, his peri area, she did not push the resident's face into the railing, he did not tell her to stop. CNA A said Resident #48 used a draw sheet, a piece of bedding used in healthcare settings to assist with repositioning patients to minimize friction and strain, since the resident was a large gentleman and his size made it impossible for her to push his face into the railing. (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 04/01/25 at 11:13 AM, the DON said Resident #48 reported CNA A was rough when she turned him to wipe his backside during incontinence care, and the resident did not sustain any injuries or experience a change of condition following the incident. He said when he interviewed CNA A she apologized and claimed she did not push the resident into the railings. The DON said residents had previously complained about CNA A being assertive and some residents found her threatening. He said it was just CNA A's nature, and even with staff the way she talked could come off as combative so they had 1on1 conversations with her to see if she could change the way she talked. The DON said after the incident with Resident #48, management realized they tried everything, but she was not getting better and since she was not a good fit she was terminated. The DON said he did not think CNA A was a safety risk to residents emotionally or physically while she was employed at the facility. In an interview on 04/01/25 at 12:19 PM, the Administrator said the facility had no records of 1on1 conversations with CNA A regarding resident care . In an interview on 04/02/25 at 10:05 AM, the ADON said when performing incontinence care there needed to be 2 people who could assist with turning using the positioning sheet that way the other person not providing care could prevent the resident from hitting the railing. She said a pillow could also be used to prevent a resident from hitting the rails when turned to the side during incontinence care. The ADON said Resident #48 was alert, oriented and communicated his needs well. She said he did not have behaviors that would deem the resistant to care but he refused aspects of care in the past centered around catheter care. The ADON said sometime in February Resident #48 said when CNA A provided incontinence care she turned him over and his face touched the railing. She said all staff were trained and expected to be empathetic with residents, to be patient, kind, have a gentle touch and voice and honor the residents wishes. The ADON said CNA A was friendly and had a stern appearance which could be an issue for someone not knowing her. She said from everything she saw, CNA A had a gently voice

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet a residents' mental, nursing and mental and psychosocial needs that were identified in the comprehensive assessment for 3 of 7 Residents (Resident #61, Resident #52 and Resident #17) reviewed for care plans. The facility failed to ensure Resident #61's care plan with interventions for the inappropriate sexual interaction on 2/25/2025 was documented in a timely manner. The facility failed to ensure Resident #52's care plan with interventions for the inappropriate sexual interaction on 2/25/2025 was documented in a timely manner. The facility failed to ensure Resident #17's care plan accurately reflected the resident's behaviors which included yelling without stimulus, fighting the air . These deficient practices could place residents at risk of nonconsensual sexual relations and not receiving proper care and services. The findings include: Record review of Resident #61's face sheet, dated 04/01/2025, revealed an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included dementia , heart failure, COPD (chronic obstructive pulmonary disease) (a lung condition caused by damage to the airway), diabetes, muscle weakness and cognitive communication deficit. Record review of Resident #61's quarterly MDS (resident assessment tool), dated 02/12/2025, revealed a BIMS score of 10 out of 15, which indicated moderate impaired cognition. Resident #61 had no potential indicators of psychosis, no presence of behavioral symptom, no rejection of care. Resident #61 had functional limitations and impairment to one side of the upper extremity. He used a walker for mobility. He required supervision or moderate assistance from staff for most ADLs. Record review of Resident #61's, undated, care plan revealed an inappropriate sexual incident on 2/25/2025 which involved Resident #52 was not addressed until 4/2/25. Further review revealed readmission from the hospital on 3/11/2025 was also not addressed until 4/2/25. Resident's care plan stated that the resident would not be allowed to be alone in any female resident's room. Record review of Resident #52 face sheet, dated 04/01/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included dementia, age-related physical debility, muscle weakness, depression, and cognitive communication deficit. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #52 quarterly MDS, dated [DATE], revealed a BIMS score of 6 out of 15, which indicated severe cognitive impairment. Resident #52 sometimes felt lonely or isolated from others. Resident #52 had no potential indicators of psychosis, no presence of behavioral symptom, no rejection of care Resident #52 required moderate to maximal assistance from staff with most ADLs and used a wheelchair for mobility. Record review of Resident #52, undated, care plan revealed Focus - Resident #52 received anti-anxiety medications daily for anxiety, date initiated 12/10/24. Interventions included: monitor/document/report PRN any adverse reactions to anti-anxiety therapy to include unexpected side effects: Mania, hostility, rage, aggressive or impulsive behavior, hallucinations. Further review revealed a sexual activity incident on 2/25/2025 which involved Resident #61 was not addressed until 4/2/25. Resident #61 and Resident #52 are not to be alone together in either of their rooms. Residents will be allowed to visit in the common areas. Record review of the facility's incident report, dated 2/25/2025, read in part: .Description of the Allegation: On 2/25/25 a staff member walked into the room of the listed female resident (Resident #52), observed the listed male resident [Resident #61] with his mouth on the breast of the female. The male was asked to leave the room without incident .