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	09/04/2022

NAME OF PROVIDER OR SUPPLIER	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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14645 Based on observation, interview, and record review the facility failed to ensure the right to be free from abuse was provided for 3 of 5 residents reviewed for abuse. (Resident #s 1, 2, and 3) The facility did not prevent Resident #1, who had a history of inappropriate sexual behavior, from sexually abusing Resident #2 on 9/1/22. Resident #1 was seen walking out of Resident #2's room. Resident #1 had blood on his thumb. Resident #2 was found with blood in her brief. Resident #1 was heard trying to get Resident #3 to go to his room. An Immediate Jeopardy (IJ) situation was identified on 9/3/22 at 2:59 p.m. While the IJ was removed on 9/4/22, the facility remained out of compliance at no actual harm with a potential for more than minimal harm with a scope identified as an isolated due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of abuse, physical harm, mental anguish, emotional distress, and death. Findings included: Record review of the facility's Abuse Prohibition Guideline dated 2022 indicated : .will ensure a safe environment for residents by prohibiting physical and mental abuse including involuntary seclusion, neglect, exploitation and misappropriation of property . E. Sexual Abuse is defined as non-consensual contact of any type with a resident, includes but is not limited to any unnecessary touching or exposure of the resident's breast or any part of the genitals without voluntary, informed consent and with the intention to arouse or gratify the sexual desire of any person. This definition is to include sexual harassment, sexual coercion, or any sexual assault. Prevention: 3. Residents identified as exhibiting abusive behaviors will be assessed and appropriate interventions included in the plan of care. 4.staff will immediately report and protect the resident if an allegation or observation of abuse has occurred. Protection: 1. All residents will be immediately protected from harm. 3. Allegations involving residents will necessitate assessment and interventions appropriate to protect the victim which may include a. temporary one on one supervision. b. transfer to another level of care. c. discharge home or to a family member/responsible party. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675220	A. Building B. Wing	09/04/2022

NAME OF PROVIDER OR SUPPLIER	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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of face sheet dated 9/4/22, 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 event 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 had moderate cognitive impairment, ambulated with a walker. He had Other behavioral symptoms not directed toward others which occurred 1 to 3 days. Resident #1 did not exhibit any wandering behaviors. 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. 5/6/22 Care plan meeting held with RP & ombudsman. Aware that any inappropriate behaviors would be immediate discharge. Record review of August 2022 behavior monitoring indicated Resident #1 did not display any behaviors. Record review of September 2022 behavior monitoring indicated Resident #1 was 8 - redirected on the 6:00 p.m. - 6:00 a.m. shift. Record review of face sheet dated 9/4/22, 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 brain to shrink (atrophy) and brain cells to die). Record review of MDS dated [DATE] indicated Resident #2 had severely impaired cognitive skills for daily decision making, had physical behaviors which occurred last 4 to 6 days but not daily, wandered last 4 to 6 days and used a wheelchair for mobility. Record review of face sheet dated 9/4/22, indicated Resident #3 was a [AGE] year-old female, admitted on [DATE], and her diagnoses included Alzheimer's (a progressive neurologic disorder that causes the brain 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 #3 had severe cognitive impairment, had no behaviors, and used a wheelchair for mobility. Record review of care plan dated 12/30/21 indicated Resident #3 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 resident's walker, 4/11/22 victim of inappropriate sexual gesture). During an observation on 9/3/22 at 9:43 a.m. with the DON, who verified staff and residents on the secure unit, of the facility's camera recordings on 9/1/22 from 6:16 p.m. to 7:28 p.m. indicated: (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	09/04/2022

NAME OF PROVIDER OR SUPPLIER	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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At 7:18 p.m. Resident #1 walked out of his room using his walker and stood near the common area. At 7:21 p.m. CNA A went into Resident #3's room and closed the door. At 7:23 p.m. LVN B left the secure unit, leaving no staff to monitor residents. At 7:24 p.m. Resident #1 walked to his room and leaned against the wall in the hallway. At 7:25 p.m. Resident #1 walked across the hall into Resident #2's room. At 7:27 p.m. CNA A left Resident #3's room and walked down the hall. She looked in Resident #1's room and then continued to a closet on hall. At 7:28 p.m. Resident #1 walked out of Resident #2's room. During an observation on 9/3/22 at 11:20 a.m., Resident #2 was in her bed. There were no visible injuries in her periarea. She had a scab on her right 3rd toenail. Resident #2 was non-verbal and not able to answer questions. She did not appear afraid. Record review of progress note dated 04/11/22 at 4:08 p.m., completed by LVN L, indicated CNA F heard Resident #3 scream no don't do that when she entered the room. The door was open and she witnessed Resident #1 standing behind Resident #3. Resident #1 was holding on to Resident #3 with one hand, his pants were down and he was exposed. Resident #3's pants were down and she was exposed. Record review of In-service training for CNA A on 7/12/22 and LVN B on 8/22/22 indicated they were trained on Supervision & Monitoring of hall 3 secure unit .There must be hallway monitor in hall 3 at all times-especially when wandering residents or residents at high risk for adverse behaviors are active. One CNA or other staff is to stay in hallway & be alert for residents wandering into other resident's rooms. CNA's can take turns being hall monitor and if a resident requires two CNA's for care there must be a nurse or other staff member to fill hall monitor roll. Record review of a progress note dated 8/31/22 at 9:00 p.m., completed by LVN B, indicated Resident #1 asked an unidentified aide if he could have her while making rounds. Record review of a progress note dated 9/1/22 at 10:23 a.m., completed by LVN D, indicated Resident #1 was noticed standing at his door looking into the hallway masturbating. The CNA that saw this told him to go to his room, to his bed to do that and he cannot do it outside of his room. After this occurred, he also was asking a female resident to come into his room. The CNA heard this and told him to stop asking female residents to his room, he said OK. Later that day he was seen looking in on female resident lying in bed and redirected by CNA. Record review of a progress note completed by LVN B dated 9/1/22 at 7:37 p.m. indicated Resident #1 was found in Resident #2's room by aide and was asked to leave the room. Aide on the hall called for another nurse to come into the unit to assess the residents. This resident (#1) was found with blood on his left thumb by other nurse. Other nurse asked this resident not to wash his hands so that she could take a picture while she was on the phone with the DON. This nurse was in the room assessing resident #2, found blood in resident #2's brief and around the vaginal and rectal area. DON notified. (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	09/04/2022

