STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745002	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kent County Nursing Home	1443 North Main Jayton, TX 79528

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 - Some Note: The nursing home is disputing this citation.	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** 43344 Based on observation, interview and record review, the facility failed to ensure the rights of the residents to be free from abuse and neglect for 1 of 7 residents (Resident #2) reviewed for abuse A. The facility failed to keep Resident #2 safe from Resident #1 on an unknown date when Dietary Aide B reported that Resident #1 had touched Resident #2's breast in the dining room on an unknown date to the Interim DON and to Regional Director J on an unknown date multiple times between May 2024-November 2024). An Immediate Jeopardy (IJ) was identified on 11/19/24 at 2:48 PM. The IJ template was provided to the facility on [DATE] at 2:48 PM. While the IJ was removed on 11/20/24 at 1:28 PM, the facility remained out of compliance at a severity level of actual harm and a scope of widespread due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk for serious psychosocial harm from abuse, humiliation, intimidation, fear, shame, agitation, and decreased quality of life. Findings included: Record review of the facility policy, Abuse Prevention Program, Revised December 2016 revealed: Policy Statement: Our Residents have the right to be free from abuse, neglect .Policy Interpretation and Implementation: As a part of the resident abuse prevention, the administration will: Protect our residents from abuse by anyone including, but not necessarily limited to other residents .Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents. Identify and assess all possible incidents of abuse; Investigate and report any allegations of abuse within timeframes as required by federal requirements; Protect residents during abuse investigations. Record review of the facility policy, Abuse Investigation and Reporting, revised July 2017 revealed: (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: The nursing home is disputing this citation.	Policy Statement: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Policy interpretation: If an incident or suspected incident of resident abuse, mistreatment, neglect, or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual. The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation. The Administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented. The Administrator will inform the resident and his/her representative of the status of the investigation and measures taken to protect the safety and privacy of the resident. Role of the investigator: The individual conducting the investigation will as a minimum; Review the completed documentation forms; Review the resident's medical record; Interview the persons reporting the incident; Interview the resident as medically appropriate; Interview staff members on ALL shifts Interview the resident's roommate; Review all events leading up to the alleged incident; and Upon conclusion of the investigation, the investigator will record the results of the investigation on approved documentation forms and provide the completed documentation to the administrator. Reporting: All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility; The resident's representative (sponsor) of record an alleged violation of abuse, neglect . Two hours if the alleged violation involves abuse . Record review of the facility policy, Recognizing Signs and Symptoms of Abuse/Neglect, Revised April 2021, revealed: Policy Statement: All types of resident abuse, neglect, exploitation, or misappropriation of resident property are strictly prohibited. All personnel are expected to report any signs and symptoms of abuse/neglect to their supervisor or to the director of nursing services immediately. Policy Interpretation: The following are signs and symptoms of abuse/neglect that should be promptly reported. This listing is not all-inclusive. Other signs and symptoms or actual abuse/neglect may be apparent. Psychological or behavioral signs of abuse or neglect: Expression of fear of a person or place, or of being left alone, or of the dark; Paranoia . There were no provider investigation reports available for review from 04/01/24-11/01/24 that involved any of the residents listed in the sample or that pertained to the identified deficient practice. Resident #1 Record Review of Resident #1's face sheet, dated 11/01/24, revealed a [AGE] year-old male that was admitted to the facility on [DATE], with a diagnosis of dementia (memory loss). Record Review of Resident #1's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 14, indicating the resident was not cognitively impaired. Section E did not reveal any documented behaviors for Resident #1. Record Review of Resident #1's Quarterly MDS assessment dated [DATE], revealed Section E did not reveal any documented behaviors for Resident #1. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #1's progress notes dated from 03/02/24- 11/01/24 did not reveal any information regarding the allegation of touching Resident #2's breast or his flirtatious behavior with female residents. Record Review of Resident #1's nursing progress notes entered by the Interim DON dated 05/14/24 at 11:47 PM indicated she spoke with the SW to speak with Resident #1 about calling female staff pet names. A letter was given outlining the facility expectations regarding not calling female staff pet names. Record review of Resident #1's care plan, dated 05/14/24, did not reveal any information regarding his flirtatious behavior towards female residents or allegations regarding touching Resident #2's breast. Resident #2 Record Review of Resident #2's face sheet, dated 11/01/24, revealed a [AGE] year-old female that was initially admitted to the facility on [DATE] and readmitted on [DATE], with the following diagnoses: dementia (memory loss) and depression (prolonged period of sadness). Record Review of Resident #2's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 08, indicating the resident was moderately cognitively impaired. Section E did not reveal any documented behaviors for Resident #2. Record Review of Resident #2's Quarterly MDS assessment dated [DATE], revealed Section E did not reveal any documented behaviors for Resident #2. Record review of Resident #2's care plan, dated 08/06/24, did not reveal any information regarding her being touched by another male resident. Further review revealed a focused area, initiated on 08/06/24, that indicated Resident #2 wanted to be in an affectionate relationship with male residents. The goal initiated on 08/06/24 and revised 10/18/24, was based on family wishes for Resident #2 to visit with male resident (unidentified) in the common area. The interventions initiated 08/06/24 included avoid improper touching, avoid going into other residents' room, keeping the family updated with family status, and talking happy about relationships with male residents. Record review of Resident #2's progress notes dated from 03/02/24- 11/01/24 did not reveal any information regarding the allegation of her breast being touched by Resident #1. Record Review of Resident #2's nursing progress notes entered by LVN H dated 08/02/24 at 7:02 PM indicated Resident #2 was in a male (unidentified) room sitting in her wheelchair and a CNA (unidentified) observed the male resident with his pants around his ankles claiming that he was going to have sex with her. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 11/01/24 at 9:22 AM, [NAME] A stated Resident #1 was a ladies' man. She said he had a history of flirting since his admission. [NAME] A stated there was a history between Resident #1 and #2. She said Resident #1's attempt to flirt and approach Resident #2 caused issues with the other resident, who was no longer at the facility. She said she had not been given any instructions or training regarding Resident #1. She said outside of the incident (Resident #1 touching Resident #2's breast) with Resident #2, she had seen him touch other residents' hands. She said Resident #4 would play with herself. She said she had been told (she could not remember by who) that she would do this when she was nervous. She said this was a known behavior (unable to report for how long) but that male residents would watch her rub on herself in a circular motion. She said staff talked to her about it as much as they could. She said there was an indication that she was about to do it because she would raise her leg. At first, she thought she (resident #4) was itching, but she believed she was checked to rule that out. She said the staff knew to redirect her, offer her a drink, or engage her in another activity. She said she had not received additional training about Resident #4's behavior, but some staff knew how to redirect her. She said if they did not see her raise her legs, it was easy to identify because all the male resident's heads would be turned towards her doing that behavior in the dining room or any common area. She said no other residents have become offended or complained that she was aware of. She said she could not confirm if the other residents were looking at Resident #4 for pleasure or out of shock. During an interview on 11/01/24 at 11:33 AM, CNA E stated over the past month, Resident #4 had a behavior of rubbing herself in her genital area. She said other staff had also noticed it. She said naturally, she and other staff would redirect her. She said they had not received specific training regarding Resident #4 rubbing her genital area. She said they had general knowledge to redirect her since sometimes she would do this in common areas. She said Resident #3 would sit and watch Resident #4 rub herself in her genital area. She said Resident #1 was her (CNA E) family member, and although she had not seen him touch the breasts of anyone, he was known as a big flirt. She said she had observed Resident #1 hold hands with Resident #2 but that Resident #2 was friendly and did not care. She said Resident #2 had a boyfriend who was no longer at the facility, and Resident #1 would stir the pot and upset the resident who was no longer at the facility by flirting with Resident #2. During an interview on 11/01/24 at 9:55 AM, the DM stated Dietary Aide B did report to her that Resident #1 had grabbed Resident #2's breast. She said she was unsure of the exact date. She said she did not witness it, but it was considered inappropriate touching. She said when it was reported to her, she told Dietary Aide B that someone needed to know. She said the ADM was not the administrator and did not know which nurse Dietary Aide B reported the incident to. She said she did not personally report the incident to anyone because she did not personally observe the incident. She said it was her understanding that Dietary Aide B reported the incident to Regional Director J and the charge nurse. She said she could not remember who the charge nurse was. She said she had observed Resident #1 to be social but not overly attentive to any one resident. She said she had not received any special instructions regarding Resident #1. She said although she did not remember the exact date, she did remember the day Dietary Aide B reported the incident. Resident #2 seemed fine and not in any distress. She said she felt if Resident #2 felt threatened, she could tell someone. She said the ADM was the abuse preventionist and had been trained that if she suspected or witnessed abuse, she was to report the allegation to the ADM immediately. She said she had not been interviewed by anyone regarding the incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 11/01/24 at 11:06 AM, the Interim DON stated she no longer worked at the facility. She said she was notified of the incident between Resident #1 and Resident #2. She said she was unsure of the exact date of the incident between Resident #1 and #2, but it was first reported when the Former ADM was employed by Dietary Aide B. She said an investigation was conducted, and it was unfounded by the Former ADM. She said Regional Director J took over after the former ADM left. She said when Regional Director J took over, the incident involving Resident #1 and #2 was brought back up. She said she interviewed Residents (Resident #1 and #2), and nothing was found. She said she was unable to list all she interviewed as she did not work there anymore . She said this may have been in April or May 2024. She said she remembered when she interviewed Resident #1 and Resident #2, both residents denied anything happening and therefore she unfounded the incident. She said there were concerns because each time the new administration would come, the incident of Resident #1 touching Resident #2's breast would come up. She said she did not believe anything had happened because no other allegations had been made since the report. She said it was her understanding that Resident #1 had not approached Resident #2 since the allegation. She said she was unsure why the allegation continued to be addressed, and it seemed to be the kitchen staff that had concerns. She said during her investigation, she found that the people named to be present were not working the day of the incident. The Interim DON said she could not list the people who worked the day of the incident, the date of the incident, and anyone she interviewed, but she unfounded the incident . She said this had been reported to her a total of three times, and she did not report the incident to HHSC during any of those times. She said she did not report the allegation of sexually inappropriate touching because Residents #1 and #2 stated the incident had not occurred, and they unfounded the incident. She said she did keep her eye on Resident #1. She said Family Member G had been notified. She said she had not received any additional reports that Resident #1 had touched any other residents. She said she did not know if she had any written documentation to support her efforts to address the allegations of sexually inappropriate touching from Resident #1. She said she never typed anything up. She said she should have typed something in his progress notes since this was brought up many times. She said she could not pinpoint specific training related to the incident because she had done so many in-services on ANE. She said she did discuss the incident with Regional Director I, and they had decided the incident was not a facility reportable incident because both residents had dementia, and both parties stated nothing happened. She said they agreed that since the kitchen staff kept reporting it, it was retaliation. She said it was not reported to HHSC because there was no proof that it happened and no witnesses. She said that it was known that Dietary Aide B was married into the family of Resident #1 and that she must also protect Resident #1's rights. She said the purpose of following the abuse policy, reporting, and investigating allegations of ANE was to protect the population from ANE, make sure their needs were met, and avoid neglect. She said she had been trained that it was all or none. She said this meant that she was to collect data, have credible witnesses, and then report the incident to HHSC. She said she felt Resident #1 was being painted as a perpetrator based on community rumors. She said she wanted to also protect Resident #1 from false allegations. In regard to documentation, she said she would have to see if she had anything. (The Interim DON did not provide any documentation during the investigation) During an interview on 11/01/24 at 11:33 AM, CNA E stated she said Resident #1 was her (CNA E) family member, and although she had not seen him touch the breasts of anyone, he was known as a big flirt. She said she had observed Resident #1 holding hands with Resident #2 but Resident #2 was friendly and did not care. She said Resident #2 had a boyfriend who was no longer at the facility, and Resident #1 would stir the pot and upset the resident who was no longer at the facility by flirting with Resident #2. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 11/01/24 at 11:55 AM, RN C stated she was notified a few months ago (unknown exact date and time) by Dietary Aide B that she witnessed Resident #1 touching Resident #2's breast. She said she was told by Dietary Aide B that it did not seem mutual. RN C said she asked Dietary Aide B if she had reported the incident to the Interim DON as they did not have an administrator at the time. She said Dietary Aide B said she had. RN C asked if anything had been done and was told by Dietary Aide B that she did not think anything had been done. RN C stated she encouraged Dietary Aide B to report it again. She said it would have been reported to Regional Director J at this time. She said it was her understanding that it was reported to Regional Director J, who responded that he was aware the incident had been investigated and unfounded. She said she was unaware if it had been reported to HHSC. She said Resident #1 had a history of being friendly with female residents since his admission. She said he would grab the female resident's hands and kiss them. She said she had never seen him grab Resident #2's breast. She said she had not received special instruction regarding Resident #1, nor had she been interviewed regarding the allegation of sexually inappropriate touching between Resident #1 and #2. During an interview on 11/01/24 at 12:01 PM Dietary Aide B stated she was aware of an instance where Resident #1 touched the breast of Resident #2 in the dining room. She said she reported the incident to the Interim DON. She said the incident happened right after Mother's Day in 2024. She said she had seen other inappropriate things from Resident #1. She said she had observed him touch Resident #2's breast more than one time. She said she observed when she opened the door that entered the dining room from the kitchen him touching Resident #2's breast, and when he saw her, he put his hands down, and his face turned red. She said she immediately reported the incident to the Interim DON in the presence of LVN L. She explained to the Interim DON that this was not the first time Resident #1 had been inappropriate with female residents. She said she told the Interim DON that the touching was against Resident #2's will. She said she knew this because Resident #2 did not participate; it was just Resident #1. She said when she reported the incident to the Interim DON, she was told by the Interim DON that she would speak to Resident #2. She said she was also told that because Resident #2 had a boyfriend (no longer at the facility at the time of the investigation), it was ok for Resident #2 to have two boyfriends if she wanted. She said the Interim DON said she would ask Resident #2 if she wanted two boyfriends. She said the Interim DON had also explained to her that the laws had changed. She said she was told that if Resident #2 could not say what happened and if she had memory loss or dementia, there was nothing they could do about it. She said the Interim DON told her to let her know if she saw anything else. She said the former ADM was the administrator at the time of the incident. She said the Interim DON reported the incident to Regional Director J, and he spoke with her about it once. She said Regional Director J asked her what happened, she explained that the incident occurred under the Former ADM and told her to let him know if it happened again. She said it had not happened again, but nothing was done. She said she had not received any special instructions or additional training on what to do regarding Resident #1. She said Regional Director J was the only person who ever asked her anything about the incident. She explained there was another incident involving Resident #1. Still, she did not report it because she was unsure if it was considered inappropriate touching. She said nothing had been done with the incident between Resident #1 and #2. She said she did report the incident between Resident #1 and #2 to the DM but was told for her to report the incident herself. She said her DM told her to report the incident because she did not personally see the incident. She said outside of the interview with the HHSC investigator, she felt the incident had not been thoroughly investigated. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 11/01/24 at 12:40 PM, Resident #2 stated no one had touched her inappropriately. She said she had a boyfriend but did not remember his name. She said she knew Resident #1, but he had never touched her inappropriately. She said if someone did touch her, she would tell the people at the front. She said no one had asked her any questions before the HHSC investigator about inappropriately being touched. During an interview on 11/01/24 at 1:25 PM, LVN F stated that she knew of the incident between Resident #1 and Resident #2. She stated she was told about the incident by RN C. She said she could not remember the exact date of the incident, but that RN C stated that it was reported to her (RN C) by Dietary Aide B. She (LVN F) stated that she was not questioned or trained in regard to Resident #1 but remembered that the Interim DON said to Dietary Aide B that Resident #2 could have more than one boyfriend if she wanted. She said the incident was also reported to Regional Director J, and it was her understanding that he did an investigation and unsubstantiated the incident, according to RN C. LVN F said Resident #1 had a history of flirting with female residents and holding their hands. She said she had not seen anything to indicate the other female residents were uncomfortable. She said no instructions had been given regarding the behavior of Resident #1 flirting or holding the female resident's hands. She said they told Resident #1 to leave the female residents alone. She said Resident #1 laughed about it. She said it appeared Resident #1 found humor because he reported to them that Resident #2 was his schoolteacher. During an interview on 11/01/24 at 2:39 PM, LVN H stated she said she was unaware of any incidents that involved Resident #1. She said Resident #1 had a history of being with the female residents. She said he liked to sit with them (female residents). During an interview on 11/01/24 at 2:59 PM, Regional Director I stated he did not know anything about a male resident touching the breast of a female resident. He said he could not recall a specific conversation with the Interim DON. He said he had multiple discussions with the Interim DON. He said the Former DON's last day was May 15th or 16th of 2024. He said there were 10 days without an administrator, and then Regional Director J came to run the facility. He said it was his expectation that if staff suspect or witness abuse, they should follow the facility policy. He said it should be reported to HHSC and investigated thoroughly. He said he was unaware of the allegation between Resident #1 and #2. He said the potential negative outcome for the residents would depend on the allegation. During an interview on 11/01/24 at 3:06 PM, Regional Director J stated he was unaware of any incident that occurred between Resident #1 and Resident #2 that involved breast touching. Regional Director J said he was aware that there was a resident who was no longer at the facility and felt that Resident #1 had stolen his woman (Resident #2). He said if there was an allegation of ANE, it should be reported and investigated. He said investigating the incident was important to ensure the resident was safe. He said the investigation process should be documented. During an interview on 11/01/24 at 3:25 PM, Resident #1 stated he had never been questioned about inappropriate behavior or accused of doing anything inappropriate. He stated he did not have a girlfriend but all the ladies at the facility liked him. He said he recently turned [AGE] years old and found out he was a lesbian because he liked girls. He said he does not touch anyone who does not want to be touched. He said he had not touched anyone since he had been at the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 11/01/24 at 4:43 PM, the DON stated he said he was unaware of any incidents that occurred between Resident #1 and Resident #2. He said he knew Resident #1 would hold people's hands, but it was not specific to female residents. He said he was unaware that Resident #1 would kiss the female residents' hands. During an interview on 11/01/24 at 4:55 PM, the ADM stated he had been trained and was familiar with the facility's ANE policy. He said he was unaware of the incident involving Resident #1 touching Resident #2's breast. He said the potential negative outcome was there could have been the continuation of abuse or whatever was going on. He said not following the abuse policy could place the resident at unnecessary risk. He said the system to monitor abuse was education and communication. He said he had not observed any of the behaviors of the residents discussed. He said he expected the facility abuse policy to be followed. He said it should have been reported to HHSC and investigated. He said everyone was responsible for following the ANE policy, but the administration oversaw the investigation process and reported the allegation to HHSC. He said he did not have a reason why following the facility policy (reporting to HHSC and investigating) was not conducted. He said the investigation process should have been documented if it was conducted . HHSC Investigator re-entered the facility on 11/19/24 at 8:45 AM to gather additional information at the request of Region 1. The ADM, the DON, the ADON, Regional Director J, and the Regional Nursing Consultant were notified on 11/19/24 at 2:48 PM and IJ situation was identified due to the above failures and the IJ template was provided. The following Plan of Removal submitted by the facility was accepted on 11/20/24 at 8:31 AM: Plan of Removal: 607: Investigate/Prevent/Correct Alleged Violations F607 Based on interviews and record review, the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse and neglect for 2 of 6 residents (Resident #1 and #2) reviewed for abuse. 1. Immediate Actions Taken for Those Residents Identified: Action: Residents #1, and #2 received a head-to-toe assessment and an emotional assessment. Person(s) Responsible: Charge Nurse & Social Worker and/or Designee Date: 11/19/2024 Action: Resident #1 was placed on 1:1 for 72-hours from 11/1-11/4. Resident #1 was no longer deemed a risk to others. Person(s) Responsible: Administrator, Director of Nursing, and/or Designee Date: 11/4/2024 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	2. How the Facility Identified Other Possibly Affected Residents: Action: Resident safe surveys completed to establish affected residents. Any other concerns noted will received a head-to-toe assessment and an emotional assessment. Person(s) Responsible: Administrator, Social Worker, and/or Designee Date: 11/19/2024 3. Measures Put into Place/System Changes to remove the immediacy, and what date these actions occurred: Action: Education provided to Administrator and Regional Director by Regional Nurse Consultant. Further, all available facility staff were in-serviced by the Administrator starting immediately after IJ was called. All identified staff that continues to work for the nursing facility by Administrator will be in-serviced over the abuse policy and investigating and reporting abuse per HHS and CMS regulations. Person(s) Responsible: RNC, Administrator or designee Date: 11/19/2024 Action: All staff educated on immediately intervening to protect residents in the event of abuse, reporting to the abuse coordinator, assessing the resident, and following up with the abuse coordinator. All staff will be educated prior to working their next shift. Person(s) Responsible: Administrator, Director of Nursing, and/or Designee Date: 11/19/2024 4. How the Corrective Actions Will be Monitored, by whom and for how long: Action: 5 staff and 5 residents will be interviewed weekly to ensure any allegations of abuse have been reported to the administrator per the regulation x4 weeks. Any allegations made during the interview will be reported immediately. Staff noted not following policy will be reeducated on the facility's abuse policy. Person(s) Responsible: Administrator and/or Designee Date: 11/20/2024 QAPI- Action: Medical Director notified of the Immediate Jeopardy template and the facility's plan to remove it. No additional recommendations at this time. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Person(s) Responsible: Administrator Date: 11/19/2024 On 11/20/24 at 11:23 AM the state surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: Record review of the facility provider investigation report, dated 11/09/24, revealed the following: A written statement signed 11/09/24 by the Interim DON said that Dietary Aide B came to her office (date not disclosed) and reported that she witnessed Resident #1 touch Resident #2 on breast in the dining room. She (the Interim DON) reported the incident to the Former ADM, but she (the Former DON) did nothing. She said some of the witnesses that Dietary Aide B reported saw the incident did not work on the day Dietary Aide B stated the incident happened. (The written statement did not contain the witnesses' or the alleged incident date). The Interim DON wrote that she spoke with Resident #1, who denied sexual contact with Resident #2, but Resident #1 did admit to holding Resident #2's hands. The Interim DON wrote in her statement that Resident #1 had no allegations of sexual contact with any resident or staff at the facility. The Interim DON wrote that Resident #2 denied anyone had touched her anywhere on her body and that she (Resident #2) felt safe. She wrote that Resident #2 confirmed that she held hands with Resident #1. She wrote that she notified Resident #2's POA. She said Dietary Aide B voiced the allegations to Resident #1, two Administrators, and the Interim DON. (The written statement did not include the names of the two administrators. A letter dated 4/4/24, signed/acknowledged by Resident #1, addressed him using pet names such as baby and honey, which made the staff feel uncomfortable. Record review of a facility in-service, ANE, and resident Rights, dated 11/02/24, revealed the following:28 Staff were in-serviced on the following: Every individual was responsible for identifying abuse, neglect, exploitation, and misappropriation in the facility and reporting any allegation or suspicion of these events to the abuse coordinator. It stated that in the event that the abuse coordinator was unavailable, the alternate abuse coordinator was the DON. Record review of facility in-service, ANE, and Reporting, dated 10/17/24, revealed the following: Regional Director J in-serviced the ADM, the DON, the ADON, and LVN K on Long-Term Care Regulation Provider 2024-14, dated 08/29/24, which discussed Reportable incidents and Timeframes. Record review of facility in-service, Event Reporting, dated 11/19/24, revealed the following: The ADM, the DON, and Regional Director J were in-serviced on event reporting. The in-service discussed key aspects (confidentiality, analysis, feedback/learning, and regulatory compliance) of event reporting. The in-service also included the required parties to be notified: the resident responsible party, emergency contact, the DON, the administration, and the abuse preventionist. Record review of facility in-service, Event Reporting, dated 11/19/24, revealed the following: The regional nursing consultant serviced [TRUNCATED]

