STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	08/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37012 Based on interview and record review, the facility failed to inform residents in advance of the risks and benefits of proposed care and treatment for 1 of 16 residents (Residents #8) reviewed for resident rights. The facility failed to inform, obtain consent and have Resident #8's physician explain the risks and benefits of proposed care, plan of treatment and/or treatment alternatives or treatment options prior to administering an injection of Depo-Provera to Resident #8 for the purpose to decrease his libido. This failure could place residents at risk of being unable to exercise their rights to make informed decisions regarding their treatment. Findings Include: Review of Resident #8's face sheet dated 8/18/21 indicated he was a [AGE] year old male, who was initially admitted to the facility on [DATE] with diagnoses to include: Huntington's Disease, Other obsessive compulsive disorder, Mild Cognitive impairment, Muscle Spasm, Unsteadiness on feet, Lack of Coordination. Review of Resident #8's Significant Change Minimum Data Set (MDS) assessment, dated 7/30/21, revealed Section B, hearing, Speech, and Vision, Resident #8 was able to make himself understood and he had the ability to understand with clear comprehension. Section C revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated he was cognitively intact. Section E Behavior revealed Resident #8 had physical behavioral symptoms directed towards others (.abusing others sexually) and other behavioral symptoms not directed toward others (public sexual acts) that had occurred within the past 1-3 days. Section E0500 indicated that the resident was at significant risk for physical illness or injury; E0600 impact on Others revealed a zero entered, which indicated there was not a risk of impact to others for physical injury, intrusion of privacy or activity of others and disruption of care or living environment. Section G revealed that Resident #8 required supervision and setup help with activities of daily living except for dressing, personal hygiene and bathing, which required the assistance of one staff member. Resident #8 did not require the use of any mobility devices. Section N revealed that Resident #8 had not received any injections within the past 7 days. Section Q indicated that Resident #8 participated in the assessment. Section V indicated that Care Areas were triggered and required a care plan decision for Behavioral Symptoms. (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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #8's care plan revealed a care plan addressing Resident #8's behaviors was not implemented until 8/12/21, which revealed the following: Problem start date: 8/12/21 Category: Behavioral Symptoms I have inappropriate sexual behaviors towards others. Created 8/12/21 by [LVN G], Goal: .I will have no inappropriate sexual behaviors towards others .Approach: staff will redirect and/or separate from others as needed. Staff will notify physician with any sexual behaviors. Staff will ensure resident takes prescribed medications Record review of resident # 8's Physician order report dated July 18th, 2021, revealed the following orders: Start Date 07/29/21 End Date 7/29/21: Depo-Provera (medroxyprogesterone) suspension; 150mg/mL; amt: 1mL; intramuscular Once a Day on the 1st of the month; 06:00AM-6:00PM, ordered by [Physician A]. Start Date 07/29/21 End Date 8/15/21 for Depo-Provera (medroxyprogesterone) suspension; 150mg/mL; amt: 1mL; intramuscular Once a Day on the 28th of the month; 06:00AM-6:00PM, ordered by [Physician A]. Start Date 08/15/21 End Date Open ended: Depo-Estradiol (estradiol cypionate) oil; 5mg/mL; amt: 150mg; intramuscular [DX: Other obsessive -compulsive disorder] Once a Day on the 15th of every 3rd month; ordered by [Physician A]. Start Date: 7/14/21 End Date: 7/14/21 Refer to Psych services for management of sexual behaviors Once-One Time . Ordered by [Physician A]. Start Date: 7/19/21 End Date: Open Ended- Please refer to senior psych care and or senior psychological care for evaluation and treatment as indicated. [Dx: Other recurrent depressive disorders]. Ordered by [Physician A]. According to the Mayo Clinic, Depo-Provera is a well-known brand name for medroxyprogesterone acetate, a contraceptive injection that contains the hormone progestin. Depo-Provera is given as an injection every three months. Depo-Provera typically suppresses ovulation, keeping your ovaries from releasing an egg. It also thickens cervical mucus to keep sperm from reaching the egg. Accessed on 8/30/21. https://www.mayoclinic.org/tests-procedures/depo-provera/about/pac-20392204 According to the Federal Drug Administration (FDA), Depo-Provera is a progestin indicated only for the prevention of pregnancy .The recommended dose is 150mg of Depo-Provera every 3 months (13 weeks) administered by deep, intramuscular (IM) injection in the gluteal or deltoid muscle Accessed on 8/30/21. https://www.accessdata.fda.gov/drugsatfda_docs/label/2015/020246s054,021583s026lbl.pdf Record review of the pharmacy manifest sheet, dated 7/29/21 revealed the following: 7/28/21 at 23:10 (11:10pm): [Resident #8] RX#5550801.00 Medroxyprogesterone 150mg/ml Quantity 1mL By signing here, I verify that the medications and items received on this delivery have been requested for fill/refill and accept receipt, Received by [nursing signature] Record review of Resident #8's progress notes revealed the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Date: 7/29/21 10:47a.m. [Recorded as Late Entry on 8/16/21 8:52pm] Depo-Estradiol injected in resident left upper extremity (LUE). Res (Resident) tolerated well. Denies any pain or discomfort. Edited by [LVN D] on 8/16/21 at 8:52pm, Reason: More Data Available. Record review of the Medication Administration Record (MAR) dated 7/29/21 did not reveal initials by a nurse to indicate administration for the medication of Depo-Estradiol. Date: 7/28/21 at 1:56pm Resident has a history of sexual behaviors. [Physician A] reviewed medications, order received Depo (Depo-Estradiol) 1mL month intramuscular (IM). Physician orders updated, essential caregiver (EC) [Family Member A] notified of updated orders . electronically signed by [Former DON] In an interview on 8/16/21 at 3:00pm, Family Member A indicated that she did not have medical power of attorney for Resident #8 and that she did not make medical decisions for him. Family Member A said that Resident #8 makes all his own medical decisions. In an interview on 8/17/21 at 2:40pm, the FNP said that she was aware of the medication Depo Provera that had been ordered for Resident #8 by Physician A. She said that she had seen the medication be used for overtly sexual behaviors in male residents. The FNP said that the Depo Provera has estrogen in it, so it decreased the male's testosterone levels and decreased their sexual impulses. The FNP said that male residents should still be able to achieve an erection but not as often as they normally would and that it is in a sense a form of a chemical castration but not as potent. In an interview on 8/17/21 at 2:59pm, the ADON said her understanding with administering the Depo-Provera shot to male residents is that it will lower the testosterone levels and lower their sex drive. The ADON was not sure if Resident #8 had been informed of the treatment plan for the Depo-Provera. In an interview on 8/17/21 at 4:00pm, the RNM said that the Depo-Provera was a preference that Physician A initiated and was told by Physician A that if that is not the treatment we initiate, then we are just asking for further resident to resident behaviors. The RNM said that it was hard to say if increased staff on the secure units would be more effective to mitigate the inappropriate sexual behaviors. The RNM said that Resident #8 should have been give an explanation by Physician A of what the Depo-Provera injection was being prescribed for prior to receiving the injection. In an additional interview on 8/17/21 at 5:26PM, Physician A said that the Depo Provera injection was not in the category of a psychotropic medication and that a consent was not required. It would be as if you were ordering a blood pressure medication to treat high blood pressure and that it would have only been necessary to inform or discuss the side effects or necessity at the next scheduled care plan meeting for [resident #8]. Physician A said that he had not spoken to Resident #8 or a family member of his regarding the treatment plan or side effects of the Depo-Provera injection. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/18/21 at 10:34am, Resident #8 said that he did recall receiving an injection, unable to recall the date but referenced it wasn't very long ago. Resident #8 said it was in his left arm and that LVN D had administered it. Resident #8 said he was not told what the injection was for. Resident #8 at this time was told by the surveyor that the injection was to decrease his sex drive due to Resident #8 not understanding what libido was. Resident #8 indicated that he did not want his sex drive decreased and would not have agreed to the injection had he been told was what it was for. Resident #8 said that he wanted to be able to achieve an erection and at this time of the interview, he said that he had not had any issues with not being able to achieve an erection. In an interview on 8/18/21 at 10:45am, LVN D said that she recalled administering an injection of Depo-Provera on July 29th, 2021. LVN D said she did explain to Resident #8 what the Depo-Provera injection was for, which LVN D said I told him it would help with his sexual urges he gets, I asked him if his behavior was appropriate or inappropriate, I explained to him that it would help with the urges he gets, and told him he needed to keep his hands to himself. LVN D said that if it is a simple yes or no, Resident #8 was able to make his own decisions but was not sure if he made his own decisions regarding his medications he was prescribed. LVN D said that the order for Depo Provera was originally received to be administered on the first day of every month, but he [Resident#8] continued with inappropriate sexual behaviors and the facility had received the medication on the 28th of July and the former DON instructed me to go ahead and administer on the 29th of July instead of waiting until August 1st. LVN D stated that is why the order was changed in the electronic chart from the first of the month to the 29th of each month. Record review of the facility's policy entitled, Medication Utilization and Prescribing-Clinical Protocol, dated April 2018 revealed the following: 1. When a medication is prescribed for any reason, the physician and staff will identify the indications (condition or problem for which it is being given, or what the medication is supposed to do or prevent), considering the resident's age, medical and psychiatric conditions, risks, health status, and exiting medication regimen .b. A symptom (confusion, pain, etc.) may have diverse causes, so it is usually relevant to try to identify likely causes and pertinent non-pharmacologic interventions. C. A diagnosis by itself may not be sufficient justification for prescribing a medication. The existence of a condition or risk does not necessarily require a treatment and the treatment may be something besides, or in addition to, medication .Cause Identification: 1. For any new onset or clinically significant symptom (for example, . change in mental status/behavior .) the physician and staff will review the possible contribution of one or more medications to the problem .Treatment/Management: .4. The staff and physician will identify and address unexpected, unintended, undesirable or excessive responses to a medication based on the severity of underlying conditions, the seriousness of any adverse drug reaction, risks of worsening of medical conditions, and other factors . (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy entitled Requesting, Refusing and or Discontinuing Care or Treatment, dated February 2021, revealed the following: Policy statement, Residents and resident representatives have the right to request, refuse and or discontinue treatment. Treatment refers to medical care, nursing care, and interventions provided to maintain or restore health and well-being, improve functional level, or relieve symptoms'. Policy Interpretation and Implementation: 1. Residents/representatives are informed in advance of: a. the care that will be furnished or made available to the resident based on his or her assessment and plan of care; b. the risk and benefits of the proposed care, treatment, treatment alternatives or treatment options; d. any changes to the resident's care plan. 2. Resident/s representatives are informed of his or her rights to: a. request, refuse and or discontinue treatment; .3. The resident is not forced to accept any care or treatment and may refuse or discontinue care or treatment at any time. This includes care or treatment prescribed by a physician, care or treatment that has been administered previously, and/or care or treatment that the resident previously agreed to but has not yet been administered .8. Detailed information relating to the request, refusal or discontinuation of treatment are documented in the resident's medical record. 9. Documentation pertaining to a resident's request, discontinuation or refusal of treatment includes at least the following: a. The date and time the care or treatment was attempted; e. that the resident was informed (to the extent of their ability to understand) of the purpose of the treatment and the potential outcome of not receiving the medication/or treatment .