NAME OF PROVIDER OR SUPPLIER	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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of an incident report dated 9/1/22, prepared by the DON, indicated alleged by a staff nurse that this resident (Resident #1) went into a female resident room and allegedly touched her inappropriately. Record review of a progress note dated 9/2/22 at 7:10 a.m. completed by the DON indicated Incorrect charting with staff education provided: resident confidentiality, charting of facts and not assumptions, and charting incorrect chart. This nurse was at facility for assessment of this resident and concern. This charting is not fact. Record review of a progress note dated 9/2/22 at 12:28 p.m. completed by the DON indicated Resident (#1) has been referred to behavioral hospital related to his inappropriate behaviors this week. This nurse spoke with LVN at behavioral and all paperwork sent to her. Residents RP is aware of referral. Resident is agreeable to go to behavioral if accepted. Record review of a progress note dated 9/1/22 at 7:56 p.m. completed by LVN B indicated Resident #2 found with blood in her brief and on her peri area after Resident #1 left her room. Resident also has dried blood on the bed. DON notified. Assessed resident and she does not appear in any pain at this time. During an interview on 9/3/22 at 8:48 AM, RN J asked surveyors if they were at the facility for the incident. When asked which incident, RN J said the incident with Resident #1. She said he had another incident and thinks it was sexual. She said she did not know the details. She said she thought resident #1 was on 15-minute checks and thought the incident had been reported to the state agency. She was the DON in April 2022 when Resident #1 was found with Resident #3. During an interview on 9/3/22 at 8:50 a.m., CNA F said Resident #1's supervision level was 15 minutes checks. She said the 15 minutes checks had been discontinued (unknown date) and then started back on 9/1/22 due to his behaviors. She said he was sexually inappropriate. She said he would masturbate in the doorway of his room. She said there was supposed to be someone in the hallway at all times to monitor residents and ensure Resident #1 did not wander into other female residents' rooms. She said there was only one CNA assigned to the secure unit from 6:00 p.m. through 6:00 a.m. and the nurse worked multiple halls. She said she was not supposed to leave the hall to do care if there was no staff to monitor the hall. She said there was not a dedicated staff to monitor the hall after 6:00 p.m. She had been trained on abuse and neglect. During an interview on 9/3/22 at 8:59 a.m., CNA G said she was aware of Resident #1's sexually inappropriate behaviors. She said there was always supposed to be a staff on the hall to supervise the residents and ensure Resident #1 did not go into other residents' rooms. During an interview on 9/3/22 at 9:00 a.m., CNA H said there was always supposed to be a staff in the hallway of the secure unit to monitor residents and to ensure Resident #1 did not go into female resident rooms. (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	09/04/2022

NAME OF PROVIDER OR SUPPLIER	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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/3/22 at 9:24 AM, the DON said resident #1 was having inappropriate sexual behaviors like masturbating in the hall and saying inappropriate things to staff. The nurses called her around 7 PM on Thursday night and said Resident #1 was seen coming out of resident #2's room. She was told there was blood on Resident #2's sheet. She was told LVN C had seen blood on resident #1's thumb. CNA A said there was blood in the middle of Resident #2's bed. She said she took a flashlight to Resident #2's room to assess the resident in order to see any tears in the periarea. She said she did not see any blood or tears in Resident #2's private area. She said Resident #2 had feces and urine in her brief. She said there was a toenail that had been ripped off and assumed that was where the blood had come from on the bed. She said the staff jumped to conclusions about sexual abuse. She did not think Resident #2 was sexually abused because the blood had come from the toenail and she did not see any blood, just brown feces in the brief. She said Resident #2 was not able to answer any questions. The DON said Resident #1 was sent to a behavior hospital on 9/2/22 due to his increased sexual behaviors. She said she did not report to the state agency or to the police because she did not think there was any sexual abuse. She said she documented in the progress notes about incorrect documentation from the LVN B who thought Resident #2 had been abused. During an interview on 9/3/22 at 9:44 AM, the DON said the nurse was supposed to be on the secure unit when the aide was working in a room so there would be somebody monitoring the hall. During an interview on 9/3/22 at 10:32 a.m., LVN D said she was the charge nurse on the secure unit. She said Resident #1 had been placed on every 15-minute checks on 9/1/22 due to having increased sexual behaviors. She said he had been on 15-minute checks after the incident with Resident #3 in April 2022, but they had been stopped because he had not been having any sexual behaviors. She said there was supposed to be someone monitoring the hall to keep residents from wandering into other resident rooms. During an interview on 9/3/22 at 11:35 AM, LVN B said she saw blood in resident #2's brief and near the resident's buttocks on the evening of 9/1/22. She said CNA A also saw the blood. LVN B she was not told someone was to be monitoring the halls prior to the incident on 9/1/22. She was aware of Resident #1 having a previous sexual incident but said he was not on any special supervision prior to 9/1/22. During an interview on 9/3/22 at 12:34 PM, LVN C said she saw resident #1 with blood on his left thumb. When asked if she was sure it was blood, she said she was 100% sure it was blood on his thumb. She said she saw resident #2's brief pulled to the side when CNA A asked her to look. CNA A thought the brief looked out of place. When she asked Resident #1 why he had blood on his thumb, he said I don't know, I don't know. (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	09/04/2022

