STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676495	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Starr County Nursing and Transitional Care	5260 Brand St Rio Grande City, TX 78582

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** 47573 Based on observation, interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, or mistreatment, were reported immediately to the State Survey Agency, within two hours if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, for 1 (R #1) of 5 residents reviewed for abuse/neglect. The facility failed to report allegations of resident abuse for R #1 to the State Survey Agency within the allotted time frame of 2 hours. This failure could place all residents at increased risk for potential abuse due to unreported allegations of abuse and neglect. The findings included: Record review of R #1 's file dated 06/07/24 reflected [AGE] year-old female with original admitted [DATE] and last admitted [DATE]. Her diagnosis included: epilepsy (seizures/convulsions), type 2 diabetes, aphasia, muscle weakness, dysphagia, bipolar disorder (mood disorder), severe intellectual disabilities, obesity, depression, anxiety disorder, and lack of expected normal physiological development in childhood. Record review of R #1's MDS assessment dated [DATE] reflected BIMS score of 2 (severely cognitively impaired). R #1 required substantial/maximal assistance (helper does more than half the effort) for eating, oral hygiene, toileting hygiene, and dressing. R #1 was also dependent (helper does all the effort) for showering and personal hygiene. (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: 676495	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Starr County Nursing and Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 5260 Brand St Rio Grande City, TX 78582	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of R #1's Care Plan dated 06/07/24 reflected R #1 had an ADL self-care performance deficit related to surgical incision to sacrum and seizure disorder. Interventions included: R #1 required a total assist of 1-2 staff for bathing/showering, dressing, eating, personal hygiene, toilet use, and transfer. Date initiated: 05/08/24. R #1 had a tendency to remove her clothes when in her room/bed. Resident has sexually inappropriate behaviors, will make sexually explicit comments/requests to staff and may at times touch self. Interventions included: discuss the behavior, intervene as necessary to protect the rights and safety of others, praise improvement, provide with privacy if behavior is obvious, and psych services as ordered. Date initiated: 06/07/24. R #1 was at risk for impairment to skin integrity related to incision to sacrum. Interventions: administer medications/supplement as ordered to address medical diagnosis, monitor for skin changes, medications/treatments for wound healing, and wound vac. Date initiated: 05/06/24. Record review of progress notes for R #1 reflected - On 05/13/24 at 3:21 PM, documented by SW. On 05/13/24, SW was contacted regarding inappropriate interactions between R #1 and RP. SW contacted supervisor for further instructions. Will contact APS regarding update on case status. Will be having a meeting with RP, SW, and administration. Will be documenting as updated. On 05/14/24 at 1:56 PM, documented by SW. Was contacted by DM that R #2 witnessed inappropriate interactions between R #1 and RP. R #1 and RP will have to be supervised during visitations at all times. Will follow up with APS on case status. Record review of complaint/grievance follow-up report dated 05/17/24 reflected on 05/17/24, DM voiced that he did not like the interaction between R #1 and RP. Re-educated RP on appropriate behavior with R #1. APS informed. Staff interviews attached. RP voiced understanding. Interviews on 05/17/24: Around 1:30 PM, DM voiced that he had an issue with RP. DM stated he observed RP kissing R #1 on the cheek as RP was leaving. DM stated RP grabbed R #1 by the top of her head and chin and R #1 said no. DM voiced SW was involved and addressed it directly with RP. ADM and AIT interviewed R #1 regarding the incident with RP. R #1 seemed to be in good spirits. R #1 voiced RP kissed her on the cheek. R #1 was asked if she was treated well by RP, and R #1 nodded her head. ADM asked if R #1 was in any pain or discomfort and R #1 voiced no. R #1 did not voice any concerns about RP at this time. ADM and AIT interviewed RP regarding the incident with R #1. RP stated he was visiting R #1 as he had not seen her in over two days. RP stated he missed R #1 and only hugged and kissed her on the cheek as any family member would do. RP continued to say that he loved R #1 dearly and that she was his only company. RP was insistent on discharging R #1 on day 28 as he believed the state would discontinue all of R #1's community benefits. ADM explained discharge process to RP. Complaint/grievance resolved on 05/17/24. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with APS on 06/07/24 at 11:05 AM., APS said she received an intake on 05/14/24 for R #1 with an allegation of sexual abuse from RP. APS said the allegation was that RP was being inappropriate with R #1 but there was no report of actual sexual contact or kissing on the mouth. APS said she visited R #1 on 05/17/24 and she tried to interview R #1, however, R #1 was not able to provide information regarding allegations. APS said she also spoke to R #2 who informed APS that RP exhibited inappropriate behaviors towards R #1 such as placing his hands in between her thighs. APS was unsure if R #2 had informed the facility about such behaviors. APS spoke to DM who informed APS that earlier on 05/17/24, DM had witnessed RP forcibly kiss R #1 on the mouth. DM said that DM intervened, told RP to stop, and asked RP to leave. APS was unsure if supervised visits had already been implemented or when they were started. APS spoke to SW who informed APS that an unknown staff had reported that RP asked staff to get R #1 undressed in front of RP. SW had spoken to RP about inappropriate interactions. APS referred the intake to LE, but the investigator informed APS that LE would not investigate further as it was the facility's responsibility to keep R #1 safe. APS said because the alleged incidents happened in the nursing home, APS would not investigate further. Observation of R #1 on 06/07/24 at 12:20 PM., R #1 did not respond to relevant questions. R #1 appeared with good personal hygiene. R #1 was not injured or in distress. R #1 was sitting up in her wheelchair, watching television. R #1 had the touch call light within reach. Record review of grievances, R #1's electronic medical chart, and the state reporting system completed on 06/07/24 at 12:35 PM reflected the incidents or concerns for R #1 and RP's interactions were not reported to the State Survey Agency. In an interview with CNA A on 06/07/24 at 1:15 PM., CNA A said R #1 and her RP were supervised during visits in the front lobby because there was some weird behavior of touching or kissing, but she did not know the details. CNA A said she did not witness this but was informed of the supervised visits. CNA A said she did believe RP was too hands on with R #1, like always hugging and kissing R #1 on the cheek, but never anything she felt she needed to report. CNA A said she was in-serviced on abuse and neglect and would report those kind of concerns to the ADM. In an interview with CNA D on 06/07/24 at 2:10 PM., CNA D said R #1 and her RP had supervised visits because there was an issue with RP kissing R #1 on the mouth. CNA D said she was not sure of the details as to what happened or who saw this, and she did not witness this herself. CNA D said it might've been CNA F that saw it. CNA D said R #1's previous roommate, did not recall her name, had also mentioned that she was uncomfortable with the way RP was with R #1, but the roommate did not say exactly what made her feel uncomfortable or say she saw something actually happen. CNA D said the facility was keeping R #1 safe and this had been reported to APS. CNA D said she was in-serviced on abuse and neglect and would report those type of concerns to the ADM right away. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the SW on 06/07/24 at 2:40 PM., the SW said on 05/13/24, CNA F informed that RP asked CNA F to take off R #1's clothes in front of him and that RP had his hand on R #1's thigh while in her room. The SW said he explained to RP that those things were not appropriate and RP understood. The SW said he followed up with APS to check on the status of previous cases or history. The SW said on 05/14/24, he was informed that R #2 was uncomfortable with RP and R #1's interactions but R #2 did not voice any specific incident or contact. The SW said on 05/14/24, he contacted APS and filed a report for R #1's safety. The SW said on 05/14/24, supervised visits were initiated, and RP visited R #1 in the dining, activities, or other common areas where staff kept an eye on him. The SW said on 05/17/24, he was informed by DM that RP had kissed R #1 on the cheek, very close to her mouth, and it was inappropriate. The SW said he spoke to RP who cried and said that he loved R #1 and he only