STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676251	A. Building B. Wing	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Misty Willow Healthcare and Rehabilitation Center	12921 Misty Willow Dr Houston, TX 77070

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 0564 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform each resident of his or her visitation rights and ensure that all visitors enjoy equal visitation privileges. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0564 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform each resident of his or her visitation rights and related facility policy and procedures, including any safety restrictions or limitation on such rights, the reason for the restriction or limitation, and to whom the restrictions apply for 1 of 17 residents (Resident #2) reviewed for resident rights. Resident #2 was not informed by the facility when her family member was no longer allowed to visit due to safety restrictions after February 2025. This failure placed residents at risk of not being informed of their rights, confusion and sadness. The findings included: Record review of Resident #2's admission Record generated on 9/23/25 revealed she was admitted to the facility on [DATE]. She had diagnoses of dementia (a group of thinking and social symptoms that interferes with daily functioning), adjustment disorder (a mental disorder defined by maladaptive response to a psychosocial stressor) and depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities). She was [AGE] years of age. Record review of Resident #2's admission Agreement dated 1/23/24 and signed by Resident #2's family member revealed the family member acknowledged that she was informed verbally and in writing of the resident right's as guaranteed through applicable federal and state laws. Record review of Resident #2's Care Plan dated 1/15/24 revealed she was using an antidepressant medication related to depression. Interventions included monitoring, documenting and reporting to physicians for ongoing signs or symptoms of depression, including sadness, irritability, anger, crying, worthlessness, etc. Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed she had a BIMS of 8, indicating she had moderate cognitive impairment. She reported feeling sometimes lonely or isolated from those around her. Record review of Resident #2's electronic medical record revealed there were no documents or progress notes regarding visitation restriction. In an interview on 9/17/25 at 10:22am, Resident #2 said she missed her family member, Family Member A, since he was not allowed to visit. She said Family Member A was no longer allowed to visit because he liked LVN R and would look at her. She said the staff asked the family member to leave her alone. She said one staff member yelled at Family Member A because he liked LVN R, and the family member yelled back and threatened him. She said, I cry because I miss him, it's been so long. She said she had not seen him in months. She said she never received a policy or notice about the visitation restriction. In a telephone interview on 9/19/25 at 11:21am, the Former DON said Family Member A was not allowed to visit because he stalked a charge nurse and the police were involved. She said the Administrator handled the situation, so he would know more about it. She said that was all she remembered. In an interview on 9/23/25 at 11:55am, the Social Worker said she was aware that Resident #2's Family Member A could not visit. She said she did know the details. In an interview on 9/23/25 at 3:15pm, the Administrator said Resident #2's family member, Family Member A, was trying to engage in an inappropriate relationship with LVN R. He said he dropped gifts on her car. He said the employee went to the police and filed a complaint. He said they followed the guidance of the police department which was to not allow him on the facility premises. He said Family Member A became aggressive and loud when they informed him of the visitation restriction. He said he was unaware of the facility provided any type of notice to Resident #2. He said some of the incident occurred in February 2025 when he was on leave. He said he review and let me know. In an interview on 9/24/25 at 9:43am, the Administrator said the AIT was at the facility in February 2025 when Family Member A was informed that he was not allowed to visit. He said Family Member A made threatening remarks during the interaction with the AIT. When asked what kind of threatening remarks, he said the family member stated he was going to beat someone. He said Resident #2 was informed by her other family members that he could no longer visit. He said he was unsure if a facility staff member discussed the visitation restriction with her. In a telephone interview on 9/24/25 at 10:21am, the AIT said he was at the facility temporarily when the Administrator was on leave. He said he was told by a staff member that Family Member A could not be at the facility. He said he spoke Spanish, so he volunteered to inform the family member. He said he told Family Member A that he was trespassing and had to leave, then the family member threatened to beat the staff and accused them of lying. He said the police were called and escorted him out. He said he could not remember the following: the staff member who told him that he could not visit, who made the decision regarding the visitation restriction, whether Family Member A was informed of the visitation restriction prior to conversation he had with him, and whether Resident #2 was informed of the visitation restriction. In a telephone interview on 9/24/25 at 10:47am, Resident #2's family