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344 Based on interviews and record review, the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse and neglect for 5 of 7 residents (Resident #1, #2, #3, #4, and #5) reviewed for abuse. A. The Interim DON failed to follow the facility's abuse policy by not reporting the allegation of sexual abuse to HHSC and documenting her investigation measures regarding Resident #1 and Resident #2 reported by Dietary Aide B on an unknown date. B. The Former ADM failed to follow the facility's abuse policy by not reporting the allegation of sexual abuse to HHSC and documenting her investigation measures regarding Resident #1 and Resident #2 reported by Dietary Aide B on an unknown date. C. The Interim DON failed to follow the facility's abuse policy by not reporting the allegation of inappropriate sexual touching to HHSC and documenting her investigation measures regarding Resident #3 and Resident #5 reported by an unknown staff on 03/07/24. D. The Former ADM failed to follow the facility's abuse policy by not reporting the allegation of inappropriate sexual touching to HHSC and documenting her investigation measures regarding Resident #3 and Resident #5 reported by an unknown staff on 03/07/24. E. [NAME] A failed to follow the facility's abuse policy by not reporting the allegation of sexual abuse to the abuse preventionist. F. The DM failed to follow the facility's abuse policy by not reporting the allegation of sexual abuse to the abuse preventionist that involved Resident #1 and Resident #2 that was reported to her by Dietary Aide B on an unknown date. G. LVN F failed to follow the facility's abuse policy by not following up, assessing Resident #4 after CNA E reported that Resident #4 felt uncomfortable around Resident #3 on an unknown date. H. The Former ADM failed to follow the facility's abuse policy by not reporting the allegation of sexual abuse to HHSC and documenting her investigation measures regarding Resident #3 and Resident #5 reported by unknown staff on an unknown date. I. The Former ADM and Interim DON failed to follow the facility's abuse policy by not notifying Family Member G that Resident #4 had expressed she felt uncomfortable around a male resident. An Immediate Jeopardy (IJ) was identified on 11/19/24 at 2:48 PM. The IJ template was provided to the facility on [DATE] at 2.48 PM. While the IJ was removed on 11/20/24 at 1:28 PM, the facility remained out of compliance at a severity level of actual harm and a scope of widespread due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. These failures could place residents as risk for abuse and neglect. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Findings included: Record review of the facility policy, Abuse Prevention Program, Revised December 2016 revealed: Policy Statement: Our Residents have the right to be free from abuse, neglect .Policy Interpretation and Implementation: As a part of the resident abuse prevention, the administration will: Protect our residents from abuse by anyone including, but not necessarily limited to other residents .Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents. Identify and assess all possible incidents of abuse; Investigate and report any allegations of abuse within timeframes as required by federal requirements; Protect residents during abuse investigations. Record review of the facility policy, Abuse Investigation and Reporting, revised July 2017 revealed: Policy Statement: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Policy interpretation: If an incident or suspected incident of resident abuse, mistreatment, neglect, or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual. The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation. The Administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented. The Administrator will inform the resident and his/her representative of the status of the investigation and measures taken to protect the safety and privacy of the resident. Role of the investigator: The individual conducting the investigation will as a minimum; Review the completed documentation forms; Review the resident's medical record; Interview the persons reporting the incident; Interview the resident as medically appropriate; Interview staff members on ALL shifts Interview the resident's roommate; Review all events leading up to the alleged incident; and Upon conclusion of the investigation, the investigator will record the results of the investigation on approved documentation forms and provide the completed documentation to the administrator. Reporting: All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility; The resident's representative (sponsor) of record an alleged violation of abuse, neglect . Two hours if the alleged violation involves abuse . Record review of the facility policy, Recognizing Signs and Symptoms of Abuse/Neglect, Revised April 2021, revealed: Policy Statement: All types of resident abuse, neglect, exploitation, or misappropriation of resident property are strictly prohibited. All personnel are expected to report any signs and symptoms of abuse/neglect to their supervisor or to the director of nursing services immediately. Policy Interpretation: The following are signs and symptoms of abuse/neglect that should be promptly reported. This listing is not all-inclusive. Other signs and symptoms or actual abuse/neglect may be apparent. Psychological or behavioral signs of abuse or neglect: Expression of fear of a person or place, or of being left alone, or of the dark; Paranoia . (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	There were no provider investigation reports available for review from 04/01/24-11/01/24 that involved any of the residents listed in the sample or that pertained to the identified deficient practice. Resident #1 Record Review of Resident #1's face sheet, dated 11/01/24, revealed a [AGE] year-old male that was admitted to the facility on [DATE], with a diagnosis of dementia (memory loss). Record Review of Resident #1's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 14, indicating the resident was not cognitively impaired. Section E did not reveal any documented behaviors for Resident #1. Record Review of Resident #1's Quarterly MDS assessment dated [DATE], revealed Section E did not reveal any documented behaviors for Resident #1. Record review of Resident #1's progress notes dated from 03/02/24- 11/01/24 did not reveal any information regarding the allegation of touching Resident #2's breast or his flirtatious behavior with female residents. Record Review of Resident #1's nursing progress notes entered by the Interim DON dated 05/14/24 at 11:47 PM indicated she spoke with the SW to speak with Resident #1 about calling female staff pet names. A letter was given outlining the facility expectations regarding not calling female staff pet names. Record review of Resident #1's care plan, dated 05/14/24, did not reveal any information regarding his flirtatious behavior towards female residents or allegations regarding touching Resident #2's breast. Resident #2 Record Review of Resident #2's face sheet, dated 11/01/24, revealed a [AGE] year-old female that was initially admitted to the facility on [DATE] and readmitted on [DATE], with the following diagnoses: dementia (memory loss) and depression (prolonged period of sadness). Record Review of Resident #2's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 08, indicating the resident was moderately cognitively impaired. Section E did not reveal any documented behaviors for Resident #2. Record Review of Resident #2's Quarterly MDS assessment dated [DATE], revealed Section E did not reveal any documented behaviors for Resident #2. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #2's care plan, dated 08/06/24, did not reveal any information regarding her being touched by another male resident. Further review revealed a focused area, initiated on 08/06/24, that indicated Resident #2 wanted to be in an affectionate relationship with male residents. The goal initiated on 08/06/24 and revised 10/18/24, was based on family wishes for Resident #2 to visit with male resident (unidentified) in the common area. The interventions initiated 08/06/24 included avoid improper touching, avoid going into other residents' room, keeping the family updated with family status, and talking happy about relationships with male residents. Record review of Resident #2's progress notes dated from 03/02/24- 11/01/24 did not reveal any information regarding the allegation of her breast being touched by Resident #1. Record Review of Resident #2's nursing progress notes entered by LVN H dated 08/02/24 at 7:02 PM indicated Resident #2 was in a male (unidentified) room sitting in her wheelchair and a CNA (unidentified) observed the male resident with his pants around his ankles claiming that he was going to have sex with her. During an interview on 11/01/24 at 9:22 AM, [NAME] A stated Resident #1 was a ladies' man. She said he had a history of flirting since his admission. [NAME] A stated there was a history between Resident #1 and #2. She said Resident #1's attempt to flirt and approach Resident #2 caused issues with the other resident, who was no longer at the facility. She said she had not been given any instructions or training regarding Resident #1. She said outside of the incident (Resident #1 touching Resident #2's breast) with Resident #2, she had seen him touch other residents' hands. She said Resident #4 would play with herself. She said she had been told (she could not remember by who) that she would do this when she was nervous. She said this was a known behavior (unable to report for how long) but that male residents would watch her rub on herself in a circular motion. She said staff talked to her about it as much as they could. She said there was an indication that she was about to do it because she would raise her leg. At first, she thought she (resident #4) was itching, but she believed she was checked to rule that out. She said the staff knew to redirect her, offer her a drink, or engage her in another activity. She said she had not received additional training about Resident #4's behavior, but some staff knew how to redirect her. She said if they did not see her raise her legs, it was easy to identify because all the male resident's heads would be turned towards her doing that behavior in the dining room or any common area. She said no other residents have become offended or complained that she was aware of. She said she could not confirm if the other residents were looking at Resident #4 for pleasure or out of shock. During an interview on 11/01/24 at 11:33 AM, CNA E stated over the past month, Resident #4 had a behavior of rubbing herself in her genital area. She said other staff had also noticed it. She said naturally, she and other staff would redirect her. She said they had not received specific training regarding Resident #4 rubbing her genital area. She said they had general knowledge to redirect her since sometimes she would do this in common areas. She said Resident #3 would sit and watch Resident #4 rub herself in her genital area. She said Resident #1 was her (CNA E) family member, and although she had not seen him touch the breasts of anyone, he was known as a big flirt. She said she had observed Resident #1 hold hands with Resident #2 but that Resident #2 was friendly and did not care. She said Resident #2 had a boyfriend who was no longer at the facility, and Resident #1 would stir the pot and upset the resident who was no longer at the facility by flirting with Resident #2. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 11/01/24 at 9:55 AM, the DM stated Dietary Aide B did report to her that Resident #1 had grabbed Resident #2's breast. She said she was unsure of the exact date. She said she did not witness it, but it was considered inappropriate touching. She said when it was reported to her, she told Dietary Aide B that someone needed to know. She said the ADM was not the administrator and did not know which nurse Dietary Aide B reported the incident to. She said she did not personally report the incident to anyone because she did not personally observe the incident. She said it was her understanding that Dietary Aide B reported the incident to Regional Director J and the charge nurse. She said she could not remember who the charge nurse was. She said she had observed Resident #1 to be social but not overly attentive to any one resident. She said she had not received any special instructions regarding Resident #1. She said although she did not remember the exact date, she did remember the day Dietary Aide B reported the incident. Resident #2 seemed fine and not in any distress. She said she felt if Resident #2 felt threatened, she could tell someone. She said the ADM was the abuse preventionist and had been trained that if she suspected or witnessed abuse, she was to report the allegation to the ADM immediately. She said she had not been interviewed by anyone regarding the incident. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 11/01/24 at 11:06 AM, the Interim DON stated she no longer worked at the facility. She said she was notified of the incident between Resident #1 and Resident #2. She said she was unsure of the exact date of the incident between Resident #1 and #2, but it was first reported when the Former ADM was employed by Dietary Aide B. She said an investigation was conducted, and it was unfounded by the Former ADM. She said Regional Director J took over after the former ADM left. She said when Regional Director J took over, the incident involving Resident #1 and #2 was brought back up. She said she interviewed Residents (Resident #1 and #2), and nothing was found. She said she was unable to list all she interviewed as she did not work there anymore. She said this may have been in April or May 2024. She said she remembered when she interviewed Resident #1 and Resident #2, both residents denied anything happening and therefore she unfounded the incident. She said there were concerns because each time the new administration would come, the incident of Resident #1 touching Resident #2's breast would come up. She said she did not believe anything had happened because no other allegations had been made since the report. She said it was her understanding that Resident #1 had not approached Resident #2 since the allegation. She said she was unsure why the allegation continued to be addressed, and it seemed to be the kitchen staff that had concerns. She said during her investigation, she found that the people named to be present were not working the day of the incident. The Interim DON said she could not list the people who worked the day of the incident, the date of the incident, and anyone she interviewed, but she unfounded the incident. She said this had been reported to her a total of three times, and she did not report the incident to HHSC during any of those times. She said she did not report the allegation of sexually inappropriate touching because Residents #1 and #2 stated the incident had not occurred, and they unfounded the incident. She said she did keep her eye on Resident #1. She said Family Member G had been notified. She said she had not received any additional reports that Resident #1 had touched any other residents. She said she did not know if she had any written documentation to support her efforts to address the allegations of sexually inappropriate touching from Resident #1. She said she never typed anything up. She said she should have typed something in his progress notes since this was brought up many times. She said she could not pinpoint specific training related to the incident because she had done so many in-services on ANE. She said she did discuss the incident with Regional Director I, and they had decided the incident was not a facility reportable incident because both residents had dementia, and both parties stated nothing happened. She said they agreed that since the kitchen staff kept reporting it, it was retaliation. She said it was not reported to HHSC because there was no proof that it happened and no witnesses. She said that it was known that Dietary Aide B was married into the family of Resident #1 and that she must also protect Resident #1's rights. She said the purpose of following the abuse policy, reporting, and investigating allegations of ANE was to protect the population from ANE, make sure their needs were met, and avoid neglect. She said she had been trained that it was all or none. She said this meant that she was to collect data, have credible witnesses, and then report the incident to HHSC. She said she felt Resident #1 was being painted as a perpetrator based on community rumors. She said she wanted to also protect Resident #1 from false allegations. In regard to documentation, she said she would have to see if she had anything. (The Interim DON did not provide any documentation during the investigation) During an interview on 11/01/24 at 11:33 AM, CNA E stated she said Resident #1 was her (CNA E) family member, and although she had not seen him touch the breasts of anyone, he was known as a big flirt. She said she had observed Resident #1 holding hands with Resident #2 but Resident #2 was friendly and did not care. She said Resident #2 had a boyfriend who was no longer at the facility, and Resident #1 would stir the pot and upset the resident who was no longer at the facility by flirting with Resident #2. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 11/01/24 at 11:55 AM, RN C stated she was notified a few months ago (unknown exact date and time) by Dietary Aide B that she witnessed Resident #1 touching Resident #2's breast. She said she was told by Dietary Aide B that it did not seem mutual. RN C said she asked Dietary Aide B if she had reported the incident to the Interim DON as they did not have an administrator at the time. She said Dietary Aide B said she had. RN C asked if anything had been done and was told by Dietary Aide B that she did not think anything had been done. RN C stated she encouraged Dietary Aide B to report it again. She said it would have been reported to Regional Director J at this time. She said it was her understanding that it was reported to Regional Director J, who responded that he was aware the incident had been investigated and unfounded. She said she was unaware if it had been reported to HHSC. She said Resident #1 had a history of being friendly with female residents since his admission. She said he would grab the female resident's hands and kiss them. She said she had never seen him grab Resident #2's breast. She said she had not received special instruction regarding Resident #1, nor had she been interviewed regarding the allegation of sexually inappropriate touching between Resident #1 and #2. During an interview on 11/01/24 at 12:01 PM Dietary Aide B stated she was aware of an instance where Resident #1 touched the breast of Resident #2 in the dining room. She said she reported the incident to the Interim DON. She said the incident happened right after Mother's Day in 2024. She said she had seen other inappropriate things from Resident #1. She said she had observed him touch Resident #2's breast more than one time. She said she observed when she opened the door that entered the dining room from the kitchen him touching Resident #2's breast, and when he saw her, he put his hands down, and his face turned red. She said she immediately reported the incident to the Interim DON in the presence of LVN L. She explained to the Interim DON that this was not the first time Resident #1 had been inappropriate with female residents. She said she told the Interim DON that the touching was against Resident #2's will. She said she knew this because Resident #2 did not participate; it was just Resident #1. She said when she reported the incident to the Interim DON, she was told by the Interim DON that she would speak to Resident #2. She said she was also told that because Resident #2 had a boyfriend (no longer at the facility at the time of the investigation), it was ok for Resident #2 to have two boyfriends if she wanted. She said the Interim DON said she would ask Resident #2 if she wanted two boyfriends. She said the Interim DON had also explained to her that the laws had changed. She said she was told that if Resident #2 could not say what happened and if she had memory loss or dementia, there was nothing they could do about it. She said the Interim DON told her to let her know if she saw anything else. She said the former ADM was the administrator at the time of the incident. She said the Interim DON reported the incident to Regional Director J, and he spoke with her about it once. She said Regional Director J asked her what happened, she explained that the incident occurred under the Former ADM and told her to let him know if it happened again. She said it had not happened again, but nothing was done. She said she had not received any special instructions or additional training on what to do regarding Resident #1. She said Regional Director J was the only person who ever asked her anything about the incident. She explained there was another incident involving Resident #1. Still, she did not report it because she was unsure if it was considered inappropriate touching. She said nothing had been done with the incident between Resident #1 and #2. She said she did report the incident between Resident #1 and #2 to the DM but was told for her to report the incident herself. She said her DM told her to report the incident because she did not personally see the incident. She said outside of the interview with the HHSC investigator, she felt the incident had not been thoroughly investigated. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 11/01/24 at 12:40 PM, Resident #2 stated no one had touched her inappropriately. She said she had a boyfriend but did not remember his name. She said she knew Resident #1, but he had never touched her inappropriately. She said if someone did touch her, she would tell the people at the front. She said no one had asked her any questions before the HHSC investigator about inappropriately being touched. During an interview on 11/01/24 at 1:25 PM, LVN F stated that she knew of the incident between Resident #1 and Resident #2. She stated she was told about the incident by RN C. She said she could not remember the exact date of the incident, but that RN C stated that it was reported to her (RN C) by Dietary Aide B. She (LVN F) stated that she was not questioned or trained in regard to Resident #1 but remembered that the Interim DON said to Dietary Aide B that Resident #2 could have more than one boyfriend if she wanted. She said the incident was also reported to Regional Director J, and it was her understanding that he did an investigation and unsubstantiated the incident, according to RN C. LVN F said Resident #1 had a history of flirting with female residents and holding their hands. She said she had not seen anything to indicate the other female residents were uncomfortable. She said no instructions had been given regarding the behavior of Resident #1 flirting or holding the female resident's hands. She said they told Resident #1 to leave the female residents alone. She said Resident #1 laughed about it. She said it appeared Resident #1 found humor because he reported to them that Resident #2 was his schoolteacher. During an interview on 11/01/24 at 2:39 PM, LVN H stated she said she was unaware of any incidents that involved Resident #1. She said Resident #1 had a history of being with the female residents. She said he liked to sit with them (female residents). During an interview on 11/01/24 at 2:59 PM, Regional Director I stated he did not know anything about a male resident touching the breast of a female resident. He said he could not recall a specific conversation with the Interim DON. He said he had multiple discussions with the Interim DON. He said the Former DON's last day was May 15th or 16th of 2024. He said there were 10 days without an administrator, and then Regional Director J came to run the facility. He said it was his expectation that if staff suspect or witness abuse, they should follow the facility policy. He said it should be reported to HHSC and investigated thoroughly. He said he was unaware of the allegation between Resident #1 and #2. He said the potential negative outcome for the residents would depend on the allegation. During an interview on 11/01/24 at 3:06 PM, Regional Director J stated he was unaware of any incident that occurred between Resident #1 and Resident #2 that involved breast touching. Regional Director J said he was aware that there was a resident who was no longer at the facility and felt that Resident #1 had stolen his woman (Resident #2). He said if there was an allegation of ANE, it should be reported and investigated. He said investigating the incident was important to ensure the resident was safe. He said the investigation process should be documented. During an interview on 11/01/24 at 3:25 PM, Resident #1 stated he had never been questioned about inappropriate behavior or accused of doing anything inappropriate. He stated he did not have a girlfriend but all the ladies at the facility liked him. He said he recently turned [AGE] years old and found out he was a lesbian because he liked girls. He said he does not touch anyone who does not want to be touched. He said he had not touched anyone since he had been at the facility. (continued on next page)