NAME OF PROVIDER OR SUPPLIER	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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/3/22 at 2:42 PM CNA A said Resident #2's brief was not centered. She said she saw blood on the sheets and began to look to see where the blood came from. She decided to change resident #2's brief. When she pulled the front down off the Resident, she saw the blood and ran to get the nurse. She said she did not change the resident until the DON arrived. She was not sure what time the DON got to the facility but thought it was about an hour or so after the incident. CNA A said she saw blood on resident #2's private area too. She said the DON said there was no blood on the resident when she arrived later that evening. She said it was still red when the DON got to the facility. CNA A said she knew they were supposed to have a monitor on the hall, but the nurse wasn't always on the hall when she needed to provide care. Resident #1 had been in the hall when she started her rounds and LVN B was still on the hall. CNA A said she had only worked at the facility since the end of July. She said a few days after she started working at the facility Resident #1 asked her if he could lick it, referring to her private area. She said CNA F told her Resident #1 was trying to coax Resident #3 into his room and they started 15-minute checks on 9/1/22. During an interview on 9/3/22 at 3:27 p.m., CNA K, who works the day shift, said the weekend prior (8/27/22 or 8/28/22) to the incident of Resident #1 going into Resident #2's room, she notified the charge nurse Resident #1 was looking into Resident #2's room and asked Resident #3 if she would go to his room. She said she thought the nurse was an agency nurse and could not recall her name. She said she told LVN D of the incident on 9/01/22. She said Resident #1 was put on 15 minutes checks. She said Resident #1 was taken off previous 15-minute checks but started to act weird and not his usual self. He was staring at Resident #2 when she was in her room. She said there was supposed to be one staff monitoring the hall of the secure unit at all times to ensure Resident #1 did not exhibit inappropriate sexual behaviors (masturbating) or go into other residents' rooms. During an interview on 9/4/22 at 11:16 a.m., the interim administrator said the DON was the abuse coordinator until a permanent administrator was hired. He said he was not told there was any allegation of sexual abuse involving the two residents. He only was told Resident #1 was in Resident #2's room and there was blood on her sheets. During an interview on 9/4/22 at 1:43 p.m., NP E said she was the NP for Resident #1. She said she told the facility not to take Resident #1 back when he had gone to the behavior hospital in April 2022 due to his sexual behaviors. She said the nurse from the secure unit sent a fax to the office on 9/1/22 informing her of the incident with Resident #1 and #2. She said she saw the fax on 9/2/22. NP E said she was not scheduled to be at the facility on 9/2/22 but felt she needed to visit the facility to find out more about the incident. She said when she got to the facility, the DON told her nothing had happened between the residents. She said if the facility was not able to meet the needs of Resident #1. She said if the facility took him back, she would be giving the resident a 30-day discharge and he would need to find another physician. During an interview on 9/4/22 at 1:50 p.m., the DON said all staff were trained on monitoring the hallway on the secure unit at the time of the previous incident with Resident #1 and then all new hires received the training at time of hire. The facility was notified of the Immediate Jeopardy on 9/3/22/22 at 2:59 p.m. and the DON was provided the Immediate Jeopardy template. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy. (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	09/04/2022

NAME OF PROVIDER OR SUPPLIER	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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Facility's Plan of Removal for Immediate Jeopardy was accepted on 9/4/22 at 11:59 a.m. and reflected the following: Please accept the following plan of removal: 1. Notify V.P of Clinical Operations of immediate Jeopardy status - Done- 09/3/22@ 3:16 PM per DON 2. Notify Regional Director of operations of Immediate Jeopardy status - Done -09/03/22@ 3:24 PM per DON. 3. Notify facility Medical Director of Immediate Jeopardy status- Notified via E-mail by DON on 09/03/22 @ 6:59 PM. 4. Initiate report of incident to HHSC. Done 09/03/22@ 3:42 per DON. 5. Notify Kirbyville Police Department of incident. Done 09/03/22 @ 5:15 PM Per DON. 6. Resident #1-Was immediately placed on 15 minute beginning @ 1040AM on 09/01/22. Attending MD /Designee were notified on 9/1@ 10:40 AM. Responsible party were notified on 9/1 @ 10:40 AM. Medication orders were received on 9/1 @ 1040 AM for Premarin 0.3 MG Daily and initiated on 9/1 @ 11AM. He remained on 15 minute monitoring until transferred to a Behavioral Hospital @ 5:06 PM on 9/2. He remains at a behavioral hospital at time of this report. Regarding resident #1 -A meeting to discuss Resident #1's readmission status to the facility will be scheduled and conducted with representatives to include ADM, Behavior Hospital, Ombudsman, Responsible Party, Med Dir, PCP, Psyche Services NP, Ombudsman and facility IDT committee. If Resident #1 returns to the facility, he will be placed on 1:1 monitoring until status is determined. 7. Resident #2 was assessed by facility DON on 9/1 @ 8:30 PM with no visible injuries noted. She was calm. Attending MD /Designee were notified on 9/2 @ 4:59 AM. Responsible party was notified on 9/2@ 4:59AM. 8. Residents who reside on the secure unit have had skin assessments completed by the Treatment Nurse for any unidentified concerns with zero concerns identified. Initiated 9/3 @ 630 PM by DON. Completed 9/3 @ 845 PM by Treatment Nurse. 9. Residents who reside on the secure unit were evaluated for any physical aggressive behaviors with none identified. Initiated 9/3/22 @ approximately 6PM by DON. Completed 9/3/22 @ 7:45 PM by DON. Care plans for Residents #1 and #2 were updated to reflect identified event and interventions were reviewed /updated if indicated (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	09/04/2022

NAME OF PROVIDER OR SUPPLIER	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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10.Facility staff were provided education by DON/Designee on: 10a) Procedures for Inappropriate Resident to Resident touching and /or Sexually Inappropriate Behaviors. Staff were instructed to separate and protect the residents. Evaluate residents involved for any injury, pain or emotional impact. Notify MD, Responsible party, DON and ADM promptly. Initiate monitoring or increased supervision if indicated and document interventions. Initiated 9/3/22 @ 6PM and completed at 7:30 PM. 36 attendees. Follow-up sessions will resume on 9/4/22. 10b) Supervision and Monitoring of Hall 3/Secure Unit. Discussion of procedures to be utilized to facilitate monitoring of unit by staff. Staff were instructed that one staff member would be responsible for being stationed in the hallway to monitor Residents in the hallway while care is being provided in other areas of the unit by another staff member. The staff member in the hallway is to monitor Residents for any wandering into other Residents' rooms or inappropriate behavior and provide redirection or request assistance from other staff if needed. Staff were educated to communicate their location with each other when leaving the unit or going into an unobserved area (i.e. Resident's room, shower, etc) to make sure the other staff member is aware of need to be on hallway monitoring duty during that time period. Staff can rotate the roles as needed to complete tasks and maintain monitoring. If two staff are required for Resident cares, then a nurse or other staff member must be in place to provide hall monitoring role. Staff were advised to call for assistance from staff outside unit if needed for additional monitoring assistance if needed. Notify DON or ADM of any concerns promptly. Initiated on 9/3/22 @ 6pm, completed 7:30 PM. 36 attendees. Follow-up sessions will resume on 9/4/22. 10c) Resident to Resident Altercations - Interventions and approaches to be implemented. Evaluate for any injuries or psychosocial impact. Increase supervision if indicated. Notify MD, Responsible party and DON/ADM promptly. Initiated 9/3/22 @6 pm, completed 7:30 PM. 36 attendees. Follow-up sessions will resume on 9/4/22. 10d) Abuse-Content. Abuse Coordinator - contact #s and the facility Abuse Prohibition Guideline. Initiated 9/3/22 @ 6pm, completed 7:30 PM. 36 attendees. Follow-up sessions will resume on 9/4/22. The DON is the Abuse Coordinator. 11. Staff who were not on duty will be notified, to come to the facility for education by the DON/designee. No staff will be allowed to work on the floor until education has been completed for items 10a-10d. Administrator, DON, and MDS Coordinator will monitor for employee completion of required education topics. Administrator, DON, MDS Coordinator and HR Director will conduct audits of current facility employees and indicate completion dates for required education. Staff are being notified to report to facility for education completion via phone and texts. Notifications started on 9/3/22 @ 5PM and are continuing 9/4/22. Administrator, DON and MDS Coordinator will continue to audit, notify and provide education items until all employees have completed the requirement. (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	09/04/2022