showed his affection towards her. The SW said after this incident, supervised visits were changed to where RP only visited R #1 in the lobby area and was closely monitored by a staff. The SW said there was one staff assigned to monitor and supervise R #1 and RP during visits at all times. The SW said there was no in-service completed for the staff but all staff were made aware of the supervised visits as it was communicated from managers to nurses, to CNAs, and to other staff. The SW said all the staff were aware of the supervision and were vigilant in keeping R #1 safe . The SW said there were no other incidents after this. The SW said it would be up to the abuse coordinator to report to the state survey agency. In an interview with LVN A on 06/07/24 at 3:25 PM., LVN A said she worked with R #1 and was aware that R #1 had supervised visits with RP because there were allegations of sexual abuse with the RP. LVN A said she was unsure of the dates, but she was immediately informed about the supervised visits and that RP could not go to R #1's room. LVN A said RP and R #1 were supervised in the lobby area by a facility staff. LVN A said she was in-serviced on abuse and neglect and would report those concerns to the abuse coordinator, which was the ADM, right away. LVN A said R #1 was not injured as a result of the allegations regarding the RP. LVN A said the abuse coordinator would report incidents to the state survey agency, if needed. In an interview with RP on 06/07/24 at 4:45 PM. RP did not answer attempts. In an interview with R #2 on 06/07/24 at 5:00 PM. R #2 did not answer attempts. In an interview with CNA F on 06/12/24 at 1:00 PM. CNA F said she worked with R #1 last month (May). CNA F said she did not remember the date, but there was one day, around midday, she was going to shower R #1 because it was her scheduled shower day. CNA F said she asked R #1 if she wanted to shower, and R #1 said yes. CNA F said RP was in the room and asked CNA F if she could take off R #1's gown in front of RP. CNA F said she explained to RP that she could not do that as CNA F needed to provide privacy to R #1 and would undress her in the bathroom. CNA F said then RP kissed R #1 on the cheek but very close to her mouth, and R #1 appeared as if she was uncomfortable or did not like what was going on. CNA F said RP also put his hand on R #1's thigh and it appeared R #1 did not want RP to touch her. CNA F said she reported that to the abuse coordinator, the ADM, and she also told SW. ADM and SW followed up with CNA F and R #1. CNA F said a few days after that, supervised visits were implemented. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DM on 06/12/24 at 1:40 PM., the DM said on 05/17/24, he saw RP was inappropriate with R #1 as he held the top of her head and bottom of her chin and kissed her. The DM said RP kissed her on the mouth, R #1 turned red, pushed RP for him to not kiss her, and R #1 said no. The DM said he intervened, told RP to stop, that it was inappropriate. The DM said he took RP to the SW's office and RP cried, saying that he loved R #1 very much. The DM said ADM assessed R #1 and R #1 was fine. The DM said RP definitely kissed R #1 on the mouth. The DM said it happened in the hallway by the nurse's station and the nurse, LVN B saw it. The DM said this was the first time anyone saw RP actually physically do something inappropriate to R #1. The DM said the protocol was for him to intervene immediately and report it to the ADM, which was what he did. The DM said ADM informed him they could not do anything else since R #1 did not voice abuse. The DM said since then RP had been supervised during visits with R #1 in the lobby. In an interview with LVN B on 06/12/24 at 2:15 PM., LVN B said she worked last month with R #1 and worked with her recently, this week. LVN B said she was aware that R #1 had supervised visits with RP because RP had been inappropriate with R #1. LVN B said there was an incident where RP kind of grabbed R #1 by the two cheeks and went in to kiss her on the cheek, and R #1 said no. LVN B said this happened right by the entrance of the 300 hall by the nurse's station, and LVN B was sitting in the nurse's station. LVN B said she did not see RP trying to kiss R #1 on the mouth. LVN B said she did not recall the date of this incident but DM saw it as well. LVN B said R #1 was not injured from that incident. LVN B said R #1 was saying no like she did not want RP to kiss her, but she only saw RP kissing R #1 on the cheek. LVN B said there was no other incident after that because RP continued with supervised visits. LVN B said on