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(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 - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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(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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure each resident was free from abuse for 2 of 17 residents (CR #2, Resident #5) reviewed for abuse in that: 1. CR #1 sexually abused Resident #5 on 4/19/25 when he touched her breast.2. CR #1 sexually abused an unknown female resident on 5/21/25 when he touched her thigh.3. CR #1 sexually abuse CR #2 on 7/14/25 when he touched her breast and on 8/3/25 when he touched her breast and in between her thighs. An IJ was identified on 9/19/25. The IJ template was provided to the facility on 9/19/25 at 4:52pm. While the IJ was removed on 9/21/25, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy as the facility continued to monitor the implementation and effectiveness of their corrective systems. These failures placed residents, who resided in the facility, at risk of abuse, and mental anguish and fearfulness. The findings included: Resident #5 Record review of Resident #5's admission Record generated on 9/19/25 revealed she was admitted to the facility on [DATE]. She had diagnoses of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), muscle weakness, macular degeneration (an eye disease that causes vision loss), anxiety disorder (a mental health condition characterized by excessive worry, fear and nervousness) and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows and manic highs). She was [AGE] years of age. Record review of Resident #5's Care Plan dated 11/14/22 revealed she was at risk of impaired cognitive function/dementia or impaired thought processes related to Alzheimer's disease. Interventions included: - Administer medications as ordered. (created on 2/24/23)- Communication: Identify yourself at each interaction. Face when speaking and make eye contact. Reduce any distractions. Use simple directive sentences. (created on 11/14/22)- Keep routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. (created on 2/24/23)- Needs supervision/assistance with all decision making. (created on 11/14/22) Record review of Resident #5's Care Plan dated 3/20/25 revealed she had potential for behavioral problems related to self-propelling in a wheelchair and at times refused to be redirected. Interventions included: - Anticipate and meet needs. (created on 3/20/25)- Stop and talk with resident when passing by. (created on 3/20/25)- Engage in simple, structured activities such as bible study, nail spa and church services. (created on 11/20/23). - Introduce to residents with similar background, interests and encourage/facilitate interaction. (created on 11/20/23)- Needs assistance/escort activity functions. (created on 11/20/23). Record review Resident #5's quarterly MDS assessment dated [DATE] revealed she had a BIMS of 0, indicating severe cognitive impairment. She required partial/moderate assistance for transfers, used a wheelchair for mobility, and required supervision while ambulating. Record review of Resident #5's Nurse Progress Note dated 4/19/25 at 8:52am revealed a nurse documented the following: Notified by CNA this resident was coming down the hall, another male resident was coming the opposite way, the male resident stopped this resident and reached out and was touched her breast. full body assessment of resident for any injuries or bruising, no noted injuries or bruising from interaction noted . In an observation on 9/17/25 at 3:58pm, Resident #5 was sitting in a wheelchair in a common area of the facility. She was not interviewable. She propelled herself in her wheelchair using her feet to ambulate. CR #2 Record review of CR #2's admission Record generated on 9/18/25 revealed she was admitted to the facility on [DATE]. She had diagnoses of dementia, depression and adjustment disorder. She was [AGE] years of age. Record review of CR #2's Care Plan dated 5/8/25 revealed she was at risk of impaired cognitive function or impaired thought processes. Interventions included: - Communication: Identify yourself at each interaction. Face when speaking and make eye contact. Reduce any distractions.use simple, directive sentences. - Social Services to provide psychosocial support as needed. Further record review of CR #2's Care Plan dated 5/8/25 revealed she was an elopement risk/wanderer related to disoriented to place, impaired safety awareness. The care plan stated she wandered into other resident's rooms and was initiated on 6/4/25. Interventions included: - Document wandering behavior and attempt diversional interventions.- Monitor wander guard placement on left lower leg. Record review of CR #2's admission MDS assessment dated [DATE] revealed she had a BIMS of 1, indicating she has severe cognitive impairment. She was dependent on staff for transfers, walking and assistance with using a manual wheelchair. Record review of CR #2's Nurse Progress Note dated 7/14/25 at 6:06pm revealed LVN E documented that a CNA reported that another resident was observed touching CR #2's breast over her