[Resident #52] was assessed head to toe and no injuries found or reported Record review of Resident #52's progress note, dated 2/26/2025 at 5:22 PM, written by SW revealed a telephone conversation between Resident #52's RP, the Administrator, and the SW. The progress note revealed the RP was asked if it were ok if Resident #52 and Resident #61 wanted to be in a consensual relationship, that it would be care planned accordingly. The progress note revealed RP planned to meet with the rest of the family within the week to discuss their thoughts on the matter. Further review of Resident #52's progress notes, dated 02/26/2025 to 04/01/2025, revealed no documentation of follow up with Resident #52's RP until 4/2/25. Record review of Resident #61's progress note, dated 2/25/2025 at 3:48 PM, written by the ADON revealed Resident #61's RP was notified via telephone that Resident #61 had an inappropriate interaction with another resident and would be sent to the hospital for a behavioral evaluation. Observation on 4/01/2025 at 10:55 AM, revealed Resident #52 was in a wheelchair, self-propelling down the hallway. Resident #52 was cleanly dressed and in no distress. In an interview on 04/01/25 at 09:30 AM, RA A said back in February she walked into a resident room, and she witnessed Resident #52 and Resident #61 engaging in sexual activity. She said Resident #52 had her shirt up and Resident #61 was sucking on her breast. RA A said she tried to intervene and separate the residents but Resident #52 said she wanted Resident #61 to stay. RA A said she did not think Resident #52 was cognizant enough to give consent, so she immediately notified her nurse . In an interview on 4/01/2025 at 11:45 AM, the DON stated on 2/25/2025 it was reported to him Resident #52 and Resident #61 were observed at the doorway of Resident #152's room. Resident #52 had her shirt up and Resident #61's mouth was on her breast. The DON stated the staff immediately intervened and separated the residents. The DON stated as far as he knew, the RP of Resident #52 did not have any problems with the friendship between Residents #52 and #61, even if it was sexual. The DON stated the MDS nurse was responsible to update care plans and expected the care plans for both Residents #61 and #52 to be updated after the incident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a telephone interview on 4/01/2025 at 6:50 PM, Resident #61's RP stated the facility notified the RP regarding the incident on 2/25/25. In an observation and interview on 4/02/2025 at 8:45 AM, revealed Resident #61 was lying on his bed awake, alert and not in distress. He stated he just got moved to his current room from another room and did not know why he was moved. In an interview on 4/2/2025 at 1:00 PM, the ADON stated usually the MDS nurse would update care plans. The ADON stated the care plan was what drove the resident's care and would need to be updated to reflect the occurrence between Residents #61 and #52. The ADON stated Resident #52 had behaviors and it should be updated to include a new approach. The ADON stated she did not know why the care plans were not updated and would have to check to see if there was information needed before the update . The ADON stated if approaches were not listed in the care plan, this would affect the care of Resident #61 and Resident #52. In a telephone interview on 4/2/2025 at 1:15 PM, MDS A stated she was one of the MDS nurses in charge of the long-term care residents. MDS A stated the unit managers were the ones responsible to update any behaviors since they were the ones responsible to conduct care conferences with the family and resident. MDS A stated other responsible staff would be the SW and the ADON. In an interview on 4/2/2025 at 1:45 PM, the SW stated the care plans for Residents #61 and #52 should be updated because it was a behavior related incident. The SW stated the purpose of the care plan was to reflect everything about the resident and if not updated the incident could happen again. Resident # 17 Record review of Resident #17's face sheet, dated 04/02/25, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #17 had diagnoses which included: type 2 diabetes, high cholesterol, pain in left leg, unspecified altered mental status, and cognitive communication deficit. Record review of Resident #17's MDS, dated [DATE], revealed severe cognitive impairment as indicated by a BIMS score of 07 out of 15. She had no potential indicators of psychosis, no Hallucinations (experiences without real external input) or delusions (beliefs that are held contrary to reality), no physical behavioral symptoms towards others like hitting, kicking, pushing; no verbal behavioral symptoms towards others like threatening others, screaming and cursing at others and no other behavioral symptoms not directed towards other like verbal/vocal symptoms like screaming, and physical symptoms such as hitting or scratching self. Resident #17 had lower extremity impairment to both sides that limited her range of motion and was always incontinent of both bladder and bowel. Record review of Resident #17's Care Plan, completed on 02/13/25, revealed Focus: At times resident yells out due to cognitive deficit; intervention- 1:1 beside in-room visits and activities if unable to attend out of room events. Focus- resident has a behavior problem Yells at staff; interventions: Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 04/01/25 at 09:35 AM revealed, Resident #17 in bed in the fetal position