STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022
NAME OF PROVIDER OR SUPPLIER Avalon Place Kirbyville		STREET ADDRESS, CITY, STATE, ZI 700 N Herndon Kirbyville, TX 75956	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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	<ul> <li>and neglect by anybody.</li> <li>**NOTE- TERMS IN BRACKETS F</li> <li>Based on observation, interview, a was provided for 4 of 11 residents</li> <li>1. The facility did not provide requi abusing Resident #2 on 04/11/22. yelling. Resident #1 was found ber penis while thrusting toward Reside</li> <li>2. The facility staff did not intervent On 4/9/22 Resident #4 was found I see what was occurring and then comminent harm.</li> <li>An Immediate Jeopardy (IJ) situatio 04/15/22, the facility remained out identified as a pattern due to the father.</li> <li>Findings included:</li> <li>1. Record review of face sheet data on [DATE] and his diagnoses inclu event or change in a person's life), with walking, balance, and coordin feeling of sadness and loss of intersomeone uses language), and sch abnormally).</li> </ul>	s of abuse such as physical, mental, so IAVE BEEN EDITED TO PROTECT C nd record review the facility failed to er reviewed for abuse. (Resident #s 1, 2, red monitoring and supervision to prev Resident #2 wandered into Resident # nind Resident #2, his hand on her shou ent #2. Residents #1 and #2's briefs we e and protect Resident #5 from Reside novering over Resident #5 yelling at his losed the door and called for the nurse of compliance at a potential for more th cility's need to evaluate the effectivened ts at risk of abuse, physical harm, men ed 04/13/22, indicated Resident #1 wa ded adjustment disorder (emotional or Parkinson's (a brain disorder that lead ation), major depressive disorder (mod rest), cognitive communication deficit ( izophrenia (a serious mental disorder i F], indicated Resident #1's BIMS score -3 days, ambulated with a walker. Ther	ONFIDENTIALITY** 25115 Insure the right to be free from abuse 4, and 5) ent Resident #1 from sexually 1's room. Resident #2 was heard Ider, holding his partially erect ere down. Int #4's verbal and physical abuse. Int #4's verbal and physical abuse. The NA B opened the door to 2. The nurse aide left Resident #5 in Image: The nurse aide left Resident #5 in

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

(X6) DATE

Facility ID: 675220

Level of Harm - Immediate jeopardy to resident health or safety       behavior and inappropriate sexual gesture with a female resident. Interventions included 15-minute monitoring and sent out to behavioral hospital for evaluation and treatment. There was no previous of for sexually inappropriate behavior available for review.         Residents Affected - Some       Record review of face sheet dated 04/13/22, indicated Resident #2 was a [AGE] year-old female, ad on [DATE], and her diagnoses included Alzheimer's (a progressive neurologic disorder that causes to to shrink (atrophy) and brain cells to die) and depression (a mood disorder that causes a persistent f sachess and loss of interest).         Record review of MDS dated [DATE] indicated Resident #2 had a BIMS score of 2 (severe cognitive impairment), wandered daily, and ambulated without assistance.         Record review of care plan dated 12/30/21 indicated Resident #2 required placement on the secure to wandering and significant safety awareness due to dementia. Interventions included assist with lo room with verbal cues, notify physician if behavior increases (1/18/22) i and out of other residents' rooms with verbal cues, notify physician if behavior increases (1/18/22) i and out of other resident staff and residents, of the facility's two separate camera recordings on 04/08/22 from 7:30 a.m. throu a.m. indicated:         At 8:09 a.m. there were no aides on the hall, Resident #2 wandered on hall and then back into her room.       At 8:16 a.m., CNA C opened the shower door and took a resident in a wheelchair out of the shower. CNA C walked past the resident room next to the shower room.	LAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022	
Kirbyville, TX 75956         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       Record review of Resident #1's care plan dated 04/11/22 indicated he displayed socially inappropriate sexual gesture with a female resident. Interventions included 15-minutes monitoring and sent out to behavioral hospital for evaluation and treatment. There was no previous a for sexually inappropriate behavior available for review.         Residents Affected - Some       Record review of face sheet dated 04/13/22, indicated Resident #2 was a [AGE] year-old female, ad on [DATE], and her diagnoses included ALbeimer's (a progressive neurosis included ALbeimer's (a progressive neurosis and Loss of Interest).         Record review of face sheet dated 04/13/22, indicated Resident #2 was a [AGE] year-old female, ad on [DATE], and her diagnoses included ALbeimer's (a progressive neurosis included Assist to sadness and loss of interest).         Record review of Gace sheet dated 04/13/22, indicated Resident #2 required placement on the secure to wandering and significant safety awareness due to dementia. Interventions included assist with lo room with verbal cues, notify physician if behavior increases (11/16/22- in and out of other resident); 7000, and ADON, who verified the identitistaff and residents, of the facility's two separate camera recordings on 04/08/22 from 7:30 a.m. throw a.m. indicated.         At 8:09 a.m. there were no aides on the hall, Resident #2 wandered on hall and then back into herowr. CNA E wandered first wanker to orom. At 8:14 a.m.,	NAME OF PROVIDER OR SUPPLIER			P CODE	
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(continued on next page)		(continued on next page)			

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of nurse note dated the shower room at approximately room. CNA C entered the room and Resident #2. Resident #1 had his p protective wear and pants were do Resident #2 from the room. DON a any redness or drainage to rectal o examination. No injuries noted. The hospital for evaluation and treatme Psych services was notified. Record review of NP E's visit repor behaviors occurred. Resident #1's Record review of nurse note dated recommendations from NP and con BIMS score of 15. Resident #1 alre obtain report. Resident #2's daugh facility send Resident #2 to the hos Record review of NP E's visit repor behaviors occurred. Resident #1's Record review of NP E's visit repor behaviors occurred. Resident #1's Record review of NP E's visit repor behaviors occurred. Resident #1's Record review of hospital records of noted. Crime lab and diagnostic sp Record review of nurse note dated reported no findings and waiting fo Record review of Resident #1's bel documented. Record review of Resident #1's bel documented. Record review of Resident #2 beha wandering into other residents' roo During an interview on 04/13/22 at heard Resident #2 say 'stop'. She sa Resident #2. She said both resider hand. She said Resident #2 was as services was contacted and increa Resident #1 denied the allegations and it was 15. She said police was She said initially, resident #2's dau	04/11/22 at 4:18 p.m., completed by th 8:15 a.m. and heard Resident #2's rais d noted Resident #2 had his pants dow benis in his hand and was saying 'get it, wn. CNA C separated Resident #1 and ind Treatment nurse examined Resider r perineal/vaginal area. Resident #2 was e physician was notified and new orders nt. The administrator was notified. Resident t dated 04/11/22 indicated Resident #1 BIMS was assessed and scored at 15. 04/11/22 at 7:48 p.m., completed by th porate nurse to inform police departme ady left facility and sent to behavioral h ter advised of police notification. Reside spital for evaluation. t dated 04/11/22 indicated Resident #1 BIMS was assessed and scored at 15. dated 04/11/22 a SANE exam was perfe ecimens were collected. There were no 04/12/22 at 6:27 p.m., completed by L <sup>N</sup> r labs. haviors from 01/01/22 through 04/08/22 i ms and the nurse was notified. 8:35 a.m. the Administrator said CNA 0 said the door was open and she saw Re its' pants and briefs were down. She sa sessed and it was not determined she sed Resident #1's Zoloft (an antidepres . She said Resident #1's last BIMS sco notified and Resident #2 was sent to th ghter did not want Resident #2 was sent to th ghter did not want Resident #2 was sent to th ghter did not want Resident #2 was sent to th ghter did not want Resident #2 was sent to th ghter did not want Resident #2 was sent to th ghter did not want Resident #2 was sent to th ghter did not want Resident #2 was sent to th ghter did not want Resident #2 was sent to th ghter did not want Resident #2 was sent to th ghter did not want Resident #2 was sent to th ghter did not want Resident #2 was sent to th ghter did not want Resident #2 was sent to th ghter did not want Resident #2 was sent to th ghter did not want Resident #2 was sent to th ghter did not want Resident #2 was sent to th ghter did not want Resident #2 was sent to th ghter did not want Resident #2 was sent to th ghter did not want Resident #2 was sent to th ghter did not want Resident #2 was sent to th ghter did	e DON, indicated CNA C exited ed voice coming Resident #1's n and was standing behind get it'. Resident #2's incontinence #2 and immediately removed th #2 in her room and did not notice as calm at the time of the s to send Resident #1 to behavioral ident #2's daughter was notified. denied any inappropriate e DON, indicated new ent of incident due to Resident #1's nospital. Officer arrived at facility to ent #2's daughter requested the denied any inappropriate ormed. There was genital injury o results available for review. VN A, indicated the hospital nurse e indicated no behaviors were ndicated there were 79 incidents of C came out of the shower room and esident #1 standing behind aid Resident #1 had his penis in his was penetrated. She said psych asant medication). She said re was a 7 but he was re-assessed ne hospital for an evaluation, but
	masturbate on the porch. She said		