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to implement written policies and procedures that prohibit and prevent abuse for 2 of 17 residents (CR #2, Resident #5) reviewed for abuse. The facility failed to implement written policies regarding abuse prevention and protection when CR #1 sexually abused Resident #5, an unidentified female resident, and CR #2 within a 4-month period between 4/19/25 and 8/3/25. The facility failed to ensure LVN B and CNA A, with knowledge of an allegation of sexual abuse on 5/21/25, reported the abuse immediately to the Administrator. An IJ was identified on 9/19/25. The IJ template was provided to the facility on 9/19/25 at 4:52pm. While the IJ was removed on 9/21/25, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy as the facility continued to monitor the implementation and effectiveness of their corrective systems. These failures placed residents, who resided in the facility, at risk of abuse, and mental anguish and fearfulness. The findings included: Record review of the facility's policy titled 'Abuse: Prevention of and Prohibition Against' dated 12/2024 stated, .Prevention.The Facility will act to protect and prevent abuse and neglect from occurring within the Facility by.Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur, to include validating that the Facility has deployed the correct number of competent staff on each shift to meet the needs of the residents. Identifying, assessing, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as.Sexually aggressive behavior such as saying sexual things, inappropriate touching/grabbing. Wandering into other's rooms/space. Protection.If an allegation of abuse, neglect, misappropriation of resident property, or exploitation is reported, discovered or suspected, the Facility will take the following steps to protect all residents from physical and psychosocial harm during and after the investigation:.Increase supervision of the alleged victim and residents.Make room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator.If the allegation of abuse, neglect, misappropriation of resident property, or exploitation involves another resident, the Facility will: Separate the residents so they do not interact with each other until circumstances of the reported incident can be determined. If a room change is appropriate, advise the residents and/or resident representatives of reason for the change in writing. Continue to assess, monitor and intervene as necessary to maximize resident health and safety. Resident #5 Record review of Resident #5's admission Record generated on 9/19/25 revealed she was admitted to the facility on [DATE]. She had diagnoses of Alzheimer's disease, muscle weakness, macular degeneration, anxiety disorder and bipolar disorder. She was [AGE] years of age. Record review of Resident #5's Care Plan dated 11/14/22 revealed she was at risk of impaired cognitive function/dementia or impaired thought processes related to Alzheimer's disease. Interventions included: - Administer medications as ordered. (created on 2/24/23)- Communication: Identify yourself at each interaction. Face when speaking and make eye contact. Reduce any distractions.Use simple directive sentences. (created on 11/14/22)- Keep routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. (created on 2/24/23)- Needs supervision/assistance with all decision making. (created on 11/14/22) Record review of Resident #5's Care Plan dated 3/20/25 revealed she had a potential for behavioral problems related to self-propelling in a wheelchair and at times refused to be redirected. Interventions included: - Anticipate and meet needs. (created on 3/20/25)- Stop and talk with resident when passing by. (created on 3/20/25)- Engage in simple, structured activities such as bible study, nail spa and church services. (created on 11/20/23). - Introduce to residents with similar background, interests and encourage/facilitate interaction. (created on 11/20/23)- Needs assistance/escort activity functions. (created on 11/20/23). Record review Resident #5's quarterly MDS assessment dated [DATE] revealed she had a BIMS of 0, indicating severe cognitive impairment. She required partial/moderate assistance for transfers, used a wheelchair for mobility, and required supervision while ambulating. In an observation on 9/17/25 at 3:58pm, Resident #5 was sitting in a wheelchair in a common area of the facility. She was not interviewable. She propelled herself in her wheelchair using her feet to ambulate. Record review of Resident #5's Nurse Progress Note dated 4/19/25 at 8:52am revealed a nurse documented the following: Notified by CNA this resident was coming down the hall, another male resident was coming the opposite way, the male resident stopped this resident and reached out and was touching her breast, full body