this day, RP was already under supervised visitations, but he was still able to visit with her in the dining or activities. LVN B said after this, RP could only visit in the lobby. In an interview with the ADON on 06/12/24 at 2:50 PM., the ADON said she was aware of the situation with R #1 and RP. The ADON said she was unsure of when the supervised visits started but they were begun because RP was inappropriate. The ADON said they tried to let RP go to the dining room and other common areas where the staff could keep an eye on him, but then RP tried to sneak R #1 to her room, so the staff redirected him and moved R #1 away. The ADON said RP also tried to kiss R #1 on the cheek, as he grabbed her face, squeezed her face, moved it to the side, and kissed her on the cheek while R #1 said no, no, no. The ADON said that was reported to APS. The ADON said RP only tried to kiss R #1's cheek, not mouth, from what she was told. The ADON said she worked with R #1 at a previous facility and ADON knew that R #1 had a history with RP having supervised visits for some reason but did not know the details so they just monitored. The ADON said R #1 had said she wanted to stay at the facility and RP was upset about that. The ADON said RP was not R #1's POA and R #1 did not have a POA, so it was R #1's decision to stay at the facility or not. The ADON said she was unsure of the date of when RP tried to kiss R #1 on the cheek but RP had also spilled coffee on R #1. The ADON said when RP tried to kiss R #1, RP had coffee in a cup which spilled on R #1 but it was probably not hot, because the nurse assessed R #1 and she did not have any injuries or pain. The ADON said R #1 did not show any emotional distress. The ADON said the facility called APS because RP was inappropriate in the way he tried to kiss her. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 06/12/24 at 3:15 PM., the DON said she had worked at the facility for only about a month, but R #1 already had supervised visits when she started working. The DON said she was not a part of reporting to APS, but APS was called because there were witnesses that said RP tried to kiss R #1 on the cheek or on the lips, not sure which one. The DON said the police came to the facility and the investigator said they could not put anybody in jail for a kiss. The DON said she believed APS called the police. The DON said R #1 was not injured from the alleged incidents and did not exhibit emotional distress. The DON said the facility provided adequate care and addressed R #1's needs as needs arose. The DON said she oversaw the clinical aspect, and the ADM was the abuse coordinator who was more familiar with the situation. In an interview with the AIT on 06/12/24 at 3:35 PM., the AIT said DM informed her and the ADM that RP tried to kiss R #1 on the cheek. The AIT said they talked to DM and followed up with R #1. The AIT said they asked R #1 questions and there was nothing bad voiced regarding RP. The AIT said she asked R #1 how she was feeling, was she in distress, or needed anything. The AIT said they asked R #1 if she was okay with RP and with RP visiting R #1, and she said yes. The AIT said they talked to R #1 because she was able to be interviewed to an extent. The AIT said she also asked R #1 if RP kissed her on the mouth or the cheek, and R #1 said cheek. The AIT said the facility implemented supervised visits as a precaution, but she was unsure of when the supervised visits were officially implemented. The AIT said the facility was aware of APS history which was the reason why they called APS. The AIT said nobody ever mentioned an allegation of abuse or sexual abuse. In an interview with R #1 on 06/12/24 at 4:20 PM., R #1 said she was doing fine. R #1 said she came back from the doctor. R #1 said the doctor told her to get better. R #1 said she did not have any problems. R #1 said she liked for RP to visit. R #1 said she did not have problems with RP. R #1 was asked other questions regarding RP, but R #1 began mumbling words or would not respond. R #1 answered yes, no, or simple words. R #1 appeared confused at times. Observation of R #1 on 06/12/24 at 4:30 PM., R #1 appeared with good personal hygiene. R #1 was not injured or in distress. R #1 was laying down in bed wearing a gown. R #1 had the touch call light within reach. Record review of R #1's order summary dated 06/12/24 reflected counseling services were ordered on 06/11/24. Record review of R #1's admission paperwork reviewed on 06/12/24 dated 05/02/24 reflected no information or notes regarding RP having inappropriate behaviors towards R #1 or a history of APS. (continued on next page)