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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 DEFIC (Each deficiency must be preceded by	IENCIES full regulatory or LSC identifying information	on)	
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	<ul> <li>prevention. She said approximately resident sitting on his bed. She said both reshe was trying to help the other resident sitting on his bed. She said both reshe was trying to help the other resident or the was trained for the shower room and walked to here down. She said Resident #1 to get it, when he walked into the room. She walked her out of the room. She said had cell phones to call the nurse if the door as Resident #1 walked by said because he could. She said she sat on his bed.</li> <li>During an interview on 04/13/22 at being in Resident #1 walked by said because he could. She said she sat on his bed.</li> <li>During an interview on 04/13/22 at inappropriate sexual behaviors. She bed.</li> <li>During an interview on 04/14/22 at exploitation. She said the staff are the not able to locate any staff training.</li> <li>During an interview on 04/14/22 at previous incidents related to inapproduring the morning meetings. She sa ware staff was not trained. She sa ware staff was not trained. She sa ware staff was not trained.</li> </ul>	<ul> <li>9:10 a.m., CNA C said she was previous 2 or 3 weeks prior she had previously 3 Resident #1 was standing between the sidents were fully dressed. She said Resident She said she thought she told LVI breakfast at approximately 8:15 a.m S am No don't do that no no no. She said Resident #1's room. She said both Res and his penis in his hand and was holdi get it as he was thrusting. She said Resident #2 was crying. She said Re said Resident #2 was crying. She said id she and CNA F were working the set there as an emergency.</li> <li>9:47 a.m., the DON said she had heard e was not told the incident was sexual.</li> <li>11:35 a.m., LVN I said she had witness thad taken off her clothes in her room. She said he stopped and stared, and the had heard of the incident where he said Resident #1 did stare at the resider said Resident #1 did stare at the resider sexual behavior. She said no stare for sexually inappropriate behaviors or 1:30 p.m., the Administrator said she was opriate sexual behavior. She said no side she had not not estimate the DON, ADON, and charge nurside she became the new Administrator said she back not in the DON or designee were the said she back on ot wander or to be able to in the grecords of the staff on the unit. She said one of the aides was stated and the DON or designee were the staff on the unit. She staff on t</li></ul>	caught Resident #1 with another the other resident's legs as she was asident #1 stepped back and said N G of the incident. She said the he said she was in the shower d she brought the other resident out ident #1 and Resident #2's pants ng Resident #2's left shoulder as asident #1 sat down on his bed d she dressed Resident #2 and cure unit together. She said they d of the incident of another resident sed an incident approximately 2 - 3 and her roommate had opened when asked why he did that he stood over the same resident while bticed Resident #1 having dent that was found sitting on his hed on abuse, neglect, and ed in the facility. She said she was resident abuse. vas said she was not aware of any taff reported the behaviors to her e were responsible for monitoring 'in January 2022 and was not responsible for ensuring staff was the secure unit should not be upposed to monitor the other ntervene for resident safety. She said she or designee were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022
NAME OF PROVIDER OR SUPPLIER Avalon Place Kirbyville		STREET ADDRESS, CITY, STATE, ZI 700 N Herndon Kirbyville, TX 75956	P CODE
For information on the nursing home's	plan to correct this deficiency, please cont	 tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	required incontinent care. She said almost finished showering a different with his incontinent care. She said	2:05 p.m., CNA F said a resident came she went into the shower room to gath nt resident so she left the shower room she did not see Resident #2 wandering ecall specific training related to monitor	er supplies. She said CNA C was and assisted the other resident g in the hall. She said she had bee
	During an interview on 04/15/22 at educated three staff on 04/13/22 we providing care. They said staff were and they were monitoring the hall. <sup>1</sup> contained the names of the staff that there was no record she was traine	nitoring and the other staff y need to take care of residents any staff training records that	
	of the incident with Residents #1 ar Resident #1 had multiple hypersext masturbating. He said he had just r	4:14 p.m., Psych NP J said he receiven ad #2. He said he had worked with Res ual behaviors in the past that included ecently started seeing Resident #2 as He said staff have to monitor, intervene	ident #1 for many years. He said exposing himself to others and she was wandering and stealing
	2.		
	Record review of face sheet dated 04/04/22 indicated Resident #4 was a [AGE] year-old admitted on [DATE]. His diagnoses included schizophrenia (a serious mental disorder in interpret reality abnormally), dementia with behaviors, delusional disorders (serious men psychosis- in which a person cannot tell what is real from what is imagined), and anxiety dread, and uneasiness).		
	Record review of MDS dated [DATI every 1 to 3 days. There were no b	E] indicated Resident #4 had severe co ehaviors documented.	ognitive impairment and wandered
	Record review of care plan dated 10/08/21 indicated Resident #4 had a history of physical aggressive behavior. Interventions included social services to evaluate and visit, activities staff to visit and provide diversional activities, talk in a calm voice when behavior is disruptive, and remove from public area when behavior is disruptive and unacceptable.		
	Record review of care plan dated 04/09/22 indicated Resident #4 exhibited aggressive behavior noted by staff standing over another resident and yelling, threatening and physical aggression directed at staff trying to diffuse the situation. Interventions included placing Resident #4 in an area for frequent observation socia services to evaluate and visit, activities staff to visit and provide diversional activities, talk in a calm voice when behavior is disruptive, and remove from public area when behavior is disruptive and unacceptable, ar sent to behavior hospital for evaluation/treatment.		
	There was no care plan to address on 03/19/22.	the verbal and physical aggression tov	vards his roommate that occurred
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022
NAME OF PROVIDER OR SUPPLIER Avalon Place Kirbyville		STREET ADDRESS, CITY, STATE, ZI 700 N Herndon	P CODE
For information on the nursing home's	plan to correct this deficiency, please cont	Kirbyville, TX 75956	adency
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC		
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #4's bef CNA C noted verbal behaviors dire- and cursing at others-nurse notified Record review of a face sheet date [DATE], and his diagnoses included striking motor behavior, typically inv and agitation), vascular dementia w resulting from conditions that affect predominantly positive symptoms of disorder (serious mood disorder), a Record review of an MDS dated [D. every 1 to 3 days. There were no p Record review of Resident Incident NA B entered Resident #4 and Res #4 was yelling at Resident #5. LVN sat on the floor by the foot of his be #4 swung his fist and struck LVN A' Resident #5 was moved to a differe During an interview on 04/13/22 at #4 and #5's room. She said she op Resident #5 lay in his bed. She said not know why she did not intervene She said she was not trained on ho Resident #4 to his bed. She said Re CNA K was on shift with her. Record review of CNA K's undated she heard shouting and rumbling in door and LVN A, CNA C and CNA I standing over Resident #5 hitting hi #5. Resident #4 started to swing an directed CNA K to get LVN I. LVN I up a shoe. LVN A moved Resident During an interview on 04/13/22 at He said he was not aware of any sp Resident #4 yelling at Resident #5 Resident #5 then he would calm do say why he did not document the in the top of his lungs at Resident #5. got between the residents. He said	havior monitoring from 01/01/22 throug cted at others included threatening oth I. There were no additional dates comp d 04/04/22 indicated Resident #5 was d catatonic schizophrenia (rare severe volving either significant reductions in v vith behavioral disturbances (changes t the blood vessels in the brain), parano f schizophrenia, including delusions ar nd anxiety. ATE] indicated Resident #5 had severe hysical or verbal behaviors noted. Report dated 04/09/22 at 5:25 a.m. ar ident #5's room and found Resident #4 A separated the residents. Resident #4 d. LVN A reached down to assist Resi 's upper right arm. Resident #4 yelled h	h 04/09/22 indicated on 04/05/22 ers, screaming/yelling at others, eleted. a [AGE] year-old male, admitted o mental disorder characterized by oluntary movement or hyperactivit o memory, thinking, and behavior oid schizophrenia (characterized b id hallucinations), major depressiv e cognitive impairment. Wandered d completed by LVN A indicated bent over Resident #5. Resident 4 sat at the foot of his bed. LVN A dent #4 from the floor and Residen was going to kill LVN A. and yelling and went to Residents anding over Resident #5 while staff to get LVN A. She said she di and was not trained on behaviors A came to the room and directed id, I'll fucking kill you. She said estigation indicated CNA C told he nd get LVN A. LVN A opened the nt #5's room. Resident #4 was to get Resident #4 off Resident the floor as he swung. LVN A ted cursing at LVN A and picked ent #4's room for their safety. ed on dementia for the secure uni aid there were other incidents of d if resident #4 was screaming at at Resident #4 was screaming at at Resident #5 when he (LVN A) n the back. He said Resident #5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675220	A. Building B. Wing	04/15/2022
NAME OF PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZI	P CODE
Avalon Place Kirbyville		700 N Herndon Kirbyville, TX 75956	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying information	on)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	<ul> <li>Record review of nurse note dated 04/09/22 at 10:47 a.m., completed by LVN A, indicated LVN A was called to Resident #4 and Resident #5's room at 5:25 a.m. LVN A found Resident #4 standing over Resident #5, yelling. LVN A directed Resident #4 to sit on his bed but he sat on the floor. LVN A attempted to help him up but Resident #4 hit LVN A on the right upper arm and started to yell he was going to kill LVN A. LVN A moved Resident #5 to another room for safety. Resident #5 stated Resident #4 hit him in the back. There was no visible injury. Resident #5 was resting in a safe bed. Notified on-call ADON, and the ADON notified the DON. DON stated she was going to send Resident #4 to a behavioral hospital.</li> <li>During an interview on 04/13/22 at 8:35 a.m. the Administrator said she was not aware of any previous incidents between Resident #5. She said she was new to the facility as of January 2022 and no one reported anything during the morning meetings. She said they were roommates. She said Resident #4 was found standing over Resident #5. She said he was put on 1-1 staffing with 15-minute monitoring and sent to a behavior hospital for evaluation and treatment.</li> </ul>		
	During an interview on 04/14/22 at 1:54 p.m., The DON said she would have separated Residents #4 and #5 and they would not have continued as roommates if she was made aware of the previous incidents. She said no one told her of the previous incidents and nothing was reported during morning meeting.		
	During an interview on 04/14/22 at 2:08 p.m., NA B said she realized after she shut the door of Residents # and #5 room that she had left Resident #5 in danger. She said she stood right outside of the door until LVN arrived and intervened.		
	and not shut the door. She said NA training. They said staff were also t LVN A should have documented th	3:34 p.m. the administrator and DON s A B was a new aide hired on and she ne rrained to request help when they need the prior incident and notified the adminis the was not able locate staff training rec- ident.	eeded more experience and to take care of residents. She said strator (the abuse coordinator
	of aggression from Resident #4. He he received reports from staff if res	4:14 p.m., psych NP J said he was not e said he was in the facility every two w idents had behaviors. He said he would nd #5 be separated and not continued t	eeks and more as needed. He said d have addressed the aggressions
	shouting from Resident #4's room. Resident #5. Resident #4 was redi	03/19/22 at 2:22 p.m., completed by LV LVN L observed Resident #4 shouting rected to the dining room and offered si for any aggressive behavior towards of	aggressively as he stood over nacks. Resident #4 refused snacks.
	Hall-3 staff are to have safety moni Observe for potential abuse behavi	ng Report dated 09/21/21 indicated the itoring of hall at all times. Staff may take iors, wandering, and/or falls and attemp clude the names of the LVN A, NA B, C	e turns, being safety monitor. ot to prevent altercations and
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building	(X3) DATE SURVEY COMPLETED
	675220	B. Wing	04/15/2022
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Avalon Place Kirbyville		700 N Herndon Kirbyville, TX 75956	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	IENCIES full regulatory or LSC identifying informati	on)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	<ul> <li>environment for residents by prohib exploitation and misappropriation of and kicking, shoving, pinching, and sue of oral, written or gestural lange their families, or within their hearing Examples include cursing, yelling, if Abuse is defined as non-consensue unnecessary touching or exposure informed consent and with the inter to include sexual harassment, sexu exhibiting abusive behaviors will be staff will immediately report and pro Protection: 1. All residents will be in necessitate assessment and intervo one on one supervision. b. transfer member/responsible party.</li> <li>The facility was notified of the Imme provided the Immediate Jeopardy to the Immediate Jeopardy.</li> <li>The Facility's Plan of Removal for I the following:</li> <li>Facility failed to prevent Resident # yelling please don't no no no Resid her shoulder . Resident #1 had a pa brief was down. Approximately 2-3 was standing between her legs how</li> <li>There were no interventions put in Facility failed to prevent Resident # #4 was seen standing over Resident interventions were put in place at the On 4/9/22 Resident #4 was found her to see what was happening and the</li> </ul>	4 from verbally and physically abusing at #5, while Resident #5 was in bed, ye be time. Hovering over Resident #5 yelling at hin en closed the door and called for the nu bot been trained on dealing with behavior removal:	ing involuntary seclusion, neglect, but is not limited to hitting, slapping, includes but is not limited to the or derogatory terms to residents or y to comprehend, or disability. Igs to frighten a resident. E. Sexual heludes but is not limited to any he genitals without voluntary, sire of any person. This definition is vention: 3. Residents identified as ns included in the plan of care. 4. iervation of abuse has occurred. egations involving residents will n which may include a. temporary iome or to a family m. and the administrator was ride a Plan of Removal to address 04/15/22 at 1:55 p.m. and reflected Dn 4/11/22 Resident #2 was heard his pants down and his hand on iward resident #2. Resident #2's sitting on Resident #1's bed. He Resident #5. On 3/19/22 Resident silling aggressively at him. No n. The nurse aide opened the door urse. She did not intervene and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022	
NAME OF PROVIDER OR SUPPLIER Avalon Place Kirbyville		STREET ADDRESS, CITY, STATE, ZI 700 N Herndon	P CODE	
		Kirbyville, TX 75956		
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		ion)	
F 0600	2. Notify Regional Director of opera	ations of Immediate Jeopardy status -		
Level of Harm - Immediate	Onsite 4/14/22@ 3 pm.			
jeopardy to resident health or safety	3. Notify facility Medical Director of	Immediate Jeopardy status-		
Residents Affected - Some	Notified via phone by ADON -4/14/2	22@ 4pm.		
	4. Resident #1 was immediately placed on 1:1 monitoring beginning @ 8:30 am on 4 /Designee and responsible party were notified. Medication orders were received. He monitoring until transferred to a Behavioral Hospital @3:30 pm on 4/11/22. He rema Hospital at time of this report.			
	5. Resident #2 was assessed by facility licensed nursing staff on 4/11/22@ 8:21 am with moted. She was calm. Attending MD /Designee and responsible party were notified. Responsible facility and requested she be sent out for exam .MD/Designee were notified of family order received to send to ER for evaluation and examination. She was transferred to a hos 8:30 pm. She returned to the facility on [DATE] @ 3 am. Verbal report was received from n indicating no abrasions, tears or injuries on physical exam, specimens were collected durin pending completion by forensics lab. She has been noted to be in pleasant mood and in no distress or discomfort noted.			
	6. Resident #3 has been assessed on numerous occasions for the past 3 weeks with no noted skin issu obvious discomfort observed.			
	7. Resident #4 was placed on 15-minute interval monitoring beginning 4/9/22 @ 6am. Attending MD/Designee were notified. Order received to transfer to behavioral hospital. Resident remained on 15-minute monitoring until transferred to Behavioral Hospital on 4/9/22 @4:45 pm. He remains at a Behavioral Hospital at the time of this report.			
	8. Resident #5 was assessed by licensed nursing staff on 4/9/22 with no injuries noted. He was placed on 15-minute monitoring beginning 4/9/22 @ 6 am and monitoring was discontinued on 4/12/22@ 7am with no further incidents noted.			
	9. Residents who reside on the secure unit have had skin assessments completed by licensed nursing staff treatment nurse for any unidentified concerns with none identified. Initiated 4/13/22 @t 11 am and Completed 4/13/22 @ 3:30 pm by Treatment Nurse.			
	10. Residents who reside on the secure unit were evaluated for any physical aggressive behaviors with none identified. Initiated 4/14/22@ approx. 4:30 pm and Completed 4/14/22@ 5:30 pm by ADON.			
	Care plans for Residents #1, 2, 4 & 5 were updated to reflect identified event and interventio reviewed .			
	11. Facility staff were provided education by DON/Designee on:			
	11a) Inappropriate Resident to Resident touching. Reporting procedures discussed.			
	(continued on next page)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022
NAME OF PROVIDER OR SUPPLIER Avalon Place Kirbyville		STREET ADDRESS, CITY, STATE, ZI 700 N Herndon Kirbyville, TX 75956	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	l tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Initiated 4/13/22@ 12:30 pm, Follow attendees on 4/13/22-51 Subseque 4/14/22 -Total attendees 11. Follow Total Attendees 29. 11b) Supervision and Monitoring of facilitate monitoring of unit. Staff we hallway on Hall 3 while care is bein with these roles and to notify the nu 11am, Follow up sessions @ 2:30   Subsequent sessions on 4/14/22@ beginning 4/15/22 @ 6 am complet 11c) Abuse -Content Abuse Coord 4/13/22@10:30 am, Follow up sess attendees 63 Subsequent sessions attendees 63 Subsequent sessions attendees Follow up sessions on 4, 12. Facility staff were provided edu 12a) Behavior Assessment, Interve 5:30 pm, Completed @ 5:50 pm on completed by 945 am. Total attend 12b) Unmanageable Residents - co 6:00 pm on 4/14/22 Attendees 35 F Total attendees 29. 13. Facility were provided educatio including reporting procedures, inter completed at 945 am. Total attende 14. Staff who were not on duty will staff will be allowed to work on the 15a, and 15b .	w up sessions @2:30 pm and 6pm Cor ent sessions on 4/14 /22@beginning @ v up sessions conducted @ 4/15/22 begint f Hall 3/Secure Unit. Content discussed ere educated that one staff would be m g delivered by the other staff member. urse if additional monitoring assistance om. and 6:00 pm. Completed @ 6:30 p 10 am, Completed@ 10 :30 am. 12 at red @ 945 am. Total attendees 29. linator - contact #s and the facility Abus sions @2:30 pm and 6 pm. Completed (15/22 beginning @10 am, Completed 15/22 beginning at 6am completed at 9 cation by DON/Designee on: ention and Monitoring - content included (17/22 Attendees 32. Follow up sess ees 22. ontent included facility policy. Initiated 4 follow up sessions on 4/15/22 beginnin m by DON/Designee on resident to resi erventions, and documentation procedu	npleted @ 6:30pm on 4/13/22 Tota 10am, Completed @ 10:30 am on ginning @ 6am completed by 9am. d and procedures discussed to onitoring Residents and the Staff were instructed to take turns is needed. Initiated 4/13/22@ m on 4/13/22. Total attendees 50 tendees Follow up sessions ee Prohibition Guideline. Initiated @ 6:30 pm on 4/13/22. Total ed @ 10:30 am on 4/14/22- 17 945 am. Total attendees 29. d facility policy. Initiated 4/14/22@ ion on 4/15/22 beginning at 6 am 4/14/22@ 5:30 pm Completed @ g at 6 am completed at 945 am. dent-resident altercations, content res. Initiated 4/15/22 at 6am ducation by the DON/designee. No ed for items #13, #14a, #14b, #14c.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022
NAME OF PROVIDER OR SUPPLIER Avalon Place Kirbyville		STREET ADDRESS, CITY, STATE, ZI 700 N Herndon	P CODE
For information on the pursing home's	plan to correct this deficiency, please con	Kirbyville, TX 75956	202001
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	IENCIES	
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	<ul> <li>(Each deficiency must be preceded by full regulatory or LSC identifying information)</li> <li>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to pr accidents.</li> <li>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115</li> <li>Based on observation, interview, and record review the facility failed to ensure residents received adequ supervision to prevent abuse for 4 of 11 residents (Resident #s 1, 2, 4, and 5) reviewed for supervision.</li> <li>1. The facility staff did not provide supervision to prevent Resident #1 from sexually abusing Resident ##</li> </ul>		
	<ul> <li>found behind Resident #2, his hand Resident #2. Residents #1 and #2's</li> <li>2. The facility staff did not separate abuse of Resident #4. On 04/9/22 I B opened the door to see what was Resident #5 in imminent harm.</li> <li>An Immediate Jeopardy (IJ) situation 04/15/22, the facility remained out of identified as a pattern due to the facility remained out of the facility remained</li></ul>	to Resident #1's room. Resident #2 was a on her shoulder, holding his partially of s briefs were down. and supervise Resident #5 to prevent Resident #4 was found hovering over F a happening and then closed the door a on was identified on 04/14/22 at 3:00 p. of compliance at a potential for more the cility's need to evaluate the effectivene s at risk of abuse, physical harm, ment	erect penis while thrusting toward his continued verbal and physical Resident #5 yelling at him. The NA and called for the nurse. NA B left .m. While the IJ was removed on han minimal harm with a scope has of the corrective systems.
	<ul> <li>[DATE] and his diagnoses included or change in a person's life), Parkir walking, balance, and coordination feeling of sadness and loss of inter someone uses language), and schi abnormally).</li> <li>Record review of MDS dated [DAT impairment), he wandered every 1- Record review of Resident #1's car</li> </ul>	04/13/22, indicated Resident #1 was a adjustment disorder (emotional or beh ison's (a brain disorder that leads to sh ), major depressive disorder (mood dis est), cognitive communication deficit (c zophrenia (a serious mental disorder in E], indicated Resident #1's BIMS score 3 days, ambulated with a walker. Then e plan dated 04/11/22 indicated he dis gesture with a female resident. Intervent	avioral reaction to a stressful even aking, stiffness, and difficulty with order that causes a persistent lifficulty with thinking and how in which people interpret reality e was 7 (severe cognitive e were no behaviors noted. played socially inappropriate
		ral hospital for evaluation and treatmer	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022	
NAME OF PROVIDER OR SUPPLI		STREET ADDRESS, CITY, STATE, ZI		
Avalon Place Kirbyville	-R	700 N Herndon	FCODE	
Avaion nace Kirbyville		Kirbyville, TX 75956		
For information on the nursing home's	plan to correct this deficiency, please cont	tact the nursing home or the state survey a	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	IENCIES full regulatory or LSC identifying informati	on)	
F 0689 Level of Harm - Immediate jeopardy to resident health or safety	Record review of face sheet dated 04/13/22, indicated Resident #2 was a [AGE] year-old female, admitted on [DATE], and her diagnoses included Alzheimer's (a progressive neurologic disorder that causes the bra to shrink (atrophy) and brain cells to die) and depression (a mood disorder that causes a persistent feeling sadness and loss of interest).			
Residents Affected - Some	Record review of MDS dated [DATI impairment), wandered daily, and a	E] indicated Resident #2 had a BIMS s mbulated without assistance.	core of 2 (severe cognitive	
	Record review of care plan dated 12/30/21 indicated Resident #2 required placement on the secure unit due to wandering and significant safety awareness due to dementia. Interventions included assist with location of room with verbal cures, notify physician if behavior increases (1/18/22- in and out of other residents' rooms, at times will take things out of other residents' rooms, 2/6/22 altercation with another resident, 2/11/22 attempted to take another residents walker, 4/11/22 victim of inappropriate sexual gesture). The care plan did not address supervision.			
		2 with the Administrator, DON and ADC wo separate camera recordings on 04/		
	At 8:09 a.m. there were no aides or	n the hall, Resident #2 wandered on ha	Ill and then back into her room.	
	Camera error exact time unknown-CNA F went into another resident's room while CNA C was in t room.			
	At 8:13 a.m. Resident #2 wandered into the hall, then into a resident room next to the shower room.			
	At 8:14 a.m., CNA C out of shower	to get a wheelchair and then back into	shower room.	
	At 8:16 a.m., CNA C opened the shower door and took a resident in a wheelchair out of the shower.			
	CNA C walked past the resident room next to the shower room.			
	CNA C walked into Resident #1's room, escorted Resident #2 out of Resident #1's room and walks back toward Resident #2's room at the opposite end of the hall.			
	At 8:19 a.m. CNA F comes out of other residents' room.			
	Record review of nurse note dated 04/11/22 at 4:08 p.m., completed by LVN D, indicated CNA C heard Resident #2 scream no don't do that when she entered the room. The door was open and she witnessed Resident #1 standing behind Resident #2. Resident #1 was holding on to Resident #2 with one hand, his pants were down and he was exposed. Resident #2's pants were down and she was exposed.			
	(continued on next page)			

