STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675801	A. Building B. Wing	04/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gilmer Nursing and Rehabilitation	703 Titus Street Gilmer, TX 75644

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 19401 Based on observation, interview, and record review the facility failed to ensure residents were free from sexual abuse for 2 of 4 residents (Resident # 2, Resident #3 Resident #5, Resident #6) reviewed for abuse from Resident #1 The facility failed to protect cognitively impaired female residents from unwanted sexual behaviors from Resident #1. The facility failed follow their Abuse Policy in providing an environment free from abuse. The facility failed to develop or update a care plan that provided actual interventions for Resident #1's aggressive sexual behaviors. The facility failed to notify/consult with the physician regarding Resident #1'scontinuous sexual inappropriate behaviors. Resident #1 resided on a Dementia care unit with 6 female residents' and his sexual aggressive behaviors were not monitored. An Immediate Jeopardy (IJ) situation was identified on 4/22/22 at 2:43 p.m. While the IJ was removed on 4/23/22, the facility remained out of compliance at no actual harm with potential for more than minimal harm with a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems. These failures placed residents on the secure unit at risk of diminished abuse and neglect. Findings included: Review of the facility census report indicated there was a census of 11 residents on the locked unit. There were 7 males and 6 females. (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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1.)Review of Resident #1's Admission Records -Information Sheet indicated he was an [AGE] year-old male admitted to the facility on [DATE]. Resident #1's diagnoses included, unspecified dementia without behavioral disturbances, mood disorder due to known psychological psychosocial condition with depressive features, personality changes due to known physiological conditions, unspecified abnormalities of gait and mobility, Wernicke's (chronic alcohol induced) encephalopathy, and history of brain trauma. Review of Resident # 1's MDS dated [DATE] indicated his cognitive status was 4 (0-7 severely impaired.) The balance during transition and walking indicated it did not occur for standing, walking or moving on and off the toilet. His functional status was he required extensive assist of one person to transfer. His locomotion on the unit was supervision set up help only, and locomotion off the unit was supervision one set up only. The MDS indicated behavioral symptoms not directed toward others physical symptoms such as hitting or scratching, self-pacing, rummaging, or public sexual acts occurred 1-3 times a week. He also had a behavior of wandering that occurred daily. Resident #1 care area assessment indicated that he had a behavioral symptom that triggered review. Review of Resident #1's care plan dated 2/2/22 indicated a focus area of behavior sexually inappropriate as evidenced by referral to a behavioral hospital on 9/27/2021 related to sexual behaviors. Paxil increased to 60 mg. A focus area of urology consult made for possible removal of penile implant device dated 9/28/21 some interventions were report incidents of inappropriate sexual behavior to charge nurse if other residents CNA or involved immediately intervening to protect the safety of all residents. The goal was resident will have no episodes of sexually inappropriate behavior in the next 90 days. The interventions were to evaluate the resident's ability to understand behavior and consequences of their behavior and explain to the resident the acceptable expressions of sexually based on the cognitive. A focus area indicated Resident #1 has impaired cognitive function dementia or impaired thought process. The resident also had a focused area of he is at risk for wandering the goal was resident number one would not leave the facility unattended. Review of physician's orders indicated Resident #1 was admitted to locked unit on 1/26/19. Review of Behavior Nursing notes dated 9/27/22, and 9/28/22 indicated to monitor Resident #1 for sexual behaviors toward residents and staff. There were no other Behavior notes noted. Review of Resident #1's nursing notes indicated: On 9/25/21 at 7:28 a.m. resident is being monitored for sexual behaviors. He continued to have intermittent impulsive behaviors at times. He is easily redirected MD made aware. Increase Paxil to 60 mg and continue to monitor behaviors. On 9/29/21 at 12:15 p.m. in appropriate behaviors with female resident. Resident relocated to a different area. On 1/21/22 at 4:35 p.m. CNA reported the resident was being sexually inappropriate in the unit dining room. The nurse spoke with the resident, but he does not recall anything. Review of Resident #1's physician's order dated 2/15/22 indicated Risperdal 0.5mg to be given one time a day related to personality change due to know physiological condition. An order dated 2/24/22 indicated to discontinue Risperdal 0.5 mg. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's nursing notes indicated: On 2/15/22 at 10:23 a.m. staff reported resident grabbing her in her private area and saying vulgar things to her, administrator notified. Review of physician orders dated 3/29/22 indicated Resident #1 had an order for Paxil 60 mg. Review of Resident #1's nursing notes dated 4/10 /22 at 12:36 p.m. indicated, Resident noted to be sexually inappropriate with several female residents. Attempted to redirect without success the resident went into another room and this nurse showed him where his room was, and he went into his room and was sleeping in the chair when last observed the nurse spoke with the resident and told him he cannot be touching females. The resident argued that he didn't know why, stated he was just helping her put her pants, on administrator notified. (Note written by LVN H) Review of Resident #1's Diagnostic Evaluation dated 9/3/21 indicated the nursing staff stated the Resident was recently involved in a consensual sexual interaction but he was also sexually inappropriate with staff. He has some delusional thought process present. The resident has problems with social situations. Increased the Residents Paxil to 40 mg. Psychiatric notes dated 11/30/21 and 2/16/22 indicated no sexual contact or exposure without consent. There was no other mention of sexual behaviors. The plan was to discharge the resident from services, Risperdal was added. The resident was discharged from services on 2/16/22. 2.) Review of Resident #2's MDS dated [DATE] indicated she was an [AGE] year-old female admitted to the facility on [DATE]. Her cognitive skills for daily decision making was 3 indicating Severely Impaired. She had behaviors that occurred 4 of 6 days. Behavioral symptoms directed towards others (hitting, kicking, pushing, scratching, grabbing, abuse other sexually) also other behavioral symptoms not directed toward others (physical symptoms such as hitting, or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing, or smearing food or bodily wastes, or verbal symptoms like screaming or disruptive sounds.) she had a behavior of rejection of care 4 to 6 days. Resident #2's functional status was she required extensive assistance for bed mobility transfer, she did not walk in the corridor, she required extensive assist of two people for dressing and toilet use. She required extensive assist with meals of one person. Resident # 2 used a manual wheelchair for mobility. Some of her diagnoses were altered mental status unspecified and Alzheimer's Disease. Review of Resident #2's care plan dated 3/30/22 indicated a focus area of cognitive function dementia or impaired thought process. Some of the interventions were the resident needed assistance or supervision with all decision making. 3.) Review of Resident #3's Admission Records -Information Sheet indicated she was [AGE] year-old female. She was admitted to the facility on [DATE]. Her diagnosis were psychotic disorders with hallucinations due to unknown psychological condition, major depression disorder recurrent severe without psychotic features, anxiety disorder unspecified, history of falling, muscle weakness, unsteadiness on feet, and lack of coordination. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident # 3's MDS dated [DATE] indicated her cognitive skills for daily decision making was 2 indicating moderately impaired. Resident # 3's behaviors were wandering, and this type of behavior occurred daily. The MDS indicated that Resident #3's functional status was in walking room with the supervision one person assist. The MDS indicated Resident #3's diagnosis were Alzheimer's dementia, anxiety disorder depression, and a history of falling. Review of Resident #3's care plan dated 2/2/22 indicated Resident #3 had a focused area of communication problem. Some of the interventions were be conscious of Resident #3's position when in groups, and activities consistent simple directive sentences and provide a safe environment. Provide her with necessary cues, stop and return if agitated. The care plan indicated Resident #3 had a focus area of wandering. Resident #3 had a focus area of ADL self-care performance deficit. Some of the interventions were toilet use in personal hygiene and the interventions was dressing required one person assist. Review of Resident #5's Admission Records -Information Sheet indicated she was a [AGE] year-old female admitted to the facility on [DATE]. Some of her diagnoses were schizoaffective disorder, bipolar type, intermittent explosive disorder, and intellectual disabilities. Review of Resident #6's Admission Records -Information Sheet indicated she was a [AGE] year-old female admitted to the facility on [DATE]. Some of her diagnoses were Alzheimer's disease, psychotic disorder, and anxiety disorder. Review of Resident #6's care plan dated 11/1/21 indicated a focus area of