NAME OF PROVIDER OR SUPPLIER	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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	12. Safe surveys were conducted for Residents on the secure unit who could be interviewed and reside in the facility general population area with no safety or abuse concerns identified. Initiated 9/3/22 @ 6pm per social worker. Completed 9/3/22 @ 7:15PM per Social Worker. 8 Residents interviewed. 14. Facility Administrator and the DON were provided education on compliance and monitoring procedures. The facility Abuse Prohibition Guide was reviewed and discussion on investigation and reporting processes reviewed. Education provided by VP of Clinical Operations. Initiated 9/3/22 @ 9PM, completed @ 9:30PM. On 9/4/22, the surveyors confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: Observations, interviews, and record reviews were conducted on 9/4/22 from 12:00 p.m. through 3:35 p.m. and included 5 alert residents, 5 nurses including 1 RN, 4 LVNs, and 4 CNAs (who work all shifts), SW, and DON. Staff were able to identify inappropriate resident to resident touching and reporting procedures, supervision/monitoring on the secure unit, resident-resident altercations, and who the abuse coordinator was. 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 on unit 3/secure unit. Staff were able to give examples of resident-to-resident touching and/or sexually inappropriate behaviors. Resident #1 remained at the behavioral hospital. Record review of his care plan was updated to reflect the incident. Resident #2 did not appear in distress and did not recall the incident. Record review of her care plan indicated it was updated to reflect the incident. Resident #3 did not appear in any distress. The in-services/staff training provided by the DON/Designee included: Inappropriate Resident to Resident touching and reporting procedures. (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	09/04/2022

NAME OF PROVIDER OR SUPPLIER	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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Supervision and Monitoring of Hall 3/Secure Unit. Content discussed and procedures discussed to facilitate monitoring of unit. Staff were educated that one staff would be monitoring Residents and the hallway on Hall 3 while care is being delivered by the other staff member. Staff were instructed to take turns with these roles and to notify the nurse if additional monitoring assistance is needed. Abuse-Content Abuse Coordinator - contact #s and the facility Abuse Prohibition Guideline. Facility staff were provided education by DON/Designee on: Behavior Assessment, Intervention and Monitoring and Unmanageable Residents. Facility staff were provided education by DON/Designee on resident to resident altercations, content including reporting procedures, interventions, and documentation procedures. Staff who were not on duty were notified to come to the facility for education by the DON/designee. All staff working in the facility were educated. Administrator, DON and MDS Coordinator indicated they will continue to audit, notify, and provide education items until all employees have completed the requirement. 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. No residents indicated they were afraid of any residents. The facility Administrator and the DON were provided education on compliance and monitoring procedures by V.P. Of Clinical Operations. On 9/4/22 at 4:05p.m., the interim Administrator was informed the IJ was removed; however, the facility remained out of compliance with no actual harm with a potential for more than minimal harm with a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems. 25115

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	09/04/2022

NAME OF PROVIDER OR SUPPLIER	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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14645 Based on interview and record review, the facility failed to ensure all alleged violations involving of mistreatment, neglect, abuse, or misappropriation of resident property were reported immediately, but not later than 24 hours after the allegation was made to other officials (including to the State Agency) for 2 of 7 residents (Resident #1 and #2) reviewed for reporting. An allegation of sexual abuse was made on 9/1/22. The facility did not report the allegation of abuse until surveyor intervention on 9/3/22. Resident #2 allegedly sexually abused Resident #1. This failure could place residents at risk of continued abuse, neglect, or misappropriation. Findings included: Record review of the facility's Abuse Prohibition Guideline 2022 indicated The Health Care Center will conduct an investigation of all alleged or suspected cases of abuse, neglect or misappropriation of property, and will provide notifications and information to the proper authorities according to state and federal regulations . Investigations 1. The Health Care Center will thoroughly investigate all alleged violations/allegations and take appropriate actions. No later than 2 hours if the allegation involves abuse or results in serious bodily injury, and no later than 24 hours if the allegation does not involve abuse and does not result in serious bodily injury. Record review of face sheet dated 9/4/22, 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 event 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 had moderate cognitive impairment, ambulated with a walker. He had Other behavioral symptoms not directed toward others which occurred 1 to 3 days. Resident #1 did not exhibit any wandering behaviors. 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. 5/6/22 Care plan meeting held with RP & Ombudsman. Aware that any inappropriate behaviors would be immediate discharge. Record review of face sheet dated 9/4/22, 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 brain to shrink (atrophy) and brain cells to die). (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	09/04/2022