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F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

In an interview with the ADM on 06/12/24 at 4:40 PM., the ADM said she was the abuse coordinator and would ensure reportable incidents were reported to the state survey agency within required timeframes. The ADM said there was nothing that had happened with R #1 that would be considered reportable to the state survey agency. The ADM said on 05/13/24, CNA F informed her that RP had asked CNA F to take off R #1's clothes in front of him, but the staff did not follow his request. The ADM said on 05/14/24 there was another concern brought up by R #2. The ADM said R #2 brought up that RP and R #2's interactions made her feel uncomfortable, but she did not say that she saw something actually happen. The ADM said she was aware that R #1 had history with APS as she knew R #1 from a previous facility. The ADM said she did not know the details of the other APS cases, but the cases had always been closed so she figured the facility could follow up with APS and check for any updates. The ADM said the supervised visits were implemented and RP was allowed to visit with R #1 in common areas like the dining room. The ADM said on 05/17/24, DM was very upset and reported that he saw RP tried to kiss R #1. The ADM said first DM said he saw RP tried to kiss R #1 on the cheek, then he said on the mouth, then he said the cheek. The ADM said she spoke to LVN B that had been present at the nurse's station, right by where it happened, and LVN B said RP only kissed R #1 on the cheek. The ADM said she reported it to APS as a precaution for R #1's safety. The ADM said she did not report to the state survey agency because there was nothing to report, no allegation. The ADM said R #1 was not injured from the alleged incident and had no negative outcome. The ADM said she did not believe R #1 would be at risk of injury or harm by the facility not reporting to the state survey agency.

Record review of the Abuse, Neglect, and Exploitation Policy (implemented 08/15/22)

Reporting/Response:

The facility will have written procedures that include:

1. Reporting of all alleged violation to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes:

a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or

b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47573 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs, for 1 (R #1) of 5 residents reviewed for care plans, in that: The facility failed to ensure R #1's care plan was revised to reflect the supervised visits with RP. This failure could place residents at risk of current needs not being met. The findings included: Record review of R #1 's file dated 06/07/24 reflected [AGE] year-old female with original admitted [DATE] and last admitted [DATE]. Her diagnosis included: epilepsy (seizures/convulsions), type 2 diabetes, aphasia, muscle weakness, dysphagia, bipolar disorder (mood disorder), severe intellectual disabilities, obesity, depression, anxiety disorder, and lack of expected normal physiological development in childhood. Record review of R #1's MDS assessment dated [DATE] reflected BIMS score of 2 (severely cognitively impaired). R #1 required substantial/maximal assistance (helper does more than half the effort) for eating, oral hygiene, toileting hygiene, and dressing. R #1 was also dependent (helper does all the effort) for showering and personal hygiene. Record review of R #1's Care Plan dated 06/07/24 reflected R #1 had an ADL self-care performance deficit related to surgical incision to sacrum and seizure disorder. Interventions included: R #1 required a total assist of 1-2 staff for bathing/showering, dressing, eating, personal hygiene, toilet use, and transfer. Date initiated: 05/08/24. R #1 had a tendency to remove her clothes when in her room/bed. Resident has sexually inappropriate behaviors, will make sexually explicit comments/requests to staff and may at times touch self. Interventions included: discuss the behavior, intervene as necessary to protect the rights and safety of others, praise improvement, provide with privacy if behavior is obvious, and psych services as ordered. Date initiated: 06/07/24. R #1 was at risk for impairment to skin integrity related to incision to sacrum. Interventions: administer medications/supplement as ordered to address medical diagnosis, monitor for skin changes, medications/treatments for wound healing, and wound vac. Date initiated: 05/06/24. Record review of R #1's Care Plans reviewed on 06/07/24 and 06/12/24 reflected that the