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	745002	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kent County Nursing Home	1443 North Main Jayton, TX 79528

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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: The nursing home is disputing this citation.	During an interview on 11/01/24 at 4:43 PM, the DON stated he said he was unaware of any incidents that occurred between Resident #1 and Resident #2. He said he knew Resident #1 would hold people's hands, but it was not specific to female residents. He said he was unaware that Resident #1 would kiss the female residents' hands. During an interview on 11/01/24 at 4:55 PM, the ADM stated he had been trained and was familiar with the facility's ANE policy. He said he was unaware of the incident involving Resident #1 touching Resident #2's breast. He said the potential negative outcome was there could have been the continuation of abuse or whatever was going on. He said not following the abuse policy could place the resident at unnecessary risk. He said the system to monitor abuse was education and communication. He said he had not observed any of the behaviors of the residents discussed. He said he expected the facility abuse policy to be followed. He said it should have been reported to HHSC and investigated. He said everyone was responsible for following the ANE policy, but the administration oversaw the investigation process and reported the allegation to HHSC. He said he did not have a reason why following the facility policy (reporting to HHSC and investigating) was not conducted. He said the investigation process should have been documented if it was conducted. Resident #3 Record Review of Resident #3's face sheet, dated 11/01/24, revealed a [AGE] year-old male that was admitted to the facility on [DATE], with a diagnosis of dementia (memory loss). Record Review of Resident #3's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 15, indicating the resident was not cognitively impaired. Section E did not reveal any documented behaviors for Resident #3. Record Review of Resident #3's Quarterly MDS assessment dated [DATE], revealed Section E did not reveal any documented behaviors for Resident #3. Record Review of Resident #3's nursing progress notes entered by LVN K dated 03/07/24 at 7:04 PM indicated Resident #3 was in the TV room and his pants were unzipped by Resident #5. The CNA (unidentified) hollered out for the residents to stop. Resident #3 did not attempt to stop Resident #5. Record Review of Resident #3's progress notes entered by the SW dated 03/12/24 at 11:36 AM indicated Resident #3 was in the activity room with a female resident unzipping his pants. It was reported that Resident #3 was allowing Resident #5 to unzip his pants. It was reported that Resident #5 had severe dementia and sought out male residents, in particular Resident #3. The SW discussed with Resident #3 about the issue of female resident having dementia and not understanding their actions. The SW informed Resident #3 about notifying staff entering the room and for him to leave the room if it happened again. Record review of Resident #3's care plan, dated 5/03/24, revealed a focused area, initiated on 05/03/24, Resident #3 had been sexually inappropriate allowing a female resident to unzip his pants in a community setting. The goal initiated on 05/03/24, was Resident #3 would have no evidence of sexually inappropriate behavior problems. The interventions included to intervene as necessary to protect the rights and safety of others, discuss the resident's behavior, and monitor behavior episodes. Resident #4 (continued on next page)

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	745002	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kent County Nursing Home	1443 North Main Jayton, TX 79528