NAME OF PROVIDER OR SUPPLIER	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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of MDS dated [DATE] indicated Resident #2 had severely impaired cognitive skills for daily decision making, had physical behaviors which occurred last 4 to 6 days but not daily, wandered last 4 to 6 days and used a wheelchair for mobility. Record review of an incident report dated 9/1/22 at 7:25 p.m., prepared by the DON, indicated Alleged by a staff nurse that this resident (Resident #1) went into a female resident room and allegedly touched her inappropriately. Record review of a progress note dated 8/31/22 at 9:00 p.m., completed by LVN B, indicated Resident #1 asked an unidentified aide if he could have her while making rounds. Record review of a progress note dated 9/1/22 at 10:23 a.m., completed by LVN D, indicated Resident #1 was noticed standing at his door looking into the hallway masturbating. The CNA that saw this told him to go to his room, to his bed to do that and he cannot do it outside of his room. After this occurred, he also was asking a female resident to come into his room. The CNA heard this and told him to stop asking female residents to his room, he said OK. Later that day he was seen looking in on female resident lying in bed and redirected by CNA. Record review of a progress note completed by LVN B dated 9/1/22 at 7:37 p.m. indicated Resident #1 was found in Resident #2's room by aide and was asked to leave the room. Aide on the hall called for another nurse to come into the unit to assess the residents. This resident (#1) was found with blood on his left thumb by other nurse. Other nurse asked this resident not to wash his hands so that she could take a picture while she was on the phone with the DON. This nurse was in the room assessing resident #2, found blood in resident #2's brief and around the vaginal and rectal area. DON notified. Record review of a progress note dated 9/1/22 at 7:56 p.m. indicated Resident #2 found with blood in her brief and on her peri area after Resident #1 left her room. Resident also has dried blood on the bed. DON notified. Assessed resident and she does not appear in any pain at this time. Record review of a progress note dated 9/2/22 at 7:10 a.m. completed by the DON indicated Incorrect charting with staff education provided: resident confidentiality, charting of facts and not assumptions, and charting incorrect chart. This nurse was at facility for assessment of this resident and concern. This charting is not fact. Record review of a progress note dated 9/2/22 at 12:28 p.m. completed by the DON indicated resident has been referred to behavioral hospital related to his inappropriate behaviors this week. This nurse spoke with LVN at behavioral and all paperwork sent to her. Residents RP is aware of referral. Resident is agreeable to go to behavioral if accepted. During an interview on 9/3/22 at 8:48 AM, RN J asked surveyors if they were at the facility for the incident. When asked which incident, RN J said the incident with Resident #1. She said he had another incident and thinks it was sexual. She said she did not know the details. She said she thought resident #1 was on 15-minute checks and thought the incident had been reported to the state agency. (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	09/04/2022

NAME OF PROVIDER OR SUPPLIER	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 contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/3/22 at 9:24 AM, the DON said Resident #1 was having inappropriate sexual behaviors like masturbating in the hall and saying inappropriate things to staff. She was made aware on 9/1/22 of the behaviors. The nurses called her around 7 PM on Thursday night (9/1/22) and said Resident #1 was seen coming out of resident #2's room. She was told there was blood on Resident #2's sheet. She was told LVN C had seen blood on resident #1's thumb. CNA A said there was blood in the middle of Resident #2's bed. She said she took a flashlight to Resident #2's room to assess the resident. Using the flashlight to see, she said there was no blood or tears in Resident #2's private area. She said Resident #2 had feces and urine in her brief. She said there was a toenail that had been ripped off and assumed that was where the blood had come from on the bed. She said the staff jumped to conclusions about sexual abuse. She did not think Resident #2 was sexually abused because she assumed the blood had come from Resident #2's toenail and she did not see any blood, just brown feces in the brief. She said Resident #2 was not able to answer any questions. The DON said Resident #1 was sent to a behavior hospital on 9/2/22 due to his sexual behaviors. She said she did not report the incident to the State agency because she did not think there was any abuse. She said she made an entry in both Residents' charts because the documentation indicated there was sexual abuse when she felt there was no abuse. She said she did get statements from the staff involved. During an interview on 9/3/22 at 12:34 PM, LVN C said she saw resident #1 with blood on his left thumb. When asked if she was sure it was blood, she said she was 100% sure it was blood on his thumb. She said he washed his hand before she could get a picture of the blood. She said she saw resident #2's brief pulled to the side when CNA A asked her to look. CNA A thought the brief looked out of place. When she asked Resident #1 why he had blood on his thumb, he said I don't know, I don't know. During an interview on 9/4/22 at 11:16 a.m., the interim administrator said the incident with Resident #1 was never given to him as an allegation of abuse or he would have reported the incident. He was only told Resident #1 was in Resident #2's room and there was blood on the sheets. He said from his understanding there was never an allegation of any abuse. He said the DON was the abuse coordinator until a permanent administrator was hired. 25115

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	09/04/2022

NAME OF PROVIDER OR SUPPLIER	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 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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14645 Based on observation, interview, and record review the facility failed to ensure residents received adequate supervision to prevent abuse for 3 of 11 residents (Resident #s 1, 2, and 3) reviewed for supervision. The facility staff did not provide supervision to prevent Resident #1 from sexually abusing Resident #2 on 9/1/22. Resident #1 was seen walking out of Resident #2's room. Resident #1 had blood on his thumb. Resident #2 was found with blood in her brief. Resident #1 was heard trying to get Resident #3 to go to his room. An Immediate Jeopardy (IJ) situation was identified on 9/3/22 at 2:59 p.m. While the IJ was removed on 9/4/22, the facility remained out of compliance at no actual harm with a potential for more than minimal harm with a scope identified as an isolated due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of abuse, physical harm, mental anguish, emotional distress, and death. Findings included: 1. Record review of face sheet dated 9/4/22, 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 event 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 had moderate cognitive impairment, ambulated with a walker. He had Other behavioral symptoms not directed toward others which occurred 1 to 3 days. Resident #1 did not exhibit any wandering behaviors. 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. 5/6/22 Care plan meeting held with RP & ombudsman. Aware that any inappropriate behaviors would be immediate discharge. Record review of face sheet dated 9/4/22, 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 brain to shrink (atrophy) and brain cells to die). Record review of MDS dated [DATE] indicated Resident #2 had severely impaired cognitive skills for daily decision making, had physical behaviors which occurred last 4 to 6 days but not daily, wandered last 4 to 6 days and used a wheelchair for mobility. (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	09/04/2022