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022
NAME OF PROVIDER OR SUPPLIER Avalon Place Kirbyville		STREET ADDRESS, CITY, STATE, ZI 700 N Herndon Kirbyville, TX 75956	P CODE
For information on the nursing home's plar	an to correct this deficiency, please cont	act the nursing home or the state survey a	agency.
· · ·	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by t	IENCIES full regulatory or LSC identifying informati	on)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of nurse note dated the shower room at approximately & room. CNA C entered the room and Resident #2. Resident #1 had his p protective wear and pants were dow Resident #2 from the room. DON at any redness or drainage to rectal or examination. No injuries noted. The hospital for evaluation and treatmer Psych services was notified. Record review of NP E's visit report behaviors occurred. Resident #1's behaviors occurred. Resident #1's behaviors occurred. Resident #1's behaviors of wandering into other redocumented. Record review of Resident #2 beha incidents of wandering into other redocumented. Resident #2. She said both resident hand. She said Resident #2 was as services was contacted and increas Resident #1 denied the allegations. and it was 15. She said Resident #7 the porch. She said approximately resident sitting on his bed. She said soft resident sitting on his bed. She said soft resident when heard Resident #2 scream Not the shower room and walked to Resident #1 to get it, when he walked into the room. She walked her out of the room. She said had cell phones to call the nurse if the purches to call the nurse if the pur	04/11/22 at 4:18 p.m., completed by th 8:15 a.m. and heard Resident #2's rais I noted Resident #2 had his pants dow enis in his hand and was saying 'get it, wn. CNA C separated Resident #1 and nd Treatment nurse examined Resider r perineal/vaginal area. Resident #2 was physician was notified and new orders it. The administrator was notified. Resident adated 04/11/22 indicated Resident #1 BIMS was assessed and scored at 15. havior monitoring from 01/01/22 through sidents' rooms and the nurse was notified. 8:35 a.m. the Administrator said CNA 0 aid the door was open and she saw Re ts' pants and briefs were down. She sa sessed and it was not determined she sed Resident #1's Zoloft (an antidepress She said Resident #1's last BIMS sco 1 had previous sexually inappropriate the e-directed. 9:10 a.m., CNA C said she was previou 2 or 3 weeks prior she had previously I Resident #1 was standing between the sidents were fully dressed. She said Re fent. She said she thought she told LV breakfast at approximately 8:15 a.m. So 0 don't do that no no no. She said she sident #1's room. She said both Reside and his penis in his hand and was holdid get it as he was thrusting. She said Resident aid Resident #2 was crying. She said d she and CNA F were working the se	<ul> <li>are DON, indicated CNA C exited ed voice coming Resident #1's in and was standing behind</li></ul>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022
NAME OF PROVIDER OR SUPPLIER Avalon Place Kirbyville		STREET ADDRESS, CITY, STATE, ZI 700 N Herndon Kirbyville, TX 75956	P CODE
For information on the nursing home's	plan to correct this deficiency, please cont	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by f		IENCIES full regulatory or LSC identifying informati	on)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety	During an interview on 04/13/22 at 11:35 a.m., LVN I said she had witnessed an incident approximately 2 months prior where another resident had taken off her clothes in her room and her roommate had opened the door as Resident #1 walked by. She said he stopped and stared, and when asked why he did that he said because he could. She said she had heard of the incident where he stood over the same resident where sat on his bed.		
Residents Affected - Some		11:53 a.m., LVN G said she had not no e said Resident #1 did stare at the resi	
	During an interview on 04/14/22 at 10:15 a.m., the DON said she was not able to locate LVN A, NA B, or CNA C's training for sexually inappropriate behaviors or resident abuse.		
	incidents related to inappropriate se not trained. She said she became t	1:30 p.m., the Administrator said she v exual behavior. She said she was not a he new Administrator in January 2022 or designee were responsible for ensu	aware LVN A, NA B, or CNA C we and was not aware staff was not
	providing resident care at the same the other residents and the hall to e safety. She said she was not able to	1:54 p.m., the DON said both aides on time. She said one of the aides was s ensure residents do not wander or to be o locate training records to indicate the or ensuring staff was trained. She coul training records.	upposed to monitor and supervise e able to intervene for resident e staff had been trained. She said
	required incontinent care. She said almost finished showering a different with his incontinent care. She said	2:05 p.m., CNA F said a resident came she went into the shower room to gath nt resident so she left the shower room she did not see Resident #2 wandering scall specific training related to monitor	ner supplies. She said CNA C was a and assisted the other resident g in the hall. She said had been
	educated three staff on 04/13/22 we providing care. They said staff were and they were monitoring the hall. contained the names of the staff that	3:34 p.m. the administrator and DON s orking on hall 300 to have one staff mo e also trained to request help when the The DON said she was not able locate at worked during the incident. She said d regarding resident to resident aggres	onitoring and the other staff y need to take care of residents any staff training records that I NA B was not a certified aide and
	of the incident with Residents #1 ar Resident #1 had multiple hypersext masturbating. He said he had just r	4:14 p.m., Psych NP J said he receive nd #2. He said he had worked with Res ual behaviors in the past that included ecently started seeing Resident #2 as He said staff have to monitor, intervent	sident #1 for many years. He said exposing himself to others and she was wandering and stealing
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220         NAME OF PROVIDER OR SUPPLIER Avalon Place Kirbyville       Avalon Place Kirbyville		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. Building       COMPLETED         B. Wing       04/15/2022         STREET ADDRESS, CITY, STATE, ZIP CODE         700 N Herndon         Kirbyville, TX 75956	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0689	2.		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		htal disorder in which people s (serious mental illness - called a d), and anxiety (a feeling of fear, ognitive impairment and wandered story of physical aggressive rities staff to visit and provide remove from public area when d aggressive behavior noted by aggression directed at staff trying rea for frequent observation social al activities, talk in a calm voice is disruptive and unacceptable, and k his roommate that occurred on h 04/09/22 indicated on 04/05/22 ers, screaming/yelling at others, oleted. VN L, indicated LVN L heard aggressively as he stood over nacks. Resident #4 refused snacks. ther residents. Resident #5 had no a [AGE] year-old male, admitted on mental disorder characterized by roluntary movement or hyperactivity o memory, thinking, and behavior
	every 1 to 3 days. There were no p (continued on next page)		s oogniuvo impairment. vvanuereu