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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: The nursing home is disputing this citation.	Record Review of Resident #4's face sheet, dated 11/01/24, revealed a [AGE] year-old female that was initially admitted to the facility on [DATE] and readmitted on [DATE], with a diagnosis of dementia (memory loss). Record Review of Resident #4's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 10, indicating the resident was moderately cognitively impaired. Section E did not reveal any documented behaviors for Resident #4. Record Review of Resident #4's Quarterly MDS assessment dated [DATE], revealed Section E did not reveal any documented behaviors for Resident #4. Record review of Resident #4's progress notes dated from 03/02/24- 11/01/24 did not reveal any information concerning Resident #3 or the behavior of rubbing herself outside of her clothing. Record review of Resident #4's care plan, dated 09/19/24, did not reveal any information regarding her concerns for Resident #3 or any behaviors of her rubbing herself outside of her clothing near her genital area. During an interview on 11/01/24 at 9:00 AM, the ADM stated he said there had been no issues since he had been at the facility but that he had to educate Resident #3 on not being flirtatious as he had touched another resident's (Resident #4) knee, but nothing out of line. During an interview on 11/01/24 at 11:33 AM, CNA E stated Resident #4 reported to her that she felt uncomfortable with Resident #3. She said other nurses had noticed her discomfort with Resident #3. She said over the past month, Resident #4 had a behavior of rubbing herself in her genital area. She said other staff had also noticed it. She said naturally, she and other staff would redirect her. She said they had not received specific training regarding Resident #4 rubbing her genital area. She said they had general knowledge to redirect her since sometimes she would do this in common areas. She said Resident #3 would sit and watch Resident #4 rub herself in her genital area. She said she was keeping an eye on them both. She said one time (unknown date and time), Resident #4 reported that Resident #3 made her uncomfortable. She said she reported this to LVN F. CNA E said she had observed Resident #3 sitting by Resident #4's door and watching her but Resident #3 would not do it often since Resident #4 had a roommate. During an interview on 11/01/24 at 1:01 PM, Resident #4 stated she felt safe. She said there was a male who made her feel uncomfortable. She [TRUNCATED]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43344 Based on interviews and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours if the alleged violation involved abuse or neglect and resulted in bodily injury, to other officials (including the State Agency) for 4 of 7 residents (Resident #1, #2, 3, and #5) reviewed for abuse. A. The Interim DON failed to follow the facility's abuse policy by not reporting the incident involving Resident #1 and Resident #2's involvement in inappropriate sexual touching reported by Dietary Aide B on an unknown date to HHSC. B. The Former ADM failed to follow the facility's abuse policy by not reporting the incident involving Resident #1 and Resident #2's involvement in inappropriate sexual touching reported by Dietary Aide B on an unknown date to HHSC. C. The Interim DON failed to follow the facility's abuse policy by not reporting the incident involving Resident #3 and Resident #5's involvement of inappropriate touching reported by an unknown staff on 03/07/24 to HHSC. D. The Former ADM failed to follow the facility's abuse policy by not reporting the incident involving Resident #3 and Resident #5's involvement of inappropriate touching reported by an unknown staff on 03/07/24 to HHSC. These failures could place residents as risk for abuse and neglect. Findings included: Resident #1 Record Review of Resident #1's face sheet, dated 11/01/24, revealed a [AGE] year-old male that was admitted to the facility on [DATE], with a diagnosis of dementia (memory loss). Record Review of Resident #1's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 14, indicating the resident was not cognitively impaired. Section E did not reveal any documented behaviors for Resident #1. Record Review of Resident #1's Quarterly MDS assessment dated [DATE], revealed under Section E did not reveal any documented behaviors for Resident #1. (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 - Some	Record review of Resident #1's progress notes dated from 03/02/24- 11/01/24 did not reveal any information regarding the allegation of touching Resident #2 breast or his flirtatious behavior with female residents. Record Review of Resident #1's nursing progress notes entered by the Interim DON dated 05/14/24 at 11:47 PM indicated she spoke with the SW to speak with Resident #1 about calling female staff pet names. A letter was given outlining the facility expectations regarding not calling female staff pet names. Record review of Resident #1's care plan, dated 05/14/24, did not reveal any information regarding his flirtatious behavior towards female residents or allegation regarding touching Resident #2's breast. Resident #2 Record Review of Resident #2's face sheet, dated 11/01/24, revealed a [AGE] year-old female that was initially admitted to the facility on [DATE] and readmitted on [DATE], with the following diagnoses: dementia (memory loss), and depression (prolonged period of sadness). Record Review of Resident #2's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 08, indicating the resident was moderately cognitively impaired. Section E did not reveal any documented behaviors for Resident #2. Record Review of Resident #2's Quarterly MDS assessment dated [DATE], revealed under Section E did not reveal any documented behaviors for Resident #2. Record review of Resident #2's care plan, dated 08/06/24, did not reveal any information regarding her being touched by another male resident .Further review revealed a focused area, initiated on 08/06/24, that indicated Resident #2 wanted to be in an affectionate relationship with male residents. The goal initiated on 08/06/24 revised 10/18/24, was based on family wishes for Resident #2 to visit with male resident (unidentified) in the common area. The interventions initiated 08/06/24 included avoid improper touching, avoid going into other residents room, keeping resident family updated with relationship status and talking often about being happy when she is in a relationship with male residents. Record review of Resident #2's progress notes dated from 03/02/24- 11/01/24 did not reveal any information regarding the allegation of her breast being touched by Resident #1. Record Review of Resident #2's nursing progress notes entered by LVN H dated 08/02/24 at 7:02 PM indicated Resident #2 was in a male (unidentified) room sitting in her wheelchair and a CNA (unidentified) observed the male resident with his pants around his ankles claiming that he was going to have sex with her. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/01/24 at 9:55 AM, the DM stated Dietary Aide B did report to her that Resident #1 had grabbed Resident #2's breast. She said she was unsure of the exact date. She said she did not witness it but considered inappropriate touching. She said when it was reported to her, she told Dietary Aide B that someone needed to know. She said the ADM was not the administrator and did not know which nurse Dietary Aide B reported the incident to. She said she did not personally report the incident to anyone because she did not personally observe the incident. She said it was her understanding that Dietary Aide B reported the incident to Regional Director J and the charge nurse. She said she could not remember who the charge nurse was. She said she had observed Resident #1 to be social but not overly attentive to any one resident. She said she had not received any special instructions regarding Resident #1. She said although she did not remember the exact date, she did remember the day Dietary Aide B reported the incident. Resident #2 seemed fine and not in any distress. She said she felt if Resident #2 felt threatened, she could tell someone. She said the ADM was the abuse preventionist and had been trained that if she suspected or witnessed abuse, she was to report the allegation to the ADM immediately. She said she had not been interviewed by anyone regarding the incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/01/24 at 11:06 AM, the Interim DON stated she no longer worked at the facility. She said she was notified of the incident between Resident #1 and Resident #2. She said she was unsure of the exact date of the incident between Resident #1 and #2, but it was first reported when the Former ADM was employed by dietary Aide B. She said an investigation was conducted, and it was unfounded by the Former ADM. She said Regional Director J took over after the former ADM left. She said when Regional Director J took over, the incident involving Resident #1 and #2 was brought back up. She said she interviewed Residents (Residents #1 and #2), and nothing was found. She said she was unable to list all she interviewed as she did not work there anymore. She said this may have been in April or May 2024. She said she remembered when she interviewed Resident #1 and Resident #2, both residents denied anything happening and therefore unfounded the incident. She said there were concerns because each time the new administration would come, the incident of Resident #1 touching Resident #2's breast would come up. She said she did not believe anything had happened because no other allegations had been made since the report. She said it was her understanding that Resident #1 had not approached Resident #2 since the allegation. She said she was unsure why the allegation continues to be addressed, and it seemed to be the kitchen staff that had concerns. She said during her investigation, she found that the people named to be present were not working the day of the incident. The Interim DON said she could not list the people who worked the day of the incident, the date of the incident, and anyone she interviewed, but she unfounded the incident. She said this had been reported to her a total of three times, and she did not report the incident to HHSC during any of those times. She said she did not report the allegation of sexually inappropriate touching because Residents #1 and #2 stated the incident had not occurred, and they unfounded the incident. She said she did keep her eye on Resident #1. She said Family Member G had been notified. She said she had not received any additional reports that Resident #1 had touched any other residents. She said she did not know if she had any written documentation to support her efforts to address the allegations of sexually inappropriate touching from Resident #1. She said she never typed anything up. She said she should have typed something in his progress notes since this was brought up many times. She said she could not pinpoint specific training related to the incident because she had done so many in-services on ANE. She said she did discuss the incident with Regional Director I, and they had decided the incident was not a facility reportable incident because both residents had dementia, and both parties stated nothing happened. She said they agreed that since the kitchen staff kept reporting it, it was retaliation. She said it was not reported to HHSC because there was no proof that it happened and no witnesses. She said that it was known that Dietary Aide B was married into the family of Resident #1 and that she must also protect Resident #1's rights. She said the purpose of following the abuse policy, reporting, and investigating allegations of ANE was to protect the population from ANE, make sure their needs were met, and avoid neglect. She said she had been trained that it was all or none. She said this meant that she was to collect data, have credible witnesses, and then report the incident to HHSC. She said she felt Resident #1 was being painted as a perpetrator based on community rumors. She said she wanted to also protect Resident #1 from false allegations. In regard to documentation, she said she would have to see if she had anything. (The Interim DON did not provide any documentation during the investigation) (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 - Some	During an interview on 11/01/24 at 11:55 AM, RN C stated she was notified a few months ago (unknown exact date and time) by Dietary Aide B that she witnessed Resident #1 touching Resident #2's breast. She said she was told by Dietary Aide B that it did not seem mutual. RN C said she asked Dietary Aide B if she had reported the incident to the Interim DON as they did not have an administrator at the time. She said Dietary Aide B said she had. RN C asked if anything had been done and was told by Dietary Aide B that she did not think anything had been done. RN C stated she encouraged Dietary Aide B to report it again. She said it would have been reported to Regional Director J at this time. She said it was her understanding that it was reported to Regional Director J, who responded that he was aware the incident had been investigated and unfounded. She said she was unaware if it had been reported to HHSC. She said Resident #1 had a history of being friendly with female residents since his admission. She said he would grab the female resident's hands and kiss them. She said she had never seen him grab Resident #2's breast. She said she had not received special instruction regarding Resident #1, nor had she been interviewed regarding the allegation of sexually inappropriate touching between Resident #1 and #2. During an interview on 11/01/24 at 12:01 PM Dietary Aide B stated she was aware of an instance where Resident #1 touched the breast of Resident #2 in the dining room. She said she reported the incident to the Interim DON. She said the incident happened right after Mother's Day in 2024. She said she had seen other inappropriate things from Resident #1. She said she had observed him touch Resident #2's breast more than one time. She said she observed when she opened the door that entered the dining room from the kitchen him touching Resident #2's breast, and when he saw her he put his hands down, and his face turned red. She said she immediately reported the incident to the Interim DON in the presence of LVN L. She explained to the Interim DON that this was not the first time Resident #1 had been appropriate with female residents. She said she told the Interim DON that the touching was against Resident #2's will. She said she knew this because Resident #2 did not participate; it was just Resident #1. She said when she reported the incident to the Interim DON, she was told by the Interim DON that she would speak to Resident #2. She said she was also told that because Resident #2 had a boyfriend (no longer at the facility at the time of the investigation), it was ok for Resident #2 to have two boyfriends if she wanted. She said the Interim DON said she would ask Resident #2 if she wanted two boyfriends. She said the Interim DON had also explained to her that the laws had changed. She said she was told that if Resident #2 could not say what happened and if she had memory loss or dementia, there was nothing they could do about it. She said the Interim DON told her to let her know if she) saw anything else. She said the former ADM was the administrator at the time of the incident. She said the Interim DON reported the incident to Regional Director J, and he spoke with her about it once. She said Regional Director J asked her what happened, she explained that the incident occurred under the Former ADM and told her to let him know if it happened again. She said it had not happened again, but nothing was done. She said she had not received any special instructions or additional training on what to do regarding Resident #1. She said Regional Director J was the only person who ever asked her anything about the incident. She explained there was another incident involving Resident #1. Still, she did not report it because she was unsure if it was considered inappropriate touching. She said nothing had been done with the incident between Resident #1 and #2. She said she did report the incident between Resident #1 and #2 to the DM but was told for her to report the incident herself. She said her DM told her to report the incident because she did not personally see the incident. She said outside of the interview with the HHSC investigator, she felt the incident had not been thoroughly investigated. (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 - Some	During an interview on 11/01/24 at 12:40 PM, Resident #2 stated no one had touched her inappropriately. She said she had a boyfriend but did not remember his name. She said she knew Resident #1, but he had never touched her inappropriately. She said if someone did touch her, she would tell the people at the front. She said no one had asked her any questions before the HHSC investigator about inappropriately being touched. During an interview on 11/01/24 at 2:59 PM, Regional Director I stated he did not know anything about a male resident touching the breast of a female resident. He said he could not recall a specific conversation with the Interim DON. He said he had multiple discussions with the Interim DON. He said the Former DON's last day was May 15th or 16th of 2024. He said there were 10 days without an administrator, and then Regional Director J came to run the facility. He said it was his expectation that if staff suspect or witness abuse, they should follow the facility policy. He said it should be reported to HHSC. He said he was unaware of the allegation between Resident #1 and #2. He said the potential negative outcome for the residents would depend on the allegation. During an interview on 11/01/24 at 1:25 PM, LVN F stated that she knew the incident between Resident #1 and Resident #2. She stated she was told about the incident by RN C. She said she could not remember the exact date of the incident but that RN C stated that it was reported to her (RN C) by Dietary Aide B. She (LVN F) stated that she was not questioned or trained in regard to Resident #1 but remembered that the Interim DON said to Dietary Aide B that Resident #2 could have more than one boyfriend if she wanted. She said the incident was also reported to Regional Director J, and it was her understanding that he did an investigation and unsubstantiated the incident, according to RN C. LVN F said Resident #1 had a history of flirting with female residents and holding their hands. She said she had not seen anything to indicate the other female residents were uncomfortable. She said no instructions had been given regarding the behavior of Resident #1 flirting or holding the female resident's hands. She said they told Resident #1 to leave the female residents alone. She said Resident #1 laughed about it. She said it appeared Resident #1 found humor because he reported to them that Resident #2 was his school teacher. She (LVN F) stated that she was not questioned or trained in regard to Resident #1 but remembered that She said the incident was also reported to Regional Director J, and it was her understanding that he did an investigation and unsubstantiated the incident, according to RN C. During an interview on 11/01/24 at 3:06 PM, Regional Director J stated he was unaware of any incident that occurred between Resident #1 and Resident #2 that involved breast touching. Regional Director J said he was aware that there was a resident who was no longer at the facility and felt that Resident #1 had stolen his woman (Resident #2). He said if there was an allegation of ANE, it should be reported to HHSC. During an interview on 11/01/24 at 3:25 PM, Resident #1 stated he had never been questioned about inappropriate behavior or accused of doing anything inappropriate. He stated he did not have a girlfriend but all the ladies at the facility liked him. He said he recently turned [AGE] years old and found out he was a lesbian because he liked girls. He said he does not touch anyone who does not want to be touched. He said he had not touched anyone since he had been at the facility. During an interview on 11/01/24 at 4:43 PM, the DON stated he said he was unaware of any incident that occurred between Resident #1 and Resident #2. He said he knew Resident #1 would hold people's hands, but it was not specific to female residents. He said he was unaware that Resident #1 would kiss the female resident hands. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kent County Nursing Home	1443 North Main Jayton, TX 79528

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 - Some	During an interview on 11/01/24 at 4:55 PM, the ADM stated he had been trained and was familiar with the facility's ANE policy. He said he was unaware of the incident involving Resident #1 touching Resident #2's breast. He said the potential negative outcome was there could have been the continuation of abuse or whatever was going on. He said not following the abuse policy could place the resident at unnecessary risk. He said the system to monitor abuse was education and communication. He said he had not observed any of the behaviors of the residents discussed. He said he expected the facility abuse policy to be followed. He said it should have been reported to HHSC. He said everyone was responsible for following the ANE policy, but the administration oversaw the investigation process and reported the allegation to HHSC. He said he did not have a reason why following the facility policy (reporting to HHSC) was not conducted. He said the investigation process should have been documented if conducted. Resident #3 Record Review of Resident #3's face sheet, dated 11/01/24, revealed a [AGE] year-old male that was admitted to the facility on [DATE], with a diagnosis of dementia (memory loss). Record Review of Resident #3's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 15, indicating the resident was not cognitively impaired. Section E did not reveal any documented behaviors for Resident #3. Record Review of Resident #3's Quarterly MDS assessment dated [DATE], revealed under Section E did not reveal any documented behaviors for Resident #3. Record Review of Resident #3's nursing progress notes entered by LVN K dated 03/07/24 at 7:04 PM indicated Resident #3 was in the TV room and his pants was unzipped by Resident #5. The CNA (unidentified) hollered out for the residents to stop. Resident #3 did not attempt to stop Resident #5. Record Review of Resident #3's progress notes entered by the SW dated 03/12/24 at 11:36 AM indicated Resident #3 was in the activity room with a female resident unzipping his pants. It was reported that Resident #3 was allowing Resident #5 to unzip his pants. It was reported that Resident #5 had severe dementia and seeks out male residents in particular Resident #3. The SW discussed with Resident #3 about the issues of female resident having dementia and not understanding their actions. The SW informed Resident #3 about notifying staff entering the room and for him to leave the room if it happens again. Record review of Resident #3's care plan, dated 5/03/24, revealed a focused area, initiated on 05/03/24, Resident #3 had been sexually inappropriate allowing a female resident to unzip his pants in a community setting. The goal initiated on 05/03/24, was Resident #3 would have no evidence of sexually inappropriate behavior problems. The interventions included to intervene as necessary to protect the rights and safety of others, discuss the resident's behavior and monitor behavior episodes. Resident #5 Record Review of Resident #5's face sheet, dated 11/01/24, revealed a [AGE] year-old male that was admitted to the facility on [DATE], with the following diagnoses: dementia (memory loss) and high risk heterosexual behavior. (continued on next page)

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Kent County Nursing Home	1443 North Main Jayton, TX 79528