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to have evidence that all alleged violations of sexual abuse were thoroughly investigated for 2 of 17 residents (CR #2, Resident #5) reviewed for abuse. The facility failed to take steps to prevent further potential abuse and take appropriate corrective action as a result of investigation findings when CR #1 sexually abused CR #2, an unidentified female resident and Resident #5 within a 4-month period between 4/19/25 and 8/3/25. An IJ was identified on 9/19/25. The IJ template was provided to the facility on 9/19/25 at 4:52pm. While the IJ was removed on 9/21/25, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy as the facility continued to monitor the implementation and effectiveness of their corrective systems. These failures placed residents, who resided in the facility, at risk of abuse, and mental anguish and fearfulness. The findings included: Resident #5 Record review of Resident #5's admission Record generated on 9/19/25 revealed she was admitted to the facility on [DATE]. She had diagnoses of Alzheimer's disease, muscle weakness, macular degeneration, anxiety disorder and bipolar disorder. She was [AGE] years of age. Record review of Resident #5's Care Plan dated 11/14/22 revealed she was at risk of impaired cognitive function/dementia or impaired thought processes related to Alzheimer's disease. Interventions included:- Administer medications as ordered. (created on 2/24/23)- Communication: Identify yourself at each interaction. Face when speaking and make eye contact. Reduce any distractions.Use simple directive sentences. (created on 11/14/22)- Keep routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. (created on 2/24/23)- Needs supervision/assistance with all decision making. (created on 11/14/22) Record review of Resident #5's Care Plan dated 3/20/25 revealed she had a potential for behavioral problems related to self-propelling in a wheelchair and at times refused to be redirected. Interventions included:- Anticipate and meet needs. (created on 3/20/25)- Stop and talk with resident when passing by. (created on 3/20/25)- Engage in simple, structured activities such as bible study, nail spa and church services. (created on 11/20/23).- Introduce to residents with similar background, interests and encourage/facilitate interaction. (created on 11/20/23)- Needs assistance/escort activity functions. (created on 11/20/23). Record review Resident #5's quarterly MDS assessment dated [DATE] revealed she had a BIMS of 0, indicating severe cognitive impairment. She required partial/moderate assistance for transfers, used a wheelchair for mobility, and required supervision while ambulating. In an observation on 9/17/25 at 3:58pm, Resident #5 was sitting in a wheelchair in a common area of the facility. She was not interviewable. She propelled herself in her wheelchair using her feet to ambulate. Record review of Resident #5's Nurse Progress Note dated 4/19/25 at 8:52am revealed a nurse documented the following: Notified by CNA this resident was coming down the hall, another male resident was coming the opposite way, the male resident stopped this resident and reached out and was touching her breast. full body assessment of resident for any injuries or bruising, no noted injuries or bruising from interaction noted . CR #2 Record review of CR #2's admission Record generated on 9/18/25 revealed she was admitted to the facility on [DATE]. She had diagnoses of dementia, depression and adjustment disorder. She was [AGE] years of age. Record review of CR #2's Care Plan dated 5/8/25 revealed she was at risk of impaired cognitive function or impaired thought processes. Interventions included:- Communication: Identify yourself at each interaction. Face when speaking and make eye contact. Reduce any distractions.use simple, directive sentences.- Social Services to provide psychosocial support as needed. Further record review of CR #2's Care Plan dated 5/8/25 revealed she was an elopement risk/wanderer related to disoriented to place, impaired safety awareness. The care plan stated she wandered into other resident's rooms and was initiated on 6/4/25. Interventions included:- Document wandering behavior and attempt diversional interventions.- Monitor wander guard placement on left lower leg. Record review of CR #2's admission MDS assessment dated [DATE] revealed she had a BIMS of 1, indicating she has severe cognitive impairment. She was dependent on staff for transfers, walking and assistance with using a manual wheelchair. Record review of CR #2's Nurse Progress Note dated 7/14/25 at 6:06pm revealed LVN E documented that a CNA reported that another resident was observed touching CR #2's breast over her clothing. The nurse completed a full body assessment with no pain or injury. Record review of CR #2's nurse progress notes revealed on 7/15/25 at 10:30pm, she was observed walking with a walker into another resident's room and she was redirected. On 7/16/25 at 6:54pm, CR #2 was diverted out of