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building	(X3) DATE SURVEY COMPLETED
	675220	B. Wing	04/15/2022
NAME OF PROVIDER OR SUPPLIEI Avalon Place Kirbyville	R	STREET ADDRESS, CITY, STATE, ZI 700 N Herndon Kirbyville, TX 75956	P CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying information)	
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	NA B entered Resident #4 and Res #4 was yelling at Resident #5. LVN sat on the floor by the foot of his be #4 swung his fist and struck LVN A Resident #5 was moved to a differe During an interview on 04/13/22 at #4 and #5's room. She said she op Resident #5 lay in his bed. She said not know why she did not intervene She said she was not trained on ho Resident #4 to his bed. She said Re CNA K was on shift with her. Record review of CNA K's undated told her she heard shouting and rur opened the door and LVN A, CNA 0 #4 was standing over Resident #5 I Resident #5. Resident #4 started to LVN A directed CNA K to get LVN I picked up a shoe. LVN A moved Re During an interview on 04/13/22 at He said he was not aware of any sp Resident #5 then he would calm do say why he did not document the in the top of his lungs at Resident #5. got between the residents. He said did not have any marks on his back Record review of nurse note dated to Resident #4 and Resident #5's ro yelling. LVN A directed Resident #4 but Resident #4 hit LVN A on the rig moved Resident #5 to another room was no visible injury. Resident #5 to	Report dated 04/09/22 at 5:25 a.m. an ident #5's room and found Resident #4 A separated the residents. Resident #4 d. LVN A reached down to assist Resid s upper right arm. Resident #4 yelled hat room. 2:08 p.m., NA B said she heard voices ened the door and saw Resident #4 states at the door and saw Resident #4 states at she shut the door and told the other set. She said she was not a certified aide w to redirect residents. She said LVN <i>J</i> esident #4 went toward his bed and said statement included in the ongoing facil nobing in the room and for her (CNA K) C and CNA K walked into Resident #4 and esident #5 to another room. All staff left 4:27 p.m., LVN A said he was not train becific care plans for Resident #4. He said wn. He said the most recent incider He said Resident #4 was pretty traum 04/09/22 at 10:47 a.m., completed by I for all conditions and started to yell a resident #5 stated Resident #4 was pretty traum 04/09/22 at 10:47 a.m., completed by I for all conditions and started to yell he was not safely. Resident #4 to a behavioral for a behavioral for sender was resting in a safe bed. Notified on-care for the said Resident #4 to a behavioral for the said resident #4 to a behavioral for sender #4 was resting in a safe bed. Notified on-care for the said Resident #4 to a behavioral for sender #4 to a behavioral for the said Resident #4 to a behavioral for the sender begins and to a for the sender	A bent over Resident #5. Resident 4 sat at the foot of his bed. LVN A dent #4 from the floor and Resident he was going to kill LVN A. and yelling and went to Residents anding over Resident #5 while staff to get LVN A. She said she did and was not trained on behaviors. A came to the room and directed id, I'll fucking kill you. She said lity's investigation indicated CNA C to go and get LVN A. LVN A and Resident #5's room. Resident vas able to get Resident #4 off t4 fell on the floor as he swung. he started cursing at LVN A and t Resident #4's room for their safety. ed on dementia for the secure unit. aid there were other incidents of d if resident #4 was not able to see' e or an incident report. He could not ht, Resident #5 when he (LVN A) in the back. He said Resident #5 hatized for the next day or two. LVN A, indicated LVN A was called tt #4 standing over Resident #5, r. LVN A attempted to help him up as going to kill LVN A. LVN A int #4 hit him in the back. There all ADON, and the ADON notified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIE Avalon Place Kirbyville	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing STREET ADDRESS, CITY, STATE, ZI 700 N Herndon	(X3) DATE SURVEY COMPLETED 04/15/2022 P CODE
For information on the nursing home's r	nian to correct this deficiency, please con	Kirbyville, TX 75956	adency
		`	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	IENCIES full regulatory or LSC identifying informati	on)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	<ul> <li>incidents between Residents #4 an reported anything during the mornin found standing over Resident #5. Smedicine) for talking to inanimate or sent to a behavior hospital for evalue During an interview on 04/14/22 at and they would not have continued no one told her of the previous incide During an interview on 04/14/22 at and #5 room that she had left Reside arrived and intervened.</li> <li>During an interview on 04/15/22 at and more the door. The DON sat they said staff were also trained to LVN A should have documented th and/or designee). The DON sat she the staff that worked during the incidents #4 and #5 be separated</li> <li>Record review of In-Service Trainin Hall-3 staff are to have safety moni Observe for potential abuse behavior incidents. The in-service did not income the interventions to reduce indivisupervision .5. Monitoring the effect interventions are implemented corr supervision is a core component of supervision is determined by the implemented corr supervision is determined by the implemented corr supervision is a core component of supervision is determined by the implemented corr supervision is determined by the implemented corr supervision is a core component of supervision is determined by the implemented corr supervision is determined by the implemented corr supervision is a core component of supervision is determined by the implemented corr supervision is determined by the implemented corr supervision is determined by the implemented corr supervision is a core component of supervision is a core component of supervision is determined by the implemented corr supervision is determined</li></ul>	1:54 p.m., The DON said she would hat as roommates if she was made aware dents and nothing was reported during 2:08 p.m., NA B said she realized after dent #5 in danger. She said she stood in 3:34 p.m. the administrator and DON s id NA B was a new aide and she need request help when they need to take of e prior incident and notified the adminis- ne was not able locate staff training rec	lity as of January 2022 and no one mates. She said Resident #4 was on Risperdal (antipsychotic ffing with 15-minute monitoring and ave separated Residents #4 and #5 of the previous incidents. She said morning meeting. The she shut the door of Residents #4 right outside of the door until LVN A aid NA B should have intervened ed more experience and training. Harden of residents. The DON said strator (the abuse coordinator ords that contained the names of made aware of previous incidents gressions and recommended mates. topic was safety monitoring-Hall-3: e turns, being safety monitor. of to prevent altercations and NA C, or CNA K. dated 2001 indicated Resident le priorities. 3. The care team shall ironment, including adequate he following: a. Ensuring that ach to Safety .2. Resident ype and frequency of the resident sident Risks and Environment ering; . onitoring policy dated 2001 ssment of physical, psychological