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #5's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 04, indicating the resident was severely cognitively impaired. Section E did not reveal any documented behaviors for Resident #5. Record Review of Resident #5's Quarterly MDS assessment dated [DATE], revealed under Section E did not reveal any documented behaviors for Resident #5. Record review of Resident #5's Order Summary Report, dated 11/01/24, reflected the resident was to take 1 tablet 2 times a day by mouth of Depakote for dementia with sexual issues related to dementia; Ordered 3/07/2024. Record Review of Resident #5's nursing progress notes entered by LVN K dated 03/07/24 at 6:00 PM indicated Resident #5 was observed unzipping Resident #3's pants and was about to put her hands in his pants. Resident #3 reported he had his hand in Resident #5's shirt. This information was reported to the Former ADM and Former Interim DON. Record review of Resident #5's care plan, dated 5/02/24, revealed a focused area, initiated on 05/02/24, Resident #5 had a behavior problem of sexual inappropriate r/t dementia. The goal initiated on 05/02/24, was that Resident #5 would have no evidence of behavior problems. The Interventions included administering Depakote, caregivers provide positive interaction, discuss resident's behavior, and monitor behavior. During an interview on 11/01/24 at 9:00 AM, the ADM stated he was the abuse preventionist. He stated he had introduced himself to all residents. He said if staff suspect or witness abuse, they should report it to him or the DON. He said the DON was the alternate abuse preventionist. He said if it were after hours, the staff would report to the charge nurse on duty, and the charge nurse would contact him or the DON. He said he had not had any facility-reported incidents since he had been at the facility. He stated he had been at the facility for a few weeks. He said when he does report any incident to HHSC, he kept a physical folder with all the information in it. He said there were no facility-reported incidents to his knowledge when he came to the facility a few weeks ago. He stated he was responsible for the facility incident reporting process. He said if an allegation of ANE were received, he would report it to HHSC. He said the system they use to monitor abuse allegations was the most recent abuse provider letter provided by HHSC. He said the potential negative outcome of not following the facility's abuse policy was abuse could continue to persist, and things could get worse for the resident. He said that although he was new to the physical facility, they were under the same management company. The ADM stated he said there had been no issues since he had been at the facility but that he had to educate Resident #3 on not being flirtatious as he had touched another resident's knee, but nothing out of line. During an interview on 11/01/24 at 12:50 PM, Resident #5 stated she felt safe. She said the staff treated her well. She stated she did not need the HHSC investigator to investigate anything for her. She said no residents had inappropriately touched her, and she had not inappropriately touched anyone. She said she felt if she had been inappropriately touched, she would tell someone. She stated she would tell the staff at the front. She said she had not had any incident of inappropriate touching or sexual abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/01/24 at 1:37 PM, Resident #3 stated he had only been told about inappropriate touching one time since his admission. He said he did not want to name the other resident but that she had run her hands up his leg. He said he had no other issues since that incident about a year ago. He said he did not remember staring at any other female residents. He asked the HHSC investigator if she knew anyone who could be his girlfriend because he would like one. During an interview on 11/01/24 at 3:06 PM, Regional Director J stated if there was an allegation of ANE, it should be reported to HHSC. During an interview on 11/01/24 at 4:43 PM, the DON stated their system to monitor ANE and ensuring staff were following of the facility's abuse policy was education through in-services. He said there are signs posted outside of the administration doors. He stated not following the facility's abuse policy, the potential negative outcome was actual harm or something detrimental could happen. He said if staff suspected or witnessed abuse, the allegation should be reported to HHSC. He said he did not have a reason why the abuse policy was not followed. He said he had been at the facility since 10/11/24 but was familiar with and had been trained on the facility's abuse policy. He said their system to monitor ANE and the following of the facility's abuse policy was education through in-services. He said that being new, he was unaware that any of the incidents/allegations discussed had been reported to HHSC. He said he was unaware of Resident #3 flirtatious behavior. He said nothing was brought up during stand-up meetings regarding the resident issues discussed. He said if there are new or ongoing behaviors, they are also reported during shift changes. He said they also had a nursing group message system. He said he had not observed any of the behaviors discussed. During an interview on 11/01/24 at 4:55 PM, the ADM stated he had been trained and was familiar with the facility's ANE policy. He said not following the abuse policy could place the resident at unnecessary risk. He said the system to monitor abuse was education and communication. He said he had not observed any of the behaviors of the residents discussed. He said he expected the facility abuse policy to be followed. He said allegations of ANE should have been reported to HHSC. He said everyone was responsible for following the ANE policy, but the administration oversaw the investigation process and reported the allegation to HHSC. He said he did not have a reason why following the facility policy (reporting to HHSC) was not conducted. During an interview on 11/01/24 at 5:40 PM, Regional Director J stated he did not find anything showing that the incident between Resident #3 and Resident #5 was reported to HHSC or investigated. During an interview on 11/01/24 at 5:34 PM, the Corporate MDS Consultant stated she went through each resident's progress notes and found the incident between Resident #3 and Resident #5. She said she was unaware if the incident had been reported to HHSC. She said she did not follow up with anything else because the note indicated it had been reported to the Interim DON and the Former ADM. She said she did not follow up with either of them. She said she was unsure if the incident had been investigated. She said she did not assess or speak with the residents. Record review of the facility policy, Abuse Prevention Program, Revised December 2016 revealed: Policy Statement Our Residents have the right to be free from abuse, neglect . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Interpretation and Implementation As a part of the resident abuse prevention, the administration will: Protect our residents from abuse by anyone including, but not necessarily limited to: other residents . Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents. Identify and assess all possible incidents of abuse; Report any allegations of abuse within timeframes as required by federal requirements; Record review of the facility policy, Abuse Investigation and Reporting, revised July 2017 revealed: Policy Statement All reports of resident abuse , neglect, exploitation, misappropriation of resident property, mistreatment and or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies . Policy interpretation If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported . Reporting All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility The resident's representative (sponsor) of record An alleged violation of abuse, neglect . Two hours if the alleged violation involves abuse There were no provider investigation reports available for review that involved any of the residents listed in the sample as of 11/04/24.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344 Based on interviews and record review the facility failed to ensure allegations of abuse, neglect, exploitation, or mistreatment have evidence that all alleged violations were thoroughly investigated and prevented further potential abuse, neglect, exploitation, or mistreatment while the investigation was in progress and reported the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation was verified appropriate corrective action were taken, for 5 of 7 residents (Resident #1, #2, #3, #4, and #5) reviewed for abuse. A. The Interim DON failed to follow the facility's abuse policy by not documenting her investigation measures and implementing protective measures regarding Resident #1 and Resident #2 involvement in inappropriate sexual touching reported by Dietary Aide B on an unknown date. B. The Former ADM failed to follow the facility's abuse policy by not documenting her investigation measures and implementing protective measures regarding Resident #1 and Resident #2 involvement in inappropriate sexual touching reported by Dietary Aide B on an unknown date. C. The Interim DON failed to follow the facility's abuse policy by not documenting her investigation measures and implementing protective measures regarding Resident #3 and Resident #5 involvement of inappropriate touching reported by an unknown staff on 03/07/24. D. The Former ADM failed to follow the facility's abuse policy by not documenting her investigation measures and implementing protective measures regarding Resident #3 and Resident #5 involvement of inappropriate touching reported by an unknown staff on 03/07/24. E. The Interim DON, LVN F, and CNA E failed to follow the facility's abuse policy by not documenting her investigation measures and implementing protective measures regarding Resident #3 and Resident #4 after Resident #4 expressed that she felt unsafe around Resident #3. An Immediate Jeopardy (IJ) was identified on 11/19/24 at 2:48 PM. The IJ template was provided to the facility on [DATE] at 2:48 PM. While the IJ was removed on 11/20/24 at 1:28 PM, the facility remained out of compliance at a severity level of actual harm and a scope of widespread due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. These failures could place residents as risk for abuse and neglect by not investigating and implementing preventative measures in place. Findings included: Resident #1 Record Review of Resident #1's face sheet, dated 11/01/24, revealed a [AGE] year-old male that was admitted to the facility on [DATE], with a diagnosis of dementia (memory loss). (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record Review of Resident #1's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 14, indicating the resident was not cognitively impaired. Section E did not reveal any documented behaviors for Resident #1. Record Review of Resident #1's Quarterly MDS assessment dated [DATE], revealed under Section E did not reveal any documented behaviors for Resident #1. Record review of Resident #1's progress notes dated from 03/02/24- 11/01/24 did not reveal any information regarding the allegation of touching Resident #2 breast or his flirtatious behavior with female residents. Record Review of Resident #1's nursing progress notes entered by the Interim DON dated 05/14/24 at 11:47 PM indicated she spoke with the SW to speak with Resident #1 about calling female staff pet names. A letter was given outlining the facility expectations regarding not calling female staff pet names. Record review of Resident #1's care plan, dated 05/14/24, did not reveal any information regarding his flirtatious behavior towards female residents or allegation regarding touching Resident #2's breast. Resident #2 Record Review of Resident #2's face sheet, dated 11/01/24, revealed a [AGE] year-old female that was initially admitted to the facility on [DATE] and readmitted on [DATE], with the following diagnoses: dementia (memory loss), and depression (prolonged period of sadness). Record Review of Resident #2's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 08, indicating the resident was moderately cognitively impaired. Section E did not reveal any documented behaviors for Resident #2. Record Review of Resident #2's Quarterly MDS assessment dated [DATE], revealed under Section E did not reveal any documented behaviors for Resident #2. Record review of Resident #2's care plan, dated 08/06/24, did not reveal any information regarding her being touched by another male resident .Further review revealed a focused area, initiated on 08/06/24, that indicated Resident #2 wanted to be in an affectionate relationship with male residents. The goal initiated on 08/06/24 revised 10/18/24, was based on family wishes for Resident #2 to visit with male resident (unidentified) in the common area. The interventions initiated 08/06/24 included avoid improper touching, avoid going into other residents room, keeping resident family updated with relationship status and talking often about being happy when she is in a relationship with male residents. Record review of Resident #2's progress notes dated from 03/02/24- 11/01/24 did not reveal any information regarding the allegation of her breast being touched by Resident #1. Record Review of Resident #2's nursing progress notes entered by LVN H dated 08/02/24 at 7:02 PM indicated Resident #2 was in a male (unidentified) room sitting in her wheelchair and a CNA (unidentified) observed the male resident with his pants around his ankles claiming that he was going to have sex with her. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 11/01/24 at 9:55 AM, the DM stated Dietary Aide B did report to her that Resident #1 had grabbed Resident #2's breast. She said she was unsure of the exact date. She said she did not witness it but considered inappropriate touching. She said when it was reported to her, she told Dietary Aide B that someone needed to know. She said the ADM was not the administrator and did not know which nurse Dietary Aide B reported the incident to. She said she did not personally report the incident to anyone because she did not personally observe the incident. She said it was her understanding that Dietary Aide B reported the incident to Regional Director J and the charge nurse. She said she could not remember who the charge nurse was. She said she had observed Resident #1 to be social but not overly attentive to any one resident. She said she had not received any special instructions regarding Resident #1. She said although she did not remember the exact date, she did remember the day Dietary Aide B reported the incident. Resident #2 seemed fine and not in any distress. She said she felt if Resident #2 felt threatened, she could tell someone. She said the ADM was the abuse preventionist and had been trained that if she suspected or witnessed abuse, she was to report the allegation to the ADM immediately. She said she had not been interviewed by anyone regarding the incident. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 11/01/24 at 11:06 AM, the Interim DON stated she no longer worked at the facility. She said she was notified of the incident between Resident #1 and Resident #2. She said she was unsure of the exact date of the incident between Resident #1 and #2, but it was first reported when the Former ADM was employed by dietary Aide B. She said an investigation was conducted, and it was unfounded by the Former ADM. She said Regional Director J took over after the former ADM left. She said when Regional Director J took over, the incident involving Resident #1 and #2 was brought back up. She said she interviewed Residents (Resident #1 and #2), and nothing was found. She said she was unable to list all she interviewed as she did not work there anymore. She said this may have been in April or May 2024. She said she remembered when she interviewed Resident #1 and Resident #2, both residents denied anything happening and therefore unfounded the incident. She said there were concerns because each time the new administration would come, the incident of Resident #1 touching Resident #2's breast would come up. She said she did not believe anything had happened because no other allegations had been made since the report. She said it was her understanding that Resident #1 had not approached Resident #2 since the allegation. She said she was unsure why the allegation continues to be addressed, and it seemed to be the kitchen staff that had concerns. She said during her investigation, she found that the people named to be present were not working the day of the incident. The Interim DON said she could not list the people who worked the day of the incident, the date of the incident, and anyone she interviewed, but she unfounded the incident. She said this had been reported to her a total of three times, and she did not report the incident to HHSC during any of those times. She said she did not report the allegation of sexually inappropriate touching because Residents #1 and #2 stated the incident had not occurred, and they unfounded the incident. She said she did keep her eye on Resident #1. She said Family Member G had been notified. She said she had not received any additional reports that Resident #1 had touched any other residents. She said she did not know if she had any written documentation to support her efforts to address the allegations of sexually inappropriate touching from Resident #1. She said she never typed anything up. She said she should have typed something in his progress notes since this was brought up many times. She said she could not pinpoint specific training related to the incident because she had done so many in-services on ANE. She said she did discuss the incident with Regional Director I, and they had decided the incident was not a facility reportable incident because both residents had dementia, and both parties stated nothing happened. She said they agreed that since the kitchen staff kept reporting it, it was retaliation. She said it was not reported to HHSC because there was no proof that it happened and no witnesses. She said that it was known that Dietary Aide B was married into the family of Resident #1 and that she must also protect Resident #1's rights. She said the purpose of following the abuse policy, reporting, and investigating allegations of ANE was to protect the population from ANE, make sure their needs were met, and avoid neglect. She said she had been trained that it was all or none. She said this meant that she was to collect data, have credible witnesses, and then report the incident to HHSC. She said she felt Resident #1 was being painted as a perpetrator based on community rumors. She said she wanted to also protect Resident #1 from false allegations. In regard to documentation, she said she would have to see if she had anything. (The Interim DON did not provide any documentation during the investigation) During an interview on 11/01/24 at 11:33 AM, CNA E stated she said Resident #1 was her (CNA E) family member, and although she had not seen him touch the breasts of anyone, he was known as a big flirt. She said she had observed Resident #1 hold hands with Resident #2 but Resident #2 was friendly and did not care. She said Resident #2 had a boyfriend who was no longer at the facility, and Resident #1 would stir the pot and upset the resident who was no longer at the facility by flirting with Resident #2. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 11/01/24 at 11:55 AM, RN C stated she was notified a few months ago (unknown exact date and time) by Dietary Aide B that she witnessed Resident #1 touching Resident #2's breast. She said she was told by Dietary Aide B that it did not seem mutual. RN C said she asked Dietary Aide B if she had reported the incident to the Interim DON as they did not have an administrator at the time. She said Dietary Aide B said she had. RN C asked if anything had been done and was told by Dietary Aide B that she did not think anything had been done. RN C stated she encouraged Dietary Aide B to report it again. She said it would have been reported to Regional Director J at this time. She said it was her understanding that it was reported to Regional Director J, who responded that he was aware the incident had been investigated and unfounded. She said she was unaware if it had been reported to HHSC. She said Resident #1 had a history of being friendly with female residents since his admission. She said he would grab the female resident's hands and kiss them. She said she had never seen him grab Resident #2's breast. She said she had not received special instruction regarding Resident #1, nor had she been interviewed regarding the allegation of sexually inappropriate touching between Resident #1 and #2. During an interview on 11/01/24 at 12:01 PM Dietary Aide B stated she was aware of an instance where Resident #1 touched the breast of Resident #2 in the dining room. She said she reported the incident to the Interim DON. She said the incident happened right after Mother's Day in 2024. She said she had seen other inappropriate things from Resident #1. She said she had observed him touch Resident #2's breast more than one time. She said she observed when she opened the door that entered the dining room from the kitchen him touching Resident #2's breast, and when he saw her he put his hands down, and his face turned red. She said she immediately reported the incident to the Interim DON in the presence of LVN L. She explained to the Interim DON that this was not the first time Resident #1 had been appropriate with female residents. She said she told the Interim DON that the touching was against Resident #2's will. She said she knew this because Resident #2 did not participate; it was just Resident #1. She said when she reported the incident to the Interim DON, she was told by the Interim DON that she would speak to Resident #2. She said she was also told that because Resident #2 had a boyfriend (no longer at the facility at the time of the investigation), it was ok for Resident #2 to have two boyfriends if she wanted. She said the Interim DON said she would ask Resident #2 if she wanted two boyfriends. She said the Interim DON had also explained to her that the laws had changed. She said she was told that if Resident #2 could not say what happened and if she had memory loss or dementia, there was nothing they could do about it. She said the Interim DON told her to let her know if she) saw anything else. She said the former ADM was the administrator at the time of the incident. She said the Interim DON reported the incident to Regional Director J, and he spoke with her about it once. She said Regional Director J asked her what happened, she explained that the incident occurred under the Former ADM, and told her to let him know if it happened again. She said it had not happened again, but nothing was done. She said she had not received any special instructions or additional training on what to do regarding Resident #1. She said Regional Director J was the only person who ever asked her anything about the incident. She explained there was another incident involving Resident #1. Still, she did not report it because she was unsure if it was considered inappropriate touching. She said nothing had been done with the incident between Resident #1 and #2. She said she did report the incident between Resident #1 and #2 to the DM but was told for her to report the incident herself. She said her DM told her to report the incident because she did not personally see the incident. She said outside of the interview with the HHSC investigator, she felt the incident had not been thoroughly investigated. (continued on next page)