facility did not address the supervised visits with RP in the plan of care. Record review of progress notes for R #1 reflected - (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/13/24 at 3:21 PM, documented by SW. On 05/13/24, SW was contacted regarding inappropriate interactions between R #1 and RP. SW contacted supervisor for further instructions. Will contact APS regarding update on case status. Will be having a meeting with RP, SW, and administration. Will be documenting as updated. On 05/14/24 at 1:56 PM, documented by SW. Was contacted by DM that R #2 witnessed inappropriate interactions between R #1 and RP. R #1 and RP will have to be supervised during visitations at all times. Will follow up with APS on case status. Record review of complaint/grievance follow-up report dated 05/17/24 reflected on 05/17/24, DM voiced that he did not like the interaction between R #1 and RP. Re-educated RP on appropriate behavior with R #1. APS informed. Staff interviews attached. RP voiced understanding. Interviews on 05/17/24: Around 1:30 PM, DM voiced that he had an issue with RP. DM stated he observed RP kissing R #1 on the cheek as RP was leaving. DM stated RP grabbed R #1 by the top of her head and chin and R #1 said no. DM voiced SW was involved and addressed it directly with RP. ADM and AIT interviewed R #1 regarding the incident with RP. R #1 seemed to be in good spirits. R #1 voiced RP kissed her on the cheek. R #1 was asked if she was treated well by RP, and R #1 nodded her head. ADM asked if R #1 was in any pain or discomfort and R #1 voiced no. R #1 did not voice any concerns about RP at this time. ADM and AIT interviewed RP regarding the incident with R #1. RP stated he was visiting R #1 as he had not seen her in over two days. RP stated he missed R #1 and only hugged and kissed her on the cheek as any family member would do. RP continued to say that he loved R #1 dearly and that she was his only company. RP was insistent on discharging R #1 on day 28 as he believed the state would discontinue all of R #1's community benefits. ADM explained discharge process to RP. Complaint/grievance resolved on 05/17/24. In an interview with APS on 06/07/24 at 11:05 AM., APS said she received an intake on 05/14/24 for R #1 with an allegation of sexual abuse from RP. APS said the allegation was that RP was being inappropriate with R #1 but there was no report of actual sexual contact or kissing on the mouth. APS said she visited R #1 on 05/17/24 and she tried to interview R #1, however, R #1 was not able to provide information regarding allegations. APS said she also spoke to R #2 who informed APS that RP exhibited inappropriate behaviors towards R #1 such as placing his hands in between her thighs. APS was unsure if R #2 had informed the facility about such behaviors. APS spoke to DM who informed APS that earlier on 05/17/24, DM had witnessed RP forcibly kiss R #1 on the mouth. DM said that DM intervened, told RP to stop, and asked RP to leave. APS was unsure if supervised visits had already been implemented or when they were started. APS spoke to SW who informed APS that an unknown staff had reported that RP asked staff to get R #1 undressed in front of RP. SW had spoken to RP about inappropriate interactions. APS referred the intake to LE, but the investigator informed APS that LE would not investigate further as it was the facility's responsibility to keep R #1 safe. APS said because the alleged incidents happened in the nursing home, APS would not investigate further. Observation of R #1 on 06/07/24 at 12:20 PM., R #1 did not respond to relevant questions. R #1 appeared with good personal hygiene. R #1 was not injured or in distress. R #1 was sitting up in her wheelchair, watching television. R #1 had the touch call light within reach. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676495	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Starr County Nursing and Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 5260 Brand St Rio Grande City, TX 78582	