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	<ul> <li>The facility was notified of the Immer provided the Immediate Jeopardy.</li> <li>The Facility's Plan of Removal for In the following:</li> <li>Facility failed to prevent Resident # yelling please don't no no no Reside her shoulder . Resident #1 had a pabrief was down. Approximately 2-3 was standing between her legs how</li> <li>There were no interventions put in place at the following was seen standing over Resider interventions were put in place at the to see what was happening and the separate the Residents. She had not be see what was happening and the separate the Residents. She had not please accept the following plan of 1. Notify V.P. of Clinical Operations 2. Notify Regional Director of operations 2. Notify facility Medical Director of operations 3. Notify facility Medical Director of Notified via phone by ADON -4/14/2</li> <li>4. Resident #1 was immediately plat /Designee and responsible party was monitoring until transferred to a Bel Hospital at time of this report.</li> <li>5. Resident #2 was assessed by far noted. She was calm. Attending ME called facility and requested she be order received to send to ER for evaluation of the send to the facility indicating no abrasions, tears or injunctional planes of the send to the facility indicating no abrasions, tears or injuncted to the facility indicating no abrasions, tears or injuncted to the facility indicating no abrasions, tears or injuncted to the facility indicating no abrasions, tears or injuncted to the facility indicating no abrasions, tears or injuncted to the facility indicating no abrasions, tears or injuncted to the facility indicating no abrasions.</li> </ul>	ediate Jeopardy on 04/14/22 at 3:00 p. emplate. The facility was asked to pro- mmediate Jeopardy was accepted on a from sexually abusing Resident #2. ent #1 was found behind Resident #2 artially erect penis and was thrusting to weeks earlier Resident #3 was found a rering over her. Both were fully clothed place. 4 from verbally and physically abusing at #5, while Resident #5 was in bed, ye to time. hovering over Resident #5 yelling at hir en closed the door and called for the mo- ot been trained on dealing with behavior removal: a of immediate Jeopardy status - On site tions of Immediate Jeopardy status - Immediate Jeopardy status-	m. and the administrator was vide a Plan of Removal to address 04/15/22 at 1:55 p.m. and reflected On 4/11/22 Resident #2 was heard , his pants down and his hand on oward resident #2. Resident #2's sitting on Resident #1's bed. He Resident #5. On 3/19/22 Resident elling aggressively at him. No m. The nurse aide opened the door urse. She did not intervene and ors. at 4/14/22 @ 3 pm 30 am on 4/11/22. Attending MD ceived. He remained on 1:1 2. He remains at the Behavioral @ 8:21 am with no visible injuries e notified. Responsible party later e notified of family's request and insferred to a hospital on 4/11/22 @ s received from nurse at Hospital pre collected during exam and are

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	<ul> <li>6. Resident #3 has been assessed on numerous occasions for the past 3 weeks with no not obvious discomfort observed.</li> <li>7. Resident #4 was placed on 15-minute interval monitoring beginning 4/9/22 @ 6am. Attend MD/Designee were notified. Order received to transfer to behavioral hospital. Resident remai 15-minute monitoring until transferred to Behavioral Hospital on 4/9/22 @4:45 pm. He remai</li> </ul>		
	attendees on 4/13/22-51 Subseque 4/14/22 -Total attendees 11. Follow Total Attendees 29. 11b) Supervision and Monitoring of facilitate monitoring of unit. Staff we hallway on Hall 3 while care is bein with these roles and to notify the nu 11am, Follow up sessions @ 2:30 p Subsequent sessions on 4/14/22@ beginning 4/15/22 @ 6 am complet 11c) Abuse -Content Abuse Coord 4/13/22@10:30 am, Follow up sess attendees 63 Subsequent sessions	inator - contact #s and the facility Abus sions @2:30 pm and 6 pm. Completed 4/14/22 beginning @10 am, Completed 15/22 beginning at 6am completed at	10am, Completed @ 10:30 am on ginning @ 6am completed by 9am. d and procedures discussed to onitoring Residents and the Staff were instructed to take turns is needed. Initiated 4/13/22@ m on 4/13/22. Total attendees 50 tendees Follow up sessions se Prohibition Guideline. Initiated @ 6:30 pm on 4/13/22. Total ad @ 10:30 am on 4/14/22- 17

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	<ul> <li>5:30 pm, Completed @ 5:50 pm on completed by 945 am. Total attended 12b) Unmanageable Residents - cc 6:00 pm on 4/14/22 Attendees 35 F Total attendees 29.</li> <li>13. Facility were provided education including reporting procedures, intercompleted at 945 am. Total attendee 14. Staff who were not on duty will staff will be allowed to work on the 15a, and 15b .</li> <li>Administrator ,DON, and MDS Coordina indicate completion dates for requir completion via phone and texts. No Administrator, DON and MDS Coore employees have completed the req 15. Safe surveys were conducted for facility general population area with Initiated 4/13/22 @ 4:00 per Social Residents interviewed.</li> <li>16. Compliance will be monitored the 16a) Review of 24-Hour Reports, A Administrator during Clinical meeting The DON and administrator will cor 16b) Findings will submitted to the faculity and corrective actions if indicate indicate indicate indicate indicate completed the req 15. Safe surveys were conducted for facility general population area with Initiated 4/13/22 @ 4:00 per Social Residents interviewed.</li> <li>16. Compliance will be monitored the 16a Review of 24-Hour Reports, A Administrator during Clinical meeting The DON and administrator will cor 16b) Findings will submitted to the faculate and corrective actions if indicated and the faculate of the faculate for the faculate of the faculate</li></ul>	ontent included facility policy. Initiated 4 Follow up sessions on 4/15/22 beginnin in by DON/Designee on resident to resi- prventions and documentation procedur eventions and documentation procedur eventions and documentation procedur eventions and documentation procedur eventions and documentation procedur floor until education has been completed rdinator will monitor for employee com- ator and HR Director will conduct audits red education . Staff are being notified i stifications started on 4/14/22 @ 3:30 p rdinator will continue to audit , notify, ar uirement . or Residents on the secure unit and resi- n no safety or abuse concerns identified Worker and Completed 4/14/22@8:20 mough: // Reports and Medical record review b ngs with corrective actions taken for ide induct clinical meetings 3 x weekly and facility QAPI Committee for review and	ion on 4/15/22 beginning at 6 am //14/22@ 5:30 pm Completed @ g at 6 am completed at 945 am. dent-resident altercations, content res. Initiated 4/15/22 at 6am ducation by the DON/designee. No ed for items #13, #14a, #14b, #14c pletion of required education topics s of current facility employees and to report to facility for education m and are continuing on 4/15/22. Ind provide education items until all side in the f. pm per facility Administrator . 10 by Nursing Management and entified concerns. this will be an ongoing process. additional

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F 0689	monitoring procedures by V.P. Of C	Clinical Operations.		
Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Monitoring of the facility's plan or re Observations, interviews, and recor and included 9 residents, 6 nurses aides, activity director, activity coord were on duty during this time. Staff	emoval occurred on 04/15/22 and include rd reviews were conducted on 04/15/22 including charge nurses, treatment nur dinator, BOM, housekeeping, dietary st were able to identify inappropriate resi d appropriate resident supervision and	2 from 12:00 p.m. through 4:35 p.m. rse, MDS nurse, 6 certified nurse taff, and the ADON and DON that dent to resident touching and	