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 11/01/24 at 12:40 PM, Resident #2 stated no one had touched her inappropriately. She said she had a boyfriend but did not remember his name. She said she knew Resident #1, but he had never touched her inappropriately. She said if someone did touch her, she would tell the people at the front. She said no one had asked her any questions before the HHSC investigator about inappropriately being touched. During an interview on 11/01/24 at 1:25 PM, LVN F stated that she knew the incident between Resident #1 and Resident #2. She stated she was told about the incident by RN C. She said she could not remember the exact date of the incident but that RN C stated that it was reported to her (RN C) by Dietary Aide B. She (LVN F) stated that she was not questioned or trained in regard to Resident #1 but remembered that the Interim DON said to Dietary Aide B that Resident #2 could have more than one boyfriend if she wanted. She said the incident was also reported to Regional Director J, and it was her understanding that he did an investigation and unsubstantiated the incident, according to RN C. LVN F said Resident #1 had a history of flirting with female residents and holding their hands. She said she had not seen anything to indicate the other female residents were uncomfortable. She said no instructions had been given regarding the behavior of Resident #1 flirting or holding the female resident's hands. She said they told Resident #1 to leave the female residents alone. She said Resident #1 laughed about it. She said it appeared Resident #1 found humor because he reported to them that Resident #2 was his school teacher. During an interview on 11/01/24 at 2:59 PM, Regional Director I stated he did not know anything about a male resident touching the breast of a female resident. He said he could not recall a specific conversation with the Interim DON. He said he had multiple discussions with the Interim DON. He said the Former DON's last day was May 15th or 16th of 2024. He said there were 10 days without an administrator, and then Regional Director J came to run the facility. He said it was his expectation that if staff suspect or witness abuse, they should follow the facility policy. He said it should be investigated thoroughly. He said he was unaware of the allegation between Resident #1 and #2. He said the potential negative outcome for the residents would depend on the allegation. During an interview on 11/01/24 at 3:06 PM, Regional Director J stated he was unaware of any incident that occurred between Resident #1 and Resident #2 that involved breast touching. Regional Director J said he was aware that there was a resident who was no longer at the facility and felt that Resident #1 had stolen his woman (Resident #2). He said if there was an allegation of ANE, it should be investigated. He said investigating the incident was important to ensure the resident was safe. He said the investigation process should be documented. During an interview on 11/01/24 at 3:25 PM, Resident #1 stated he had never been questioned about inappropriate behavior or accused of doing anything inappropriate. He stated he did not have a girlfriend but all the ladies at the facility liked him. He said he recently turned [AGE] years old and found out he was a lesbian because he liked girls. He said he does not touch anyone who does not want to be touched. He said he had not touched anyone since he had been at the facility. During an interview on 11/01/24 at 4:43 PM, the DON stated he said he was unaware of any incident that occurred between Resident #1 and Resident #2. He said he knew Resident #1 would hold people's hands, but it was not specific to female residents. He said he was unaware that Resident #1 would kiss the female resident hands. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kent County Nursing Home	1443 North Main Jayton, TX 79528

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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 Note: The nursing home is disputing this citation.	During an interview on 11/01/24 at 4:55 PM, the ADM stated he had been trained and was familiar with the facility's ANE policy. He said he was unaware of the incident involving Resident #1 touching Resident #2's breast. He said the potential negative outcome was there could have been the continuation of abuse or whatever was going on. He said not following the abuse policy could place the resident at unnecessary risk. He said allegations of ANE should have been investigated. He said the system to monitor abuse was education and communication. He said he had not observed any of the behaviors of the residents discussed. He said he expected the facility abuse policy to be followed. He said allegations of ANE should have been investigated along with preventative measures put in place to protect residents involved. He said everyone was responsible for following the ANE policy, but the administration oversaw the investigation process. He said he did not have a reason why following the facility policy (investigating) was not conducted. He said the investigation process should have been documented if conducted. Resident #3 Record Review of Resident #3's face sheet, dated 11/01/24, revealed a [AGE] year-old male that was admitted to the facility on [DATE], with a diagnosis of dementia (memory loss). Record Review of Resident #3's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 15, indicating the resident was not cognitively impaired. Section E did not reveal any documented behaviors for Resident #3. Record Review of Resident #3's Quarterly MDS assessment dated [DATE], revealed under Section E did not reveal any documented behaviors for Resident #3. Record Review of Resident #3's nursing progress notes entered by LVN K dated 03/07/24 at 7:04 PM indicated Resident #3 was in the TV room and his pants was unzipped by Resident #5. The CNA (unidentified) hollered out for the residents to stop. Resident #3 did not attempt to stop Resident #5. Record Review of Resident #3's progress notes entered by the SW dated 03/12/24 at 11:36 AM indicated Resident #3 was in the activity room with a female resident unzipping his pants. It was reported that Resident #3 was allowing Resident #5 to unzip his pants. It was reported that Resident #5 had severe dementia and seeks out male residents in particular Resident #3. The SW discussed with Resident #3 about the issues of female resident having dementia and not understanding their actions. The SW informed Resident #3 about notifying staff entering the room and for him to leave the room if it happens again. Record review of Resident #3's care plan, dated 5/03/24, revealed a focused area, initiated on 05/03/24, Resident #3 had been sexually inappropriate allowing a female resident to unzip his pants in a community setting. The goal initiated on 05/03/24, was Resident #3 would have no evidence of sexually inappropriate behavior problems. The interventions included to intervene as necessary to protect the rights and safety of others, discuss the resident's behavior and monitor behavior episodes. Resident #4 Record Review of Resident #4's face sheet, dated 11/01/24, revealed a [AGE] year-old female that was initially admitted to the facility on [DATE] and readmitted on [DATE], with a diagnosis of dementia (memory loss). (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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record Review of Resident #4's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 10, indicating the resident was moderately cognitively impaired. Section E did not reveal any documented behaviors for Resident #4. Record Review of Resident #4's Quarterly MDS assessment dated [DATE], revealed under Section E did not reveal any documented behaviors for Resident #4. Record review of Resident #4's progress notes dated from 03/02/24- 11/01/24 did not reveal any information concerning Resident #3 or the behavior of rubbing herself outside of her clothing. Record review of Resident #4's care plan, dated 09/19/24, did not reveal any information regarding her concerns for Resident #3 or any behaviors of her rubbing herself outside of her clothing near her genital area. During an interview on 11/01/24 at 9:00 AM, the ADM stated he said there had been no issues since he had been at the facility but that he had to educate Resident #3 on not being flirtatious as he had touched another resident's (Resident #4) knee, but nothing out of line. During an interview on 11/01/24 at 1:01 PM, Resident #4 stated she felt safe. She said there was a male who made her feel uncomfortable. She said she did not know his name. She stated no one asked her about him. She was unable to tell why he made her uncomfortable. She said no one had touched her inappropriately. She said that if someone did touch her, she thinks she would tell someone. During an interview on 11/01/24 at 1:25 PM, LVN F stated she said she could not remember if it was reported to her that Resident #4 was uncomfortable around Resident #3. She said she could not remember the date, but the incident occurred about a month ago. She said she could not remember which aide came to her. She said she observed Resident #3 sitting outside Resident #4's room and thought it was weird. She said Resident #4 was in her bed. She said she looked off for a moment, and when she looked back up, Resident #3 was gone. She said she asked the aide (unknown at the time) to go check on him because Resident #3 had an inappropriate sexual incident with another resident in the past. She said it was her understanding that Resident #3 and another Resident #5 were fondling each other. She said she wanted to ensure Resident #3 was not in the room with Resident #4. She said she did report the weird behavior observed by Resident #3 to Regional Director J. She said Resident #3 will follow and target Resident #5 than other residents. She said Regional Director J told her to keep an eye on Resident #3. She said no additional training was given regarding Resident #3. She said she reported it to Regional Director J because of Resident #3's past. She said she did not believe the incident between Resident #3 and #5 was mishandled. She did not know why she thought it was not handled correctly. During an interview on 11/01/24 at 1:37 PM, Resident #3 stated he had only been told about inappropriate touching one time since his admission. He said he did not want to name the other resident but that she had run her hands up his leg. He said he had no other issues since that incident about a year ago. He said he did not remember staring at any other female residents. He asked the HHSC investigator if she knew anyone who could be his girlfriend because he would like one. (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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 11/01/24 at 2:39 PM, LVN H stated a couple of weeks ago (exact date unknown) that she was coming from the outside patio and observed Resident #3 had his hand on Resident #4's knee. She said she reported the incident to the ADM because there had been some incidents in the past that included Resident #3 and inappropriate sexual behavior. She said it was known that Resident #3 liked to stare and watch female residents. She said he had a history with Resident #4, where he would watch her and stare at her outside of Resident #4s room. She said they naturally redirect Resident #3 but had never been explicitly trained on what to do with Resident #3. During an interview on 11/01/24 at 3:06 PM, Regional Director J stated if there was an allegation of ANE, it should be investigated. He said investigating the incident was important to ensure the resident was safe. He said the investigation process should be documented. He said he was unaware that Resident #4 reported that she felt unsafe around Resident #3 because this was not reported to him. During an interview on 11/01/24 at 4:43 PM, the DON stated he said he was unaware that Resident #4 was uncomfortable around Resident #3. He said their system to monitor ANE and the following of the facility's abuse policy was education through in-services. He said there are signs posted outside of the administration doors. He said if staff suspected or witnessed abuse, the allegation should be investigated. He said after the incident was reported, the allegation would be investigated and assessed, the resident evaluated, and all witnesses and potential witnesses would be interviewed. He said he did not have a reason why the abuse policy was not followed. He said the investigation was not conducted because he was unaware of the incidents. He said that being new, he was unaware that any of the incidents/allegations discussed had been investigated. He said he was unaware of Resident #3 flirtatious behavior. He was unaware that Resident #3 had an incident where he sat outside of Resident #4's room, which made her uncomfortable. He said nothing was brought up during stand-up meetings regarding the resident issues discussed. He said if there are new or ongoing behaviors, they are also reported during shift changes. He said they also had a nursing group message system. He said Resident #3 touching Resident #4 was not placed in the nursing group message. He said Resident #3 behavior of staring at Resident #4 was also not included in the group message because he did not know anything about it. He said he had not observed any of the behaviors discussed. During an interview on 11/01/24 at 4:55 PM, the ADM stated he had been trained and was familiar with the facility's ANE policy. He said he was aware that Resident #3 had touched Resident #4's leg, but at the time of the report, LVN H reassured him that there was nothing inappropriate. He said he was unaware of his history of staring at Resident #4 outside her door. He said at the time, LVN H reported more information on Resident #3's history. He said he did not interview anyone else outside of LVN H regarding Resident #3 touching Resident #4's leg. He said the potential negative outcome was there could have been the continuation of abuse or whatever was going on. He said not following the abuse policy could place the resident at unnecessary risk. He said the system to monitor abuse was education and communication. He said he had not observed any of the behaviors of the residents discussed. He said he expected the facility abuse policy to be followed. He said allegations of ANE should have been investigated. He said everyone was responsible for following the ANE policy, but the administration oversaw the investigation process. He said he did not have a reason why following the facility policy (investigating) was not conducted. He said the investigation process should have been documented if conducted. (continued on next page)