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 37012 Based on interviews and record reviews the facility failed to protect the resident's right to be free from sexual abuse for four (4) (Residents' #7, #8, #9, and #12) of sixteen (16) residents reviewed for abuse and neglect, as evidenced by: The facility failed to: a) Protect Resident #12 (unable to consent) from Resident #8 being sexually inappropriate with him on 06/11/21, Resident #8 was observed by facility staff to display inappropriate sexual behavior with Resident #12 when guiding Resident #12's hand on Resident #8's penis in an up/down motion. b) Protect Resident #9, on 7/14/21, from exposure to Resident #8 standing over him, masturbating while Resident #9 was lying in his bed. (Resident #9 unable to consent). c) Protect Resident #7 and #8 from being sexually inappropriate, (Resident #7 is unable to consent) with one another on an unknown date the mid part of July 2021, unknown date around the end of July 2021 and on 7/28/21; specifically Resident #7 and Resident #8 were witnessed being fully exposed from the waist down and engaged in inappropriate sexual activity that ranged from Resident #7 having his hand on Resident #8's erect penis moving in an upward and downward motion, Resident #7's hand being observed in the anal region of Resident #8's body moving in an upward and downward motion and Resident #7 having his erect penis between Resident #8's buttocks. An Immediate Jeopardy (IJ) existed from 6/11/21 until 8/11/21. The IJ was determined to be at past noncompliance as the facility had implemented actions that corrected the noncompliance prior to the beginning of the survey. These failures placed residents at risk of unwanted sexual advances, abuse and mistreatment. Findings Included: Resident #7 Review of Resident #7's face sheet dated 8/18/21 indicated he was a [AGE] year old male, who was initially admitted to the facility on [DATE] with diagnoses to include: Dementia with behavioral disturbance, Other obsessive-compulsive disorder, Personality change due to known physiological condition, Major depressive disorder, single episode, severe without psychotic features, Pseudobulbar affect, Anoxic brain damage, not elsewhere classified, Essential hypertension (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 #7's Quarterly Minimum Data Set (MDS) assessment, dated 7/09/21, revealed Section B, hearing, Speech, and Vision, Resident #7 was rarely/never understood or rarely/never had the ability to understand others. Section C revealed Resident #7 was unable to perform a Brief Interview for Mental Status (BIMS), therefore a staff assessment for mental status was obtained and indicated there was a memory problem and that the resident was able to recall the location of his own room, and his cognitive skills for daily decision making were moderately impaired (decisions poor; cues/supervision required) and Resident #7 was noted to have disorganized thinking (rambling or irrelevant conversation, unclear or illogical flow of ideas Section E Behavior revealed Resident #7 had not displayed any behaviors. Section G revealed that Resident #7 required supervision and setup help with activities of daily living except for dressing, toilet use, personal hygiene and bathing, which required extensive assistance of one staff member. Resident #7's Care Plan revealed the following: Problem Start Date: 6/20/2019, Category: Behavioral Symptoms .I have episodes of inappropriate behavior. I leave my room naked and need reminding to get some clothes on. I leave my room with my pants half down and without my shoes on. Goal: I will have less than (1) episodes of inappropriate behavior and no injuries to myself or others over the next 90 days .Approach .Redirect prn. Assist with ADL's to prevent exposure and falls .Observe my interaction with other residents to prevent offensive behavior or negative resident to resident interaction .Edited 7/27/2021 Category: Behavioral Symptoms .Problem start date: 01/03/2020, Resident has episodes of hitting other residents and staff members .Goal: Resident will not harm self or others and will have decreased episodes of hitting others through next review date. Approach .Assess whether the behavior endangers the resident and/or others. Intervene if necessary. Edited 7/27/21 . Problem start date: 08/13/2021, Category: Behavioral Symptoms: I have inappropriate sexual behaviors at times. Created 8/13/21 by [LVN G] goal: Goal Target Date 11/1/21 I will have no episodes of inappropriate behaviors .Approach: Staff will redirect me as needed, ensure I am taking my medications, and notify physician with any increase in behaviors Electronically signed [LVN G] Record review of Resident #7's progress notes revealed the following: 7/29/21 at 9:35am, Resident has had increased sexual activity. [Physician A] notified, new orders received for Depo 1mL monthly. Physician orders updated. EC notified of new orders. Electronically signed by [Former DON]. 7/30/21 at 2:11pm, Resident was moved to Unit 2 on 7/29/21 and is adjusting well to the change of environment. No immediate problems were noted at this time. Will continue to monitor. Electronically signed by LVN I. In an interview on 8/16/21 at 1:47 pm, Family Member B said that she had not been notified of any inappropriate sexual behaviors in June or July. Family Member B did recall receiving a phone call about moving her brother to another room, Family Member B did not recall who called her, but did say it was due to the fact he had too much stuff and needed a bigger room. Resident #8 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #8's face sheet dated 8/18/21 indicated he was a [AGE] year old male, who was initially admitted to the facility on [DATE] with diagnoses to include: Huntington's Disease, Other obsessive compulsive disorder, Mild Cognitive impairment, Muscle Spasm, Unsteadiness on feet, Lack of Coordination. Review of Resident #8's Significant Change Minimum Data Set (MDS) assessment, dated 7/30/21, revealed Section B, hearing, Speech, and Vision, Resident #8 was able to make himself understood and he had the ability to understand with clear comprehension. Section C revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated he was cognitively intact. Section E Behavior revealed Resident #8 had physical behavioral symptoms directed towards others (.abusing others sexually) and other behavioral symptoms not directed toward others (public sexual acts) that had occurred within the past 1-3 days. Section E0500 indicated that the resident was at significant risk for physical illness or injury; E0600 impact on Others revealed a zero entered, which indicated there was not a risk of impact to others for physical injury, intrusion of privacy or activity of others and disruption of care or living environment. Section G revealed that Resident #8 required supervision and setup help with activities of daily living except for dressing, personal hygiene and bathing, which required the assistance of one staff member. Resident #8 did not require the use of any mobility devices. Section N revealed that Resident #8 had not received any injections within the past 7 days. Section Q indicated that Resident #8 participated in the assessment. Section V indicated that Care Areas were triggered and required a care plan decision for Behavioral Symptoms. Record review of Resident #8's care plan revealed a care plan addressing Resident #8's behaviors was not implemented until 8/12/21, which revealed the following: Problem start date: 8/12/21 Category: Behavioral Symptoms I have inappropriate sexual behaviors towards others. Created 8/12/21 by [LVN G], Goal: .I will have no inappropriate sexual behaviors towards others .Approach: staff will redirect and/or separate from others as needed. Staff will notify physician with any sexual behaviors. Staff will ensure resident takes prescribed medications Resident #9 Record review of Resident 9's electronic face sheet dated 8/30/21, revealed he was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses to include: Vascular Dementia without behavioral Disturbance, Psychotic Disorder, Major depressive Disorder, Generalized Anxiety, Mild Cognitive Impairment . Resident #12 Record review of Resident #12's electronic face sheet dates 8/30/21, revealed he was a [AGE] year old male, admitted to the facility on [DATE] with diagnoses to include: Dementia in other diseases with behavioral disturbance, Essential Hypertension, Bipolar Disorder, Major Depressive Disorder, Chronic Pain, Pseudobulbar Affect . Record review of the facility's Self-report form 3613-A, dated 8/13/21, indicated Resident #12 was not interviewable. Record review of Resident # 8's Physician order report dated July 18th, 2021, revealed the following orders: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Start Date: 7/14/21 End Date: 7/14/21 Refer to Psych services for management of sexual behaviors Once-One Time . Ordered by [Physician A]. Start Date: 7/19/21 End Date: Open Ended- Please refer to senior psych care and or senior psychological care for evaluation and treatment as indicated. [Dx: Other recurrent depressive disorders]. Ordered by [Physician A]. Record review of Resident #8's progress notes revealed the following entries: Date: 7/27/21 at 4:19pm, Social Worker (SW) also spoke with [Family Member A] regarding res. (Resident #8) sexual behaviors and discussed with her intervention plans for res. SW informed [Family Member A], per DON res. Referred to inpatient [psychiatric service] to evaluate behavior and prescribe medications as needed. SW also informed her if psych team recommends inpatient psych res. Will be referred to [Psychiatric Hospital]. Per [Family Member A], she verbalized understanding and consent with treatment plansSW will follow up with [FNP] .with [Psychiatric Service] to help determine treatment plans. Electronically Signed by [SW]. Date: 7/28/21 at 1:56pm Resident (#8) has a history of sexual behaviors. [Physician A] reviewed medications, order received Depo (Depo-Estradiol) 1mL month intramuscular (IM). Physician orders updated, essential caregiver (EC) [Family Member A] notified of updated orders . electronically signed by [Former DON] Record review of an interview with Resident #8, conducted by the RNM on 8/16/21 at 10:30am revealed the following: [Resident #8] statement: Interview performed by: [RNM] [Vice President of Operations], Do you recall being involved with any incidents involving your anus? No. So, no one has ever inserted anything in your behind? Or attempted to? No. Have you been involved in any sexual encounters at the nursing center and if so, with who? Yes, [Resident #7]. What was the occurrence here? He [Resident #7] gave me a 'hand job'. Did you feel like this was consensual? Yes. You didn't force him, and he didn't force you? No.Obtained By: [RNM] and [Vice President of Operations]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 8/15/21 at 2:59pm, LVN B said that she had worked at the facility off and on since 2008, she said that she often is assigned to Unit 1, which is a male secure unit. LVN B said that she had been witness to several inappropriate behaviors on Unit #1, specifically she recalled an incident that happened on 6/11/21, she said she recalled the day specifically because it was a day [Physician A] was in the building rounding on the residents'. She said that she and Physician A entered Resident #8's room and found Resident #8 with Resident #12's hand wrapped around Resident #8's erect penis. LVN B said that Resident #8 had his hand wrapped around Resident #12's hand guiding Resident #12's hand up and down in a motion that appeared to be masturbating. LVN B said that Resident #12 was just sitting there he did not seem distressed, appeared to be going along with it. LVN B said that Resident #12 was severely cognitively impaired and was not able to make his own decisions. LVN B said that she intervened and instructed Resident #8 that the actions were inappropriate, and she said Resident #8 began pulling his pants back up. LVN B said she immediately informed the DON and due to Physician A being right there with me, she did not have to call him he already was witness to it. LVN B said that when she notified the Former DON, she seemed kind of giddy as if it was funny to her, and specifically instructed LVN B not to chart it because nobody was in distress. LVN B said she did not notify any family members at the direction of the former DON and after the communication to the Former DON, Physician A responded to her and that is how you keep state out of your building. LVN B said it appeared he was in agreement with the Former DON and agreed not to document anything in the chart. The Former DON had stressed to LVN B that as long as both residents were not in any distress and they were okay, there was nothing to chart. LVN B said she disagreed with the Former DON but due to previous circumstances, she followed her direction and did not chart it for fear of retaliation. She said that the Former DON had a Persnickety attitude and she had crossed her before and had multiple shifts taken away from her. LVN B said that she needed the shifts and therefore followed her direction even though she knew it was not right. LVN B said that she personally did not notify the Administrator regarding the incident. LVN B said that Resident #8 is often redirected due to masturbating in inappropriate places, she said often times he will be at the doorway in his room, peaking his head out and masturbating. She said that he is redirected to his side of the room and offered the privacy curtain. LVN B said that Resident #7 will often masturbate in his room, but no knowledge of any sexual behaviors towards other residents. (continued on next page)

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	675746	A. Building B. Wing	08/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 8/15/21 at 5:05PM, Physician A said that he had received a phone call from the RNM on 8/11/21 informing him that the facility was being investigated for a compliance hotline complaint about several things that have happened in the building and it included resident to resident sexual behavior. A couple of resident to resident altercations that had caused harm and were not reported either, elopements, that he had no knowledge of and should have been notified immediately and that documentation had been deleted from the clinical records by the Former DON. Physician A said that he was notified regarding several of the incidents that were being investigated, however he assumed the Former DON and Administrator were reporting accurately to the state. Physician A said that the knowledge he had regarding several residents (unable at the time of the interview to recall all the resident's by name) with inappropriate sexual behaviors was through a telephone call by the Former DON. Physician A said that she had notified him that there had been some exhibitions, male residents had been pleasuring themselves and exposing themselves in front of other residents and that he gave verbal orders to start the residents on medications to control their sexual behaviors, which was a medication called Depo Provera. Physician A said that the purpose of this medication is to cancel out the testosterone effect and reduces the libido of the male residents. Physician A said that he recalled Resident #8 having inappropriate locations of masturbation and did not recall Resident #8 having himself fully exposed with Resident #12, however did recall walking in the room and finding Resident #8 having an erection but was fully clothed. Physician A said that Resident #8 had known behaviors that were inappropriate, now that I recall, the one young resident, he was very young, [AGE] years old, (Resident #8), was having exhibitions that were inappropriate on the patio, not in the privacy in his room. Physician A said that Resident #8 was also known to be found in other resident's rooms pleasuring himself, verbally harassing the staff during ADL care such as showers. Physician A said he had received different reports on different dates regarding the inappropriate sexual behaviors between Resident #7 and resident #8. Physician A did recall Resident #8 being mentioned in more than one. Physician A said that it is abnormal for Resident #8 to have public sexual display in the inappropriate places he had been found. Physician A said that in regards to being notified, he said that he wasn't necessarily reported with a list of problems that I (the surveyor) was addressing, but that he had not been given notification immediately, it was several weeks later for some of the incidents. Physician A said that he did recall rounding with LVN B back the first part of June, unable to recall the exact date, but said that he did witness LVN B report to the Former DON regarding the inappropriate sexual behavior between Resident #8 and Resident #12, however Physician A did not recall the DON advising LVN B to not document the incident and then Physician A commented that he could not be 100% sure that he witnessed LVN B talking to the Former DON. Record review of Resident #8's progress notes revealed the following entry on 6/11/21: 6/11/21 3:49PM, Resident was seen by [Physician A] today. No new orders. No complaints noted at this time. Electronically signed by the Former ADON. In an interview on 8/16/21 at 3:00pm, Family Member A indicated that she did not have medical power of attorney for Resident #8 and that she did not make medical decisions for him. Family Member A said that Resident #8 makes all his own medical decisions. Family Member A did indicate that she had been contacted by the Administrator and informed her that Resident #8 had been having inappropriate sexual behaviors that ranged from masturbation in other resident's rooms to an inappropriate sexual act with a man that had Alzheimer's. Family Member A said that the facility told her that if the behaviors continued Resident #8 would have to be discharged and that they were going to have him evaluated and maybe start some new medication, but did not explain what the medication was or what it was for. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 8/16/21 at 2:21pm, NA H said that she had worked Unit #1 regularly and that she was unable to recall the exact date but thought it was about a month ago (Mid July 2021), Resident #7 had been getting in Resident #8's bed regularly, which was not unusual behavior for Resident #7 to forget where his room was and crawl in another residents bed, however on one occasion NA H said that she witnessed Resident #7 to have his brief pulled down and Resident #8 had his underwear pulled down, both male residents were exposed and Resident #7 had his penis erect and it was between Resident #8's buttocks, NA H did not feel that there was penetration and felt that she intervened right as the act was occurring. NA H said that she had informed LVN C, LVN D and LVN B. NA H said that there was another incident that involved Resident #7 and Resident #8 just a couple of weeks ago and that she witnessed Resident #8 have his underwear down and they were in the doorway of Resident #8's room. Resident #7 was behind Resident #8 and Resident #7 had his hand in the area of Resident #8's anus and Resident #7's hand was observed going in an upward and downward motion. NA H said that she did not visibly see any penetration to Resident #8 and Resident #8 was not trying to get away from Resident #7. NA H said that she separated the two residents and was traumatized by the incident. She said that the van driver came in and saw that she was upset and immediately went and reported it to the former ADON. NA H said that the former ADON never came and discussed anything with her regarding the incident, nor the Former Administrator. In an interview on 8/18/21 at 10:25am, CNA A said that she had witnessed Resident #7 and Resident #8 be sexually inappropriate with each other. CNA A said that she was working about two and a half weeks ago (End of July) and was charting in the hallway. CNA A said that she just happened to go down to the end of the hall and caught Resident #7 in Resident #8's room. CNA A said that she saw Resident #8's hand on top of Resident #7's hand, and that Resident #7 was holding Resident #8's erect penis and Resident #8 was guiding Resident #7's hand up and down Resident #8's penis. CNA A also recalled an incident, unable to recall the exact date, with Resident #8 being found in Resident #9's room. Resident #9 was in bed and Resident #8 was standing over Resident #9 masturbating. CNA A said that she reported the incident to the former DON and ADON and was told he was on birth control and that is all she knew was done about it. CNA A said that when there are inappropriate behaviors, she reports it to her charge nurse or the DON. In an interview on 8/18/21 at 10:45am, LVN D said that the secure units are sometimes staffed with two CNAs or NAs, however, there have been many times that there has only been one aid on the secure unit to supervise residents. LVN D said that she has on multiple occasions walked in and found residents being sexually inappropriate. LVN D said that one specific incident was between Resident #8 and Resident #12, could not recall the exact date, but witnessed Resident #8 grab Resident #12's buttocks. LVN D said she redirected Resident #8 and explained that touching other residents was inappropriate. LVN D said that she told the Administrator immediately about the behavior and the Administrator and the DON came on to the unit and spoke to Resident #8 and was instructed that they (former administrator and DON) would take care of it. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 8/17/21 at 3:19pm, Resident #8 said that he had come from another long-term care facility, was not certain why he had to move from that facility and did not care that he was on a male secure unit. Resident was alert and oriented and was able to recall his name, the date, where he was at, nursing facility, town, state; was able to recall who the president is currently. Resident #8 said that he had had sexual interactions with male residents on the secure male unit, specifically Resident #8 named [Resident #7]. Resident #8 said that the sexual interactions took place in his room more than once and Resident #7 had given me a hand job. Resident #8 said that the sexual interactions with Resident #7 made him feel bad and that he did not want to be touched by Resident #7. Resident #8 indicated that he was scared when Resident #7 touched his penis. Resident #8 said that Resident #7 had touched him on his butt with his penis and that he had not told any staff members because he was scared. Resident #8 said he did not want to be touched there. Resident #8 denied being inappropriate sexually with any other residents on the male unit, specifically Resident #12. Resident #8 stated that Resident #7 no longer resided on the unit and that made him feel good. Attempted phone interviews with the Former DON at the phone number provided by the facility; were: 8/16/21 at 2:14pm, voicemail message left. 8/18/21 at 4:03pm, voicemail message left. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 8/18/21 at 5:20pm, the former DON said that she had been suspended pending an investigation that she was not sure what for and that her and that she voluntarily resigned from the facility and was no longer employed at the facility. The Former DON said that she did not have any knowledge of any resident's in the building having inappropriate sexual behaviors. The Former DON said that I know there have been innuendos, but nothing specific. The Former DON was asked if she specifically had any knowledge of Resident #7, Resident #8 having inappropriate sexual behaviors towards other residents on the secure male unit #1, she replied No Ma'am. When asked by the surveyor, Without a doubt, you have no knowledge of any staff member ever reporting inappropriate sexual behavior's to you with Resident #7, Resident #8?, the Former DON replied, I don't know now; I know [Resident #8] was wanting to engage and [Resident #7], I never .I know that sexual behavior residents have sexual behaviors, and that is the type of residents that they [the facility] took. At this time of the interview, the Former DON was read by the surveyor a progress note dated 7/28/21 Date: 7/28/21 at 1:56pm Resident has a history of sexual behaviors. [Physician A] reviewed medications, order received Depo (Depo-Estradiol) 1mL month intramuscular (IM). Physician orders updated, essential caregiver (EC) [Family Member A] notified of updated orders . electronically signed by [Former DON] and the Former DON confirmed that her name was correct as the electronically signed signature as [Former DON] and stated that sounds like my progress note. The Former DON said the inappropriate sexual behavior was probably having his [Resident #8's] hands in his pants and pleasuring himself more in the common areas verses in his room privately. I honestly do not remember what his inappropriate sexual behaviors could have been, he was talked to several times regarding his inappropriate comments while receiving a shower by the aides. (the Former DON could not recall what he was specifically talked to about). The Former DON was asked if Resident #8 exposed himself often in front of other residents? The Former DON replied, It was enough to where, it got my attention. The Former DON could not recall what staff, specifically got her attention. The Former DON said that when I would go and investigate it, no one would ever come out and say that there were inappropriate sexual behaviors. The Former DON said that Resident #8 had admitted to the facility in April 2021 and was admitted on the all-male secure unit #1 due to being at a previous facility where he had displayed inappropriate sexual behaviors towards female residents. The Former DON said that Resident #8 always has a look of smiling, it is hard to tell if he really knows. The Former DON said that she did not recall when his inappropriate sexual behaviors began, it was all hearsay, he would ask people if he could pleasure them or if they would pleasure him. Hearsay, the former DON said was from the nurses. The Former DON did not feel the need to investigate and report hearsay to the abuse coordinator since it is just hearsay, you could spend all day on hearsay, and it depends on the content and what you heard. The Former DON denied NA H reporting anything to the former ADON regarding Resident #7 and Resident #8. The Former DON denied any knowledge of LVN B reporting any alleged allegations involving Resident #8 being inappropriate with Resident #12. The Former DON replied when asked if she had ever instructed her staff to not document or tell staff that she would document an incident with I have helped them with charting if they needed help. The Former DON was asked if she was involved in the room change for Resident #7, she replied I am sure. The Former DON said that the reason Resident #7 was moved to the secure unit #2 was because Resident #7 and Resident #8 was observed gravitating more towards each other, it seemed to be happening more frequently. The former DON said that when I walked onto the unit, they were together, may have been in common areas, one time when I walked onto the common area, [Resident #7] was standing with his hands in his pants, not a behavior, that was normal to me, I'm not sure what I would have reported to state. The Former DON said that she participated in facility internal investigations, she would perform head to toe assessments, might do safe surveys for the residents, I would do lots of interviews, reportable events to the state would be allegations of abuse/neglect, unwitnessed falls, injuries of unknown origin, misappropriation of property, most of the time the administrator would determine if it needed to be self-reported. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 8/17/21 at 12:59pm, the Social Worker said that she recalled when Resident #8 was admitted to the facility and that at the time, he did not seem to have any sexual inappropriate behaviors, however he had begun over the past several weeks to display inappropriate sexual behaviors. The Social Worker said that a night nurse, unable to recall exact name, had verbalized to her in passing one morning that Resident #8 had been sexually inappropriate. The Social Worker said at that time, she did not clarify anything else and soon after the Former DON and Former ADON had discussed in a morning meeting the inappropriate behaviors and the need to have him evaluated by psychiatric services and possibly send him to a psychiatric hospital. The Social Worker referenced her progress notes and explained that she had been in contact with his grandmother regarding his care and potential need for psychiatric evaluation at a local psychiatric hospital. The Social Worker said that the Former ADON expressed that she had a background in psychiatric nursing and she trusted the Former DON and her judgement and it appeared that they were handling the situation appropriately to her knowledge. The social worker said she did not realize that the psychiatric consult had not been obtained until a few days ago on 8/12/21. In an interview on 8/17/21 at 2:40pm, the FNP said that she had recently performed a psychiatric evaluation for Resident #8. The FNP said that she did not receive a lot of information from him, he basically just answered yes and no to the questions she asked. She did indicate that due to his diagnosis of Huntington's Disease it is difficult for him to express himself. The FNP said that the facility had expressed to her that he had been having some inappropriate sexual behaviors. The FNP said that she was aware of the medication Depo Provera that had been ordered for Resident #8 by Physician A. She said that she had seen the medication be used for overtly sexual behaviors in male residents. The FNP said that she understood that Resident #8's plan of care moving forward was that the facility was currently looking to find placement for him in another long-term care facility that could better manage his inappropriate sexual behaviors. The FNP said that the Depo Provera has estrogen in it, so it decreased the male's testosterone levels and decreased their sexual impulses. The FNP said that male residents should still be able to achieve an erection but not as often as they normally would and that it is in a sense a form of a chemical castration but not as potent. Record review of the facility's interview with the Former Administrator, performed by the [NAME] President of Operations, revealed the following: Date 8/12/21 at 6:22PM, Interview: [Former Administrator], Which sexual incidents were you aware of? [Resident #8 was performing 'oral' on other residents. Educated resident and spoke to him as well. Attempted phone interviews with the Former Administrator at the phone number provided by the facility; were: 8/16/21 at 2:15pm, voicemail message left. 8/18/21 at 4:03pm, voicemail message left. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's policy entitled, Abuse Prevention Program, dated June 2021, revealed the following: Policy Statements: 1. The Administrator is responsible for the overall coordination and implementation of our Center's abuse prevention program policies and procedures. 2. Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms .5. Our Center will not condone any form of resident abuse or neglect. To aid in abuse prevention, all personnel are to report any signs and symptoms of abuse/neglect to their supervisor and to the Abuse Prevention Coordinator immediately. 6. Our Center will protect residents from harm, reprisal, discrimination or coercion during investigations of abuse allegations. 7. All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as [TRUNCATED]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37012 Based on interview, and record review, it was determined the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported to the proper authorities within the prescribed timeframes for fifteen (15) of sixteen (16) residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15) reviewed for abuse and neglect. The facility failed to: a) Report an allegation immediately or within two hours of sexual abuse between Resident #12 and Resident #8 to the State Survey Agency. b) Report an allegation immediately or within two hours of sexual abuse between Resident #9 and Resident #8 to the State Survey Agency. c) Report an allegation immediately or within two hours of sexual abuse between Resident #7 and Resident #8 to the State Survey Agency. d) Report an allegation immediately or within two hours of sexual abuse between resident #10 and Resident #11 to the State Survey Agency. e) Report an allegation of physical abuse between Resident #1 and Resident #15 to the State Survey Agency immediately, but not later than 2 hours after the allegation was made. f) Report an allegation of physical abuse between Resident #3 and Resident #4 to the State Survey Agency immediately, but not later than 2 hours after the allegation was made. g) Report an allegation of physical abuse between Resident #5 and Resident #3 to the State Survey Agency immediately, but not later than 2 hours after the allegation was made. h) Report an allegation of physical abuse between Resident #6 and Resident #2 to the State Survey Agency immediately, but not later than 2 hours after the allegation was made. i) Report an unwitnessed fall, resulting in injury of Resident #2 to the State Survey Agency Report immediately, but not later than 24 hours after the allegation was made. j) Report an elopement of Resident #13 to the State Survey Agency Report immediately, but not later than 24 hours after the allegation was made. k) Report an elopement of Resident #14 to the State Survey Agency Report immediately, but not later than 24 hours after the allegation was made. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This failure could affect residents by placing them at risk of not having incidents of abuse, neglect, exploitation, injuries of unknown origin and misappropriation of resident property being reviewed and investigated in a timely manner by the facility and State Survey Agency. Findings include: In a telephone interview on 8/14/21 at 6:50PM, the [NAME] President of Operations said that she and the Regional Nurse Manager had just acquired the oversight of the facility approximately two weeks ago and had received an anonymous phone call to the corporations hotline number that they have internally for staff to report concerns to. The [NAME] President of Operations said that the corporate office reacted to the allegations made immediately and she and the RNM were at the facility the next day, which was 8/11/21. The [NAME] President of Operations said that initially the concern was regarding an elopement that had not been documented correctly and/or investigated. The [NAME] President of Operations said that she and the RNM through investigations and interviews conducted with multiple staff members, identified several areas of concern that rose to the level to self-report the allegations to the state. The [NAME] President of Operations said that through investigation and interviews with staff and residents it was identified that there were approximately 11 allegations that required a self-report, which were 4 allegations of resident to resident inappropriate sexual behaviors; 4 allegations of resident to resident altercations that resulted in injury; 2 elopements that were not documented accurately or reported; and an unwitnessed fall that resulted in injury. In addition, there were numerous clinical records that had been marked invalid by the former DON without permission from the original author of the entry. The [NAME] President of Operations said that through interviews conducted with staff, they had been reporting the allegations to the Former DON and the Administrator and nothing was being done regarding the allegations. Staff were being directed to not chart regarding some of the allegations or was told that the Former DON would do the charting. The [NAME] President of Operations said that the Administrator, DON and both of the ADONS were all suspended, however after multiple interviews and investigation it was felt that one of the ADON's had no involvement and therefore has been brought back to work and is currently serving as the interim DON. The [NAME] President of Operations said that the Administrator and the DON voluntarily resigned the following day and since have not returned phone calls in attempts made to interview either of them. The [NAME] President of Operations said that the RNM, the ADON and other department heads had worked diligently to ensure the safety of all of the residents and had put several interventions in place immediately and at the time of this interview were still conducting in-services with all staff, conducting elopement drills, head to toe skin assessments had been done on all residents, elopement assessments were conducted on all resident, BIMS scores had been reassessed on all residents that had been mentioned in the allegations, abuse/neglect in-service was conducted along with a skill check offs test regarding abuse/neglect. Chart audits have been conducted, education to staff regarding abuse/neglect, incident/accident reporting, the corporate compliance line, missing resident and will soon be in servicing about nursing documentation. Have conducted several elopement drills, will continue until all shifts and rotations have received drill. Resident safety surveys were conducted with approximately 38 residents. The corporation had hired an interim administrator and she was currently in route to the facility. The medical director had been contacted and an emergency QAPI meeting had been held. Physician A [The Medical Director] had come into the facility on Thursday 8/12/21 and saw residents that were involved in the allegations. [Psychiatric Service] came into the facility and performed psychiatric evaluations on all residents involved in the allegations to ensure safety and well-being of mental health. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The following allegations were discovered after the RNM and the [NAME] President of Operations conducted an internal investigation in the facility: Resident #7 Review of Resident #7's face sheet dated 8/18/21 indicated he was a [AGE] year old male, who was initially admitted to the facility on [DATE] with diagnoses to include: Dementia with behavioral disturbance, Other obsessive-compulsive disorder, Personality change due to known physiological condition, Major depressive disorder, single episode, severe without psychotic features, Pseudobulbar affect, Anoxic brain damage, not elsewhere classified, Essential hypertension Review of Resident #7's Quarterly Minimum Data Set (MDS) assessment, dated 7/09/21, revealed Section B, hearing, Speech, and Vision, Resident #7 was rarely/never understood or rarely/never had the ability to understand others. Section C revealed Resident #7 was unable to perform a Brief Interview for Mental Status (BIMS), therefore a staff assessment for mental status was obtained and indicated there was a memory problem and that the resident was able to recall the location of his own room, and his cognitive skills for daily decision making were moderately impaired (decisions poor; cues/supervision required) and Resident #7 was noted to have disorganized thinking (rambling or irrelevant conversation, unclear or illogical flow of ideas Section E Behavior revealed Resident #7 had not displayed any behaviors. Section G revealed that Resident #7 required supervision and setup help with activities of daily living except for dressing, toilet use, personal hygiene and bathing, which required extensive assistance of one staff member. Resident #7's Care Plan care plan revealed the following: Category: Behavioral Symptoms .I have episodes of inappropriate behavior. I leave my room naked and need reminding to get some clothes on. I leave my room with my pants half down and without my shoes on. Goal: I will have less than (1) episodes of inappropriate behavior and no injuries to myself or others over the next 90 days .Approach .Redirect prn. Assist with ADL's to prevent exposure and falls .Observe my interaction with other residents to prevent offensive behavior or negative resident to resident interaction . Edited 7/27/2021 Category: Behavioral Symptoms .Problem start date: 01/03/2020, Resident has episodes of hitting other residents and staff members .Goal: Resident will not harm self or others and will have decreased episodes of hitting others through next review date. Approach .Assess whether the behavior endangers the resident and/or others. Intervene if necessary. Edited 7/27/21 . Problem start date: 08/13/2021, Category: Behavioral Symptoms: I have inappropriate sexual behaviors at times. Created 8/13/21 by [LVN G] goal: Goal Target Date 11/1/21 I will have no episodes of inappropriate behaviors .Approach: Staff will redirect me as needed, ensure I am taking my medications, and notify physician with any increase in behaviors Electronically signed [LVN G] Record review of Resident #7's progress notes revealed the following: 7/29/21 at 9:35am, Resident has had increased sexual activity. [Physician A] notified, new orders received for Depo 1mL monthly. Physician orders updated. EC notified of new orders. Electronically signed by [Former DON]. (continued on next page)

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	675746	A. Building B. Wing	08/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/30/21 at 2:11pm, Resident was moved to Unit 2 on 7/29/21 and is adjusting well to the change of environment. No immediate problems were noted at this time. Will continue to monitor. Electronically signed by LVN I. Resident #8 Review of Resident #8's face sheet dated 8/18/21 indicated he was a [AGE] year old male, who was initially admitted to the facility on [DATE] with diagnoses to include: Huntington's Disease, Other obsessive compulsive disorder, Mild Cognitive impairment, Muscle Spasm, Unsteadiness on feet, Lack of Coordination. Review of Resident #8's Significant Change Minimum Data Set (MDS) assessment, dated 7/30/21, revealed Section B, hearing, Speech, and Vision, Resident #8 was able to make himself understood and he had the ability to understand with clear comprehension. Section C revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated he was cognitively intact. Section E Behavior revealed Resident #8 had physical behavioral symptoms directed towards others (.abusing others sexually) and other behavioral symptoms not directed toward others (public sexual acts) that had occurred within the past 1-3 days. Section E0500 indicated that the resident was at significant risk for physical illness or injury; E0600 impact on Others revealed a zero entered, which indicated there was not a risk of impact to others for physical injury, intrusion of privacy or activity of others and disruption of care or living environment. Section G revealed that Resident #8 required supervision and setup help with activities of daily living except for dressing, personal hygiene and bathing, which required the assistance of one staff member. Resident #8 did not require the use of any mobility devices. Section N revealed that Resident #8 had not received any injections within the past 7 days. Section Q indicated that Resident #8 participated in the assessment. Section V indicated that Care Areas were triggered and required a care plan decision for Behavioral Symptoms. Record review of Resident #8's care plan revealed a care plan addressing Resident #8's behaviors was not implemented until 8/12/21, which revealed the following: Problem start date: 8/12/21 Category: Behavioral Symptoms I have inappropriate sexual behaviors towards others. Created 8/12/21 by [LVN G], Goal: .I will have no inappropriate sexual behaviors towards others .Approach: staff will redirect and/or separate from others as needed. Staff will notify physician with any sexual behaviors. Staff will ensure resident takes prescribed medications Resident #9 Record review of Resident 9's electronic face sheet dated 8/30/21, revealed he was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses to include: Vascular Dementia without behavioral Disturbance, Psychotic Disorder, Major depressive Disorder, Generalized Anxiety, Mild Cognitive Impairment . Resident #12 Record review of Resident #12's electronic face sheet dates 8/30/21, revealed he was a [AGE] year old male, admitted to the facility on [DATE] with diagnoses to include: Dementia in other diseases with behavioral disturbance, Essential Hypertension, Bipolar Disorder, Major Depressive Disorder, Chronic Pain, Pseudobulbar Affect . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident # 8's Physician order report dated July 18th, 2021, revealed the following orders: Start Date: 7/14/21 End Date: 7/14/21 Refer to Psych services for management of sexual behaviors Once-One Time . Ordered by [Physician A]. Start Date: 7/19/21 End Date: Open Ended- Please refer to senior psych care and or senior psychological care for evaluation and treatment as indicated. [Dx: Other recurrent depressive disorders]. Ordered by [Physician A]. Record review of Resident #8's progress notes revealed the following entries: Date: 7/27/21 at 4:19pm, Social Worker (SW) also spoke with [Family Member A] regarding res. (Resident #8) sexual behaviors and discussed with her intervention plans for res. Per [Family Member A], res was sexually active in his youth when asked if she was aware whether he was sexually assaulted or victimized as a child; [Family Member A] responded [Resident #8] was not raped or assaulted in any way that she knew of. She stated res. Was sent to prison for six years from [AGE] years old to [AGE] years old; [Family Member A] thinks he was assaulted in that environment. Stated she thinks this because he was never the same after prison in her home; she seemed to fear his behavior due to having young grandchildren in the home and placed him at a [long term care facility]. [Family Member A] states she has spoken with him about his behavior and told him he would go to jail again; she states she thinks he wants that. SW informed [Family Member A], per DON res. Referred to inpatient [psychiatric service] to evaluate behavior and prescribe medications as needed. SW also informed her if psych team recommends inpatient psych res. Will be referred to [Psychiatric Hospital]. Per [Family Member A], she verbalized understanding and consent with treatment plans. SW informed her SW completed BIMS with res. And res. Is aware of his actions; she verbalized he has always been the smart one of all her grandkids. SW will follow up with [FNP] .with [Psychiatric Service]to help determine treatment plans. Electronically Signed by [SW]. Date: 7/28/21 at 1:56pm Resident has a history of sexual behaviors. [Physician A] reviewed medications, order received Depo (Depo-Estradiol) 1mL month intramuscular (IM). Physician orders updated, essential caregiver (EC) [Family Member A] notified of updated orders . electronically signed by [Former DON] #9 and 8 In an interview on 8/18/21 at 10:28am, CNA A recalled an incident, unable to recall the exact date, with Resident #8 being found in Resident #9's room. Resident #9 was in bed and Resident #8 was standing over Resident #9 masturbating. CNA A said that she reported the incident to the former DON and ADON and was told he as on birth control and that is all she knew was done about it. #8 and 12 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 8/15/21 at 2:59pm, LVN B said that she had worked at the facility off and on since 2008, she said that she often is assigned to Unit 1, which is a male secure unit. LVN B said that she had been witness to several inappropriate behaviors on Unit #1, specifically she recalled an incident that happened on 6/11/21, she said she recalled the day specifically because it was a day [Physician A] was in the building rounding on the residents'. She said that she and Physician A entered Resident #8's room and found Resident #8 with Resident #12's hand wrapped around Resident #8's erect penis. LVN B said that Resident #8 had his hand wrapped around Resident #12's hand guiding Resident #12's hand up and down in a motion that appeared to be masturbating. LVN