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F 0726	Ensure that nurses and nurse aider that maximizes each resident's well	s have the appropriate competencies to I being.	o care for every resident in a way
Level of Harm - Immediate jeopardy to resident health or safety	**NOTE- TERMS IN BRACKETS H	IAVE BEEN EDITED TO PROTECT C	ONFIDENTIALITY** 25115
Residents Affected - Some		nd record review, the facility failed to er sary to care for resident needs for 4 of sing staff.	
	The facility did not ensure LVN A, NA B and CNA F were trained to supervise and intervene for residents with behaviors.		
	The facility did not provide required monitoring and supervision to prevent Resident #1 from sexually abusing Resident #2 on 04/11/22. Resident #2 wandered into Resident #1's room. Resident #2 was heard yelling. Resident #1 was found behind Resident #2, his hand on her shoulder, holding his partially erect penis while thrusting toward Resident #2. Residents #1 and #2's briefs were down.		
	The facility staff did not intervene and protect Resident #5 from Resident #4's verbal and 4/9/22 Resident #4 was found hovering over Resident #5 yelling at him. The NA B opener what was occurring and then closed the door and called for the nurse. NA B left Resident harm.		
	An Immediate Jeopardy (IJ) situation was identified on 04/14/22 at 3:00 p.m. While the IJ was removed on 04/15/22, the facility remained out of compliance at a potential for more than minimal harm with a scope identified as a pattern due to the facility's need to evaluate the effectiveness of the corrective systems.		
	These failures placed residents at in needed skills and competencies.	risk of receiving supervision and interve	entions from staff without the
	Findings included:		
	Record review of face sheet dated 04/13/22, indicated Resident #1 was a [AGE] year-old male, admitted on [DATE] and his diagnoses included adjustment disorder (emotional or behavioral reaction to a stressful even or change in a person's life), Parkinson's (a brain disorder that leads to shaking, stiffness, and difficulty with walking, balance, and coordination), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), cognitive communication deficit (difficulty with thinking and how someone uses language), and schizophrenia (a serious mental disorder in which people interpret reality abnormally).		
	Record review of MDS dated [DATE], indicated Resident #1's BIM score was 7 (severe cognitive impairment), he wandered every 1-3 days, ambulated with a walker. There were no behaviors noted.		
	Record review of Resident #1's care plan dated 04/11/22 indicated he displayed socially inappropriate behavior and inappropriate sexual gesture with a female resident. Interventions included 15-minute monitoring and sent out to behavioral hospital for evaluation and treatment. There was no previous care plan for sexually inappropriate behavior available for review.		
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022
NAME OF PROVIDER OR SUPPLIER Avalon Place Kirbyville		STREET ADDRESS, CITY, STATE, ZI 700 N Herndon Kirbyville, TX 75956	P CODE
For information on the nursing home's	plan to correct this deficiency, please con		agency.
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by		CIENCIES full regulatory or LSC identifying informati	on)
F 0726 Level of Harm - Immediate jeopardy to resident health or safety	Record review of face sheet dated 04/13/22, indicated Resident #2 was a [AGE] year-old female, admitted on [DATE], and her diagnoses included Alzheimer's (a progressive neurologic disorder that causes the brai to shrink (atrophy) and brain cells to die) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of MDS dated [DATE] indicated Resident #2 had a BIMS score of 2 (severe cognitive		
Residents Affected - Some	<ul> <li>impairment), wandered daily, and ambulated without assistance.</li> <li>Record review of care plan dated 12/30/21 indicated Resident #2 required placement on the secure unit due to wandering and significant safety awareness due to dementia. Interventions included assist with location of room with verbal cues, notify physician if behavior increases (1/18/22- in and out of other residents' rooms, at times will take things out of other residents' rooms, 2/6/22 altercation with another resident, 2/11/22 attempted to take another residents walker, 4/11/22 victim of inappropriate sexual gesture). The care plan did not address supervision.</li> <li>Observation conducted on 04/14/22 with the Administrator, DON and ADON, who verified the identity of the staff and residents, of the facility's two separate camera recordings on 04/08/22 from 7:30 a.m. through 8:30</li> </ul>		
		n the hall, Resident #2 wandered on ha CNA F went into another resident's roc	
	At 8:13 a.m. Resident #2 wandered	l into the hall, then into a resident room	n next to the shower room.
	At 8:14 a.m., CNA C out of shower	to get a wheelchair and then back into	shower room.
	At 8:16 a.m., CNA C opened the sh	nower door and took a resident in a whe	eelchair out of the shower.
	CNA C walked past the resident ro	om next to the shower room.	
	CNA C walked into Resident #1's re toward Resident #2's room at the o	oom, escorted Resident #2 out of Resident #2 out of Resident posite end of the hall.	dent #1's room and walks back
	At 8:19 a.m. CNA F comes out of other residents' room.		
	Record review of nurse note dated 04/11/22 at 4:08 p.m., completed by LVN D, indicated CNA C heard Resident #2 scream no don't do that when she entered the room. The door was open and she witnessed Resident #1 standing behind Resident #2. Resident #1 was holding on to Resident #2 with one hand, his pants were down and he was exposed. Resident #2's pants were down and she was exposed.		
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022	
NAME OF PROVIDER OR SUPPLIER Avalon Place Kirbyville		STREET ADDRESS, CITY, STATE, ZI 700 N Herndon Kirbyville, TX 75956	P CODE	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey a	agency.	
(X4) ID PREFIX TAG			CIENCIES full regulatory or LSC identifying information)	
F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of nurse note dated the shower room at approximately room. CNA C entered the room and Resident #2. Resident #1 had his p protective wear and pants were do Resident #2 from the room. DON a any redness or drainage to rectal o examination. No injuries noted. The hospital for evaluation and treatme Psych services was notified. Record review of NP E's visit repor behaviors occurred. Resident #1's Record review of Resident #1's bel were documented. Record review of Resident #2 beha incidents of wandering into other re- During an interview on 04/13/22 at heard Resident #2 say 'stop'. She s Resident #2. She said both resider hand. She said Resident #2 was as services was contacted and increat Resident #1 denied the allegations and it was 15. She said Resident # the porch. She said he was easily r During an interview on 04/13/22 at prevention. She said approximately resident sitting on his bed. She said sitting on his bed. She said soft recent incident occurred after room when heard Resident #2 scree of the shower room and walked to 1 he was trying to help the other resi- most recent incident occurred after room when heard Resident #2 scree of the shower room and walked to 1 he was telling Resident #2 to get it, when he walked into the room. She walked her out of the room. She said had cell phones to call the nurse if During an interview on 04/14/22 at	04/11/22 at 4:18 p.m., completed by th 8:15 a.m. and heard Resident #2's rais d noted Resident #2 had his pants dow benis in his hand and was saying 'get it, wn. CNA C separated Resident #1 and nd Treatment nurse examined Resider r perineal/vaginal area. Resident #2 was e physician was notified and new orders int. The administrator was notified. Resident t dated 04/11/22 indicated Resident #1 BIMS was assessed and scored at 15. havior monitoring from 01/01/22 through esidents' rooms and the nurse was notified 8:35 a.m. the Administrator said CNA ( said the door was open and she saw Re its' pants and briefs were down. She sa sesses and it was not determined she sed Resident #1's Zoloft (an antidepres . She said Resident #1's last BIMS sco 1 had previous sexually inappropriate to re-directed. 9:10 a.m., CNA C said she was previous / 2 or 3 weeks prior she had previously d Resident #1 was standing between the sidents were fully dressed. She said Re dent. She said she thought she told LV breakfast at approximately 8:15 a.m. S am No don't do that no no no. She said reading in his hand and was hold get it as he was thrusting. She said reading and CNA F were working the se there as an emergency. 10:15 a.m., the DON said she was not ropriate behaviors or resident abuse. S	<ul> <li>are DON, indicated CNA C exited ed voice coming Resident #1's n and was standing behind get it'. Resident #2's incontinence #2 and immediately removed at #2 in her room and did not notice as calm at the time of the sto send Resident #1 to behavioral ident #2's daughter was notified.</li> <li>denied any inappropriate</li> <li>a 04/08/22 indicated no behaviors</li> <li>04/08/22 indicated there were 79 fed.</li> <li>C came out of the shower room and esident #1 standing behind aid Resident #1 had his penis in his was penetrated. She said psych estimates at 7 but he was re-assessed behaviors and would masturbate on</li> <li>usly trained on abuse and neglect caught Resident #1 with another he other resident's legs as she was esident #1 state of the shower discussion the other resident out ident #1 and Resident #2's pants ng Resident #2's left shoulder as esident #1 state own on his bed discussion the shower. She said the she said she was in the shower discussion the shower discussion the shower discussion the other resident was not his bed discussion the shower that and Resident #2's pants and Resident #2's left shoulder as esident #1 state own on his bed discussion the shower discussion</li></ul>	
	(continued on next page)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022
NAME OF PROVIDER OR SUPPLIER Avalon Place Kirbyville		STREET ADDRESS, CITY, STATE, ZIP CODE 700 N Herndon Kirbyville, TX 75956	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	<ul> <li>CNA C were not trained. She said is staff was not trained. She said she</li> <li>During an interview on 04/14/22 at providing resident care at the same the other residents and the hall to esafety. She said she could not loca were responsible for ensuring staff could not locate the training record</li> <li>During an interview on 04/14/22 at required incontinent care. She said almost finished showering a differe with his incontinent care. She said working for 2 months and did not reincident on 04/08/22.</li> <li>During an interview on 04/15/22 at educated staff working on hall 300 staff were also trained to request h hall. The DON said she was not ab that worked during the incident. She trained regarding resident-to-reside During an interview on 04/15/22 at residents' behaviors.</li> <li>2.</li> <li>Record review of face sheet dated admitted on [DATE]. His diagnoses interpret reality abnormally), demer psychosis- in which a person canned dread, and uneasiness).</li> <li>Record review of Care plan dated 1 behavior. Interventions included so</li> </ul>	<ul> <li>2:05 p.m., CNA F said a resident came she went into the shower room to gath nt resident so she left the shower room she did not see Resident #2 wandering eall specific training related to monitor</li> <li>3:34 p.m. the administrator and DON s to have one staff monitoring and the ot elp when they need to take care of resile locate any staff training records that e said NA B was not a certified aide an ent aggression prior to the incident betw</li> <li>4:14 p.m., Psych NP J said staff have in the behaviors, delusional disorder:</li> <li>E] indicated Resident #4 was a [</li> <li>E] indicated Resident #4 had severe contained the services to evaluate and visit, activity voice when behavior is disruptive, and</li> </ul>	anuary 2022 and was not aware asible for ensuring staff was trained. the secure unit should not be upposed to monitor and supervise a able to intervene for resident e unit. She said she or designee e staff were not trained or she e out of his room and the resident per supplies. She said CNA C was and assisted the other resident ing the hall. She said she had been ing the residents prior to the said they had re-inserviced staff and her staff providing care. They said dents and they were monitoring the contained the names of the staff d there was no record she was ween Resident #4 and Resident #5. to monitor, intervene, and divert [AGE] year-old male who was natal disorder in which people s (serious mental illness - called a d), and anxiety (a feeling of fear, ponitive impairment and wandered story of physical aggressive rities staff to visit and provide

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675220	A. Building B. Wing	04/15/2022
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Avalon Place Kirbyville		700 N Herndon Kirbyville, TX 75956	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of care plan dated 0 staff standing over another residem to diffuse the situation. Intervention services to evaluate and visit, activ when behavior is disruptive, and re sent to behavior hospital for evalua aggression towards his roommate for Record review of Resident #4's bell CNA C noted verbal behaviors dire and cursing at others-nurse notified Record review of nurse note dated shouting from Resident #4's room. Resident #5. Resident #4 was redii LVN L notified CNAs to be on alert apparent injuries and denied pain. Record review of a face sheet date [DATE], and his diagnoses included striking motor behavior, typically im and agitation), vascular dementia v resulting from conditions that affect predominantly positive symptoms of disorder (serious mood disorder), a Record review of an MDS dated [D every 1 to 3 days. There were no p Record review of Resident Incident NA B entered Resident #4 and Res #4 was yelling at Resident #5. LVN sat on the floor by the foot of his bé #4 swung his fist and struck LVN A Resident #5 was moved to a differe During an interview on 04/13/22 at #4 and #5's room. She said she op Resident #5 lay in his bed. She sai not know why she did not intervene She said she was not trained on ho	4/09/22 indicated Resident #4 exhibite t and yelling, threatening and physical a is included placing Resident #4 in an ar ities staff to visit and provide diversional move from public area when behavior in tion/treatment. There was no care plan that occurred on 03/19/22. havior monitoring from 01/01/22 through cted at others included threatening other d. There were no additional dates comp 03/19/22 at 2:22 p.m., completed by LV LVN L observed Resident #4 shouting rected to the dining room and offered st for any aggressive behavior towards of d 04/04/22 indicated Resident #5 was a d catatonic schizophrenia (rare severe volving either significant reductions in v vith behavioral disturbances (changes t t the blood vessels in the brain), parance of schizophrenia, including delusions ar and anxiety. ATE] indicated Resident #5 had severe hysical or verbal behaviors noted. Report dated 04/09/22 at 5:25 a.m. an sident #5's room and found Resident #4 A separated the residents. Resident #4 ed. LVN A reached down to assist Resid 's upper right arm. Resident #4 yelled f	d aggressive behavior noted by aggression directed at staff trying rea for frequent observation social al activities, talk in a calm voice is disruptive and unacceptable, and to address the verbal and physical h 04/09/22 indicated on 04/05/22 ers, screaming/yelling at others, oleted. VN L, indicated LVN L heard aggressively as he stood over nacks. Resident #4 refused snacks. ther residents. Resident #5 had no a [AGE] year-old male, admitted on mental disorder characterized by roluntary movement or hyperactivity to memory, thinking, and behavior oid schizophrenia (characterized by nd hallucinations), major depressive e cognitive impairment. Wandered then over Resident #5. Resident 4 sat at the foot of his bed. LVN A dent #4 from the floor and Resident the was going to kill LVN A.

NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE X00N Place Kirbyville       Avalon Place Kirbyville     STREET ADDRESS, CITY, STATE, ZIP CODE X00N Place Kirbyville       For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.       (K4) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES [Each deficiency most be proceeded by full regulatory or LSG identifying information]       F 0728     Level of Ham - Immediate peoparty to resident health or setty       Resident & Affected - Some     Resord review of CNA K's undated statement included in the enging facility's investigation indicated CNA C told her she heard shoulding and runbing in the room and for her (CNA K) to go and qu LVN A. LVN A opened the door and LVN A, CNA C and CNA K walked into Resident #4 and resident #4 and fact of the vas and target and runbing in the room and for her (CNA K) to go and qu LVN A. LVN A opened the door and LVN A, CNA C and CNA K walked into Resident #4 and the stated or anning at LVN A and the vas and target and runbing in the room and for her (CNA K) to go and qu LVN A. LVN A opened the door and LVN A, CNA C and CNA K walked into Resident #4 and the stated of the vas and target and runbing in the room and for her sected the fact of the vas and target and runbing in the room and for her sected the #4 and fact of the vas and target and the vas not attract or an age to the vas not trained and there was resident #5 then the wuld calm down, metal the to the resident #4 and there was not trained and there was resident #5 then the wuld calm down, metal the to anti-Resident #4 was screening at the top of his lungs at Resident #5 the and Resident #5 the and Resident #6 did not have any marks on the back. He and Resident #4 and Resident #6 did not have any marks on the bac	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022
Availan Place Kirbyville         700 N Herndon Kirbyville, TX 75956           For information on the nursing home's the 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 0726         Record review of CNA K's undated statement included in the ongoing facility's investigation indicated CNA C to told her she heard shouling and rumbling in the room and for her (CNA R) to go and get LVM A LVN A opened the door and LVN A, CNA C and CNA K walked into Resident #4 and Resident #6 of safety           Resident SAffected - Some         Resident #5 Resident #6 thit main and cursing at LVM A. Resident #4 and Resident #6 of resident #5. Resident #5 A nove and LVN A. CNA C and CNA K walked into Resident #4 and her state or unit. He sade he was not interview on 04173222 at 422 m. LVN A. Resident #4 and her states curre unit. He sade he was not interview on 0417322 at 423 m. LVN A. Resident #4 and her states the loose and the value of any specific care plans for Resident #4 and her states the loo era an indent report. He could not resident #5 then her was not haver of any specific care plans for Resident #4 was not trained on a care indent for the sade the s			D. wing	
Kindsville, TX 75956           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 0726 Level of Harm - Immediate jeoparty to residen thealth or safety         Record review of CNA K's undated statement included in the ongoing facility's investigation indicated CNA C toid her she heard shouling and runbing in the room and for her (CNA K) to go and get LNN A. LVN A opened the door and LVN A, CNA C and CAA K valked hor Resident #4 and Resident #4 of T Resident #5. Resident #5. Institute # stated to swing and curse at LVN A axes able to get Resident #4 of T Resider #5. Resident #5. States of the swing and curse at LVN A axes able to get Resident #4 of T Resider #5. Resident #5 to another room. All staff left Resident #4 in the state of the socure unit. He said the was not aware of any specific care plans for Resident #4 and he stated cursing at LVN A and picked up a show. LVN A moved Resident #5 to another new or and interimed point the societ Resider #4 yealing at Resident #5 to another new or and interimed the point her condition the Resider #4 yealing at Resident #5 to another new or and interimed the point her safet to and Resider #4 by alling at Resident #5 to another new or and interimed the point her safet to another Resider #4 by alling at Resident #5 to another new or and interimed the point her safet. Not review of nurse not added 04/09/221 to 47 a m_ completed by LVN A, indicated LVN A was called to the point hungs at Resident #5 to another soft by a safe Resident #6 to the Acon the State Breakient #6 to and the Acon Resident #6 in his back. The said Resident #6 is a nut here anone the fore. LVN A, indicated LVN A was called to Resident #6 in t	NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
(X4) ID PREFIX TAC         SUMMARY STATEMENT OF DEFICIENCIES [Each deficiency must be preceded by full regulatory or LSC identifying information)           F 0726 Level of Harm - Immediate jeopardy to resident health or safety         Record review of CNA K's undated statement included in the ongoing facility's investigation indicated CNA C told her she heard shouling and rumbing in the room and for her (CNA K) to go and get LVN A. LVN A opened the door and LVN A. CNA C and CNA K walked into Resident #4 and Resident #55 moor. Resident #4 was standing over Resident #6 hitting him and cursing at LVN A. Nam desident #55 moor. Resident #4 was standing over Resident #6 hitting him and cursing at LVN A was able to get Resident #4 for Resident #5. Resident #4 to get LVN L. LVN I tried to taking and cursing at LVN A and he started cursing at LVN A level de up a shoe. LVN A moved Resident #6 to another room. All staff left Resident #4 so not her is safety LVN A directed ONA K oget LVN L. LVN I tried to taking the was not able to see Resident #5 then he would cain down. He said he did not do a nume or an incident report. He could not say wity he did not document the incident. He said the did not do a nume or an incident report. He could not say wity he did not document the incident. He said hereident H4 was not able to see Resident #5 then he would cain down. He said Resident #4 was pretly traumatized for a day or woo.           Record review of nurse note dated 04/09/22 at 10:47 a.m., completed by LVN A, indicated LVN A was called to Resident #5 to another room at 525 a.m. LVN A found Resident #5 that he was not able to por his lungs at Resident #5 to ich nis bed but he said nesident #4 to tail was creating at the top of his lungs at another room resident #4 anot he floor. UNA attempted to help him up but Resident #4 hit LVN A on the right upper arm and started to yell he was going to will. Record review of nurse note dated 04/0	Avalon Place Kirbyville			
(Each deficiency must be preceded by full regulatory or LSC identifying information)         F 0726         Level of Harm - Immediate jeopardy to resident health or safety         Rescord review of CNA K's undated statement included in the ongoing facility's investigation indicated CNA C told her she heard shouling and rumbling in the room and for her (CNA K) to go and get LVN A. LVN A opened the door and LVN A. CNA C and CNA K walked into Resident #4 and Resident #55 room. Resident #4 was standing over Resident #5 hitting him and cursing at hum. UN A was able to get Resident #4 off Resident #5. Resident #4 stanted to swing and curse at LVN A. Resident #4 foll on the floor as he swung. LVN A directed CNA K to get LVN I. LVN I tide to tak to Resident #4 foll on the floor as he swung. LVN A directed CNA K to get LVN I. LVN I tak to tak to Resident #4 foll on the floor as he swung. LVN A directed CNA K to get LVN I. LVN A side he was not trained on dementia for the secure unit. He said he was not aware of any specific care plans for Resident #4 he said there were other incidents of Resident #5 then he would caim down. He said he did not do a nurse note on an incident report. He could not say why he did not document the incident. He said the was not shole to redirect him. He said Tesident #5 when he (LVN A) got between the residents. He said Resident #4 continued to yell at Resident #5 did not have any marks on his back. He said Resident #4 was grety traumatced for a day or two.         Resord review of nurse note dated 04/09/22 at 1/04 7 a.m., completed by LVN A, indicated LVN A was called to Resident #4 and Resident #5 room at 5.25 a.m. LVN A found Resident #6. did not have any marks on his back. He said Resident #6 and He houst not LVN A attempted to help him up but Resident #4 hit LVN A on the right upper arm and started to yell he was going to kill LVN A. LVN A and for som that	For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			agency.
Level of Harm - Immediate jeopardy to resident health or safetytold her she heard shouting and rumbling in the room and for her (CNA K) to go and get LVN A. LVN A opened the door and LVN A, CNA C and CNA K walked into Resident #4 and Resident #5 or nom. Resident at was standing over Resident #5 hitting him and cursing at him. LVN A was able to get Resident #4 off Resident #5. Resident #4 started to swing and curse at LVN A. Resident #4 and he started cursing at LVN A and picked up a shoe. LVN A moved Resident #5 to another norm. All staff left Resident #4 strong to the value of the staff was not trained on dementia for the secure unit. He said her was not aware of any specific care plans for Resident #4 he said there were other incidents of Resident #5 then he would calm down. He said he was not trained on dementia for the secure unit. He said her was not aware of any specific care plans for Resident #4 he said there were other incidents for Resident #5 hen he would calm down. He said he was not trained on dementia for the could not say why he did not document the incident. He said the most recent incident report. He could not say why he did not document the incident. He said the did not do a nurse note or an incident report. He could not say why he did not document the incident. He said Resident #5 said Resident #5 did not have any marks on his back. He said Resident #6 said Resident #6 to another one incident was not able to regive the was pretty traumatized for a day or two.Resident #4 and Resident #4 hor ther inght upper arm and started to yell at Resident #4 his the head. There was no visible injury. Resident #4 to an the said ne was ord right outside of the door ont field the DON bon's tated she was going to saft Resident #5 to another room for safety. Resident #5 to another room for safety. Resident #5 to another room for safety. Resident #4 to an the Boot notified the DON. DON stated she was go	(X4) ID PREFIX TAG			on)
	Level of Harm - Immediate jeopardy to resident health or safety	told her she heard shouting and rur opened the door and LVN A, CNA ( #4 was standing over Resident #5 I Resident #5. Resident #4 started to LVN A directed CNA K to get LVN I picked up a shoe. LVN A moved Re During an interview on 04/13/22 at He said he was not aware of any sy Resident #4 yelling at Resident #5 Resident #5 then he would calm do say why he did not document the in the top of his lungs at Resident #5. got between the residents. He said did not have any marks on his back Record review of nurse note dated to Resident #4 and Resident #5's ro yelling. LVN A directed Resident #4 but Resident #4 hit LVN A on the rig moved Resident #5 to another room was no visible injury. Resident #5 w the DON. DON stated she was goir During an interview on 04/14/22 at and #5 room that she had left Resid arrived and intervened. During an interview on 04/15/22 at and not shut the door. The DON sai The DON said staff were also traine said she was not able locate staff tr During an interview on 04/15/22 at of aggression from Resident #4. He Residents #4 and #5 be separated Record Review of LVN A (DOH 09/ files indicated there was no records residents with behaviors.	mbling in the room and for her (CNA K) C and CNA K walked into Resident #4 hitting him and cursing at him. LVN A w o swing and curse at LVN A. Resident #4 LVN I tried to talk to Resident #4 and esident #5 to another room. All staff left 4:27 p.m., LVN A said he was not train becific care plans for Resident #4. He se but he was able to redirect him. He said wm. He said he did not do a nurse note cident. He said the most recent incider He said Resident #4 continued to yell Resident #5 said Resident #4 hit him it c. He said Resident #4 was pretty traun 04/09/22 at 10:47 a.m., completed by I bom at 5:25 a.m. LVN A found Resider I to sit on his bed but he sat on the floo ght upper arm and started to yell he was n for safety. Resident #4 to a behavioral 2:08 p.m., NA B said she realized after dent #5 in danger. She said she stood to 3:34 p.m. the administrator and DON s id NA B was a new aide and she need at to request help when they need to ta raining records for LVN A, NA B and CI 4:14 p.m., psych NP J said he was not a said he would have addressed the ag and not continued their status as room 09/21), NA B (DOH 04/01/22) and CN/	to go and get LVN A. LVN A and Resident #5's room. Resident vas able to get Resident #4 off #4 fell on the floor as he swung. he started cursing at LVN A and t Resident #4's room for their safety. ed on dementia for the secure unit. said there were other incidents of d if resident #4 was not able to see' e or an incident report. He could not nt, Resident #5 when he (LVN A) in the back. He said Resident #5 natized for a day or two. LVN A, indicated LVN A was called at #4 standing over Resident #5, or. LVN A attempted to help him up as going to kill LVN A. LVN A ent #4 hit him in the back. There all ADON, and the ADON notified hospital. The shut the door of Residents #4 right outside of the door until LVN A eaid NA B should have intervened ed more experience and training. ake care of residents. The DON NA F. made aware of previous incidents gressions and recommended mates. A F (DOH 02/01/22)'s personnel