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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 - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the SW on 06/07/24 at 2:40 PM., the SW said on 05/13/24, CNA F informed that RP asked CNA F to take off R #1's clothes in front of him and that RP had his hand on R #1's thigh while in her room. The SW said he explained to RP that those things were not appropriate and RP understood. The SW said he followed up with APS to check on the status of previous cases or history. The SW said on 05/14/24, he was informed that R #2 was uncomfortable with RP and R #1's interactions but R #2 did not voice any specific incident or contact. The SW said on 05/14/24, he contacted APS and filed a report for R #1's safety. The SW said on 05/14/24, supervised visits were initiated, and RP visited R #1 in the dining, activities, or other common areas where staff kept an eye on him. The SW said the supervised visits were not added to R #1's care plan and there was no documentation for the things reported on 05/13/24 and 05/14/24 other than the progress notes he entered in R #1's file. The SW said the staff were all made aware of the supervised visits by communication between departments. The SW said on 05/17/24, he was informed by DM that RP had kissed R #1 on the cheek, very close to her mouth, and it was inappropriate. The SW said he spoke to RP who cried and said that he loved R #1 and he only showed his affection towards her. The SW said after this incident, supervised visits were changed to where RP only visited R #1 in the lobby area and was closely monitored by a staff. The SW said there was one staff assigned to monitor and supervise R #1 and RP during visits at all times. The SW said there was no in-service completed for the staff but all staff were made aware of the supervised visits as it was communicated from managers to nurses, to CNAs, and to other staff. The SW said all the staff were aware of the supervision and were vigilant in keeping R #1 safe. The SW said there were no other incidents after this. In an interview with the ADON on 06/12/24 at 2:50 PM., the ADON said she was aware of the situation with R #1 and RP. The ADON said she was unsure of when the supervised visits started but they were begun because RP was inappropriate. The ADON said they tried to let RP go to the dining room and other common areas where the staff could keep an eye on him, but then RP tried to sneak R #1 to her room, so the staff redirected him and moved R #1 away. The ADON said the staff were not in-serviced for the supervised visits but the staff were all aware as they were informed by their department managers. The ADON said the facility had a care plan meeting with RP and then RP called and had forgotten about what was discussed in the meeting so she was unsure of how capable RP would be to care for R #1 at home. The ADON said the supervised visits were not part of R #1's care plan. The ADON said RP also tried to kiss R #1 on the cheek, as he grabbed her face, squeezed her face, moved it to the side, and kissed her on the cheek while R #1 said no, no, no. The ADON said after that incident, the supervised visits were only in the lobby area where an assigned staff monitored R #1 and RP at all times. The ADON said that was reported to APS. The ADON said RP only tried to kiss R #1's cheek, not mouth, from what she was told. The ADON said she worked with R #1 at a previous facility and ADON knew that R #1 had a history with RP having supervised visits for some reason but did not know the details so they just monitored. The ADON said R #1 had said she wanted to stay at the facility and RP was upset about that. The ADON said RP was not R #1's POA and R #1 did not have a POA, so it was R #1's decision to stay at the facility or not. The ADON said she was unsure of the date of when RP tried to kiss R #1 on the cheek but at that same time RP had also spilled coffee on R #1. The ADON said when RP tried to kiss R #1, RP had coffee in a cup which spilled on R #1 but it was probably not hot, because the nurse assessed R #1 and she did not have any injuries or pain. The ADON said R #1 did not show any emotional distress. The ADON said the facility called APS because RP was inappropriate in the way he tried to kiss her. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676495	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Starr County Nursing and Transitional Care	5260 Brand St Rio Grande City, TX 78582

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with R #1 on 06/12/24 at 4:20 PM., R #1 said she was doing fine. R #1 said she came back from the doctor. R #1 said the doctor told her to get better. R #1 said she did not have any problems. R #1 said she liked for RP to visit. R #1 said she did not have problems with RP. R #1 was asked other questions regarding RP, but R #1 began mumbling words or would not respond. R #1 answered yes, no, or simple words. R #1 appeared confused at times. Observation of R #1 on 06/12/24 at 4:30 PM., R #1 appeared with good personal hygiene. R #1 was not injured or in distress. R #1 was laying down in bed wearing a gown. R #1 had the touch call light within reach.