B said that Resident #12 was just sitting there he did not seem distress, appeared to be going along with it. LVN B said that she intervened and instructed Resident #8 that the actions were inappropriate, and she said Resident #8 began pulling his pants back up. LVN B said she immediately informed the DON and due to Physician A being right there with me, she did not have to call him he already was witness to it. LVN B said that when she notified the Former DON, she seemed kind of giddy as if it was funny to her, and specifically instructed LVN B not to chart it because nobody was in distress. LVN B said she did not notify any family members at the direction of the former DON and after the communication to the Former DON, Physician A responded to her and that is how you keep state out of your building. LVN B said it appeared he was in agreement with the Former DON and agreed not to document anything in the chart. The Former DON had stressed to LVN B that as long as both residents were not in any distress and they were okay, there was nothing to chart. LVN B said she disagreed with the Former DON but due to previous circumstances, she followed her direction and did not chart it for fear of retaliation. She said that the Former DON had a Persnickety attitude and she had crossed her before and had multiple shifts taken away from her. LVN B said that she needed the shifts and therefore followed her direction even though she knew it was not right. LVN B said that she personally did not notify the Administrator regarding the incident. LVN B said that Resident #8 is often redirected due to masturbating in inappropriate places, she said often he will be at the doorway in his room, peaking his head out and masturbating. She said that he is redirected to his side of the room and offered the privacy curtain. LVN B said that Resident #7 will often masturbate in his room, but no knowledge of any sexual behaviors towards other residents. In an interview on 8/18/21 at 10:45am, LVN D said that the secure units are sometimes staffed with two CNAs or NAs, however, there have been many times that there has only been one aid on the secure unit to supervise residents. LVN D said that she has on multiple occasions walked in and found residents being sexually inappropriate. LVN D said that one specific incident was between Resident #8 and Resident #12, could not recall the exact date, but witnessed Resident #8 grab Resident #12's buttocks. LVN D said she redirected Resident #8 and explained that touching other residents was inappropriate. LVN D said that she told the Administrator immediately about the behavior and the Administrator and the DON came on to the unit and spoke to Resident #8 and was instructed that they (administrator and DON) would take care of it. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 8/15/21 at 5:05PM, Physician A said that he had received a phone call from the RNM on 8/11/21 informing him that the facility was being investigated for a compliance hotline complaint about several things that have happened in the building and it included resident to resident sexual behavior. A couple of resident to resident altercations that had caused harm and were not reported either, elopements, that he had no knowledge of and should have been notified immediately and that documentation had been deleted from the clinical records by the Former DON. Physician A said that he had a good communication line with the Former DON and Administrator. Physician A said that he was notified regarding several of the incidents that were being investigated, however he assumed the Former DON and Administrator were reporting accurately to the state. Physician A said that the knowledge he had regarding several residents (unable at the time of the interview to recall all the resident's by name) with inappropriate sexual behaviors was through a telephone call by the Former DON. Physician A said that she had notified him that there had been some exhibitions, male residents had been pleasuring themselves and exposing themselves in front of other residents and that he gave verbal orders to start the residents on medications to control their sexual behaviors, which was a medication called Depo Provera. Physician A said that the purpose of this medication is to cancel out the testosterone effect and reduces the libido of the male residents. Physician A said that he recalled Resident #8 having inappropriate locations of masturbation and did not recall Resident #8 having himself fully exposed with Resident #12, however did recall walking in the room and finding Resident #8 having an erection but was fully clothed. Physician A said that Resident #8 had known behaviors that were inappropriate, now that I recall, the one young resident, he was very young, [AGE] years old, (Resident #8), was having exhibitions that were inappropriate on the patio, not in the privacy in his room. Physician A said that Resident #8 was also known to be found in other resident's rooms pleasuring himself, verbally harassing the staff during ADL care such as showers. I received different reports on different dates, recall Resident #8 being mentioned in more than one. Physician A said that he did recall rounding with LVN B back the first part of June, unable to recall the exact date, but said that he did witness LVN B report to the Former DON regarding the inappropriate sexual behavior between Resident #8 and Resident #12, however Physician A did not recall the DON advising LVN B to not document the incident and then Physician A commented that he could not be 100% sure that he witnessed LVN B talking to the Former DON. Record review of Resident #8's progress notes revealed the following entry on 6/11/21: 6/11/21 3:49PM, Resident was seen by [Physician A] today. No new orders. No complaints noted at this time. Electronically signed by the Former ADON. In an interview on 8/16/21 at 3:00pm, Family Member A indicated that she did not have medical power of attorney for Resident #8 and that she did not make medical decisions for him. Family Member A said that Resident #8 makes all his own medical decisions. Family Member A did indicate that she had been contacted by the Administrator and informed her that Resident #8 had been having inappropriate sexual behaviors that ranged from masturbation in other resident's rooms to an inappropriate sexual act with a man that had Alzheimer's. Family Member A said that the facility told her that if the behaviors continued Resident #8 would have to be discharged and that they were going to have him evaluated and maybe start some new medication, but did not explain what the medication was or what it was for. #7 and 8 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 8/16/21 at 2:21pm, NA H said that she had worked Unit #1 regularly and that she was unable to recall the exact date but thought it was about a month ago (Mid July 2021), Resident #7 had been getting in Resident #8's bed regularly, which was not unusual behavior for Resident #7 to forget where his room was and crawl in another residents bed, however on one occasion NA H said that she witnessed Resident #7 to have his brief pulled down and Resident #8 had his underwear pulled down, both male residents were exposed and Resident #7 had his penis erect and it was between Resident #8's buttocks, NA H did not feel that there was penetration and felt that she intervened right as the act was occurring. NA H said that she had informed LVN C, LVN D and LVN B. NA H said that there was another incident that involved Resident #7 and Resident #8 just a couple of weeks ago and that she witnessed Resident #8 have his underwear down and they were in the doorway of Resident #8's room. Resident #7 was behind Resident #8 and Resident #7 had his hand in the area of Resident #8's anus and Resident #7's hand was observed going in an upward and downward motion. NA H said that she did not visibly see any penetration to Resident #8 and Resident #8 was not trying to get away from Resident #7. NA H said that she separated the two residents and was traumatized by the incident. She said that the van driver came in and saw that she was upset and immediately went and reported it to the former ADON. NA H said that the former ADON never came and discussed anything with her regarding the incident, nor the Former ADON or Administrator. In an interview on 8/18/21 at 10:25am, CNA A said that she had witnessed Resident #7 and Resident #8 be sexually inappropriate with each other. CNA A said that she was working about two and a half weeks ago (End of July) and was charting in the hallway. CNA A said that she just happened to go down to the end of the hall and caught Resident #7 in Resident #8's room. CNA A said that she saw Resident #8's hand on top of Resident #7's had, and that Resident #7 was holding Resident #8's erect penis and Resident #8 was guiding Resident #7's hand up and down Resident #8's penis. CNA A said that she mostly worked on the male secure unit #1 and that it is very hard to supervise all the residents and provide care at the same time with only one staff member assigned to the secure units. CNA A said that if the unit only has one staff working or assigned that day, residents often go unsupervised for about 10-20 minutes depending on the care she is providing and there were residents that had physical, verbal and sexual behaviors on the male secure unit as well as resident's that were at risk for falls. Attempted phone interviews with the Former DON at the phone number provided by the facility; were: 8/16/21 at 2:14pm, voicemail message left. 8/18/21 at 4:03pm, voicemail message left. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 8/18/21 at 5:20pm, the former DON said that she had been suspended pending an investigation that she was not sure what for and that her and that she voluntarily resigned from the facility and was no longer employed at the facility. The Former DON said that she did not have any knowledge of any resident's in the building having inappropriate sexual behaviors. The Former DON said that I know there have been innuendos, but nothing specific. The Former DON was asked if the specifically had any knowledge of Resident #7, Resident #8 and Resident #10 having inappropriate sexual behaviors towards other residents on the secure male unit #1, she replied No Ma'am. When asked by the surveyor, Without a doubt, you have no knowledge of any staff member ever reporting inappropriate sexual behavior's to you with Resident #7, Resident #8 and Resident #10?, the Former DON replied, I don't know now; I know [Resident #8] was wanting to engage and [Resident #7], I never .I know that sexual behavior residents have sexual behaviors, and that is the type of residents that they [the facility] took. At this time of the interview, the Former DON was read by the surveyor a progress note dated 7/28/21 Date: 7/28/21 at 1:56pm Resident has a history of sexual behaviors. [Physician A] reviewed medications, order received Depo (Depo-Estradiol) 1mL month intramuscular (IM). Physician orders updated, essential caregiver (EC) [Family Member A] notified of updated orders . electronically signed by [Former DON] and the Former DON confirmed that her name was correct as the electronically signed signature as [Former DON] and stated that sounds like my progress note. The Former DON said the inappropriate sexual behavior was probably having his [Resident #8's] hands in his pants and pleasuring himself more in the common areas verses in his room privately. I honestly do not remember what his inappropriate sexual behaviors could have been, he was talked to several times while taking a shower with the aids, (the Former DON could not recall what he was specifically talked to about). The Former DON was asked if Resident #8 exposed himself often in front of other residents? The Former DON replied, It was enough to where, it got my attention. The Former DON could not recall what staff, specifically got her attention. The Former DON said that when I would go and investigate it, no one would ever come out and say that there were inappropriate sexual behaviors. The Former DON said that she could not recall any inappropriate behavior with Resident #10, she replied I think [Resident #10], No, I don't recall any inappropriate behavior, but that doesn't mean I wasn't .I am not recalling anything regarding [Resident #10], that was the week I buried my grandmother and do not recall, I was very busy. The Former DON said that Resident #8 had admitted to the facility in April 2021 and was admitted on the all-male secure unit #1 due to being at a previous facility where he had displayed inappropriate sexual behaviors towards female residents. The Former DON said that Resident #8 always has a look of smiling, it is hard to tell if he really knows. The Former DON said that she did not recall when his inappropriate sexual behaviors began, it was all hearsay, he would ask people if he could pleasure them or if they would pleasure him. Hearsay, the former DON said was from the nurses. The Former DON did not feel the need to investigate and report hearsay to the abuse coordinator since it is just hearsay, you could spend all day on hearsay, and it depends on the content and what you heard. The Former DON denied NA H reporting anything to the former ADON regarding Resident #7 and Resident #8. The Former DON denied any knowledge of LVN B reporting any alleged allegations involving Resident #8 being inappropriate with Resident #12. The Former DON replied when asked if she had ever instructed her staff to not document or tell staff that she would document an incident with I have helped them with charting if they needed help. The Former DON was asked if she was involved in the room change for Resident #7, she replied I am sure. The Former DON said that the reason Resident #7 was moved to the secure unit #2 was because Resident #7 and Resident #8 was observed gravitating more towards each other, it seemed to be happening more frequently. The former DON said that when I walked onto the unit, they were together, may have been in common areas, one time when I walked onto the common area, [Resident #7] was standing with his hands in his pants, not a behavior, that was normal to me, I'm not sure what I would have reported to state. The Former DON said that she participated in facility interval investigations, she would perform head to toe assessments, might do safe surveys for the residents, I would do lots of interviews, reportable events to the state would be allegations of abuse/neglect, unwitnessed falls, injuries of unknown origin, misappropriation of property, most of the time the administrator would determine if it needed to be self-reported. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 8/17/21 at 12:59pm, the Social Worker said that she recalled when Resident #8 was admitted to the facility and that at the time, he did not seem to have any sexual inappropriate behaviors, however he had begun over the past several weeks to display inappropriate sexual behaviors. The Social Worker said that a night nurse, unable to recall exact name, had verbalized to her in passing one morning that Resident #8 had been sexually inappropriate. The Social Worker said at that time, she did not clarify anything else and soon after the Former DON and Former ADON had discussed in a morning meeting the inappropriate behaviors and the need to have him evaluated by psychiatric services and possibly send him to a psychiatric hospital. The Social Worker referenced her progress notes and explained [TRUNCATED]