sexually inappropriate behavior as evidenced by enhanced interest in male visitors. At times she is more visual, other times she attempts to reach out for the person. The initial start dated was 7/20/21, a revision was done on 8/20/21. An intervention was to evaluate Resident #6's ability to understand behavior and consequences of that behavior. Review of Resident #6's Event Nurses Notes dated 9/3/21 and 9/4/21 indicated she would not stay away from male resident, inappropriate sexual behaviors with male resident, and will not stay out of male resident room. During an interview with LVN B on 4/20/22 at 2:50 p.m. she said Resident #1 was very confused. Sometimes he got sexually aggressive with other residents. He had a penial implant. The urologist deflated the implant however, he still had times he got sexually inappropriate, he would masturbate, and tried to touch female residents, and staff. They put him on anti-depressants. When he was inappropriate, we try to move him and get his mind somewhere else. There was only one resident on the unit that would be able to complain. Resident #5 will scream if he goes near her door. She said she was not aware of any inappropriate behaviors by Resident #1 towards Resident #5. They do not get along, but she does not know why. . During an interview on 4/21/22 at 9:30 a.m. SNA C said Resident #1 was sexually inappropriate. She said he tried to play with himself in front of staff. She said she saw him touch a female resident in the past (Resident #6) and that resident was now discharged . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/21/22 at 9:39 a.m. LVN D said Resident #1 had dementia and was diabetic. LVN said he was not actually aggressive but had sexual behaviors. He would expose himself to anyone and masturbated in front of other people. LVN said Resident #1 thought other women were his wife. LVN D said she saw him touch the aides sometime. He tried to touch female residents occasionally. LVN said one resident (Resident #6) thought he was her husband but she passed away. Some of the ladies in the past welcomed his touch. During an interview on 4/21/22 at 10:15 a.m. with CNA F said Resident #1 would play with himself in the dining room in front of other residents. She said he tried to touch her inappropriately. He would try to touch female residents on the leg. A few weeks ago, he was masturbating in the dining room. She took him to his room and told him it was inappropriate. He said, Why? It feels good. During an interview on 4/21/22 at 10:39 a.m. the MDS Coordinator LVN G said she was also responsible for completing care plans. She said Resident #1 had a penile implant that was malfunctioning to the point it would not go down in September 2021. He was sent to the urologist and they deflated it. They said he had a button in his testicles that was pushed to deflate it. It could also be pushed and inflate it if he wanted. She said the care plans dated 9/27/21 and 9/28/21 concerned his behaviors at that time and his trip to the urologist for deflation. The MDS coordinator said occasionally, Resident #1 had a tendency of sexually inappropriate behaviors. She said those were his only care plans dealing with the sexual behaviors. She said he would play with himself and others if he could do so. During an interview on 4/21/22 at 11:20 a.m. the DON said she never actually saw sexually inappropriate behaviors from Resident #1. He liked to antagonize Resident #5. The DON said she only saw Resident #1 go to her door. Resident #5 had a very traumatic childhood if said anything inappropriate. It could upset her. Resident #5 would scream when he went near her room. She said when Resident # 1 was inappropriate he would be redirected. The DON said she had heard other staff say Resident #1 was inappropriate in the past. She was not aware of any recent issues. During an interview with the Administrator on 4/21/22 at 12:11 p.m. the Administrator said she did not know the timeline with Resident #1. When he started to be aggressive with staff they reached out to the urologist. They reached out to his family. There was a female resident (Resident #6) that was sexually promiscuous. She enticed Resident #1 back in September of last year. According to the Administrator that was when Resident #1 started exhibiting sexually inappropriate behaviors. She said the two residents would hold hands and her behavior escalated his behaviors. Resident #6 thought Resident #1 was her husband or boyfriend. His family told us she looked like his wife. His behaviors were masturbating and touching the CNAs. According to the Administrator that type of behavior stopped months ago. The Administrator said the nurse did not tell her about the incident on 4/10/22 that was in the nursing notes. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 4/21/22 at 12:37 p.m. with LVN H (the nurse who wrote the note on 4/10/22) said she was glad to be called. LVN H said on 4/10/22 Resident #2 was sitting at a table in the dining room. Resident #1 was observed rubbing Resident #2's left breast. He saw LVN H and he started rubbing Resident #2's arm. Resident #1 was moved away from the female resident. Resident #3 went into a vacant room to use the bathroom. LVN H said when she entered the room Resident #3 was sitting on the bed with her brief around her ankle. Resident #1 was sitting in his wheelchair in front of the bed and had his hand on his upper thigh. She and RN I helped her get dressed Resident #3 dressed and helped Resident #1 out of the room. The DON had a death in her family, and she did not want to call her. LVN H said she called and left a message on administrators' phone and the Administrator never returned the call. She said she placed the call on 4/10/22 12:46 p.m. (A screenshot of her phone was sent with the date and time. The administrator verified that was her number.) LVN H said in between times Resident #1 rolled toward a female resident (she could not remember who) flickering his tongue in a provocative way. Later in the afternoon she told the Activity Director the exact same story. She said she put a vague description in the nurses note. She did not know what to chart or how to chart. She did not notify the family members or call the physician. LVN H said she told the aides to watch Resident #1, she told them he was touching female residents. During an interview on 4/21/22 at 12:47 p.m. the, Activity Director said Resident #1 was who he was. He wanted to be with women. The Activity Director said she had no idea what LVN H said about Resident #1. She did say something about Resident #1, but she complained about everything and everyone. The Activity Director said all she knew about Resident #1 was that he liked women, and he will rub on them. She said some of the staff said Resident #1 would follow females around. During an interview on 4/21/22 at 1:22 p.m. CNA J said Resident #1 had days when he is really perverted, he will try to touch on female butts. She said she had not seen him touch residents but had seen him touch staff. She had not heard him say anything vulgar. She said if she talked to him, he would have a conversation. A couple of months ago he tried to touch her bottom, but after she told him to stop, he stopped. According to CNA J he understood what stop meant. She said it had probably been about 2 months since she saw him do anything. However, she had only worked on the unit once or twice this month. During an interview on 4/21/22 at 1:31 p.m., CNA F said she was not working in the unit on 4/10/22. She said when she went to Unit the nurse, LVN H said on 4/10/22 to watch Resident#1. He was touching Resident #2 or Resident #3. CNA F said she could not remember exactly what she said. It was around lunch time. CNA F said Resident #3 for certain. LVN H did not go into details. She had seen Resident #1 on two occasions in the past sitting at the table in the dining room masturbating and told him that was not appropriate. He was at the dining room table and other residents were with him. The last time was about 3 weeks ago, another resident pointed him out. CNA F said she did not see him doing anything. She left to go and do something and when she returned, he was out in the open masturbating. Sometimes when Resident #1 was changed he would try to touch the aide. Resident #1 did not know the difference between staff and residents he touched her on the bottom. He did not know from the back who the CNA was, according to her she could have been a resident. CNA F said Resident #3 would walk down the hall in only her brief. She is really confused sometimes. Resident #3 would take her clothes off but could not put them back on by herself. She often went to others room to use the bathroom. CNA F said she did not think Resident #2 and Resident # 3 could say no to sexual overtures. CNA F said usually Resident # 5 was the one that says things to Resident #1. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 4/21/22 at 1:48 p.m., RN I said on 4/10/22 she saw Resident #1 in the room with Resident #3. RN I said she did not know what he was doing, she had not his hands. When she came into the room what she saw was Resident #1 in the room with Resident #3. She saw Resident #3's pants and brief were down. She thought LVN H charted his behavior. RN I said she did not remember what exactly was said, she was anxious that day it was her first day on the job. She remembered LVN H called and left a message on administrations phone. She said LVN H told the aides on the unit to watch him, and the two nurses watched him on the camera. An interview with the Administrator and observation of the facility video monitoring of the unit was done on 4/21/22 at 2:27 p.m. The date observed was 4/10/22. Resident #3 was observed to be walking all morning. Resident #3 walked to a chair in the dining room and sat down in a chair with arm rests. The video showed at approximately 8:58 a.m. Resident #1 wheeled up to Resident #3. They had a conversation. There is no volume on the video. He started to rub and pat