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety 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. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's nursing, mental and psychosocial needs for 1 of 17 residents (CR #1) reviewed for comprehensive care plans in that: CR #1's care plan was not revised when he sexually abused Resident #5, an unidentified resident and CR #2 and had one sexual inappropriate behavior within a 4-month period between 4/19/25 and 8/3/25. Nursing staff, including LVN B, CNA A, LVN C, CNA B, LVN D and CNA C, were unaware of interventions for CR #1 that would prevent further sexual abuse from occurring. An IJ was identified on 9/19/25. The IJ template was provided to the facility on 9/19/25 at 4:52pm. While the IJ was removed on 9/21/25, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy as the facility continued to monitor the implementation and effectiveness of their corrective systems. These failures placed residents, who resided in the facility, at risk of not having their behavioral needs met, which could lead to abuse, emotional distress and serious harm. The findings included: Record review of CR #1's care profile generated on 9/17/25 revealed he was admitted to the facility on [DATE]. He had diagnoses of diabetes, chronic obstructive pulmonary disease, cognitive communication deficit, adjustment disorder with anxiety, and dementia. He was [AGE] years of age. Record review of CR #1's MDS assessment dated [DATE] revealed he had a BIMS of 3, indicating he had severe cognitive impairment. He had a PHQ-9 score of 7, indicating he had mild depression symptoms. No behaviors were noted. He required supervision for transfers and wheelchair mobility assistance. Record review of CR #1's Nurse Progress Note dated 4/19/25 at 8:43am revealed LVN A documented the following: Notified by CNA this resident was coming down the hall, another resident was coming the opposite was (sic), this resident stopped resident in the hall and was seen by CNA reaching out and touching the female residents (sic) breast, the female resident was trying to move his hand away and notified me the nurse. I spoke with resident about how this was inappropriate and he should not be touching other resident in that way. Resident stated 'that's my friend and I was just saying hello.' Removed female resident from the situation.notified Administrator and DON.will be keeping residents apart and this resident in line of sight for monitoring. Further record review of CR #1's Nurse Progress Notes revealed he was sent to a local Behavioral hospital on 4/19/25 and returned on 4/29/25. Record review of a Provider Investigation Report dated 4/25/25 and signed by the Administrator revealed on 4/19/25, CR #1 touched Resident #5's left breast area. Resident #5 was assessed on 4/19/25 at 8:10am and education was provided to CR #1 that the behavior was inappropriate. The nurse notified Resident #5's responsible party and physician, CR #1's responsible party. The psychological service provider assessed CR #1 on 4/19/25 at 2:20pm and made a recommendation for behavioral hospital evaluation. Education was provided to facility staff regarding resident rights, types of abuse, abuse reporting, resident-to-resident altercation reporting guidelines. The Administrator noted the allegation was unsubstantiated, stating, (CR #1) did not exhibit any signs or symptoms of the inappropriate behavior. Facility staff, who witnessed the incident intervened immediately and separate the residents for resident safety. (Psychological Services) provider assessed (CR #1) on 4/19/25 and sent the referral for in-patient treatment.(CR #1) is currently at the hospital.(Resident #1) is also stable with normal vitals and no signs or symptoms of distress. Record review of CR #1's care plan dated initiated on 5/1/25 revealed he had the potential to demonstrate sexually inappropriate behaviors toward female residents and staff related to poor impulse control. Interventions included: Assess and anticipate resident needs: food thirst, toileting, comfort level etc. (created 5/1/25) Cognitive assessment (created 5/1/25) Evaluate for side effects of medications (created 5/1/25) Psychiatric/psychogeriatric consult as indicated. (created 5/1/25) Record review of CR #1's Nurse Progress Note dated 5/17/25 at 12:46pm revealed LVN A documented the following: Resident was told several times by a female resident to please leave her alone and stop talking to her, resident would not listen and kept staring and trying to ask her questions, another nurse intervened and asked resident to move away from the female, female resident stated he was making her feel uncomfortable, resident continued to try to talk to female, finally resident rollway away to hallway, then was seen stopping and looking every residents (sic) room for a couple of minutes before rolling to the next doorway, this nurse approached resident asking why he was looking in everyone's room, he stated just wanted to see what they were doing. Educated on giving people privacy. In a