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Kent County Nursing Home	1443 North Main Jayton, TX 79528

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 11/01/24 at 5:34 PM, the Corporate MDS Consultant stated she went through each resident's progress notes and found the incident between Resident #3 and Resident #5. She said she was unaware if the incident had been reported to HHSC. She said she did not follow up with anything else because the note indicated it had been reported to the Interim DON and the Former ADM. She said she did not follow up with either of them. She said she was unsure if the incident had been investigated. She said she did not assess or speak with the residents. During an interview on 11/01/24 at 5:40 PM, Regional Director J stated he did not find anything showing that the incident between Resident #3 and Resident #5 was investigated. Resident #5 Record Review of Resident #5's face sheet, dated 11/01/24, revealed a [AGE] year-old male that was admitted to the facility on [DATE], with the following diagnoses: dementia (memory loss) and high risk heterosexual behavior. Record Review of Resident #5's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 04, indicating the resident was severely cognitively impaired. Section E did not reveal any documented behaviors for Resident #5. Record Review of Resident #5's Quarterly MDS assessment dated [DATE], revealed under Section E did not reveal any documented behaviors for Resident #5. Record review of Resident #5's Order Summary Report, dated 11/01/24, reflected the resident was to take 1 tablet 2 times a day by mouth of Depakote for dementia with sexual issues related to dementia; Ordered 3/07/2024. Record Review of Resident #5's nursing progress notes entered by LVN K dated 03/07/24 at 6:00 PM indicated Resident #5 was observed unzipping Resident #3's pants and was about to put her hands in his pants. Resident #3 reported

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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** 43344 Based on interviews and record review, the facility failed to develop and implement a person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 2 of 7 residents (Resident #1 and #4) reviewed for comprehensive care plans. Resident #1's comprehensive care plan did not include his known behavior for sexual inappropriateness (kissing residents hands and the alleged touching of the breast) and flirtatious behavior towards female residents and specifically Resident #2. Resident #4's comprehensive care plan did not include her known behavior for sexual inappropriateness (masturbating on the outside of her clothing) in common areas. This failure could place residents at risk for not having their individualized needs met. The findings included: Resident #1 Record Review of Resident #1's face sheet, dated 11/01/24, revealed a [AGE] year-old male that was admitted to the facility on [DATE], with a diagnosis of dementia (memory loss). Record Review of Resident #1's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 14, indicating the resident was not cognitively impaired. Section E did not reveal any documented behaviors for Resident #1. Record Review of Resident #1's Quarterly MDS assessment dated [DATE], revealed Section E did not reveal any documented behaviors for Resident #1. Record review of Resident #1's progress notes dated from 03/02/24- 11/01/24 did not reveal any information regarding the allegation of touching Resident #2's breast or his flirtatious behavior with female residents but revealed the following: Record Review of Resident #1's nursing progress notes entered by the Interim DON dated 05/14/24 at 11:47 PM indicated she spoke with the SW to speak with Resident #1 about calling female staff pet names. A letter was given outlining the facility expectations regarding not calling female staff pet names. Record review of Resident #1's care plan, dated 05/14/24, did not reveal any information regarding his flirtatious behavior towards female residents or allegation regarding touching Resident #2's breast. There were no observations of Resident #1 having inappropriate contact with female residents during the visit. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 Record Review of Resident #2's face sheet, dated 11/01/24, revealed a [AGE] year-old female that was initially admitted to the facility on [DATE] and readmitted on [DATE], with the following diagnoses: dementia (memory loss), and depression (prolonged period of sadness). Record Review of Resident #2's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 08, indicating the resident was moderately cognitively impaired. Section E did not reveal any documented behaviors for Resident #2. Record Review of Resident #2's Quarterly MDS assessment dated [DATE], revealed Section E did not reveal any documented behaviors for Resident #2. Record review of Resident #2's progress notes dated from 03/02/24- 11/01/24 did not reveal any information regarding the allegation of her breast being touched by Resident #1. Record Review of Resident #2's nursing progress notes entered by LVN H dated 08/02/24 at 7:02 PM indicated Resident #2 was in a male (unidentified) room sitting in her wheelchair and a CNA (unidentified) observed the male resident with his pants around his ankles claiming that he was going to have sex with her. Record review of Resident #2's care plan, dated 08/06/24, did not reveal any information regarding her being touched by another male resident. Further review revealed a focused area, initiated on 08/06/24, Resident #2 wanted to be in an affectionate relationship with male residents. The goal initiated on 08/06/24 revised 10/18/24, was based on family wishes for Resident #2 to visit with male resident (unidentified) in the common area. The Interventions initiated 08/06/24 included avoid improper touching, avoid going into other residents room, keeping resident family updated with relationship status and talking often about being happy when she is in a relationship with male residents. Resident #4 Record Review of Resident #4's face sheet, dated 11/01/24, revealed a [AGE] year-old female that was initially admitted to the facility on [DATE] and readmitted on [DATE], with the following diagnoses: dementia (memory loss). Record Review of Resident #4's Comprehensive MDS assessment dated [DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 10, indicating the resident was moderately cognitively impaired. Section E did not reveal any documented behaviors for Resident #4. Record Review of Resident #4's Quarterly MDS assessment dated [DATE], revealed Section E did not reveal any documented behaviors for Resident #4. There were no observations observed during the visit of Resident #4 masturbating on the outside of her clothing. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/01/24 at 9:22 AM, [NAME] A stated Resident #1 was a ladies' man. She said he had a history of flirting since his admission. [NAME] A stated there was a history between Resident #1 and #2. She said Resident #1's attempt to flirt and approach Resident #2 caused issues with the other resident, who was no longer at the facility. She said she had not been given any instructions or training regarding Resident #1. She said outside of the incident (Resident #1 touching Resident #2's breast) with Resident #2, she had seen him touch other residents' hands. She said Resident #4 would play with herself. She said she had been told (she could not remember by who) that she would do this when she was nervous. She said this was a known behavior (unable to report for how long) but that male residents would watch her rub on herself in a circular motion. She said staff talked to her about it as much as they could. She said there was an indication that she was about to do it because she would raise her leg. At first, she thought she (resident #4) was itching, but she believed she was checked to rule that out. She said the staff knew to redirect her, offer her a drink, or engage her in another activity. She said she had not received additional training about Resident #4's behavior, but some staff knew how to redirect her. She said if they did not see her raise her legs, it was easy to identify because all the male resident's heads would be turned towards her doing that behavior in the dining room or any common area. She said no other residents have become offended or complained that she was aware of. She said she could not confirm if the other residents were looking at Resident #4 for pleasure or out of shock. During an interview on 11/01/24 at 11:33 AM, CNA E stated over the past month, Resident #4 had a behavior of rubbing herself in her genital area. She said other staff had also noticed it. She said naturally, she and other staff would redirect her. She said they had not received specific training regarding Resident #4 rubbing her genital area. She said they had general knowledge to redirect her since sometimes she would do this in common areas. She said Resident #3 would sit and watch Resident #4 rub herself in her genital area. She said Resident #1 was her (CNA E) family member, and although she had not seen him touch the breasts of anyone, he was known as a big flirt. She said she had observed Resident #1 hold hands with Resident #2 but that Resident #2 was friendly and did not care. She said Resident #2 had a boyfriend who was no longer at the facility, and Resident #1 would stir the pot and upset the resident who was no longer at the facility by flirting with Resident #2. During an interview on 11/01/24 at 11:55 AM, RN C stated Resident #1 had a history of being friendly with female residents since his admission. She said he would grab the female resident's hands and kiss them. She said she had never seen him grab Resident #2's breast. She said she had not received special instruction regarding Resident #1. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/01/24 at 12:01 PM Dietary Aide B stated she was aware of an instance where Resident #1 touched the breast of a female Resident #2 in the dining room. She said she reported the incident to the Interim DON. She said the incident happened right after Mother's Day in 2024. She said she had seen other inappropriate things from Resident #1. She said she had observed him touch Resident #2's breast more than one time. She said she observed when she opened the door that entered the dining room from the kitchen him touching Resident #2's breast, and when he saw her observe her, he put his hands down, and his face turned red. She said she immediately reported the incident to the Interim DON in the presence of LVN L. She explained to the Interim DON that this was not the first time Resident #1 had been inappropriate with female residents. She said she told the Interim DON that the touching was against Resident #2's will. She said she knew this because Resident #2 did not participate; it was just Resident #1. She said that when she reported the incident to the Interim DON, she was told by the Interim DON that she would speak to Resident #2 about it. She said she was also told that because Resident #2 had a boyfriend (no longer at the facility at the time of the investigation), it was ok for Resident #2 to have two boyfriends if she wanted. During an interview on 11/01/24 at 12:40 PM, Resident #2 stated that no one had touched her inappropriately. She said she had a boyfriend but did not remember his name. She said she knew Resident #1, but he had never touched her inappropriately. During an interview on 11/01/24 at 1:01 PM, Resident #4 stated there was a male who made her feel uncomfortable. She said she did not know his name. She was unable to tell why he made her uncomfortable. During an interview on 11/01/24 at 1:25 PM, LVN F said that Resident #1 had a history of flirting with female residents and holding their hands. She said she had not seen anything to indicate that the other female residents were uncomfortable. She said no instructions had been given regarding the behavior of Resident #1 flirting or holding the female resident's hands. She said they told Resident #1 to leave the female residents alone. She said Resident #1 laughed about it. She said it appeared that Resident #1 found humor because he reported to them that Resident #2 was his school teacher. During an interview on 11/01/24 at 2:39 PM, LVN H said he (Resident #1) had a history of being with the female residents throughout the day. She said he liked to sit with them. She was unaware if Resident #1 had touched Resident #2's breast. During an interview on 11/01/24 at 3:25 PM, Resident #1 stated he was a lesbian because he liked girls. He said he does not touch anyone who does not want to be touched. He said he had not touched anyone since he had been at the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745002	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kent County Nursing Home	1443 North Main Jayton, TX 79528

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/01/24 at 4:43 PM, the DON stated he was familiar with and trained on the facility's care plan process. He said the potential negative outcome of not implementing the care plan process was that the needs of the residents may not be met. He said the purpose of having a care plan was to meet the needs of the resident. He said he was unaware that Resident #4 had a behavior where she would rub herself near her genital area in public areas in the facility. He said he knew Resident #1 would hold people's hands, but it was not specific to female residents He said the system to monitor care plans was to bring up behaviors and care plans during stand-up meetings. He said nothing was brought up during stand-up meetings regarding the resident issues discussed. He said if there are new or ongoing behaviors, they are also reported during shift changes. He said administration staff had the ability to add behavior to monitor in PCC (electronic medical record). He said they also had a nursing group message system. He said he had not observed any of the behaviors discussed. He said he expected the care plan to be up-to-date and accurate. He said revisions should also be done timely. He said the care plan should be updated within 24 hours for revisions. He said he did not have any reason why the care plans were not completed. He said the potential negative outcome for Resident #4 if she had the behavior was staff may not know how to intervene. During an interview on 11/01/24 at 4:55 PM, the ADM stated he was familiar with the facility's care plan policy and had been trained. He said he was newer to the facility and had not physically laid eyes on a lot of the care plans at the facility. He said the care plan should customize the residents' care. He said the potential negative outcome regarding not care planning Resident #4's behavior was she may not be given the proper privacy. The ADM said he had not found staff that knew about Resident #4's behavior of rubbing herself near her genital area and other residents watching. He said that regarding Resident #1, staff may not know how to watch out for or address the flirtatious behavior. He said he was unaware of all the behaviors discussed. He said the scheduled care plan meetings were the system to monitor care plans. He said he expected the care plans to be updated, current, and accurate. He said he believed a revision or change should be updated within 24 hours. He said the MDS Coordinator was responsible and out on vacation. He said he did not have a reason why the care plans were not updated or revised. During an interview on 11/11/24 at 4:24 PM, the MDS Coordinator stated she was the MDS Coordinator and on vacation until 11/12/24. She said she was unaware of Resident #4's behavior of rubbing herself outside of her clothing near her genital area. She said she knew Resident #1 had flirtatious behavior and was holding female residents' hands. She said she only knew he did this with Resident #2. She said if there were missing care plans or revisions, it was because, for a while, she was not only the MDS coordinator, but she was also the assistant director of nursing and responsible for scheduling staff. She said she was sometimes up late at night trying to find staff. She said she forgot to add Resident #1's behavior of being flirtatious. She said she had been trained and was familiar with the facility policy on care plans and care plan revisions. She said she expected all the care plans to be accurate and up to date. She said if the care plan was not up to date and accurate, then staff would not know what to do to meet the needs of the residents. She said staff had been trained to come to her with any new behaviors so that they could care plan. She said that recently, with the new administration, staff will go to them, which may cause some information to be missed. She said she did not have a system at the time of the interview to monitor or review care plans because she was doing so many roles. Record review of facility policy, Care Plans, Comprehensive Person Centered, Revision March 2022, revealed: (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	Policy Statement: 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. Policy Interpretation and Implementation The comprehensive, person-centered care plan: includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, . Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.