NAME OF PROVIDER OR SUPPLIER	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 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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of face sheet dated 9/4/22, indicated Resident #3 was a [AGE] year-old female, admitted on [DATE], and her diagnoses included Alzheimer's (a progressive neurologic disorder that causes the brain 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 #3 had severe cognitive impairment, had no behaviors, and used a wheelchair for mobility. Record review of care plan dated 12/30/21 indicated Resident #3 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 resident's walker, 4/11/22 victim of inappropriate sexual gesture). During an observation on 9/3/22 at 9:43 a.m. with the DON, who verified staff and residents on the secure unit, of the facility's camera recordings on 9/1/22 from 6:16 p.m. to 7:28 p.m. indicated: At 7:18 p.m. Resident #1 walked out of his room using his walker and stood near the common area. At 7:21 p.m. CNA A went into Resident #3's room and closed the door. At 7:23 p.m. LVN B left the secure unit, leaving no staff to monitor residents. At 7:24 p.m. Resident #1 walked to his room and leaned against the wall in the hallway. At 7:25 p.m. Resident #1 walked across the hall into Resident #2's room. At 7:27 p.m. CNA A left Resident #3's room and walked down the hall. She looked in Resident #1's room and then continued to a closet on hall. At 7:28 p.m. Resident #1 walked out of Resident #2's room. During an observation on 9/3/22 at 11:20 a.m., Resident #2 was in her bed. There were no visible injuries in her periarea. She had a scab on her right 3rd toenail. Resident #2 was non-verbal and not able to answer questions. She did not appear afraid. Record review of progress note dated 04/11/22 at 4:08 p.m., completed by LVN L, indicated CNA F heard Resident #3 scream no don't do that when she entered the room. The door was open and she witnessed Resident #1 standing behind Resident #3. Resident #1 was holding on to Resident #3 with one hand, his pants were down and he was exposed. Resident #3's pants were down and she was exposed. Record review of a progress note dated 8/31/22 at 9:00 p.m., completed by LVN B, indicated Resident #1 asked an unidentified aide if he could have her while making rounds. (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	09/04/2022

NAME OF PROVIDER OR SUPPLIER	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 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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a progress note dated 9/1/22 at 10:23 a.m., completed by LVN D, indicated Resident #1 was noticed standing at his door looking into the hallway masturbating. The CNA that saw this told him to go to his room, to his bed to do that and he cannot do it outside of his room. After this occurred, he also was asking a female resident to come into his room. The CNA heard this and told him to stop asking female residents to his room, he said OK. Later that day he was seen looking in on female resident lying in bed and redirected by CNA. Record review of Resident #1's Q (every) 15 Min (minute) Monitoring indicated the facility began monitoring Resident #1 every 15 minutes beginning 9/1/22 at 10:45 a.m. Record review of a progress note completed by LVN B dated 9/1/22 at 7:37 p.m. indicated Resident #1 was found in Resident #2's room by aide and was asked to leave the room. Aide on the hall called for another nurse to come into the unit to assess the residents. This resident (#1) was found with blood on his left thumb by other nurse. Other nurse asked this resident not to wash his hands so that she could take a picture while she was on the phone with the DON. This nurse was in the room assessing resident #2, found blood in resident #2's brief and around the vaginal and rectal area. DON notified. Record review of a progress note dated 9/1/22 at 7:56 p.m. indicated Resident #2 found with blood in her brief and on her peri area after Resident #1 left her room. Resident also has dried blood on the bed. DON notified. Assessed resident and she does not appear in any pain at this time. Record review of a progress note dated 9/2/22 at 7:10 a.m. completed by the DON indicated Incorrect charting with staff education provided: resident confidentiality, charting of facts and not assumptions, and charting incorrect chart. This nurse was at facility for assessment of this resident and concern. This charting is not fact. Record review of a progress note dated 9/2/22 at 12:28 p.m. completed by the DON indicated resident has been referred to behavioral hospital related to his inappropriate behaviors this week. This nurse spoke with LVN at behavioral and all paperwork sent to her. Residents RP is aware of referral. Resident is agreeable to go to behavioral if accepted. During an interview on 9/3/22 at 8:48 AM, RN J asked surveyors if they were at the facility for the incident. When asked which incident, RN J said the incident with Resident #1. She said he had another incident and thinks it was sexual. She said she did not know the details. She said she thought resident #1 was on 15-minute checks and thought the incident had been reported to the state agency. She was the DON in April 2022 when Resident #1 was found with Resident #3. During an interview on 9/3/22 at 8:50 a.m., CNA F said Resident #1's supervision level was 15 minutes checks. She said the 15 minutes checks had been discontinued (unknown date) and then started back up due to his behaviors. She said he was sexually inappropriate. She said he would masturbate in the doorway of his room. She said there was supposed to be someone in the hallway at all times to monitor residents and ensure Resident #1 did not wander into other female residents' rooms. She said there was only one CNA assigned to the secure unit from 6:00 p.m. through 6:00 a.m. and the nurse worked multiple halls. She said she was not supposed to leave the hall to do care if there was no staff to monitor the hall. She said there was not a dedicated staff to monitor the hall after 6:00 p.m. (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	09/04/2022

NAME OF PROVIDER OR SUPPLIER	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 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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/3/22 at 9:24 AM, the DON said resident #1 was having inappropriate sexual behaviors like masturbating in the hall and saying inappropriate things to staff. The nurses called her around 7 PM on Thursday night and said Resident #1 was seen coming out of resident #2's room. She was told there was blood on Resident #2's sheet. She was told LVN C had seen blood on resident #1's thumb. CNA A said there was blood in the middle of Resident #2's bed. She said she took a flashlight to Resident #2's room to assess the resident. She said she did not see any blood or tears in Resident #2's private area. She said Resident #2 had feces and urine in her brief. She said there was a toenail that had been ripped off and assumed that was where the blood had come from on the bed. She said the staff jumped to conclusions about sexual abuse. She did not think Resident #2 was sexually abused because the blood had come from the toenail and she did not see any blood, just brown feces in the brief. The DON said Resident #1 was sent to a behavior hospital on 9/2/22 due to his sexual behaviors. During an interview on 9/3/22 at 9:44 AM, while viewing the video footage, the DON said the nurse was supposed to be on the secure unit when the aide was working in a room so there would be somebody monitoring the hall. She said she could see on the video, the halls were not being monitored when Resident #1 went into Resident #2's room between the 15-minute checks. During an interview on 9/3/22 at 10:32 a.m., LVN D said she was the charge nurse on the secure unit. She said Resident #1 had been placed on every 15-minute checks on 9/1/22 due to having increased sexual behaviors. She said he had been on 15-minute checks after the incident with Resident #3 in April 2022, but they had stopped because he had not been having any sexual behaviors. She said there was supposed to be someone monitoring the hall to keep residents from wandering into other resident rooms. During an interview on 9/3/22 at 11:35 AM, LVN B said she saw blood in resident #2's brief and near the resident's buttocks on the evening of 9/1/22. She said CNA A also saw the blood. LVN B she was not told someone was to be monitoring the halls prior to the incident on 9/1/22. She was aware of Resident #1 having a previous sexual incident but said he was not on any special supervision prior to 9/1/22. During an interview on 9/3/22 at 12:34 PM, LVN C said she saw resident #1 with blood on his left thumb. When asked if she was sure it was blood, she said she was 100% sure it was blood on his thumb. She said she saw resident #2's brief pulled to the side when CNA A asked her to look. CNA A thought the brief looked out of place. When she asked Resident #1 why he had blood on his thumb, he said I don't know, I don't know. (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	09/04/2022

NAME OF PROVIDER OR SUPPLIER	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 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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/3/22 at 2:42 PM CNA A said Resident #2's brief was not centered. She said she saw blood on the sheets and began to look to see where the blood came from. She decided to change resident #2's brief. When she pulled the front down off the Resident, she saw the blood and ran to get the nurse. She said she did not change the resident until the DON arrived. She was not sure what time the DON got to the facility but thought it was about an hour or so after the incident. CNA A said she saw blood on resident #2's private area too. She said the DON said there was no blood on the resident when she arrived later that evening. She said it was still red when the DON got to the facility. CNA A said she knew they were supposed to have a monitor on the hall, but the nurse wasn't always on the hall when she needed to provide care. Resident #1 had been in the hall when she started her rounds and LVN B was still on the hall. CNA A said she had only worked at the facility since the end of July. She said a few days after she started working at the facility Resident #1 asked her if he could lick it, referring to her private area. She said CNA F told her Resident #1 was trying to coax Resident #3 into his room and they started 15-minute checks on 9/1/22. During an interview on 9/3/22 at 3:27 p.m., CNA K, who works the day shift, said the weekend prior (8/27/22 or 8/28/22) to the incident of Resident #1 going into Resident #2's room, she notified the charge nurse Resident #1 was looking into Resident #2's room and asked Resident #3 if she would go to his room. She said she thought the nurse was an agency nurse and could not recall her name. She said she told LVN D of the incident on 9/01/22. She said Resident #1 was put on 15 minutes checks. She said Resident #1 was taken off previous 15-minute checks but started to act weird and not his usual self. He was staring at Resident #2 when she was in her room. She said there was supposed to be one staff monitoring the hall of the secure unit at all times to ensure Resident #1 did not exhibit inappropriate sexual behaviors (masturbating) or go into other residents' rooms. During an interview on 9/3/22 at 1:46 p.m., NP I said the facility notified him on 9/1/22 of Resident #1's increased behaviors. He said he advised the facility to contact Resident #1's physician and obtain a prescription for Premarin (a female hormone). He said it would have prevented sexual urges. During an interview on 9422 at 12:53p.m., the SW said she was not aware of any incidents involving Resident #1. She said she should have been told and she would have done a mental health assessment. The SW said she was employed by the facility at the time of the previous incident in April 2022 with Resident #1 when he was found behind Resident #3 and both of them had their pants down. She said there had been a care plan meeting with Resident #1's family and ombudsman. She said they talked about Resident #1's sexual behaviors and if it happened again, he would be immediately discharged . She said it should be in the care plan. During an interview on 9/4/22 at 1:43 p.m., NP E said she was the NP for Resident #1. She said she told the facility not to take Resident #1 back when he had gone to the behavior hospital in April 2022 due to his sexual behaviors. She said the nurse from the secure unit sent a fax to the office on 9/1/22 informing her of the incident with Resident #1 and #2. She said she saw the fax on 9/2/22. NP E said she was not scheduled to be at the facility on 9/2/22 but felt she needed to visit the facility to find out more about the incident. She said when she got to the facility, the DON told her nothing had happened between the residents. She said if the facility was not able to meet the needs of Resident #1. She said if the facility took him back, she would be giving the resident a 30-day discharge and he would need to find another physician. (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	09/04/2022

NAME OF PROVIDER OR SUPPLIER	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 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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's Safety and Supervision of Residents policy revised July 2017 indicated Facility-Oriented Approach to Safety -1. Our facility-oriented approach to safety addresses risks for groups of residents . Individualized, Resident-Centered Approach to Safety - .2. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. Systems Approach to Safety - 1. The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazard identified in the environment and individual resident risk factors, and then adjusts interventions accordingly. W. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. 3. The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment (such as construction) or if there is a change in the resident's condition. The facility was notified of the Immediate Jeopardy on 9/3/22/22 at 2:59 p.m. and the DON was provided the Immediate Jeopardy template. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy. The Facility's Plan of Removal for Immediate Jeopardy was accepted on 9/4/22 at 11:59 a.m. and reflected the following: Please accept the following plan of removal: 1. Notify V.P of Clinical Operations of immediate Jeopardy status - Done- 09/3/22@ 3:16 PM per DON 2. Notify Regional Director of operations of Immediate Jeopardy status - Done -09/03/22@ 3:24 PM per DON. 3. Notify facility Medical Director of Immediate Jeopardy status- Notified via E-mail by DON on 09/03/22 @ 6:59 PM. 4. Initiate report of incident to HHSC. Done 09/03/22@ 3:42 per DON. 5. Notify Kirbyville Police Department of incident. Done 09/03/22 @ 5:15 PM Per DON. (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	09/04/2022