Resident #3 on the arm for about a minute. His fingers are seen moving up and down. Both residents were facing the same direction. He was sitting on her right side. Resident #1 reached his right hand over and started to rub Resident #3's knee and his hand went higher. Resident #3 got up and wandered around the building. Approximately 3 or 4 minutes later she came back and sat down in the same chair. This time Resident #1 wheeled closer to the front of Resident #3. He reached over and started to rub her knee, it appeared to be her left knee. Resident #1's hand immediately went higher up her leg toward the inside of Resident #3's thigh. It was hard to tell exactly how high the rubbing went because of the view of the camera. This went on for about 30 seconds. Resident # 3 got up and started to walk again. At approximately 9:19 a.m. Resident #1 wheeled up to Resident # 2, who was sitting at a table facing away from the camera. He looked around first, he was facing the camera. He was on her left side. Then Resident #1 took his hand and ran it through her hair. Resident #2 just sat there and did not move. He then started to rub on her left arm. Resident #2 did not move. He then reached his hands into her chest area and started to rub. He rubbed for a several seconds. Resident #2 moved her arm down to the table and blocks his access to her chest area. A few minutes later he started to rub her chest area again and a nurse moved him away from the Resident #2. The Administrator said that was not where Resident #2's breast was located. She did say she would not want a man rubbing her in the chest regardless of where her breast was located. Review of a facility self-report dated 4/21/22 indicated Resident #1 was reported to have been sexually inappropriate with residents on the morning of 4/10/22. This was discovered on 4/21/22 when surveyor read a progress note and inquired further into the events of 4/10/22. Resident #1 was placed on 15-minute checks and the physician was notified. During an interview on 4/22/22 at 10:12 a.m. the DON said they received Resident #1's notes from the psychiatrist's office. They were not in Resident #1's chart or at the facility until she requested them on yesterday. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/22/22 at 10:43 a.m. the Administrator said they did not know what to do with Resident #1. When they tried to send him to the behavioral hospital in September 2021the hospital would not take him due to his Wernicke's diagnosis, and the family said you can do what you need to do. She said he was on medications and the only other interventions was redirection. She said yesterday she made a facility self-report and put Resident # 1 on 15-minute monitoring to see how he is doing. She said that would last for 72 hours. After that time the DON would determine his baseline. From that 72-hour determination they would make changes if necessary. The Administrator said she had no idea prior to yesterday Resident #1 continued to exhibit sexually inappropriate behavior. She had not heard any issues since February. She said it was LVN H's perception of what had occurred. During an interview on 4/22/22 at 11:01 a.m. Activities Assistant said she had seen Resident #1 be sexually inappropriate a few weeks ago. Resident #1 was speaking inappropriately to Resident #3 but Resident #3 did not understand. The Activity Assistant said sometimes Resident #1 acted like he did not know what he is saying. Then there are days when he said things like. Come lay down with me, and I will make you feel good. The Activities Assistant said a few months ago he touched her on the bottom. She said she told the nurse but did not know who the nurse was. During an interview on 4/22/22 at 11:09 a.m. LVN D said no one told her anything recently about Resident #1. Resident #1 was currently on 15-minute monitoring. She said Resident #1 would misinterpret anything more than just minimal contact as something intimate. LVN D said she had not seen the note for 4/10/22. During an interview on 4/22/22 at 12:02 p.m. the SW she said she had worked part time for the facility for about a year. She would visit with Resident #1 when going through the unit. Resident #1 had never done anything vulgar with her. She said she heard bits and pieces about his behavior over the last year or so. However, she had not heard anything recently. During an interview on 4/22/22 at 1:47 p.m. Resident #1's MD said he increased Resident #1's medication because of his sexually inappropriate behaviors. He said he was not aware his sexual behaviors had continued. He said in Resident #1's case mediations would not be 100 percent effective. He could not say what he would do because he does not have all the facts. The MD said he needed to know how often his behaviors occurred, are they sporadic, are they getting worse. he said he might consider a medication adjustment if he had all the facts. Review the facilities abuse policy last revised 3/29/2018 indicated: The resident has the right to be free from abuse. The resident should not be subject to abuse by anyone including but not limited to facility staff or other residents . The facility will provide and ensure the promotion and protection of resident's rights. It is everyone's responsibility to recognize, report, and promptly investigate alleged abuse. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled using technology. Willful as used in this definition of abuse means the individual must have acted deliberately not that the individual must have intended to inflict injury or harm. Prevention the facility will provide the residents family and staff and environment free from abuse and neglect. The facility will be responsible to identify correct and intervene in situations of possible abuse neglect. The facility has placed a method to identify events such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility Secure Environment Admission Criteria and Process policy dated 2/1/17. The policy said the goal of the Secure Care Environment is meet the individual needs of residents with dementia related to illnesses. The Secure Care Environment will provide a safe environment that maximizes independence and provides an activity intensive atmosphere. Residents eligible for admission will have a diagnosis of dementia or related illness, have a physician's order, one or more of the criteria should be met but exceptions will be at the discretion of the administrator, and made on an individual basis. The residents admitted , if they exhibit physical abusive and or combative behaviors, they must be manageable through therapeutic approaches and or low to moderate medications. During an interview on 4/22/22 at 2:43 p.m. RN compliance nurse-Regional nurse consultant and Administrator were informed of the IJ situation. They were provided with the IJ template and it was explained to them. They were told they need to provide a Plan of Removal. The following Plan of Removal was submitted by the facility on 4/22/22 at 6:05 p.m. 4/22/2022 Plan of Removal Problem: Sexual Abuse Interventions: An additional designated staff member will be 1 on 1 for resident who initiated the encounter began on 4/22/22. 1 on 1 monitoring until discharge from the facility. The resident who initiated the encounters had his care plan updated on 4/22/22 regarding his sexual behaviors and the need for 1 on 1 supervision at this time. The ADM/DON/ADON/Human Resources Coordinator will interview other interview able residents regarding any inappropriate behavior from other residents on 4/22/22. The DON/ADON/MDS Nurse will complete a skin assessment on all residents on the secured unit. The ADM/DON/ADON will interview staff assigned to the secured unit regarding if they have observed any inappropriate/sexual behavior among residents on 4/22/22. After interviews, determine if other residents have the potential to act sexually inappropriate, if so, act accordingly with placing the resident on 1 on 1 supervision and get a social service or psychological evaluation. The ADM/DON/ADON will begin in-service on 4/22/22 for all staff. If staff is not working, they will be in serviced on 4/23/22. If staff are not in-serviced, they will be in-serviced prior to assuming their duties on their next scheduled shift regarding: (continued on next page)

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	675801	A. Building B. Wing	04/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gilmer Nursing and Rehabilitation	703 Titus Street Gilmer, TX 75644

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o Abuse/Neglect including resident sexual abuse/inappropriateness. Sexual abuse can occur when 1 or more residents are unable to consent to sexual activity that includes touching or exposure of breast, anus or genitalia. Sexual inappropriateness can be masturbating in a public area and/or, rubbing other areas of another resident's body (arm, back, legs) and kissing when 1 or both residents are unable to give consent. o If observed or reported: Separate the residents immediately The resident who instigated the act will be placed 1 on 1 supervision until further direction from Administrator or DON. Report any sexual abuse/inappropriateness to the administrator and DON immediately either in person or by speaking with them on the phone. The Regional Compliance nurse in-serviced the DON and Administrator on 4/22/22 regarding residents who are sexually inappropriate, including: o Continuing 1 on 1 supervision o Social Service and Psychological evaluations as needed if sexual inappropriate behaviors are identified. o Discharging the resident to psychiatric care, home, or another facility that can meet the resident's needs. i. e. a resident discharge to a same sex facility or unit. o Report any sexual abuse/inappropriateness to the physician immediately. The medical director was notified regarding this plan on 4/22/22 at 4:16pm. During an interview on 4/22/22 at 5:10 p.m. the administered said thy have a QA meeting at least once a month. She said