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37012 Based on interview and record review, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation and injuries of unknown origin were thoroughly investigated, prevented further abuse, neglect, exploitation and mistreatment and put corrective actions in place for fifteen (15) of sixteen (16) residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15) reviewed for abuse and neglect. The facility failed to: a) Thoroughly investigate an allegation of sexual abuse between Resident #12 and Resident #8 to the State Survey Agency. b) Thoroughly investigate an allegation of sexual abuse between Resident #9 and Resident #8 to the State Survey Agency. c) Thoroughly investigate an allegation of sexual abuse between Resident #7 and Resident #8 to the State Survey Agency. d) Thoroughly investigate an allegation of sexual abuse between resident #10 and Resident #11 to the State Survey Agency. e) Thoroughly investigate an allegation of physical abuse between Resident #1 and Resident #15. f) Thoroughly investigate an allegation of physical abuse between Resident #3 and Resident #4. g) Thoroughly investigate an allegation of physical abuse between Resident #5 and Resident #3. h) Thoroughly investigate an allegation of physical abuse between Resident #6 and Resident #2. i) Thoroughly investigate an unwitnessed fall, resulting in injury of Resident #2. j) Thoroughly investigate an elopement of Resident #13. k) Thoroughly investigate an elopement of Resident #14. These failures placed residents at risk for continued sexual abuse, neglect, and potential for decreased quality of life. The Findings Include: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a telephone interview on 8/14/21 at 6:50PM, the [NAME] President of Operations said that she and the Regional Nurse Manager had just acquired the oversight of the facility approximately two weeks ago and had received an anonymous phone call to the corporations hotline number that they have internally for staff to report concerns to. The [NAME] President of Operations said that the corporate office reacted to the allegations made immediately and she and the RNM were at the facility the next day, which was 8/11/21. The [NAME] President of Operations said that initially the concern was regarding an elopement that had not been documented correctly and/or investigated. The [NAME] President of Operations said that she and the RNM through investigations and interviews conducted with multiple staff members, identified several areas of concern that rose to the level to self-report the allegations to the state. The [NAME] President of Operations said that through investigation and interviews with staff and residents it was identified that there were approximately 11 allegations that required a self-report, which were 4 allegations of resident to resident inappropriate sexual behaviors; 4 allegations of resident to resident altercations that resulted in injury; 2 elopements that were not documented accurately or reported; and an unwitnessed fall that resulted in injury. In addition, there were numerous clinical records that had been marked invalid by the former DON without permission from the original author of the entry. The [NAME] President of Operations said that through interviews conducted with staff, they had been reporting the allegations to the Former DON and the Administrator and nothing was being done regarding the allegations. Staff were being directed to not chart regarding some of the allegations or was told that the Former DON would do the charting. The [NAME] President of Operations said that the Administrator, DON and both of the ADONS were all suspended, however after multiple interviews and investigation it was felt that one of the ADON's had no involvement and therefore has been brought back to work and is currently serving as the interim DON. The [NAME] President of Operations said that the Administrator and the DON voluntarily resigned the following day and since have not returned phone calls in attempts made to interview either of them. The [NAME] President of Operations said that the RNM, the ADON and other department heads had worked diligently to ensure the safety of all of the residents and had put several interventions in place immediately and at the time of this interview were still conducting in-services with all staff, conducting elopement drills, head to toe skin assessments had been done on all residents, elopement assessments were conducted on all resident, BIMS scores had been reassessed on all residents that had been mentioned in the allegations, abuse/neglect in-service was conducted along with a skill check offs test regarding abuse/neglect. Chart audits have been conducted, education to staff regarding abuse/neglect, incident/accident reporting, the corporate compliance line, missing resident and will soon be in servicing about nursing documentation. Have conducted several elopement drills, will continue until all shifts and rotations have received drill. Resident safety surveys were conducted with approximately 38 residents. The corporation had hired an interim administrator and she was currently in route to the facility. The medical director had been contacted and an emergency QAPI meeting had been held. Physician A [The Medical Director] had come into the facility on Thursday 8/12/21 and saw residents that were involved in the allegations. [Psychiatric Service] came into the facility and performed psychiatric evaluations on all residents involved in the allegations to ensure safety and well-being of mental health. The following allegations were discovered after the RNM and the [NAME] President of Operations conducted an internal investigation in the facility: A, B, & C Resident #7 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #7's face sheet dated 8/18/21 indicated he was a [AGE] year old male, who was initially admitted to the facility on [DATE] with diagnoses to include: Dementia with behavioral disturbance, Other obsessive-compulsive disorder, Personality change due to known physiological condition, Major depressive disorder, single episode, severe without psychotic features, Pseudobulbar affect, Anoxic brain damage, not elsewhere classified, Essential hypertension Review of Resident #7's Quarterly Minimum Data Set (MDS) assessment, dated 7/09/21, revealed Section B, hearing, Speech, and Vision, Resident #7 was rarely/never understood or rarely/never had the ability to understand others. Section C revealed Resident #7 was unable to perform a Brief Interview for Mental Status (BIMS), therefore a staff assessment for mental status was obtained and indicated there was a memory problem and that the resident was able to recall the location of his own room, and his cognitive skills for daily decision making were moderately impaired (decisions poor; cues/supervision required) and Resident #7 was noted to have disorganized thinking (rambling or irrelevant conversation, unclear or illogical flow of ideas Section E Behavior revealed Resident #7 had not displayed any behaviors. Section G revealed that Resident #7 required supervision and setup help with activities of daily living except for dressing, toilet use, personal hygiene and bathing, which required extensive assistance of one staff member. Resident #7's Care Plan care plan revealed the following: Category: Behavioral Symptoms .I have episodes of inappropriate behavior. I leave my room naked and need reminding to get some clothes on. I leave my room with my pants half down and without my shoes on. Goal: I will have less than (1) episodes of inappropriate behavior and no injuries to myself or others over the next 90 days .Approach .Redirect prn. Assist with ADL's to prevent exposure and falls .Observe my interaction with other residents to prevent offensive behavior or negative resident to resident interaction . Edited 7/27/2021 Category: Behavioral Symptoms .Problem start date: 01/03/2020, Resident has episodes of hitting other residents and staff members .Goal: Resident will not harm self or others and will have decreased episodes of hitting others through next review date. Approach .Assess whether the behavior endangers the resident and/or others. Intervene if necessary. Edited 7/27/21 . Problem start date: 08/13/2021, Category: Behavioral Symptoms: I have inappropriate sexual behaviors at times. Created 8/13/21 by [LVN G] goal: Goal Target Date 11/1/21 I will have no episodes of inappropriate behaviors .Approach: Staff will redirect me as needed, ensure I am taking my medications, and notify physician with any increase in behaviors Electronically signed [LVN G] Record review of Resident #7's progress notes revealed the following: 7/29/21 at 9:35am, Resident has had increased sexual activity. [Physician A] notified, new orders received for Depo 1mL monthly. Physician orders updated. EC notified of new orders. Electronically signed by [Former DON]. 7/30/21 at 2:11pm, Resident was moved to Unit 2 on 7/29/21 and is adjusting well to the change of environment. No immediate problems were noted at this time. Will continue to monitor. Electronically signed by LVN I. Resident #8 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #8's face sheet dated 8/18/21 indicated he was a [AGE] year old male, who was initially admitted to the facility on [DATE] with diagnoses to include: Huntington's Disease, Other obsessive compulsive disorder, Mild Cognitive impairment, Muscle Spasm, Unsteadiness on feet, Lack of Coordination. Review of Resident #8's Significant Change Minimum Data Set (MDS) assessment, dated 7/30/21, revealed Section B, hearing, Speech, and Vision, Resident #8 was able to make himself understood and he had the ability to understand with clear comprehension. Section C revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated he was cognitively intact. Section E Behavior revealed Resident #8 had physical behavioral symptoms directed towards others (.abusing others sexually) and other behavioral symptoms not directed toward others (public sexual acts) that had occurred within the past 1-3 days. Section E0500 indicated that the resident was at significant risk for physical illness or injury; E0600 impact on Others revealed a zero entered, which indicated there was not a risk of impact to others for physical injury, intrusion of privacy or activity of others and disruption of care or living environment. Section G revealed that Resident #8 required supervision and setup help with activities of daily living except for dressing, personal hygiene and bathing, which required the assistance of one staff member. Resident #8 did not require the use of any mobility devices. Section N revealed that Resident #8 had not received any injections within the past 7 days. Section Q indicated that Resident #8 participated in the assessment. Section V indicated that Care Areas were triggered and required a care plan decision for Behavioral Symptoms. Record review of Resident #8's care plan revealed a care plan addressing Resident #8's behaviors was not implemented until 8/12/21, which revealed the following: Problem start date: 8/12/21 Category: Behavioral Symptoms I have inappropriate sexual behaviors towards others. Created 8/12/21 by [LVN G], Goal: .I will have no inappropriate sexual behaviors towards others .Approach: staff will redirect and/or separate from others as needed. Staff will notify physician with any sexual behaviors. Staff will ensure resident takes prescribed medications Resident #9 Record review of Resident 9's electronic face sheet dated 8/30/21, revealed he was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses to include: Vascular Dementia without behavioral Disturbance, Psychotic Disorder, Major depressive Disorder, Generalized Anxiety, Mild Cognitive Impairment . Resident #12 Record review of Resident #12's electronic face sheet dates 8/30/21, revealed he was a [AGE] year old male, admitted to the facility on [DATE] with diagnoses to include: Dementia in other diseases with behavioral disturbance, Essential Hypertension, Bipolar Disorder, Major Depressive Disorder, Chronic Pain, Pseudobulbar Affect . Record review of Resident # 8's Physician order report dated July 18th, 2021, revealed the following orders: Start Date: 7/14/21 End Date: 7/14/21 Refer to Psych services for management of sexual behaviors Once-One Time . Ordered by [Physician A]. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Start Date: 7/19/21 End Date: Open Ended- Please refer to senior psych care and or senior psychological care for evaluation and treatment as indicated. [Dx: Other recurrent depressive disorders]. Ordered by [Physician A]. Record review of Resident #8's progress notes revealed the following entries: Date: 7/27/21 at 4:19pm, Social Worker (SW) also spoke with [Family Member A] regarding res. (Resident #8) sexual behaviors and discussed with her intervention plans for res. SW will follow up with [FNP] .with [Psychiatric Service] to help determine treatment plans. Electronically Signed by [SW]. Date: 7/28/21 at 1:56pm Resident has a history of sexual behaviors. [Physician A] reviewed medications, order received Depo (Depo-Estradiol) 1mL month intramuscular (IM). Physician orders updated, essential caregiver (EC) [Family Member A] notified of updated orders . electronically signed by [Former DON] Record review of an interview on 08/16/21 at 10:30am with Resident #8, conducted by the RNM on 8/16/21 at 10:30am revealed the following: [Resident #8] statement: Interview performed by: [RNM] [Vice President of Operations], Do you recall being involved with any incidents involving your anus? No. So, no one has ever inserted anything in your behind? Or attempted to? No. Have you been involved in any sexual encounters at the nursing center and if so, with who? Yes, [Resident #7]. What was the occurrence here? He [Resident #7] gave me a 'hand job'. Did you feel like this was consensual? Yes. You didn't force him, and he didn't force you? No.Obtained By: [RNM] and [Vice President of Operations]. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 8/15/21 at 2:59pm, LVN B said that she had worked at the facility off and on since 2008, she said that she often is assigned to Unit 1, which is a male secure unit. LVN B said that she had been witness to several inappropriate behaviors on Unit #1, specifically she recalled an incident that happened on 6/11/21, she said she recalled the day specifically because it was a day [Physician A] was in the building rounding on the residents'. She said that she and Physician A entered Resident #8's room and found Resident #8 with Resident #12's hand wrapped around Resident #8's erect penis. LVN B said that Resident #8 had his hand wrapped around Resident #12's hand guiding Resident #12's hand up and down in a motion that appeared to be masturbating. LVN B said that Resident #12 was just sitting there he did not seem distress, appeared to be going along with it. LVN B said that she intervened and instructed Resident #8 that the actions were inappropriate, and she said Resident #8 began pulling his pants back up. LVN B said she immediately informed the DON and due to Physician A being right there with me, she did not have to call him he already was witness to it. LVN B said that when she notified the Former DON, she seemed kind of giddy as if it was funny to her, and specifically instructed LVN B not to chart it because nobody was in distress. LVN B said she did not notify any family members at the direction of the former DON and after the communication to the Former DON, Physician A responded to her and that is how you keep state out of your building. LVN B said it appeared he was in agreement with the Former DON and agreed not to document anything in the chart. The Former DON had stressed to LVN B that as long as both residents were not in any distress and they were okay, there was nothing to chart. LVN B said she disagreed with the Former DON but due to previous circumstances, she followed her direction and did not chart it for fear of retaliation. She said that the Former DON had a Persnickety attitude and she had crossed her before and had multiple shifts taken away from her. LVN B said that she needed the shifts and therefore followed her direction even though she knew it was not right. LVN B said that she personally did not notify the Administrator regarding the incident. LVN B said that Resident #8 is often redirected due to masturbating in inappropriate places, she said often he will be at the doorway in his room, peaking his head out and masturbating. She said that he is redirected to his side of the room and offered the privacy curtain. LVN B said that Resident #7 will often masturbate in his room, but no knowledge of any sexual behaviors towards other residents. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 8/15/21 at 5:05PM, Physician A said that he had received a phone call from the RNM on 8/11/21 informing him that the facility was being investigated for a compliance hotline complaint about several things that have happened in the building and it included resident to resident sexual behavior. A couple of resident to resident altercations that had caused harm and were not reported either, elopements, that he had no knowledge of and should have been notified immediately and that documentation had been deleted from the clinical records by the Former DON. Physician A said that he had a good communication line with the Former DON and Administrator. Physician A said that he was notified regarding several of the incidents that were being investigated, however he assumed the Former DON and Administrator were reporting accurately to the state. Physician A said that the knowledge he had regarding several residents (unable at the time of the interview to recall all the resident's by name) with inappropriate sexual behaviors was through a telephone call by the Former DON. Physician A said that she had notified him that there had been some exhibitions, male residents had been pleasuring themselves and exposing themselves in front of other residents and that he gave verbal orders to start the residents on medications to control their sexual behaviors, which was a medication called Depo Provera. Physician A said that the purpose of this medication is to cancel out the testosterone effect and reduces the libido of the male residents. Physician A said that he recalled Resident #8 having inappropriate locations of masturbation and did not recall Resident #8 having himself fully exposed with Resident #12, however did recall walking in the room and finding Resident #8 having an erection but was fully clothed. Physician A said that Resident #8 had known behaviors that were inappropriate, now that I recall, the one young resident, he was very young, [AGE] years old, (Resident #8), was having exhibitions that were inappropriate on the patio, not in the privacy in his room. Physician A said that Resident #8 was also known to be found in other resident's rooms pleasuring himself, verbally harassing the staff during ADL care such as showers. The reports that you received regarding Resident #8 and resident #7, were all from the DON, I received different reports on different dates, recall Resident #8 being mentioned in more than one. Physician A said that he did recall rounding with LVN B back the first part of June, unable to recall the exact date, but said that he did witness LVN B report to the Former DON regarding the inappropriate sexual behavior between Resident #8 and Resident #12, however Physician A did not recall the DON advising LVN B to not document the incident and then Physician A commented that he could not be 100% sure that he witnessed LVN B talking to the Former DON. Record review of Resident #8's progress notes revealed the following entry on 6/11/21: 6/11/21 3:49PM, Resident was seen by [Physician A] today. No new orders. No complaints noted at this time. Electronically signed by the Former ADON. In an interview on 8/16/21 at 3:00pm, Family Member A indicated that she did not have medical power of attorney for Resident #8 and that she did not make medical decisions for him. Family Member A said that Resident #8 makes all his own medical decisions. Family Member A did indicate that she had been contacted by the Administrator and informed her that Resident #8 had been having inappropriate sexual behaviors that ranged from masturbation in other resident's rooms to an inappropriate sexual act with a man that had Alzheimer's. Family Member A said that the facility told her that if the behaviors continued Resident #8 would have to be discharged and that they were going to have him evaluated and maybe start some new medication, but did not explain what the medication was or what it was for. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 8/16/21 at 2:21pm, NA H said that she had worked Unit #1 regularly and that she was unable to recall the exact date but thought it was about a month ago (Mid July 2021), Resident #7 had been getting in Resident #8's bed regularly, which was not unusual behavior for Resident #7 to forget where his room was and crawl in another residents bed, however on one occasion NA H said that she witnessed Resident #7 to have his brief pulled down and Resident #8 had his underwear pulled down, both male residents were exposed and Resident #7 had his penis erect and it was between Resident #8's buttocks, NA H did not feel that there was penetration and felt that she intervened right as the act was occurring. NA H said that she had informed LVN C, LVN D and LVN B. NA H said that there was another incident that involved Resident #7 and Resident #8 just a couple of weeks ago and that she witnessed Resident #8 have his underwear down and they were in the doorway of Resident #8's room. Resident #7 was behind Resident #8 and Resident #7 had his hand in the area of Resident #8's anus and Resident #7's hand was observed going in an upward and downward motion. NA H said that she did not visibly see any penetration to Resident #8 and Resident #8 was not trying to get away from Resident #7. NA H said that she separated the two residents and was traumatized by the incident. She said that the van driver came in and saw that she was upset and immediately went and reported it to the former ADON. NA H said that the former ADON never came and discussed anything with her regarding the incident, nor the Former ADON or Administrator. In an interview on 8/18/21 at 10:25am, CNA A said that she had witnessed Resident #7 and Resident #8 be sexually inappropriate with each other. CNA A said that she was working about two and a half weeks ago (End of July) and was charting in the hallway. CNA A said that she just happened to go down to the end of the hall and caught Resident #7 in Resident #8's room. CNA A said that she saw Resident #8's hand on top of Resident #7's had, and that Resident #7 was holding Resident #8's erect penis and Resident #8 was guiding Resident #7's hand up and down Resident #8's penis. CNA A said that she mostly worked on the male secure unit #1 and that it is very hard to supervise all the residents and provide care at the same time with only one staff member assigned to the secure units. CNA A said that if the unit only has one staff working or assigned that day, residents often go unsupervised for about 10-20 minutes depending on the care she is providing and there were residents that had physical, verbal and sexual behaviors on the male secure unit as well as resident's that were at risk for falls. CNA A also recalled an incident, unable to recall the exact date, with Resident #8 being found in Resident #9's room. Resident #9 was in bed and Resident #8 was standing over Resident #9 masturbating. CNA A said that she reported the incident to the former DON and ADON and was told he as on birth control and that is all she knew was done about it. In an interview on 8/18/21 at 10:45am, LVN D said that the secure units are sometimes staffed with two CNAs or NAs, however, there have been many times that there has only been one aid on the secure unit to supervise residents. LVN D said that she has on multiple occasions walked in and found residents being sexually inappropriate. LVN D said that one specific incident was between Resident #8 and Resident #12, could not recall the exact date, but witnessed Resident #8 grab Resident #12's buttocks. LVN D said she redirected Resident #8 and explained that touching other residents was inappropriate. LVN D said that she told the Administrator immediately about the behavior and the Administrator and the DON came on to the unit and spoke to Resident #8 and was instructed that they (administrator and DON) would take care of it. Attempted phone interviews with the Former DON at the phone number provided by the facility; were: 8/16/21 at 2:14pm, voicemail message left. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/18/21 at 4:03pm, voicemail message left. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 8/18/21 at 5:20pm, the former DON said that she had been suspended pending an investigation that she was not sure what for and that her and that she voluntarily resigned from the facility and was no longer employed at the facility. The Former DON said that she did not have any knowledge of any resident's in the building having inappropriate sexual behaviors. The Former DON said that I know there have been innuendos, but nothing specific. The Former DON was asked if the specifically had any knowledge of Resident #7, Resident #8 and Resident #10 having inappropriate sexual behaviors towards other residents on the secure male unit #1, she replied No Ma'am. When asked by the surveyor, Without a doubt, you have no knowledge of any staff member ever reporting inappropriate sexual behavior's to you with Resident #7, Resident #8 and Resident #10?, the Former DON replied, I don't know now; I know [Resident #8] was wanting to engage and [Resident #7], I never .I know that sexual behavior residents have sexual behaviors, and that is the type of residents that they [the facility] took. At this time of the interview, the Former DON was read by the surveyor a progress note dated 7/28/21 Date: 7/28/21 at 1:56pm Resident has a history of sexual behaviors. [Physician A] reviewed medications, order received Depo (Depo-Estradiol) 1mL month intramuscular (IM). Physician orders updated, essential caregiver (EC) [Family Member A] notified of updated orders . electronically signed by [Former DON] and the Former DON confirmed that her name was correct as the electronically signed signature as [Former DON] and stated that sounds like my progress note. The Former DON said the inappropriate sexual behavior was probably having his [Resident #8's] hands in his pants and pleasuring himself more in the common areas verses in his room privately. I honestly do not remember what his inappropriate sexual behaviors could have been, he was talked to several times while taking a shower with the aids, (the Former DON could not recall what he was specifically talked to about). The Former DON was asked if Resident #8 exposed himself often in front of other residents? The Former DON replied, It was enough to where, it got my attention. The Former DON could not recall what staff, specifically got her attention. The Former DON said that when I would go and investigate it, no one would ever come out and say that there were inappropriate sexual behaviors. The Former DON said that Resident #8 had admitted to the facility in April 2021 and was admitted on the all-male secure unit #1 due to being at a previous facility where he had displayed inappropriate sexual behaviors towards female residents. The Former DON said that Resident #8 always has a look of smiling, it is hard to tell if he really knows. The Former DON said that she did not recall when his inappropriate sexual behaviors began, it was all hearsay, he would ask people if he could pleasure them or if they would pleasure him. Hearsay, the former DON said was from the nurses. The Former DON did not feel the need to investigate and report hearsay to the abuse coordinator since it is just hearsay, you could spend all day on hearsay, and it depends on the content and what you heard. The Former DON denied NA H reporting anything to the former ADON regarding Resident #7 and Resident #8. The Former DON denied any knowledge of LVN B reporting any alleged allegations involving Resident #8 being inappropriate with Resident #12. The Former DON replied when asked if she had ever instructed her staff to not document or tell staff that she would document an incident with I have helped them with charting if they needed help. The Former DON was asked if she was involved in the room change for Resident #7, she replied I am sure. The Former DON said that the reason Resident #7 was moved to the secure unit #2 was because Resident #7 and Resident #8 was observed gravitating more towards each other, it seemed to be happening more frequently. The former DON said that when I walked onto the unit, they were together, may have been in common areas, one time when I walked onto the common area, [Resident #7] was standing with his hands in his pants, not a behavior, that was normal to me, I'm not sure what I would have reported to state. The Former DON said that she participated in facility interval investigations, she would perform head to toe assessments, might do safe surveys for the residents, I would do lots of interviews, reportable events to the state would be allegations of abuse/neglect, unwitnessed falls, injuries of unknown origin, misappropriation of property, most of the time the administrator would determine if it needed to be self-reported. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 8/17/21 at 12:59pm, the Social Worker said that she recalled when Resident #8 was admitted to the facility and that at the time, he did not seem to have any sexual inappropriate behaviors, however he had begun over the past several weeks to display inappropriate sexual behaviors. The Social Worker said that a night nurse, unable to recall exact name, had verbalized to her in passing one morning that Resident #8 had been sexually inappropriate. The Social Worker said at that time, she did not clarify anything else and soon after the Former DON and Former ADON had discussed in a morning meeting the inappropriate behaviors and the need to have him evaluated by psychiatric services and possibly send him to a psychiatric hospital. The Social Worker referenced her progress notes and explained that she had been in contact with his grandmother regarding his care and potential need for psychiatric evaluation at a local psychiatric hospital. The Social Worker said that the Former ADON expressed that she had a background in psychiatric nursing and trusted the Former DON and Former ADON's judgement and it appeared that they were handling the situation appropriately to her knowledge. The social worker did not realize that the psychiatric consult had not been obtained until a few days ago on 8/12/21. In an interview on 8/17/21 at 2:40pm, the FNP said that she had recently performed a psychiatric evaluation for Resident #8. The FNP said that she did not receive a lot of information from him, he basically just answered yes and no to the questions she asked. She did indicate that due to his diagnosis of Huntington's Disease it is difficult for him to express himself. The FNP said that the facility had expressed to her that he had been having some inappropriate sexual behaviors. The FNP said that she was aware of the medication Depo Provera that had been ordered for Resident #8 by Physician A. She said that she had seen the medication be used for overtly sexual behaviors in male residents. In an interview on 8/17/21 at 3:19pm, Resident #8 said that he had come from another long-term care facility, was not certain why he had to move from that facility and did not care that he was on a male secure unit. Resident was alert and oriented and was able to recall his name, the date, where he was at, nursing facility, town, state; was able to recall who the president is currently. Resident #8 said that he had had sexual interactions with male reside [TRUNCATED]