NAME OF PROVIDER OR SUPPLIER	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 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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. Resident #1-Was immediately placed on 15 minute beginning @ 10:40AM on 09/01/22. Attending MD /Designee were notified on 9/1@ 10:40 AM. Responsible party were notified on 9/1 @ 10:40 AM. Medication orders were received on 9/1 @ 1040 AM for Premarin 0.3 MG Daily and initiated on 9/1 @ 11AM. He remained on 15 minute monitoring until transferred to a Behavioral Hospital @ 5:06 PM on 9/2. He remains at a behavioral hospital at time of this report. Regarding resident #1 -A meeting to discuss Resident #1's readmission status to the facility will be scheduled and conducted with representatives to include ADM, Behavior Hospital, Ombudsman, Responsible Party, Med Dir, PCP, Psyche Services NP, Ombudsman and facility IDT committee. If Resident #1 returns to the facility, he will be placed on 1:1 monitoring until status is determined. 7. Resident #2 was assessed by facility DON on 9/1 @ 8:30 PM with no visible injuries noted. She was calm. Attending MD /Designee were notified on 9/2 @ 4:59 AM. Responsible party was notified on 9/2@ 4:59AM. 8. Residents who reside on the secure unit have had skin assessments completed by the Treatment Nurse for any unidentified concerns with zero concerns identified. Initiated 9/3 @ 630 PM by DON. Completed 9/3 @ 845 PM by Treatment Nurse. 9. Residents who reside on the secure unit were evaluated for any physical aggressive behaviors with none identified. Initiated 9/3/22 @ approximately 6PM by DON. Completed 9/3/22 @ 7:45 PM by DON. Care plans for Residents #1 and #2 were updated to reflect identified event and interventions were reviewed /updated if indicated. 10.Facility staff were provided education by DON/Designee on: 10a) Procedures for Inappropriate Resident to Resident touching and /or Sexually Inappropriate Behaviors. Staff were instructed to separate and protect the residents. Evaluate residents involved for any injury, pain or emotional impact. Notify MD, Responsible party, DON and ADM promptly. Initiate monitoring or increased supervision if indicated and document interventions. Initiated 9/3/22 @ 6PM and completed at 7:30 PM. 36 attendees. Follow-up sessions will resume on 9/4/22. 10b) Supervision and Monitoring of Hall 3/Secure Unit. Discussion of procedures to be utilized to facilitate monitoring of unit by staff. Staff were instructed that one staff member would be responsible for being stationed in the hallway to monitor Residents in the hallway while care is being provided in other areas of the unit by another staff member. The staff member in the hallway is to monitor Residents for any wandering into other Residents' rooms or inappropriate behavior and provide redirection or request assistance from other staff if needed. Staff were educated to communicate their location with each other when leaving the unit or going into an unobserved area (i.e. Resident's room, shower, etc) to make sure the other staff member is aware of need to be on hallway monitoring duty during that time period. Staff can rotate the roles as needed to complete tasks and maintain monitoring. If two staff are required for Resident cares, then a nurse or other staff member must be in place to provide hall monitoring role. Staff were advised to call for assistance from staff outside unit if needed for additional monitoring assistance if needed. Notify DON or ADM of any concerns promptly. Initiated on 9/3/22 @ 6pm, completed 7:30 PM. 36 attendees. Follow-up sessions will resume on 9/4/22. (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	09/04/2022

NAME OF PROVIDER OR SUPPLIER	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 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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10c) Resident to Resident Altercations - Interventions and approaches to be implemented. Evaluate for any injuries or psychosocial impact. Increase supervision if indicated. Notify MD, Responsible party and DON/ADM promptly. Initiated 9/3/22 @6 pm, completed 7:30 PM. 36 attendees. Follow-up sessions will resume on 9/4/22. 10d) Abuse-Content. Abuse Coordinator - contact #s and the facility Abuse Prohibition Guideline. Initiated 9/3/22 @ 6pm, completed 7:30 PM. 36 attendees. Follow-up sessions will resume on 9/4/22. The DON is the Abuse Coordinator. 11. Staff who were not on duty will be notified, to come to the facility for education by the DON/designee. No staff will be allowed to work on the floor until education has been completed for items 10a-10d. Administrator, DON, and MDS Coordinator will monitor for employee completion of required education topics. Administrator, DON, MDS Coordinator and HR Director will conduct audits of current facility employees and indicate completion dates for required education. Staff are being notified to report to facility for education completion via phone and texts. Notifications started on 9/3/22 @ 5PM and are continuing 9/4/22. Administrator, DON and MDS Coordinator will continue to audit, notify and provide education items until all employees have completed the requirement. 12. Safe surveys were conducted for Residents on the secure unit who could be interviewed and reside in the facility general population area with no safety or abuse concerns identified. Initiated 9/3/22 @ 6pm per social worker. Completed 9/3/22 @ 7:15PM per Social Worker. 8 Residents interviewed. 14. Facility Administrator and the DON were provided education on compliance and monitoring procedures. The facility Abuse Prohibition Guide was reviewed and discussion on investigation and reporting processes reviewed. Education provided by VP of Clinical Operations. Initiated 9/3/22 @ 9PM, completed @ 9:30PM. On 9/4/22, the surveyors confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: Observations, interviews, and record reviews were conducted on 9/4/22 from 12:00 p.m. through 3:35 p.m. and included 5 alert residents, 5 nurses including 1 RN, 4 LVNs, and 4 CNAs (who work all shifts), SW, and DON. Staff were able to identify inappropriate resident to resident touching and reporting procedures, supervision/monitoring on the secure unit, resident-resident altercations, and who the abuse coordinator was. 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. (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	09/04/2022

NAME OF PROVIDER OR SUPPLIER	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 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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 on unit 3/secure unit. Staff were able to give examples of resident-to-resident touching and/or sexually inappropriate behaviors. Resident #1 remained at the behavioral hospital. Record review of his care plan was updated to reflect the incident. Resident #2 did not appear in distress and did not recall the incident. Record review of her care plan indicated it was updated to reflect the incident. Resident #3 did not appear in any distress. The in-services/staff training provided by the DON/Designee included: Inappropriate Resident to Resident touching and reporting procedures. Supervision and Monitoring of Hall 3/Secure Unit. Content discussed and procedures discussed to facilitate monitoring of unit. Staff were educated that one staff would be monitoring Residents and the hallway on Hall 3 while care is being delivered by the other staff member. Staff were instructed to take turns with these roles and to notify the nurse if additional monitoring assistance is needed. Abuse-Content Abuse Coordinator - contact #s and the facility Abuse Prohibition Guideline. Facility staff were provided education by DON/Designee on: Behavior Assessment, Intervention and Monitoring and Unmanageable Residents. Facility staff were provided education by DON/Designee on resident-to-resident altercations, content including reporting procedures, interventions, and documentation procedures. Staff who were not on duty were notified to come to the facility for education by the DON/designee. All staff working in the facility were educated. Administrator, DON and MDS Coordinator indicated they will continue to audit, notify, and provide education items until all employees have completed the requirement. 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. No residents indicated they were afraid of any residents during interviews of residents on the secure unit. The facility Administrator and the DON were provided education on compliance and monitoring procedures by V.P. Of Clinical Operations. (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	09/04/2022

NAME OF PROVIDER OR SUPPLIER	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 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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/4/22 at 4:05p.m., the interim Administrator was informed the IJ was removed; however, the facility remained out of compliance with no actual harm with a potential for more than minimal harm with a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems. 25115