she, the DON, Medical director and 15 department heads attend the meeting and aides are invited. She said the way their QA program works was they had QA daily reviews. That was how they determined what to look at during the actual meeting. She said they do real time evaluations such as the 24-hour reports. However, they had not discussed Resident #1's behavior during the QA meeting. During an interview on 4/22/22 at 4:52 p.m. LVN K said occasionally, Resident #1 would try to touch a female resident. He used to always hold his penis. He would try to touch ladies on the legs and anywhere he could. He was easily redirected. He had two ladies that were chasing after him back in September 2021 and they were both discharged . It has been a while since she saw him do anything. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/22/22 at 5:10 p.m. the Administered said thy had a QA meeting at least once a month. She said she, the DON, Medical director and 15 department heads attend the meeting and aides are invited. She said their QA program worked because they had QA daily reviews. That was how they determined what to look at during the actual meeting. She said they do real time evaluations such as the 24-hour reports. However, they had not discussed Resident #1's behavior during the QA meeting. Review of Resident #1's physician orders indicated he was discharged from the facility on 4/22/22 at 9:00 p. m. Review of Skin Assessments dated 4/22/22 for 11 residents on the locked unit did not indicate any issues. Review of written interviews dated 4/22/22 with 8 staff who worked the unit did not indicate any current issues of inappropriate behaviors. Review of Safe Survey Questionnaire on Sexual Abuse dated 4/22 and 4/23/22 for 45 interview able residents of the facility with no concerns noted. Interviews with 2 LVN (10-6), 1 RN and 1 LVN (weekend doubles) 2 CNAs, 2 SNAs, 1 laundry staff, Dietary Manager, Activity Director, and 1 MA revealed they had received the in service on abuse, inappropriate behaviors, notification, and identification of resident-to-resident behaviors and they appeared knowledgable of the training [TRUNCATED]

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19401 Based on interview and record review the facility failed to administer medications as prescribed by the physician resulting in a significant medication error for 1 of 2 resident reviewed for medications. (Resident #4) The facility failed to administer Resident #4 Eliquis- Apixaban (blood thinner) as prescribed for a DVT. After 4 days without the medications the Residents leg was swollen and painful. He was sent back to the hospital for treatment of pain and discomfort. This was determined to be past non-compliance due to the facility having implemented actions that corrected the non-compliance prior to the beginning of the survey. This failure could place residents at risk for pain, discomfort, and jeopardized his health and safety. Finding included: Review of Resident #4's Admission Records -Information Sheet indicated he was a [AGE] year-old male admitted to the facility on [DATE]. Some of Resident #4's diagnoses were metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood) unspecified dementia (loss of memory, problem solving skills and other thinking abilities) without behavioral disturbances, and unspecified abnormalities of gait and mobility. Review of Resident #4's nursing notes indicated he was transferred to the hospital on 2/6/22 at 7:15 a.m. related to venous Doppler (technique used to evaluate blood flow through the veins.) The results were positive for DVT (Deep Vein Thrombosis or blood clot in a deep vein) to the right leg. Review of Resident #4's hospital discharge medication list dated 2/11/22 indicated to continue Apixaban twice daily orally, 10 mg for two more days and then 5 mg two times a day after that for at least three months. Review of nurse's notes dated 2/11/22 at 12:49 p.m. indicated Resident #4 was readmitted with orders for Apixaban 10 mg tablet by mouth for two days for DVT. Then change to 5mg by mouth for 3 months. Review of nurse's notes dated 2/11/22 at 7:36 p.m. indicated Resident #4 orders for Apixaban 10 mg tablet by mouth for two days then dose change not available signed by LVN A. Review of the February 2022 MAR for Resident #4 revealed Apixaban 10 mg tablet given by mouth two times a day for DVT for two days and change to 5mg. The MAR indicated the medication was never given and was discontinued on 2/11/22 at 4:55 p.m. Review of Resident #4's February 2022 MAR indicated Apixaban 5mg by mouth two times a day for DVT for 3 months. The MAR indicated it was never given and was discontinued on 2/11/22 at 4:56 p.m. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of nursing note dated 2/14/22 at 12:01 a.m. indicated Resident #4's right leg swollen about twice the size as it was yesterday. The Resident was [NAME] in pain. The nurse was unable to palpate pulse but foot warm with noted pillar, physician note sent resident to ER. Review of Resident #4's A hospital note dated 2/14/22 at 2:00 a.m. indicated the patient presented with pain, swelling, and redness. The onset of symptoms of episode began to occur gradually. Symptom's severity department were unchanged he was here for pain in his leg and swelling initially reported by the nursing home. They said it started yesterday and it's gotten quite worse. However, some of their paperwork dated 2/3/22 noted he was going to be started on Eliquis for DVT in the leg. The patient was not on thinners currently and no diagnosis of DVT listed. He has no other complaints aside from the pain in his leg. The patient was discharged from here on 2/11/22 with a diagnosis of DVT and was supposed to be started on Eliquis and sent back with this at time of discharge. Review of the physician consult report dated 2/14/22 at 2:16 a.m. indicated Resident #4 with apparent known DVT to right lower extremity here for right lower extremity pain and swelling doesn't appear to be on thinners with start Lovenox. Review of Resident #4's nursing note dated 2/15/22 at 12:50 PM stated residents sent back to at the hospital around 4:00 AM with redness warmth and swelling too left lower extremity. Nurses were in serviced on the importance of transcribing orders correctly from hospital paperwork once admitted back to the facility. Review of Resident #4's Hospital patient report dated 2/18/22 and 8:57 AM indicated the resident right lower extremity venous Doppler sonogram examination was positive for DVT. Review of a nursing note dated 2/19/22 at 1:55 a.m. indicated resident here from the hospital for readmit he was awake responsive. Review of a Medication Error Form indicated the error occurred on 2/11/22 at 4:55 p.m. Upon returning from the hospital LVN A discontinued new orders for Eliquis which had been entered into the computer on a previous shift. LVN A said, I thought it meant to discontinue medications since it was under the discharged medications tab on return orders for the hospital. Actions taken to correct or prevent reoccurrence was to continue education and medication reconciliation and physician notification. The form was signed 2/14/22. Review of a facility self-report dated 2/14/22 indicated Resident #4 as admitted back to the facility from the hospital on 2/11/22 with an order for Eliquis -Apixaban (Blood Thinner). The report indicated on 2/14/22 Resident #4 was sent to the ER and the physician noted that this order was not followed. Attached to the report was medication error monitoring forms from 2/16 through 3/2/22. During an interview on 4/20/22 at 1:25 p.m. the Administrator said Resident #4 came to the facility with an order to start Eliquis-blood thinner. She said that Eliquis was discontinued on his medication list. He was at the facility for a few days but started having an issue with his leg. The Administrator stated the Resident #4 was discharged back to the hospital and came back. The doctor gave a regimen of Lovenox, he got better, and he went home. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview and record review on 4/21/22 at 11:20 a.m. the DON said LVN A was the nurse that failed to transcribe Resident #4's physician order. He had a DVT which was a deep vine thrombosis a blood clot. Resident #4 record review with DON indicated Resident #4's initial admitted was 1/6/22. He was sent to the hospital on 2/6/22 and came back to the facility on [DATE]. He did not receive Eliquis for his DVT diagnosis. He was sent back to the hospital on 2/15/22. The DON said LVN A put the order on MAR and discontinued it on the same day. The DON said LVN A said it was not available. During an interview on 4/22/22 at 3:45 p.m. LVN A said after she reviewed Resident #4's hospital orders and her notes she determined the medication error was all her fault. She looked at the hospital discharge medications list and thought it indicated to discontinue the medications. She was counseled and received am in serviced on medication transcription errors. It was determined these failures were corrected prior to the surveyor entering the facility. Facility took the following actions to correct the non-compliance: Review of an Inservice training dated 2/22/22 indicated it was essential that residents ordered anticoagulation medication Eliquis or Apixaban or receiving this medication, all new admit orders need to be checked for accuracy and we have to ensure medications or enter correctly going forward our residents on Eliquis will have their have a narcotic sign off sheet for all administered doses. Please make sure you are reordering medications at least three days before dose on card to ensure pharmacy has adequate time to refill. All residents currently on Eliquis takes two times a day so please order when you were down to eight to six doses left on the card. Review of a nursing note dated 3/29/22 indicated the Resident #4 was discharged to an assisted living with medications and belonging he left the facility via transport per wheelchair propelled by staff.