under a blanket. The resident's bed was low to the ground and fall mats were located next to the bed. She appeared well dressed, well-groomed and in no immediate distress. The resident was confused and answered yes to all questions and her responses were sometimes unrelated to the questions being asked. In an interview on 04/01/25 at 11:13 AM, the DON said Resident #17 was constantly yelling and was receiving psych services. She was bed bound and her behaviors were typically late in the evening and early in the morning. The DON said the resident sometimes fought and yelled unprovoked and without any stimulus. In an interview on 04/02/25 at 12:20 PM, the ADON said Resident #17 was confused and had behaviors such as screaming out unprovoked, rolling out of bed but those behaviors had become less frequent. She said all Resident #17's behaviors should have been documented in the chart and MDS because documentation drives the care, accurate care. The ADON said the MDS when completed should accurately reflect the patient, painting a clear picture. She said an inaccurate MDS could place residents at risk of error. In an interview on 04/02/25 at 01:17 PM, MDS A said resident MDSs were completed through an interdisciplinary process, but she went over the document. She said the MDS should accurately reflect the residents', and she only knew Resident #17 screamed and yelled when she needed services like repositioning. MDS A said she was never notified or observed any documentation in Resident #17's chart that she had behaviors such as yelling unprovoked or fighting the air . In an interview on 04/02/25 at 01:30 PM, LVN B said she was Resident #17's nurse. She said Resident #17's usual behavior included yelling out unprovoked, but she had not noticed her fighting without stimulus . On 04/02/25 at 01:2 PM, a written request was made to the Administrator for the facility policy on accuracy of assessment. The policy was not provided prior to exit. Record review of the facility's policy and procedure for Health Care Plans, revised in March 2024, read in part: .It is the policy . to involve all disciplines in the development of a resident health care plan that recognizes the resident's right to achieve his/her personal health goals. Purpose: To ensure the development of a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . 1. An interdisciplinary team approach is used to develop a plan of care that meets the specific needs identified. 2. The process for meeting the goals includes providing supportive care, treating a disease or condition, rehabilitating physical or psychosocial impairment, and promoting health .6. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' condition change .8. The interdisciplinary Team must review and update the care plan: c. When the resident has been readmitted to the facility from a hospital stay

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review the facility failed to ensure in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 1 medication carts (Unit 2-B Nursing Cart) reviewed for medication storage . The facility failed to ensure Unit 2-B Nursing cart revealed was not unlocked and unattended with medication on top of the cart. This failure could place residents at risk of adverse reactions to medications and misappropriation of medications. Findings include: An observation on 04/01/25 at 09:03 AM of the unlocked and unattended Unit 2-B Nursing cart revealed, a vial which contained Resident #16's Timolol eye drops, a medication used to treat glaucoma, on the top of the cart. The cart was in front of a patient room with the drawers easily accessible and facing the hall . In an observation and interview on 04/01/25 at 09:10 AM, inventory of the Unit 2-B Nursing Cart with LVN B revealed all drawers in the cart were unlocked and contained: Drawer 1 - More than 30 Lancets, a device with a small needle used to prick fingers to collect blood for blood sugar monitoring. - More than 10 pen needles, a short needle attached to pens used to inject medications under the skin. - Open and in use Basaglar and Novolog Insulin pens for Resident #16 - Open and in use Novolog Insulin and Insulin Glargine pens for Resident #2 - An open an in-use Humalog Insulin pen for Resident #8 - An open and in use Novolog 70-30 Insulin pen for Resident #1 - An open and in use Humalog Insulin pen - Alcohol prep Pads Drawer 2 - Topical medications including Nystatin 100,000, an anti-fungal, unit per gram for Resident #57. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Drawer 3 - Multiple syringes which contained needles in sealed packets - 3 nail clippers - Hydrocortisone 1% cream - Syringe containing Saline for line flush Drawer 4 - Fluticasone Nasal Spray for Resident #51 - Inhaler for Resident #33 - Syringes which contained needles in sealed packets LVN B said all medications should be stored in nursing carts and carts must be locked when not under direct supervision of nursing staff. She said she left Resident #16's medication on top of the cart and forgot to lock the cart because another resident needed help. LVN B said unattended medications and unlocked medication carts could place residents at risk for medication errors or injuries if needles were accessed. In an interview on 04/01/25 at 11:13 AM, the DON said nursing carts were expected to be locked when not in use and under continuous supervision of staff to ensure the resident and medication safety. He said unlocked nursing carts and accessible medications placed residents at risk of unauthorized access to carts, medications errors or puncture injuries. Record review of the facility's policy titled Medication Administration revised 08/2024 revealed, 12- Never leave medication cart unlocked/ If the cart must be left due to an emergency, the cart is to be locked. All medications insured the cart and secured at all times, so they are inaccessible to resident. Do not leave medication on top of cart unattended.