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NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Avalon Place Kirbyville		700 N Herndon Kirbyville, TX 75956	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	IENCIES full regulatory or LSC identifying informati	on)
F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	<ul> <li>facility will not use any individual as other basis unless: a. That individual That person has completed a trainine valuation program approved by the S483.150) and (b) of the Requiremaniate who has worked less than 4 man a state-approved training and complete training and the following:</li> <li>Facility failed to prevent Resident # yelling please don't no no no Resid her shoulder . Resident #1 had a probrief was down. Approximately 2-3 was standing between her legs how there were no interventions put in place at the On 4/9/22 Resident #4 was found her separate the Residents. She had not please accept the following plan of 1. Notify V.P. of Clinical Operations</li> </ul>	4 from verbally and physically abusing at #5, while Resident #5 was in bed, ye be time. Hovering over Resident #5 yelling at hin en closed the door and called for the nu bot been trained on dealing with behavio	s full-time, temporary, per diem, or nursing related services; and b. n program, or a competency deemed competent as provided in not sue any induvial as a nurse time employee and participating in demonstrated competence through betency evaluation program; or c. quirements of Participation. topic was safety monitoring-Hall-3: e turns, being safety monitor. to to prevent altercations and CNA F. m. and the administrator was ide a Plan of Removal to address 04/15/22 at 1:55 p.m. and reflected Dn 4/11/22 Resident #2 was heard his pants down and his hand on ward resident #2. Resident #2's sitting on Resident #1's bed. He desident #5. On 3/19/22 Resident filing aggressively at him. No m. The nurse aide opened the door urse. She did not intervene and ors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022
NAME OF PROVIDER OR SUPPLIER Avalon Place Kirbyville		STREET ADDRESS, CITY, STATE, ZIP CODE 700 N Herndon Kirbyville, TX 75956	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0726	3. Notify facility Medical Director of Immediate Jeopardy status-		
Level of Harm - Immediate jeopardy to resident health or	Notified via phone by ADON -4/14/2	22@ 4pm.	
Residents Affected - Some	4. Resident #1 was immediately placed on 1:1 monitoring beginning @ 8:30 am on 4/11/22. Attending MD /Designee and responsible party were notified. Medication orders were received. He remained on 1:1 monitoring until transferred to a Behavioral Hospital @3:30 pm on 4/11/22. He remains at the Behavioral Hospital at time of this report.		
	5. Resident #2 was assessed by facility licensed nursing staff on 4/11/22@ 8:21 am with no visible injuries noted. She was calm. Attending MD /Designee and responsible party were notified. Responsible party later called facility and requested she be sent out for exam .MD/Designee were notified of family's request and order received to send to ER for evaluation and examination. She was transferred to a hospital on 4/11/22 @ 8:30 pm. She returned to the facility on [DATE] @ 3 am. Verbal report was received from nurse at Hospital indicating no abrasions, tears or injuries on physical exam, specimens were collected during exam and are pending completion by forensics lab. She has been noted to be in pleasant mood and in no immediate distress or discomfort noted.		
	6. Resident #3 has been assessed on numerous occasions for the past 3 weeks with no noted skin issues or obvious discomfort observed.		
	7. Resident #4 was placed on 15-minute interval monitoring beginning 4/9/22 @ 6am. Attending MD/Designee were notified. Order received to transfer to behavioral hospital. Resident remained on 15-minute monitoring until transferred to Behavioral Hospital on 4/9/22 @4:45 pm. He remains at a Behavioral Hospital at the time of this report.		
	8. Resident #5 was assessed by licensed nursing staff on 4/9/22 with no injuries noted. He was placed on 15-minute monitoring beginning 4/9/22 @ 6 am and monitoring was discontinued on 4/12/22@ 7am with no further incidents noted.		
	9. Residents who reside on the secure unit have had skin assessments completed by licensed nursing staff treatment nurse for any unidentified concerns with none identified. Initiated 4/13/22 @t 11 am and Completed 4/13/22 @ 3:30 pm by Treatment Nurse.		
	10. Residents who reside on the secure unit were evaluated for any physical aggressive behaviors with none identified. Initiated 4/14/22@ approx. 4:30 pm and Completed 4/14/22@ 5:30 pm by ADON.		
	Care plans for Residents #1, 2, 4 & 5 were updated to reflect identified event and interventions were reviewed .		
	11. Facility staff were provided education by DON/Designee on:		
	11a) Inappropriate Resident to Resident touching. Reporting procedures discussed.		
	Initiated 4/13/22@ 12:30 pm, Follow up sessions @2:30 pm and 6pm Completed @ 6:30pm on 4/13/22 Total attendees on 4/13/22-51 Subsequent sessions on 4/14 /22@beginning @ 10am, Completed @ 10:30 am on 4/14/22 -Total attendees 11. Follow up sessions conducted @ 4/15/22 beginning @ 6am completed by 9am. Total Attendees 29.		
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022		
NAME OF PROVIDER OR SUPPLIER Avalon Place Kirbyville		STREET ADDRESS, CITY, STATE, ZI 700 N Herndon Kirbyville, TX 75956			
For information on the nursing home's	plan to correct this deficiency, please cont	tact the nursing home or the state survey a	agency.		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)				
F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some					
	employees have completed the requirement . 15. Safe surveys were conducted for Residents on the secure unit and reside in the				
	facility general population area with no safety or abuse concerns identified.				
	Initiated 4/13/22 @ 4:00 per Social Worker and Completed 4/14/22@8:20 pm per facility Administrator . 10 Residents interviewed.				
	(continued on next page)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	675220	A. Building B. Wing	04/15/2022		
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	STREET ADDRESS, CITY, STATE, ZIP CODE		
Avalon Place Kirbyville		700 N Herndon Kirbyville, TX 75956			
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.		
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F 0726	16. Compliance will be monitored the	hrough:			
Level of Harm - Immediate jeopardy to resident health or safety	16a) Review of 24-Hour Reports, A/I Reports and Medical record review by Nursing Management and Administrator during Clinical meetings with corrective actions taken for identified concerns.				
Residents Affected - Some	The DON and administrator will con	nduct clinical meetings 3 x weekly and	this will be an ongoing process.		
	16b) Findings will submitted to the	facility QAPI Committee for review and	additional		
	Audits and corrective actions if indicated.				
	17. Facility Administrator and the DON were provided education on compliance and				
	monitoring procedures by V.P. Of Clinical Operations.				
	Monitoring of the facility's plan or removal occurred on 04/15/22 and included the following:				
	Observations, interviews, and record reviews were conducted on 04/15/22 from 12:00 p.m. through 4:35 p.m. and included 9 residents, 6 nurses including charge nurses, treatment nurse, MDS nurse, 6 certified nurse aides, activity director, activity coordinator, BOM, housekeeping, dietary staff, and the ADON and DON that were on duty during this time. Staff were able to identify inappropriate resident to resident touching and reporting procedures. Staff provided appropriate resident supervision and redirection. There were no observed concerns.				
	Staff were able to discuss the required supervision and monitoring of Hall 3/Secure Unit.				
	Staff were able to identify the Abuse Coordinator, indicated reporting was immediate to the charge nurse or administrator and were able to give example of physical, verbal, sexual abuse and immediate intervention procedures. Staff were able to give examples of behavior monitoring and documentation, appropriate notification, and facility assessment procedures.				
	Staff were able to identify Unmana	geable Residents and indicated approp	riate facility policy.		
	Staff were able to give examples of resident to resident-resident altercations, reporting procedures, interventions, and documentation procedures.				
	Resident #1 remained at the behavioral hospital.				
	Resident #2 did not appear in distress and did not recall the incident.				
	Resident #3 continued wandering around the secure unit and did not appear anxious or distressed.				
	Resident #4 remained at a behavioral hospital.				
	Resident #5 did not recall the incident and displayed no signs of anxiety.				
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       Avalon Place Kirbyville     700 N Herndon       Kirbyville, TX 75956     Kirbyville, TX 75956			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC		
F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Care plans for Residents #1, #2, #4 reviewed. The in-services/staff training provid Inappropriate Resident to Resident Supervision and Monitoring of Hall monitoring of unit. Staff were educa 3 while care is being delivered by th and to notify the nurse if additional contact #s and the facility Abuse Pr Facility staff were provided education	touching and reporting procedures. 3/Secure Unit. Content discussed and ated that one staff would be monitoring ne other staff member. Staff were instri- monitoring assistance is needed. Abus rohibition Guideline. on by DON/Designee on: and Monitoring and Unmanageable R	ied event and interventions were procedures discussed to facilitate Residents and the hallway on Hall ucted to take turns with these roles se-Content Abuse Coordinator -