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37012 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan that was developed within 7 days after completion of the comprehensive assessment and no later than 21 days after admission into the facility for one of sixteen residents (Resident #13) reviewed for care plan. The facility did not ensure Resident #13's care plan was developed within 7 days from the comprehensive assessment, and no later than 21 days from her admission on 6/4/21. This failure had the potential to affect the residents by placing them at risk for unmet care needs. Findings included: Record reviewed of Resident #13 's electronic face sheet, dated 8/23/21, revealed Resident #13 was a [AGE] year-old female, admitted on [DATE] with diagnoses to include: Vascular dementia with behavioral disturbance, Alzheimer's disease, hearing Loss, Essential Hypertension, Cerebrovascular disease. Record review of Resident #13's admission Minimum Data Set (MDS) dated [DATE] revealed a BIMS of 00, indicating severe cognitive impairment. Section E Behaviors did not indicate Resident #13 had exhibited any behaviors and Section G indicted that Resident #13 required Supervision or Limited Assistance of one staff member for all ADLs. Record review of Resident #13's comprehensive care plan was dated 8/10/21 for Resident #13. Specifically, Resident #13 was care planned for the following: Category Falls: Falls/Safety/Elopement Risk Goal: Resident will remain free of injuries and falls .Approach Assess resident's footwear for proper fit and non-skid soles, Encourage use of call light, Instruct and remind resident on safety measures . In an interview on 8/23/21 at 2:12pm, LVN G said that Resident #13's comprehensive care plan was not created until 08/01/2021 and that Resident #13 was admitted to the facility on [DATE]. LVN G said that the facility has 14 days to complete the initial comprehensive care plan from the admitted and that at the very least it should have been created within 21 days of her admitted . LVN G said that she did not know why it was late being done. In an interview on 8/23/21 at 2:38pm, the RNM said that care plans should be developed within 14 days of admission and anytime there is a change in the resident's health or plan of care, the care plan should be updated. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy entitled, Care Plans, Comprehensive Person-Centered, dated December 2020, revealed the following: Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical psychosocial and functional needs is developed and implemented for each resident. The services provided or arranged by the facility as outlined by the comprehensive care plan, are provided by qualified persons, are culturally competent and trauma informed. Policy Interpretation and Implementation: 1. The Interdisciplinary Team (IDT), in connection with the resident and his/her family or legal representative, develops and implements a comprehensive, person centered care plan for each resident.8. The comprehensive, person-centered care plan will .b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; g. Incorporate identified problem areas' h. incorporate risk factors associated with identified problems; 9. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. 10. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. 12. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS). 13. Assessments of resident are ongoing and care plans are revised as information about the residents and resident's conditions change. 14. The Interdisciplinary Team must review and update the Resident's diagnoses within the clinical software system. When a new diagnosis is established .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37012 Based on interview and record review, the facility failed to maintain medical records on each resident, in accordance with accepted professional standards and practices, that were complete and accurately documented for four (4) of sixteen (16) (Residents #1, Resident #2, Resident #6, and Resident #15) residents whose records were reviewed for accuracy. The facility failed to ensure the Former DON did not alter other staff members clinical documentation after being informed there had been resident to resident altercations, which resulted in injury for Resident's #1, Resident #2, Resident #6 and Resident #15. These failures could place residents who have resident to resident altercations at risk of having an incomplete and inaccurate medical record. The Findings Include: Resident #1 Record review of Resident #1's electronic face sheet dated 8/30/21 revealed that Resident #1 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses to include: Encephalopathy, Mood disorder, schizoaffective disorder, Dementia, Restlessness and agitation, Hypertension. Record review of the Event Report dated 7/13/21 at 9:30PM created by LVN E revealed that the Event Report was marked Invalid on 07/19/2021 at 2:48pm by the Former DON on 7/19/21 at 2:48pm with a reason for invalidation being: Incorrect Data. The event report details revealed [Resident #1] .Aggressive/combative behavior wanting to hit another resident with his cane. Electronically signed by LVN E. Resident #15 Record review of Resident #15's electronic face sheet revealed he was a [AGE] year-old male, with an initial admitted [DATE] with diagnoses to include: Epilepsy, Dementia without behavioral disturbance, Major depressive disorder, Acute combined systolic and diastolic heart failure. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #15's progress notes revealed the following entries had been marked invalid by the Former DON and indicated wrong resident: Marked Invalid by: [Former DON] on 7/14/21 at 8:20am Reason: wrong resident .7/13/21 10:08 PM -INVALID-- .note type: Telehealth Evaluation .Date of service 7/13/21 10:08pm .Details: Nurse name: [LVN E]Name: [Resident #15] Primary Chief Complaint: headache History of Present Illness: [AGE] year old male with past medical history of DVT on Eliquis (a blood thinner) was another resident and the other resident hit him in the head with a cane. Patient subsequently developed some bruising along the left temporal region. Patient is otherwise baseline. Nursing staff has initiated neuro checks Assessment/Plan: Patient with a contusion to the left temporal region of his head. Patient is mentating at his baseline. Patient is answering questions appropriately and has no cognitive or neurologic defects at this time based on nursing assessment. Discussed with patient continuing to observe at the facility or transfer to emergency department for imaging. I explained to the patient that there may be a chance he could have bleeding inside his head because he is on Eliquis and patient stated he did not want to go to the ED (Emergency Department). As such will have facility monitor him for any neurologic changes and perform neuro checks, if he has any change in his mental/neurologic status nursing staff is to contact us so we can evaluate. Patient is agreeable to this plan . Electronically signed, *Imported Record [Physician B] In an interview on 8/20/21 at 3:42PM, LVN E said that she was working the secure unit #2, the day that Resident #1 and resident #15 were involved in a resident to resident altercation. LVN E said that she was on the hall passing her medications and heard some commotion going on yelling get outta here. LVN E said a CNA was in the hallway charting and immediately went into [Resident #1's] room and saw [Resident #15] backing up out of the room. LVN E said she then saw Resident #1 hit Resident #15 with his cane and a knot came up on Resident #15's forehead afterwards. LVN E said that she contacted the ADON and was advised to get a third eye consult, which is a telehealth visit from a physician. LVN E said that Physician B recommended Resident #15 to go to the emergency room for further evaluation due to the fact that he was on a blood thinner, but Resident #15 declined and was monitored at the facility. LVN E said that she was not made aware that the documentation from the Third Eye Consultation performed by Physician B had been marked invalid, nor did she know that the Former DON had marked her progress note for Resident #1 invalid and confirmed that Resident #1 and Resident #15 were involved in an altercation on 7/13/21 and it involved Resident #1 hitting Resident #15 with his cane. Resident #2 Record review of the facility's electronic face sheet dated, 8/20/21 revealed Resident #2 was admitted to the facility on [DATE] with diagnoses to include: Idiopathic Aseptic Necrosis of Right Femur, Idiopathic aseptic Necrosis of Left Femur, Pain, Syncope and collapse, Reduced Mobility, Repeated Falls, Muscle Wasting and Atrophy, Left Thigh, Right lower Leg, Left Lower Leg, Muscle Weakness, Schizoaffective Disorder . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Event Report for Resident #2 dated 8/4/21 created by the Former DON revealed the following: Description: Resident in her room on the floor, on her (R) side in fetal position with a moderate amount of blood on floor. Full passive ROM performed, toleration well. Pupils Equal Reactive to Light .Noted 3cm skin tear above her (R) eye that is superficial in depth. Assisted resident up off of the floor, cleansed skin tear, applied steri strips with pressure dressing, doctor and family were notified .Was the incident Witnessed or Not Witnessed, Not Witnessed (Proceed to Required State Reporting was check, Witness Statements, Resident was checked on this entry, however no witness statements were entered. Required state reporting box was checked no (proceed to Provider Actions), Provider Actions IDT Reviewed Incident Yes, no risk identified, Root cause, Not aware of limitation or other residents' personal space. Actions Taken to Minimize Risk of Re-occurrence, Increased visuals as appropriate. New diagnosis of Avascular necrosis to bilateral hips. Electronically signed by the Former DON with a completion Date of 8/9/21 at 2:42PM. Record review of Resident #2's progress notes revealed the following entries had been marked invalid by the Former DON and indicated incorrect data: Marked Invalid by: [Former DON] on 7/26/21 1:09pm, Reason: Incorrect Data 07/23/21 5:47pm -Invalid-resident was pushed to ground by another resident after exam no injuries found did not hit head, escorted to dining area and proceeded to eat supper without further incident. Electronically signed by RN A. In an interview on 8/20/21 at 1:50pm, RN A said that he was the RN on duty when Resident #6 pushed Resident #2 down. RN A said that he could not recall the CNA that reported the incident to him, was unsure how many staff members were on the female sure unit but knew often times it was just one staff member. RN A said that he assessed Resident #2 and there were no obvious injuries, nothing else to really report. RN A said he attempted to interview Resident #6 and she told him to Get Out. RN A said he created an event in the electronic health record and did not have any knowledge or communication from the Former DON as to why she marked the event invalid. RN A reviewed the documentation from his original event and verified that it was true and accurate information and should not have been marked invalid. Resident #6 Record review of Resident #6's electronic face sheet dated 8/23/21, revealed that Resident #6 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: Parkinson's Disease, Essential Hypertension, Schizoaffective Disorder, Type 2 Diabetes Mellitus. Record review of Resident #6's care plan revealed the following: Problem Behavioral Symptoms, Problem Start Date 8/13/21, I have aggressive behaviors at times .Goal: I will have no aggressive episodes for next 90 days .Approach .Staff will redirect resident as needed, ensure resident is taking medications, and notify physician with any increase in behaviors. Record review of Resident #6's progress notes revealed the following entries had been marked invalid by the Former DON and indicated Incorrect Data: Marked invalid by: [Former DON] on 7/26/2021 at 1:08pm. 7/23/21 -Invalid-resident pushed another resident to ground. No injuries resulted. Electronically signed by RN A (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Event Report dated 7/23/21 at 5:52PM created by RN A revealed that the Event Report was marked Invalid on 07/26/2021 at 1:16pm by the Former DON with a reason for invalidation being: Incorrect Data. The event report details revealed [Resident #6] .Aggressive/combative behavior [Resident #6] wanted to push [Resident #2], no injuries found. Electronically signed by RN A. Attempted phone interview on 8/20/21 at 1:40pm with the former DON to discuss the invalid documentation and conflicting event reports, no answer, message was left on her voicemail. Attempted phone interview on 8/24/21 at 1:31pm with the Former DON to discuss the invalid documentation, conflicting elopement interviews and conflicting event reports, no answer, message left on voicemail. In an interview on 8/15/21 at 2:30pm, the Regional [NAME] President of Operations said that during the facility's investigation chart audits, it was found that the Former DON had marked nurse's progress notes and reports invalid or incorrect data, or wrong resident on multiple resident records. The [NAME] President of Operations said that marking a chart invalid does not delete it from the clinical record, but it does grey it out indicating it is not an active part of the resident's Clinical Record. In an interview on 8/23/21 at 2:38pm, the RNM said that the facility did not have a specific policy for marking documentation invalid, but she did say that best practice is to not ever mark another staff member's documentation invalid. The RNM said that the Former DON should have never marked the electronic documentation invalid, there should have been more justification and explanation as to why it was marked invalid and at the very least, discussed with the nurses and explained to them that she was altering their clinical documentation. The RNM said she should have documented in a progress note her findings and not have altered someone else's documentation. Record review of the facility's policy entitled, Charting and Documentation, dated July 2017, revealed the following: Policy Statement: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation: 1. Documentation in the medical record may be electronic, manual or a combination .3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate .