STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676040	A. Building B. Wing	08/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at the Prairies	106 Del Norte Dr El Campo, TX 77437

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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** 34463 Based on observation, interview, and record review, the facility failed to ensure each resident was free from abuse and neglect for three of Nine residents (Resident #1, Resident #2, and CR#3) reviewed for abuse and neglect. The facility failed to provide adequate supervision for Resident #2 who had a history of wandering and sexual inappropriate behaviors. Resident #2 was found in Resident #1's room sexually abusing Resident #1. The facility failed to provide adequate supervision for CR#3 who had a history of sexual inappropriate behaviors. CR#3 was found sexually abusing Resident #1. The facility failed to adequately supervise Resident #1 who had a history of wandering to prevent her from being sexually abused. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 08/04/21 at 11:35 AM. While the Immediate Jeopardy was removed on 08/07/21, the facility remained out of compliance at the scope of a pattern and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to train staff and evaluate the effectiveness of their plan. These failures placed residents on the secure unit at risk of diminished abuse and neglect. Findings Included: Record review of Resident #2's face sheet revealed Resident #2 was a [AGE] year old male that was admitted to the facility on [DATE] with a diagnoses of Parkinson's disease, psychosis, muscle wasting atrophy, anxiety disorder, vitamin D deficiency, muscle weakness, abnormality of gain and mobility, lack of coordination, hallucinations, pain, benign prostate hyperplasia, hyperlipidemia, anemia, vitamin B deficiency, depressive disorders, irritable bowel syndrome, and constipation. Record review of Resident #2's Physician Progress Note dated 07/02/21 revealed .Review of Systems . Psychiatric: Staff reports agitation, some sexual behavior (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #2's MDS dated [DATE] revealed Resident #2 had a BIMS of 11 of 15 which meant he had moderate cognitive impairment. Record review of Resident #2's Care Plan dated 04/15/21 revealed Resident #2 experienced wandering, moved with no rational purpose, seemingly oblivious to needs or safety, and goes into other resident rooms. The interventions indicated staff are to remove resident from other resident's rooms and unsafe situations and staff are to provide comfort measures for basic needs. The resident care plan indicated Resident #2 had episodes of adverse behavior verbally aggressive-cursing, racial slurs, yelling/screaming, fabricate facts, unreliable history, manipulates staff, had inappropriate behavior of disrobing in common areas, urinates in public, masturbates in public, and verbally entices other conflicts related to psychosis. Interventions were for staff to anticipate the resident's behavior and re-direct the resident when in close proximity to others that might invoke aggression, asses for triggers that may contribute / prompt behaviors, and attempt to redirect resident to safe area when increased behavior noted. Record review of Resident #1's face sheet revealed Resident #1 was a [AGE] year-old female, admitted to the facility on [DATE] with a diagnoses of Alzheimer's disease, wandering, abnormalities of gait, lack of coordination, and muscle weakness. Record review of Resident #1's MDS dated [DATE] revealed she had a BIMS of 99 which meant she was unable to complete the interview. Record review of Resident #1's Care Plan dated 10/20/20 revealed Resident #1 experienced wandering, moved with no rational purpose, and was seemingly oblivious to her needs or safety. The interventions are for staff to remove the resident from other resident's rooms and unsafe situations, when resident begins to wander, provide comfort measures for basic needs. Record review of Resident #1's progress notes dated 01/26/2021 written by DON revealed at around 11am the resident and another resident were found in the same room together with the door open. The two residents were immediately separated, and she was assisted to her room. She was noted with bm on self and was taken to shower by CNA. Head to toe skin assessment was done and no skin break down noted. RP was notified. 2pm NP here to see resident and noted redness to peri area with discharge ordered lab and medication for yeast. NP notified RP of findings . Record review of Resident #2's Progress Notes dated 03/06/2021 11:20 written by RN C revealed . Patient sitting next to resident in dining room on station 2. Patient was talking with resident. Patient started to rub on other resident's leg. Patient and resident separated, patient educated on personal space and not touching other residents (especially without their permission). CNA and RN asked patient to go back down to station 3, patient non-compliant, continues to wheel back and forth down the hallway on station 2 . Record review of Resident #2's Progress Notes dated 03/11/2021 written by RN C revealed Patient sitting in dining room on station 2 with another resident. Patient attempted to hold resident's hand under dining room table, resident pulled hand away from resident and told him no, she had a boyfriend. Patient told resident he didn't care. Patient sat very close to resident and ate his soup. RN redirected and educated patient on not making other residents feel uncomfortable. Asked patient to return to station 3 to eat soup/lunch. Patient wheeled himself to station 3 but continues to wheel up and down the hallway on station 1 and 2 . (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 Resident #2's Hospital Progress Note dated 03/12/21 revealed . Patient arrived on unit via wheelchair from ED after medical clearance at 8:15PM .He was nervous and slightly irritable .Per nursing home report, he was swinging at staff and cursing them and residents. He was intrusive, going into other residents' rooms and being difficult to redirect. He has been hallucinating that he sees or hears people who are not there and is paranoid someone may be after him or that staff has stolen his cell phone which he lost or misplaced .He is inappropriate at times with female residents trying to hold their hand or making them feel uncomfortable. He refuses nursing care and assessment at times . Record review of Resident #2's Progress Notes dated 06/18/21 written by RN A revealed . CNA reported this resident entered a female resident's room while she was lying in bed and kissed her on the head at 9:45 pm. When CNA asked res to leave female residents room, he showed her his middle finger, nurse went to resident and requested he go to his room and remain in bed and not get up to go into female res. rooms . In an interview on 07/20/21 at 1:26 PM, CNA A stated on 07/17/21 she was on station #2 when a resident on her station wanted some ice so she went to the memory care unit to get the ice. She stated when she walked by Resident #1's room she saw the back of Resident #2 while he sat on the side of Resident #1s bed with his pants down. She said Resident #1 was in her bed with her brief off and her pants down. She stated Resident #2's hands were on Resident #1's thighs. She stated she told Resident #2 to leave Resident #1's room. CNA A stated she reported what she saw to RN A who was behind the desk outside the memory care unit. She stated CNA B was the only aide on duty in the memory care unit. In an interview on 07/20/21 at 2:13 PM, CNA B stated on 07/17/21 she was in the dining room watching the other residents when she heard a CNA A say, what are you doing. CNA B stated when she got up Resident #2 was already walking toward his room. She stated Resident #2 did touch residents on shoulder, but other residents did that as well. She stated she was on the memory care unit by herself at the time of the incident. She stated RN A went back and forth to the unit periodically. In an interview on 07/20/21 at 3:00 PM, CNA B stated on 07/17/21 the incident between Resident #1 and Resident #2 happened after supper somewhere between 6PM to 7:30 PM. She said usually she had Resident #1 with her but there was another resident that was more confused that day, so she needed to supervise that resident a little more. She stated the incident between Resident #1 and Resident #2 happened quickly because both residents were sitting with her in the day room before the incident occurred. She could not remember the last time she saw them. (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 07/20/21 at 12:28 PM, RN A stated on 07/17/21 CNA A from Station #2, came to the Memory Care Unit to get some ice for a resident on her station. When she passed Resident #1's room she saw Resident #2 standing next to Resident #1's bed, his pants were down around his ankles. Resident #1 was laying on the bed her pants were down below her knees with her brief on and had some feces on her buttocks. CNA A reported Resident #2 was touching Resident #1 on her right hip/thigh area and CNA A told him to stop and redirected him out the room. CNA A got RN A and she went and assessed Resident #1. Resident #1 had no injuries, no secretions or blood in vaginal area. She was cleaned up and brought into the dinner room. Resident #2 went into his room and the DON was notified. RN A stated Resident #1 was ambulatory, and she could use her hands and legs. She stated she was not sure how Resident #1's pants were removed. She stated Resident #1 had no previous incidents like this before. RN A said Resident #2 did approach women and rub them on shoulder and kiss them on the forehead. She said it was reported to her that he kissed Resident #1 on the mouth before, but she did not witness this. Record review of Resident #2's Progress Notes dated 07/19/21 written by DON revealed .Resident was noted in another resident's room. The residents were immediately separated and redirected. Resident was moved to 45A and psych service was started. New order to increase Depakote due to behaviors. NP and RP notified of changed . Record review of Resident #1's Progress Notes dated 07/19/21 written by DON revealed . spoke to RP about another resident that was found in resident's room while she laid in bed, residents were immediately separated. Head to toe skin assessment was done, no discoloration or skin break down was noted. NP was notified of incident. Resident is noted laughing, walking with no problems . Observation and interview on 07/20/21 at 10:07 AM revealed Resident #1 was sitting in a chair in dayroom. Resident #1 did not respond to questions, just laughed when questioned. Observation and interview on 07/20/21 at 10:09 AM revealed Resident #2 laid down in bed. Resident #2 stated he did not have any concerns with abuse at the facility. He stated some of the older men would come and lay down in his bed. He stated he remembered being moved to a new room recently but did not know why. He did not remember going into a female's room or any sexual activity with a female. In an interview on 07/20/21 at 10:55 AM the DON stated, it was reported to her by the RN A that Resident #2 was found in Resident #1's bedroom on 07/17/21. Resident #1's sheets were down to her ankles and she was in her gown. The resident had feces in her brief. The DON stated she was not sure if Resident #1's brief was off. The DON stated Resident #2's pants were down; she was not sure if his penis was erect. The DON stated the nurse aide redirected the residents. RN A completed a head to toe assessment and no redness, bruising or discoloration was noted. Resident #2 was sent to his room and the NP was notified as well as the responsible party. The DON stated Resident #1 and Resident #2's rooms were across from each other so Resident #2 was moved to a different room . The DON stated Resident #2 had a history of wandering into other residents' rooms . She stated she did not have an incident investigation report for either incident because nothing happened between the residents. In an interview on 08/02/21 at 11:20 the DON stated Resident #1 had a yeast infection which caused the redness and was not related to the incident between her and CR#3. (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 07/20/21 at 12:02 PM the Administrator stated it was reported to her that Resident #2 wandered into Resident #1's room and his pants were down. The staff immediately separated them, and Resident #2 was moved to a different room away from her, nothing physical occurred. The physician was notified but there was not a justification to send the resident to the psych hospital. Resident #2 was sent to the psych hospital a while back for a different situation . The Administrator stated Resident #2 was her family member, but she does not treat him any differently from the other residents, she is harder on him and expects more from him. In an interview on 07/20/21 at 12:37 PM, the DON stated the NP could not justify sending Resident #2 to the behavioral hospital. The DON stated Resident #2's Depakote was increased due to his increased behaviors. The DON stated Resident #2 would be seen by the local behavioral services next week and they are more familiar with his needs. The DON said the facility typically had two staff assigned to the memory care area. The nurse was usually in the hallway during the evening and the aide was in the dayroom or helping residents. In an interview on 07/20/21 at 12:38 PM, the Administrator stated she was not sure what to do and wanted to know the state agency's recommendation for this situation. She stated the best case was to have Resident #2 transferred to another facility, she was his dual power of attorney. She could have him transferred to a different facility quickly. In an interview on 07/20/21 at 1:35 PM, the Administrator stated she was not aware of the other sexual behaviors by Resident #2, she did not read the hospital notes or physician notes. She was having Resident #2 moved to an all-male facility. In an interview on 07/20/21 at 1:41 PM, the DON stated Resident #2 was being sent to the behavioral hospital and he will not be returning. In an interview on 07/20/21 at 2:27 PM, CNA C stated Resident #2 had a history of touching other female residents. Staff would redirect him and report him to administration, but he would curse out staff and keep doing the same things. Staff had to redirect him before he could go too far with touching other residents. Staff were scared to say something because he was the Administrators family member. In an interview on 07/20/21 at 2:29 PM, MA A stated she worked on the secure unit at times and Resident #2 had a history of touching other female residents. In an interview on 07/20/21 at 2:45 PM, RN A stated there was one nurse aide assigned to the memory care unit. MA B was assigned to that unit but was scheduled to come in at 8 PM. MA B passed the 8 PM medications and she passed the 4PM medications on the memory care unit. RN A said the memory care unit was part of station #3 but the nurse aide for station #3 did not work on the memory care unit. Staff on the memory care unit had to get staff from station #3 to help with transfers when needed. In an interview on 07/20/21 at 3:34 PM, the DON stated the facility usually had two people assigned to the memory care unit. The nurse had a camera at the desk of station #3 so she could see what was going on the memory care unit. Today Resident #2 was sent to the behavioral hospital and was accepted to another facility. (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 08/02/21 at 11:10 AM the NP stated the Resident #2 had sexual behaviors and they were discussed with the facility. There were discussions regarding proper placement, moving to another facility closer to family, or a higher level of care. Resident#2 mentioned he wanted to have a girlfriend and that was not possible in this type of environment. Resident #2 was a younger resident, so he was given a sex toy. The nurses trained him to use the toy, he was doing pretty good with that. Resident #2 did not have any issues up until he was found in another resident's room. No sexual activity was reported between Resident #2 and Resident #1 during that incident. Behavioral Services had increased his Depakote, but she was not sure when that occurred. 2. Record review of CR#3's face sheet revealed he was an [AGE] year old male that was admitted to the facility on [DATE] and discharged on [DATE] with a diagnosis of psychosis, fever, pain, neuromuscular dysfunction of bladder, constipation, bipolar disorder, Alzheimer's disease, and repeated falls. Record review of CR#3's MDS dated [DATE] revealed he had a BIMS of 3 which meant he had severe cognitive impairment. Record review of CR#3's care plan dated 05/04/21 revealed CR#3 resided on the secure unit due to risk of exit seeking and risk for injury from wandering related to dementia as evidence by impaired cognition and safety awareness. CR#3 was at risk for injury from others while residing in secure unit due to altered cognition. Staff approaches are to monitor and discuss activity preference, allow resident to choose activity inside and outside that do not pose a safety risk, call resident by name when giving care, involve in care as much as possible, explain procedures using terms/gestures resident can understand, and keep environment free from possible hazards. Record review of CR#3's baseline care plan dated 01/18/21 revealed CR#3 had inappropriate sexual behavior of attempts to touch staff and other residents inappropriately. Staff approaches were to monitor resident frequently for any attempts to make inappropriate sexual advances, attempt to redirect resident if any hypersexual behaviors were noted, separate from other residents temporarily if any inappropriate behaviors are noted, call MD and family, and medicate as ordered . Record review of CR#3's progress notes dated 01/17/2021 written by RN B revealed .Pt up ambulating ad lib in secure unit with no c/o pain or discomfort voiced or noted. Pt noted with very inappropriate sexual behaviors-towards staff and female residents. Pt informed of inappropriateness of acts and redirected. Np made aware of behaviors . Record review of CR#3's progress notes dated 01/18/2021 written by LVN A revealed . CNA to room to do vitals, was sexually inappropriate, rubbing on her leg, asked her if he could put something in there, when she asked .he told her his little penis. She told him no, he told her to come back later . Record review of CR#3's progress notes dated 01/26/2021 written by DON revealed . 11am resident was noted in a room with another resident with door open and were immediately separated by CNA. Resident was noted with hypersexual tendency. NP was notified of situation and ordered for resident to be sent to senior care at [hospital]for med adjustment. RP was notified of situation and ordered. 12pm resident was transferred to senior care via van driver. (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 08/03/21 at 10:37 AM CNA D stated she was on the secure unit by herself when the incident occurred between Resident #1 and CR#3.on 01/26/21. She was back there by herself at the time. It was the 6am-2pm shift. She remembers hitting the glass to get RN C's attention to come into the secure unit to assist. It is hard when you work the secure unit by yourself. In an interview on 08/05/21 at 12:50 PM RN B stated CR#3 would always make sexual comments about doing dirty sexual stuff. CR#3 would not touch but he would tell staff to come and get into the bed with him while giving medicine. Staff tried to keep an eye on the resident, when he would speak like that staff would redirect him. None of the touch incidents occurred when she was on duty. In an interview on 08/05/21 at 1:53 PM LVN A stated CR#3 was trying to get the nurse aide to get into the bed with him. CR#3 told her he wanted to put something inside of her. He did this several times when he first came to the facility. CR#3 had sexually inappropriate behaviors. He would ask to touch and feel female residents and staff. LVN A was not sure which nurse aide that was but this was during the 10p-06a shift. LVN A said Resident #1 had a history of wandering in other resident's rooms. Resident #1 did not understand what she was doing and she has to be watched. She had seen her walk into other male resident's rooms before. Resident #1 just laughs when spoken to and does not know what was going on. Record review of Resident #3's face sheet revealed she was a [AGE] year old female that was admitted to the facility on [DATE] with a diagnosis of hemiplegia and hemiparesis, muscle wasting atrophy, bipolar disorder, transient ischemic attach, cerebral infarction, Parkinson's disease, heart failure, epilepsy and hypertensive chronic kidney disease. Record review of Resident #3's MDS dated [DATE] revealed she had a BIMS of 8 which meant she had mild cognitive impairment. Observation and interview on 08/04/21 at 11:58 AM revealed Resident #3 was sitting in a wheelchair, resident was in a pleasant mood. Resident #3 stated she did not recall being touched by a male resident at the facility, but she remembered by touched by a family friend at [AGE] years old. Record review of Resident #4's face sheet revealed she was an [AGE] year-old female she was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease, dementia, urinary tract infection, anemia, muscle wasting atrophy, insomnia, and hypothyroidism. Record review of Resident #4's MDS dated [DATE] revealed she did not have a BIMS score. Observation and interview on 08/04/21 at 12:02 PM revealed Resident #4 was sitting in wheelchair, resident in a pleasant mood. Resident could not communicate and answer questions clearly. (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 08/02/21 at 12:35 PM RN C stated CNA D told her it was an incident between Resident #1 and CR#3. CR#3 was standing over Resident #1. Resident #1 had BM in brief which was down, CR#3 had no fecal matter on his penis. Resident #1 was lying in CR#3's bed. RN C asked CR#3 what happened but he could not answer. She contacted the DON and NP. Residents were separated. CR#3's briefs was on and he did not have an erection. It was reported to her by a resident that Resident #2 came up to a female resident in dining room and touched her on the hand, she separated the residents and spoke with Resident #2 about the behaviors. She said Resident #2 had another incident, he came in the dining room and touched a female resident on the leg. The residents were separated. She was not sure which incident involved Resident #3 or Resident #4 . One of the incidents occurred on 3/6/21, the other incident occurred on 3/11/21. Resident #4 has dementia and cannot communicate. Resident #3 may not be here anymore. Resident #2 would come from Station #3 and wheel himself to Station #2. He was placed on the secure unit sometime in March or April of 2021. In an interview on 08/07/21 at 7:05 AM the DON stated its important monitor residents with sexual inappropriate behaviors because residents that cannot consent to sexual encounters can become abused, especially in the dementia unit. The facility does not want residents taking advantage of other residents. It made other residents feel uncomfortable. Record review of the facility policy Safety and Supervision of Residents dated December 2007 revealed Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accident are facility-wide priorities Facility-Oriented Approach to Safety .1. Our facility-oriented approach to safety addresses risks for groups of residents. 2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QA&A reviews safety and incident/accident reports; and a facility-wide commitment to safety at all levels of the organization .Systems Approach to Safety 2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. 3. The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment (such as construction) or if there is a change in the resident's condition . An Immediate Jeopardy was identified on 08/04/21 11:35 AM and the DON was informed of IJ in the area of accidents/supervision and the IJ template was provided to him via email at 11:51 AM and a plan of removal was requested. The plan of removal was accepted on 08/06/21 at 8:32 AM and included: .PLAN OF REMOVAL Name of facility: [facility name] Date: August 4, 2021 Immediate action: Resident #2 was discharged from the facility on 7/20/21 at 5:00 PM. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #1 was assessed at the time of the incident without any concerns. Resident #1 was re-assessed on 8/4/21 by the Director of Nursing and found to be without distress with good food intakes and hydration per normal for the resident. Resident #1s care plan was reviewed and revised to show supervision and monitoring and communicate any changes in the plan of care prior to staff starting their shift through direct report. The C.N.A. profile will be update appropriately to reflect any changes in care. On 8/4/21 at 12:45, The nursing administrative team assessed the residents who reside on the secured unit by completing wandering assessments and supervision needs as well as changes in their usual activities of daily living. Behavior tracking logs and care plans were reviewed and revised as needed. No concerns were revealed. On 8/4/21 the Director of Nursing re-evaluated the staffing for the secured unit so that there would always be two (2) staff assigned on the schedule for the day and evening shift to give care appropriate within their scope of practice. The facility secured a contract with a nursing agency on 1/7/2021 to fulfill any needs resulting in not being able to staff the facility. If agency staff is required on the secured unit, they will receive the same training as regular facility staff, prior to working on the secured unit. There are currently no residents residing on the secured unit who require the assist of two (2) staff however if a resident becomes a two (2) person assist, they will be re-assessed by the Director of Nursing/designee for continued residency on the unit. If a resident required two (2) person assist because of illness or other situation, the staff will be instructed to ask staff outside the unit for assistance so that residents are always monitored by a staff. On 8/4/21 the Director of Nursing began a direct-staff in-service regarding the monitoring and safety of residents including sexual behaviors and re-direction of residents with aggressive behaviors using crisis prevention intervention (CPI) training utilizing a power point. The regional nurse consultant educated the Director of Nursing regarding this training. Also included in this training is the procedure for relieving staff for breaks so that the two (2) staff criteria are not broken as well as seeking assistance should a resident require a two (2) person assist. Direction was given to staff to monitor for residents wandering into another resident's room's and to re-direct following CPI training strategies. Staff will routinely round the secured unit to identify concerns and huddle at change of shift to give report on shift occurrences. If any concerns with resident behavior are identified, sexual or otherwise, the staff will separate residents and keep on 1:1 monitoring of any resident with sexual inappropriate behavior or otherwise until a sufficient intervention implemented under the direction of the Director of Nursing. The charge nurse will notify the administrator and Director of Nursing immediately for any concerns with any resident with sexual inappropriate behavior or otherwise. Any concerns with any resident with sexual inappropriate behavior or otherwise will be reviewed in the morning Clinical Meeting, behavior tracking will be updated, and plan of care reviewed and revised as needed. Nursing administration will communicate any findings to the staff on the secured unit and the Resident Profile (C.N.A. plan of care) will be updated. This training will be completed by end of day 8/5/21. Any staff not receiving this education by end of day 8/4/21 will be required to receive it before beginning their next assigned shift. Facilities Plan to ensure compliance quickly (continued on next page)

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Paradigm at the Prairies	106 Del Norte Dr El Campo, TX 77437

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Director of Nursing will be responsible for monitoring the daily staffing schedules to validate there are two (2) staff scheduled for the day and evening shift for the secured unit. Staffing agency will be utilized if needed to staff this unit. If staffing agency is not available, then administrative staff will assist in staffing the secured unit. The administrator/designee will bring all concerns to the monthly quality assurance performance improvement meeting for tracking, trending, and further interdisciplinary team (IDT) review . Surveyor Verification of Plan of Removal was as follows: Observation on 08/04/21 at 12:50 PM on the memory care unit revealed the facility had 2 staff on unit. Observation on 08/05/21 at 1:40 PM on the memory care unit revealed the facility had 2 staff on unit. Observation on 08/06/21 at 12:45 PM on the memory care unit revealed the facility had 3 staff on unit. Observation on 08/07/21 at 6:00 AM on the memory care unit revealed the facility had 2 staff on unit. Interviews were started on 08/06/21 at 1:07 PM and continued through 08/07/21 at 7:05 AM with 31 staff across all three shifts, including weekdays, weekends, and multiple departments. The staff were interviewed regarding the plan of removal: MA D, CNA E, CNA F, Medical Records, LVN A, RN C, CNA G, ADON A, MDS Coordinator A, MDS Coordinator B, ADON B, CNA C, CNA H, RN A, Maintenance Director, Social Worker, CNA J, Activity Aide, RN D, Dietary Cook, Floor Tech, CNA J, DON, CNA K, Laundry Aide, PTA, CNA L, CNA M, MA D, CNA D, and Transportation. Staff were able to verbalize the plan of removal. Record review of the behavior tracking logs for memory care residents revealed no concerns with behavior monitoring. Record review of the care plans for 11 of 11 memory care residents revealed no concerns with care plan updates. Record review of the facility contracts revealed the facility had contracts with 2 staffing agencies dated 5/27/20 and 6/22/21. Record review of the facility C.N.A. profile revealed the facility updated care plans were in the kiosk for memory care residents with wandering behaviors. Record review of the facility staffing sheets dated 08/04/21, 08/05/21, 08/06/21 and 08/07/21 revealed the facility had 2 staff members assigned to the 6a-2p and 2p-10p shifts. (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 in-service sheets dated 08/04/21 revealed staff on from multiple department including (Nursing Department, Housekeeping, Activities, Dietary, Maintenance, Transportation, Business Office, Social Services, Laundry) were in-serviced on sexual inappropriate behaviors, sexual triggers, de-escalation, reporting incidents to administration immediately, 2 staff on the memory care unit, supervision on the secure unit, swapping out staff for breaks and lunch, and calling out from work on the secure unit. While the DON was informed that the Immediate Jeopardy was removed on 08/07/21 at 7:05 AM, the facility remained out of compliance at the scope of a pattern and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to trai [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** 34463 Based on observation , interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, are reported immediately, but no later than 24 hours after the allegation is made for 3 of 9 residents (Resident #1, #2 and CR#3) reviewed for abuse and neglect. The facility failed to report incidents of sexual inappropriate behaviors involving Resident # 1,#2 and CR#3 to the state agency . This failure could place facility residents on the secure unit at risk of injury, abuse, and neglect. Findings include: Resident #1 Record review of Resident #1's face sheet revealed Resident #1 was a [AGE] year-old female, admitted to the facility on [DATE] with a diagnoses of Alzheimer's disease, wandering, abnormalities of gait, lack of coordination, and muscle weakness. Record review of Resident #1's MDS dated [DATE] revealed she had a BIMS of 99 which meant she was unable to complete the interview. Record review of Resident #1's Care Plan dated 10/20/20 revealed Resident #1 experienced wandering, moved with no rational purpose, and was seemingly oblivious to her needs or safety. The interventions are for staff to remove the resident from other resident's rooms and unsafe situations, when resident begins to wander, provide comfort measures for basic needs. Record review of Resident #1's progress notes dated 01/26/2021 written by DON revealed at around 11am the resident and another resident were found in the same room together with the door open. The two residents were immediately separated, and she was assisted to her room. She was noted with bm on self and was taken to shower by CNA. Head to toe skin assessment was done and no skin break down noted. RP was notified. 2pm NP here to see resident and noted redness to peri area with discharge ordered lab and medication for yeast. NP notified RP of findings . Record review of Resident #1's Progress Notes dated 07/19/21 written by DON revealed . spoke to RP about another resident that was found in resident's room while she laid in bed, residents were immediately separated. Head to toe skin assessment was done, no discoloration or skin break down was noted. NP was notified of incident. Resident is noted laughing, walking with no problems . Observation and interview on 07/20/21 at 10:07 AM revealed Resident #1 was sitting in a chair in dayroom. Resident #1 did not respond to questions, just laughed when questioned. Resident #2 (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 #2's face sheet revealed Resident #2 was a [AGE] year old male that was admitted to the facility on [DATE] with a diagnoses of Parkinson's disease, psychosis, muscle wasting atrophy, anxiety disorder, vitamin D deficiency, muscle weakness, abnormality of gain and mobility, lack of coordination, hallucinations, pain, benign prostate hyperplasia, hyperlipidemia, anemia, vitamin B deficiency, depressive disorders, irritable bowel syndrome, and constipation . Record review of Resident #2's MDS dated [DATE] revealed Resident #2 had a BIMS of 11 of 15 which meant he had moderate cognitive impairment. Record review of Resident #2's Care Plan dated 04/15/21 revealed Resident #2 experienced wandering, moved with no rational purpose, seemingly oblivious to needs or safety, and goes into other resident rooms. The interventions indicated staff are to remove resident from other resident's rooms and unsafe situations and staff are to provide comfort measures for basic needs. The resident care plan indicated Resident #2 had episodes of adverse behavior verbally aggressive-cursing, racial slurs, yelling/screaming, fabricate facts, unreliable history, manipulates staff, had inappropriate behavior of disrobing in common areas, urinates in public, masturbates in public, and verbally entices other conflicts related to psychosis. Interventions are for staff to anticipate resident behavior and re-direct the resident when in close proximity to others that might invoke aggression, asses for triggers that may contribute / prompt behaviors, and attempt to redirect resident to safe area when increased behavior noted. Record review of Resident #2's Physician Progress Note dated 07/02/21 revealed .Review of Systems . Psychiatric: Staff reports agitation, some sexual behavior Record review of Resident #2's Hospital Progress Note dated 03/12/21 revealed . Patient arrived on unit via wheelchair from ED after medical clearance at 8:15PM .He was nervous and slightly irritable .Per nursing home report, he was swinging at staff and cursing them and residents. He was intrusive, going into other residents' rooms and being difficult to redirect. He has been hallucinating that he sees or hears people who are not there and is paranoid someone may be after him or that staff has stolen his cell phone which he lost or misplaced .He is inappropriate at times with female residents trying to hold their hand or making them feel uncomfortable. He refuses nursing care and assessment at times . Record review of Resident #2's Progress Notes dated 03/06/2021 11:20 written by RN C revealed . Patient sitting next to resident in dining room on station 2. Patient was talking with resident. Patient started to rub on other resident's leg. Patient and resident separated, patient educated on personal space and not touching other residents (especially without their permission). CNA and RN asked patient to go back down to station 3, patient non-compliant, continues to wheel back and forth down the hallway on station 2 . Record review of Resident #2's Progress Notes dated 03/11/2021 written by RN C revealed Patient sitting in dining room on station 2 with another resident. Patient attempted to hold resident's hand under dining room table, resident pulled hand away from resident and told him no, she had a boyfriend. Patient told resident he didn't care. Patient sat very close to resident and ate his soup. RN redirected and educated patient on not making other residents feel uncomfortable. Asked patient to return to station 3 to eat soup/lunch. Patient wheeled himself to station 3 but continues to wheel up and down the hallway on station 1 and 2 . (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 #2's Progress Notes dated 06/18/21 written by RN A revealed . CNA reported this resident entered a female resident's room while she was lying in bed and kissed her on the head at 9:45 pm. When CNA asked res to leave female residents room, he showed her his middle finger, nurse went to resident and requested he go to his room and remain in bed and not get up to go into female res. rooms . Record review of Resident #2's Progress Notes dated 07/19/21 written by DON revealed .Resident was noted in another resident's room. The residents were immediately separated and redirected. Resident was moved to 45A and psych service was started. New order to increase Depakote due to behaviors. NP and RP notified of changed . Observation and interview on 07/20/21 at 10:09 AM revealed Resident #2 laid down in bed. Resident #2 stated he did not have any concerns with abuse at the facility. He stated some of the older men would come and lay down in his bed. He stated he remembered being moved to a new room recently but did not know why. He did not remember going into a female's room or any sexual activity with a female. CR#3 Record review of CR#3's face sheet revealed he was an [AGE] year-old male that was admitted to the facility on [DATE] and discharged on [DATE] with a diagnosis of psychosis, fever, pain, neuromuscular dysfunction of bladder, constipation, bipolar disorder, Alzheimer's disease, and repeated falls. Record review of CR#3's MDS dated [DATE] revealed he had a BIMS of 3 which meant he had severe cognitive impairment. Record review of CR#3's baseline care plan dated 01/18/21 revealed CR#3 had inappropriate sexual behavior of attempts to touch staff and other residents inappropriately. Staff approaches were to monitor resident frequently for any attempts to make inappropriate sexual advances, attempt to redirect resident if any hypersexual behaviors were noted, separate from other residents temporarily if any inappropriate behaviors are noted, call MD and family, and medicate as ordered . Record review of CR#3's care plan dated 051/0415/21 revealed CR#3 resided on the secure unit due to risk of exit seeking and risk for injury from wandering related to dementia as evidence by impaired cognition and safety awareness. CR#3 was at risk for injury from others while residing in secure unit due to altered cognition. Staff approaches are to monitor and discuss activity preference, allow resident to choose activity inside and outside that don't pose a safety risk, call resident by name when giving care, involve in care as much as possible, explain procedures using terms/gestures resident can understand, and keep environment free from possible hazards. Record review of CR#3's progress notes dated 01/17/2021 written by RN B revealed .Pt up ambulating ad lib in secure unit with no c/o pain or discomfort voiced or noted. Pt noted with very inappropriate sexual behaviors-towards staff and female residents (Resident #1) . Pt informed of inappropriateness of acts and redirected. Np made aware of behaviors . Record review of CR#3's progress notes dated 01/18/2021 written by LVN A revealed . CNA to room to do vitals, was sexually inappropriate, rubbing on her (Resident #1) leg, asked her if he could put something in there, when she asked .he told her his little penis. She told him no, he told her to come back later . (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 CR#3's progress notes dated 01/26/2021 written by DON revealed . 11am resident was noted in a room with another resident with door open and were immediately separated by CNA. Resident was noted with hypersexual tendency. NP was notified of situation and ordered for resident to be sent to senior care at [hospital]for med adjustment. RP was notified of situation and ordered. 12pm resident was transferred to senior care via van driver. In an interview on 08/03/21 at 10:37 AM CNA D stated she was on the secure unit by herself when the incident occurred between Resident #1 and CR#3.on 01/26/21. She was back there by herself at the time. It was the 6am-2pm shift. She remembers hitting the glass to get RN C's attention to come into the secure unit to assist. It is hard when you work the secure unit by yourself. In an interview on 08/05/21 at 12:50 PM RN B stated CR#3 would always make sexual comments about doing dirty sexual stuff. CR#3 would not touch but he would tell staff to come and get into the bed with him while giving medicine. Staff tried to keep an eye on the resident, when he would speak like that staff would redirect him. None of the touch incidents occurred when she was on duty. In an interview on 08/05/21 at 1:53 PM LVN A stated CR#3 was trying to get the nurse aide to get into the bed with him. CR#3 told her he wanted to put something inside of her. He did this several times when he first came to the facility. CR#3 had sexually inappropriate behaviors. He would ask to touch and feel female residents and staff. LVN A was not sure which nurse aide that was but this was during the 10p-06a shift. LVN A said Resident #1 had a history of wandering in other resident's rooms. Resident #1 did not understand what she was doing and she has to be watched. She had seen her walk into other male resident's rooms before. Resident #1 just laughs when spoken to and does not know what was going on. In an interview on 07/20/21 at 10:55 AM the DON stated, it was reported to her by the RN A that Resident #2 was found in Resident #1's bedroom. Resident #1's sheets were down to her ankles and she was in her gown. The resident had feces in her brief. The DON stated she was not sure if Resident #1's brief was off. The DON stated Resident #2's pants were down; she was not sure if his penis was erect. The DON stated the nurse aide redirected the residents. RN A completed a head to toe assessment and no redness, bruising or discoloration was noted. Resident #2 was sent to his room and the NP was notified as well as the responsible party. The DON stated Resident #1 and Resident #2's rooms were across from each other so Resident #2 was moved to a different room. The DON stated Resident #2 had a history of wandering into other residents' rooms. She stated she did not have an incident investigation report for either incident because nothing happened between the residents. (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 07/20/21 at 12:28 PM, RN A stated on 07/17/21 CNA A from Station #2, came to the Memory Care Unit to get some ice for a resident on her station. When she passed Resident #1's room she saw Resident #2 standing next to Resident #1's bed, his pants were down around his ankles. Resident #1 was laying on the bed her pants were down below her knees with her brief on and had some feces on her buttocks. CNA A reported Resident #2 was touching Resident #1 on her right hip/thigh area and CNA A told him to stop and redirected him out the room. CNA A got RN A and she went and assessed Resident #1. Resident #1 had no injuries, no secretions or blood in vaginal area. She was cleaned up and brought into the dinner room. Resident #2 went into his room and the DON was notified. RN A stated Resident #1 was ambulatory, and she could use her hands and legs. She stated she was not sure how Resident #1's pants were removed. She stated Resident #1 had no previous incidents like this before. RN A said Resident #2 did approach women and rub them on shoulder and kiss them on the forehead. She said it was reported to her that he kissed Resident #1 on the mouth before, but she did not witness this. In an interview on 07/20/21 at 12:37 PM, the DON stated the NP could not justify sending Resident #2 to the behavioral hospital. The DON stated Resident #2's Depakote was increased due to his increased behaviors. The DON stated Resident #2 would be seen by the local behavioral services next week and they are more familiar with his needs. The DON said the facility typically had two staff assigned to the memory care area. The nurse was usually in the hallway during the evening and the aide was in the dayroom or helping residents. In an interview on 07/20/21 at 12:38 PM, the Administrator stated she was not sure what to do and wanted to know the state agency's recommendation for this situation. She stated the best case was to have Resident #2 transferred to another facility, she was his dual power of attorney. She could have him transferred to a different facility quickly. In an interview on 07/20/21 at 1:26 PM, CNA A stated on 07/17/21 she was on station #2 when a resident on her station wanted some ice so she went to the memory care unit to get the ice. She stated when she walked by Resident #1's room she saw the back of Resident #2 while he sat on the side of Resident #1s bed with his pants down. She said Resident #1 was in her bed with her brief off and her pants down. She stated Resident #2's hands were on Resident #1's thighs. She stated she told Resident #2 to leave Resident #1's room. CNA A stated she reported what she saw to RN A who was behind the desk outside the memory care unit. She stated CNA B was the only aide on duty in the memory care unit. In an interview on 07/20/21 at 2:13 PM, CNA B stated on 07/17/21 she was in the dining room watching the other residents when she heard a CNA A say, what are you doing. CNA B stated when she got up Resident #2 was already walking toward his room. She stated Resident #2 did touch residents on shoulder, but other residents did that as well. She stated she was on the memory care unit by herself at the time of the incident. She stated RN A went back and forth to the unit periodically. In an interview on 07/20/21 at 3:00 PM, CNA B stated on 07/17/21 the incident between Resident #1 and Resident #2 happened after supper somewhere between 6PM to 7:30 PM. She said usually she had Resident #1 with her but there was another resident that was more confused that day, so she needed to supervise that resident a little more. She stated the incident between Resident #1 and Resident #2 happened quickly because both residents were sitting with her in the day room before the incident occurred. She could not remember the last time she saw them. (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 07/20/21 at 1:35 PM, the Administrator stated she was not aware of the other sexual behaviors by Resident #2, she did not read the hospital notes or physician notes. She was having Resident #2 moved to an all-male facility. In an interview on 08/02/21 at 10:19 AM the DON stated there was no proof that anything happened between Resident #1 and Resident #2 and there was no signs of trauma. Resident #1 and Resident #2 could not have been in the room long with each other, so this was not reported to the state. She said did investigate, the residents were assessed, Resident #1 had BM on her body, Resident #2 did not have any BM on his fingers. She spoke to the aides and nurse on duty, she called the NP. The DON stated she did have witness statements given by the staff members but did not have an incident report. Record review of the facility policy Abuse and Neglect - Clinical Protocol dated April 2013 revealed Treatment/Management 1. the facility management and staff will institute measure to address the needs of residents and minimize the possibility of abuse and neglect. 2. The management and staff, with the support of the physicians, will address situations of suspected or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34463 Based on interview and record review, the facility failed to develop and implement comprehensive person-centered care plans for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 (Resident #2) of 9 residents reviewed for comprehensive care plans. The facility failed to develop a comprehensive person-centered care plan to address Resident #2's sexual inappropriate behaviors of touching female residents. This failure could place residents at risk of not receiving individualized care and services to meet their needs. Findings included: Resident #2 Record review of Resident #2's face sheet revealed Resident #2 was a [AGE] year old male that was admitted to the facility on [DATE] with a diagnoses of Parkinson's disease, psychosis, muscle wasting atrophy, anxiety disorder, vitamin D deficiency, muscle weakness, abnormality of gain and mobility, lack of coordination, hallucinations, pain, benign prostate hyperplasia, hyperlipidemia, anemia, vitamin B deficiency, depressive disorders, irritable bowel syndrome, and constipation . Record review of Resident #2's MDS dated [DATE] revealed Resident #2 had a BIMS of 11 of 15 which meant he had moderate cognitive impairment . Record review of Resident #2's Care Plan dated 04/15/21 revealed Resident #2 experienced wandering, moved with no rational purpose, seemingly oblivious to needs or safety, and goes into other resident rooms. The interventions indicated staff are to remove resident from other resident's rooms and unsafe situations and staff are to provide comfort measures for basic needs. The resident care plan indicated Resident #2 had episodes of adverse behavior verbally aggressive-cursing, racial slurs, yelling/screaming, fabricate facts, unreliable history, manipulates staff, had inappropriate behavior of disrobing in common areas, urinates in public, masturbates in public, and verbally entices other conflicts related to psychosis. Interventions are for staff to anticipate resident behavior and re-direct the resident when in close proximity to others that might invoke aggression, asses for triggers that may contribute / prompt behaviors, and attempt to redirect resident to safe area when increased behavior noted. Record review of Resident #2's Physician Progress Note dated 07/02/21 revealed .Review of Systems . Psychiatric: Staff reports agitation, some sexual behavior (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at the Prairies	106 Del Norte Dr El Campo, TX 77437

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's Hospital Progress Note dated 03/12/21 revealed . Patient arrived on unit via wheelchair from ED after medical clearance at -8:15PM .He was nervous and slightly irritable .Per nursing home report, he was swinging at staff and cursing them and residents. He was intrusive, going into other residents' rooms and being difficult to redirect. He has been hallucinating that he sees or hears people who are not there and is paranoid someone may be after him or that staff has stolen his cell phone which he lost or misplaced .He is inappropriate at times with female residents trying to hold their hand or making them feel uncomfortable. He refuses nursing care and assessment at times . Record review of Resident #2's Progress Notes dated 03/11/2021 written by RN C revealed Patient sitting in dining room on station 2 with another resident. Patient attempted to hold resident's hand under dining room table, resident pulled hand away from resident and told him no, she had a boyfriend. Patient told resident he didn't care. Patient sat very close to resident and ate his soup. RN redirected and educated patient on not making other residents feel uncomfortable. Asked patient to return to station 3 to eat soup/lunch. Patient wheeled himself to station 3 but continues to wheel up and down the hallway on station 1 and 2 . Record review of Resident #2's Progress Notes dated 06/18/21 written by RN A revealed . CNA reported this resident entered a female resident's room while she was lying in bed and kissed her on the head at 9:45 pm. When CNA asked res to leave female residents room, he showed her his middle finger, nurse went to resident and requested he go to his room and remain in bed and not get up to go into female res. rooms . Record review of Resident #2's Progress Notes dated 07/19/21 written by DON revealed .Resident was noted in another resident's room. The residents were immediately separated and redirected. Resident was moved to 45A and psych service was started. New order to increase Depakote due to behaviors. NP and RP notified of changed . Observation and interview on 07/20/21 at 10:09 AM revealed Resident #2 laid down in bed. Resident #2 stated he did not have any concerns with abuse at the facility. He stated some of the older men would come and lay down in his bed. He stated he remembered being moved to a new room recently but did not know why. He did not remember going into a female's room or any sexual activity with a female. In an interview on 07/20/21 at 1:26 PM, CNA A stated on 07/17/21 she was on station #2 when a resident on her station wanted some ice so she went to the memory care unit to get the ice. She stated when she walked by Resident #1's room she saw the back of Resident #2 while he sat on the side of Resident #1s bed with his pants down. She said Resident #1 was in her bed with her brief off and her pants down. She stated Resident #2's hands were on Resident #1's thighs. She stated she told Resident #2 to leave Resident #1's room. CNA A stated she reported what she saw to RN A who was behind the desk outside the memory care unit. She stated CNA B was the only aide on duty in the memory care unit. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/20/21 at 12:28 PM, RN A stated on 07/17/21 CNA A from Station #2, came to the Memory Care Unit to get some ice for a resident on her station. When she passed Resident #1's room she saw Resident #2 standing next to Resident #1's bed, his pants were down around his ankles. Resident #1 was laying on the bed her pants were down below her knees with her brief on and had some feces on her buttocks. CNA A reported Resident #2 was touching Resident #1 on her right hip/thigh area and CNA A told him to stop and redirected him out the room. CNA A got RN A and she went and assessed Resident #1. Resident #1 had no injuries, no secretions or blood in vaginal area. She was cleaned up and brought into the dinner room. Resident #2 went into his room and the DON was notified. RN A stated Resident #1 was ambulatory, and she could use her hands and legs. She stated she was not sure how Resident #1's pants were removed. She stated Resident #1 had no previous incidents like this before. RN A said Resident #2 did approach women and rub them on shoulder and kiss them on the forehead. She said it was reported to her that he kissed Resident #1 on the mouth before, but she did not witness this. In an interview on 07/20/21 at 10:55 AM the DON stated, it was reported to her by the RN A that Resident #2 was found in Resident #1's bedroom. Resident #1's sheets were down to her ankles and she was in her gown. The resident had feces in her brief. The DON stated she was not sure if Resident #1's brief was off. The DON stated Resident #2's pants were down; she was not sure if his penis was erect. The DON stated the nurse aide redirected the residents. RN A completed a head to toe assessment and no redness, bruising or discoloration was noted. Resident #2 was sent to his room and the NP was notified as well as the responsible party. The DON stated Resident #1 and Resident #2's rooms were across from each other so Resident #2 was moved to a different room. The DON stated Resident #2 had a history of wandering into other residents' rooms. She stated she did not have an incident investigation report for either incident because nothing happened between the residents. In an interview on 07/20/21 at 12:02 PM the Administrator stated it was reported to her that Resident #2 wandered into Resident #1's room and his pants were down. The staff immediately separated them, and Resident #2 was moved to a different room away from her, nothing physical occurred. The physician was notified but there was not a justification to send the resident to the psych hospital. Resident #2 was sent to the psych hospital a while back for a different situation. The Administrator stated Resident #2 was her family member, but she does not treat him any differently from the other residents, she is harder on him and expects more from him. In an interview on 08/02/21 at 3:11 PM MDS Coordinator B stated she was not aware of the sexual issues with Resident#2, she care-planned what she told. In an interview on 08/07/21 at 7:05 AM the DON stated it was important to have a care plan for residents, so staff are aware of resident behaviors. The care plan needs to match the behaviors. Its helps staff understand what the behaviors the resident had. The MDS revises the care plans, the DON was responsible to monitor the care plans to make sure they are completed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy Care Plans-Comprehensive dated October 2010 revealed An individual comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Policy Interpretation and Implementation 2. The comprehensive care plan is based on a thorough assessment that includes but is not limited to the MDS . 5. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s), rather than addressing only symptoms or triggers .6. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require careful data gathering, proper sequencing of events and complex clinical decisions making .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34463 Based on observations, interviews and record reviews, the facility failed to ensure residents received adequate supervision for 3 (Resident #1, Resident #2, CR#3) of 9 residents reviewed for accident and incidents. The facility did not provide adequate supervision for Resident #2 who had a history of wandering and sexual inappropriate behaviors. Resident #2 was found in Resident #1's room sexually abusing Resident #1 The facility did not provide adequate supervision for CR#3 who had a history of sexual inappropriate behaviors. CR#3 was found sexually abusing Resident #1. The facility did not provide adequate supervision for Resident #1 who had a history of wandering. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 08/04/21 at 11:35 AM. While the Immediate Jeopardy was removed on 08/07/21, the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm with a scope of isolation due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems These failures could place residents on the secure unit at risk of, a diminished quality of life, abuse, neglect, and serious injury. Findings Included: Record review of Resident #2's face sheet revealed Resident #2 was a [AGE] year old male that was admitted to the facility on [DATE] with a diagnoses of Parkinson's disease, psychosis, muscle wasting atrophy, anxiety disorder, vitamin D deficiency, muscle weakness, abnormality of gain and mobility, lack of coordination, hallucinations, pain, benign prostate hyperplasia, hyperlipidemia, anemia, vitamin B deficiency, depressive disorders, irritable bowel syndrome, and constipation. Record review of Resident #2's Physician Progress Note dated 07/02/21 revealed .Review of Systems . Psychiatric: Staff reports agitation, some sexual behavior Record review of Resident #2's MDS dated [DATE] revealed Resident #2 had a BIMS of 11 of 15 which meant he had moderate cognitive impairment. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #2's Care Plan dated 04/15/21 revealed Resident #2 experienced wandering, moved with no rational purpose, seemingly oblivious to needs or safety, and goes into other resident rooms. The interventions indicated staff are to remove resident from other resident's rooms and unsafe situations and staff are to provide comfort measures for basic needs. The resident care plan indicated Resident #2 had episodes of adverse behavior verbally aggressive-cursing, racial slurs, yelling/screaming, fabricate facts, unreliable history, manipulates staff, had inappropriate behavior of disrobing in common areas, urinates in public, masturbates in public, and verbally entices other conflicts related to psychosis. Interventions were for staff to anticipate the resident's behavior and re-direct the resident when in close proximity to others that might invoke aggression, asses for triggers that may contribute / prompt behaviors, and attempt to redirect resident to safe area when increased behavior noted. Record review of Resident #1's face sheet revealed Resident #1 was a [AGE] year-old female, admitted to the facility on [DATE] with a diagnoses of Alzheimer's disease, wandering, abnormalities of gait, lack of coordination, and muscle weakness. Record review of Resident #1's MDS dated [DATE] revealed she had a BIMS of 99 which meant she was unable to complete the interview. Record review of Resident #1's Care Plan dated 10/20/20 revealed Resident #1 experienced wandering, moved with no rational purpose, and was seemingly oblivious to her needs or safety. The interventions are for staff to remove the resident from other resident's rooms and unsafe situations, when resident begins to wander, provide comfort measures for basic needs. Record review of Resident #1's progress notes dated 01/26/2021 written by DON revealed at around 11am the resident and another resident were found in the same room together with the door open. The two residents were immediately separated, and she was assisted to her room. She was noted with bm on self and was taken to shower by CNA. Head to toe skin assessment was done and no skin break down noted. RP was notified. 2pm NP here to see resident and noted redness to peri area with discharge ordered lab and medication for yeast. NP notified RP of findings . Record review of Resident #2's Progress Notes dated 03/06/2021 11:20 written by RN C revealed . Patient sitting next to resident in dining room on station 2. Patient was talking with resident. Patient started to rub on other resident's leg. Patient and resident separated, patient educated on personal space and not touching other residents (especially without their permission). CNA and RN asked patient to go back down to station 3, patient non-compliant, continues to wheel back and forth down the hallway on station 2 . Record review of Resident #2's Progress Notes dated 03/11/2021 written by RN C revealed Patient sitting in dining room on station 2 with another resident. Patient attempted to hold resident's hand under dining room table, resident pulled hand away from resident and told him no, she had a boyfriend. Patient told resident he didn't care. Patient sat very close to resident and ate his soup. RN redirected and educated patient on not making other residents feel uncomfortable. Asked patient to return to station 3 to eat soup/lunch. Patient wheeled himself to station 3 but continues to wheel up and down the hallway on station 1 and 2 . (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #2's Hospital Progress Note dated 03/12/21 revealed . Patient arrived on unit via wheelchair from ED after medical clearance at 8:15PM .He was nervous and slightly irritable .Per nursing home report, he was swinging at staff and cursing them and residents. He was intrusive, going into other residents' rooms and being difficult to redirect. He has been hallucinating that he sees or hears people who are not there and is paranoid someone may be after him or that staff has stolen his cell phone which he lost or misplaced .He is inappropriate at times with female residents trying to hold their hand or making them feel uncomfortable. He refuses nursing care and assessment at times . Record review of Resident #2's Progress Notes dated 06/18/21 written by RN A revealed . CNA reported this resident entered a female resident's room while she was lying in bed and kissed her on the head at 9:45 pm. When CNA asked res to leave female residents room, he showed her his middle finger, nurse went to resident and requested he go to his room and remain in bed and not get up to go into female res. rooms . In an interview on 07/20/21 at 1:26 PM, CNA A stated on 07/17/21 she was on station #2 when a resident on her station wanted some ice so she went to the memory care unit to get the ice. She stated when she walked by Resident #1's room she saw the back of Resident #2 while he sat on the side of Resident #1s bed with his pants down. She said Resident #1 was in her bed with her brief off and her pants down. She stated Resident #2's hands were on Resident #1's thighs. She stated she told Resident #2 to leave Resident #1's room. CNA A stated she reported what she saw to RN A who was behind the desk outside the memory care unit. She stated CNA B was the only aide on duty in the memory care unit. In an interview on 07/20/21 at 2:13 PM, CNA B stated on 07/17/21 she was in the dining room watching the other residents when she heard a CNA A say, what are you doing. CNA B stated when she got up Resident #2 was already walking toward his room. She stated Resident #2 did touch residents on shoulder, but other residents did that as well. She stated she was on the memory care unit by herself at the time of the incident. She stated RN A went back and forth to the unit periodically. In an interview on 07/20/21 at 3:00 PM, CNA B stated on 07/17/21 the incident between Resident #1 and Resident #2 happened after supper somewhere between 6PM to 7:30 PM. She said usually she had Resident #1 with her but there was another resident that was more confused that day, so she needed to supervise that resident a little more. She stated the incident between Resident #1 and Resident #2 happened quickly because both residents were sitting with her in the day room before the incident occurred. She could not remember the last time she saw them. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 07/20/21 at 12:28 PM, RN A stated on 07/17/21 CNA A from Station #2, came to the Memory Care Unit to get some ice for a resident on her station. When she passed Resident #1's room she saw Resident #2 standing next to Resident #1's bed, his pants were down around his ankles. Resident #1 was laying on the bed her pants were down below her knees with her brief on and had some feces on her buttocks. CNA A reported Resident #2 was touching Resident #1 on her right hip/thigh area and CNA A told him to stop and redirected him out the room. CNA A got RN A and she went and assessed Resident #1. Resident #1 had no injuries, no secretions or blood in vaginal area. She was cleaned up and brought into the dinner room. Resident #2 went into his room and the DON was notified. RN A stated Resident #1 was ambulatory, and she could use her hands and legs. She stated she was not sure how Resident #1's pants were removed. She stated Resident #1 had no previous incidents like this before. RN A said Resident #2 did approach women and rub them on shoulder and kiss them on the forehead. She said it was reported to her that he kissed Resident #1 on the mouth before, but she did not witness this. Record review of Resident #2's Progress Notes dated 07/19/21 written by DON revealed .Resident was noted in another resident's room. The residents were immediately separated and redirected. Resident was moved to 45A and psych service was started. New order to increase Depakote due to behaviors. NP and RP notified of changed . Record review of Resident #1's Progress Notes dated 07/19/21 written by DON revealed . spoke to RP about another resident that was found in resident's room while she laid in bed, residents were immediately separated. Head to toe skin assessment was done, no discoloration or skin break down was noted. NP was notified of incident. Resident is noted laughing, walking with no problems . Observation and interview on 07/20/21 at 10:07 AM revealed Resident #1 was sitting in a chair in dayroom. Resident #1 did not respond to questions, just laughed when questioned. Observation and interview on 07/20/21 at 10:09 AM revealed Resident #2 laid down in bed. Resident #2 stated he did not have any concerns with abuse at the facility. He stated some of the older men would come and lay down in his bed. He stated he remembered being moved to a new room recently but did not know why. He did not remember going into a female's room or any sexual activity with a female. In an interview on 07/20/21 at 10:55 AM the DON stated, it was reported to her by the RN A that Resident #2 was found in Resident #1's bedroom on 07/17/21. Resident #1's sheets were down to her ankles and she was in her gown. The resident had feces in her brief. The DON stated she was not sure if Resident #1's brief was off. The DON stated Resident #2's pants were down; she was not sure if his penis was erect. The DON stated the nurse aide redirected the residents. RN A completed a head to toe assessment and no redness, bruising or discoloration was noted. Resident #2 was sent to his room and the NP was notified as well as the responsible party. The DON stated Resident #1 and Resident #2's rooms were across from each other so Resident #2 was moved to a different room . The DON stated Resident #2 had a history of wandering into other residents' rooms . She stated she did not have an incident investigation report for either incident because nothing happened between the residents. In an interview on 08/02/21 at 11:20 the DON stated Resident #1 had a yeast infection which caused the redness and was not related to the incident between her and CR#3. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 07/20/21 at 12:02 PM the Administrator stated it was reported to her that Resident #2 wandered into Resident #1's room and his pants were down. The staff immediately separated them, and Resident #2 was moved to a different room away from her, nothing physical occurred. The physician was notified but there was not a justification to send the resident to the psych hospital. Resident #2 was sent to the psych hospital a while back for a different situation . The Administrator stated Resident #2 was her family member, but she does not treat him any differently from the other residents, she is harder on him and expects more from him. In an interview on 07/20/21 at 12:37 PM, the DON stated the NP could not justify sending Resident #2 to the behavioral hospital. The DON stated Resident #2's Depakote was increased due to his increased behaviors. The DON stated Resident #2 would be seen by the local behavioral services next week and they are more familiar with his needs. The DON said the facility typically had two staff assigned to the memory care area. The nurse was usually in the hallway during the evening and the aide was in the dayroom or helping residents. In an interview on 07/20/21 at 12:38 PM, the Administrator stated she was not sure what to do and wanted to know the state agency's recommendation for this situation. She stated the best case was to have Resident #2 transferred to another facility, she was his dual power of attorney. She could have him transferred to a different facility quickly. In an interview on 07/20/21 at 1:35 PM, the Administrator stated she was not aware of the other sexual behaviors by Resident #2, she did not read the hospital notes or physician notes. She was having Resident #2 moved to an all-male facility. In an interview on 07/20/21 at 1:41 PM, the DON stated Resident #2 was being sent to the behavioral hospital and he will not be returning. In an interview on 07/20/21 at 2:27 PM, CNA C stated Resident #2 had a history of touching other female residents. Staff would redirect him and report him to administration, but he would curse out staff and keep doing the same things. Staff had to redirect him before he could go too far with touching other residents. Staff were scared to say something because he was the Administrators family member. In an interview on 07/20/21 at 2:29 PM, MA A stated she worked on the secure unit at times and Resident #2 had a history of touching other female residents. In an interview on 07/20/21 at 2:45 PM, RN A stated there was one nurse aide assigned to the memory care unit. MA B was assigned to that unit but was scheduled to come in at 8 PM. MA B passed the 8 PM medications and she passed the 4PM medications on the memory care unit. RN A said the memory care unit was part of station #3 but the nurse aide for station #3 did not work on the memory care unit. Staff on the memory care unit had to get staff from station #3 to help with transfers when needed. In an interview on 07/20/21 at 3:34 PM, the DON stated the facility usually had two people assigned to the memory care unit. The nurse had a camera at the desk of station #3 so she could see what was going on the memory care unit. Today Resident #2 was sent to the behavioral hospital and was accepted to another facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 08/02/21 at 11:10 AM the NP stated the Resident #2 had sexual behaviors and they were discussed with the facility. There were discussions regarding proper placement, moving to another facility closer to family, or a higher level of care. Resident#2 mentioned he wanted to have a girlfriend and that was not possible in this type of environment. Resident #2 was a younger resident, so he was given a sex toy. The nurses trained him to use the toy, he was doing pretty good with that. Resident #2 did not have any issues up until he was found in another resident's room. No sexual activity was reported between Resident #2 and Resident #1 during that incident. Behavioral Services had increased his Depakote, but she was not sure when that occurred. 2. Record review of CR#3's face sheet revealed he was an [AGE] year old male that was admitted to the facility on [DATE] and discharged on [DATE] with a diagnosis of psychosis, fever, pain, neuromuscular dysfunction of bladder, constipation, bipolar disorder, Alzheimer's disease, and repeated falls. Record review of CR#3's MDS dated [DATE] revealed he had a BIMS of 3 which meant he had severe cognitive impairment. Record review of CR#3's care plan dated 05/04/21 revealed CR#3 resided on the secure unit due to risk of exit seeking and risk for injury from wandering related to dementia as evidence by impaired cognition and safety awareness. CR#3 was at risk for injury from others while residing in secure unit due to altered cognition. Staff approaches are to monitor and discuss activity preference, allow resident to choose activity inside and outside that do not pose a safety risk, call resident by name when giving care, involve in care as much as possible, explain procedures using terms/gestures resident can understand, and keep environment free from possible hazards. Record review of CR#3's baseline care plan dated 01/18/21 revealed CR#3 had inappropriate sexual behavior of attempts to touch staff and other residents inappropriately. Staff approaches were to monitor resident frequently for any attempts to make inappropriate sexual advances, attempt to redirect resident if any hypersexual behaviors were noted, separate from other residents temporarily if any inappropriate behaviors are noted, call MD and family, and medicate as ordered . Record review of CR#3's progress notes dated 01/17/2021 written by RN B revealed .Pt up ambulating ad lib in secure unit with no c/o pain or discomfort voiced or noted. Pt noted with very inappropriate sexual behaviors-towards staff and female residents. Pt informed of inappropriateness of acts and redirected. Np made aware of behaviors . Record review of CR#3's progress notes dated 01/18/2021 written by LVN A revealed . CNA to room to do vitals, was sexually inappropriate, rubbing on her leg, asked her if he could put something in there, when she asked .he told her his little penis. She told him no, he told her to come back later . Record review of CR#3's progress notes dated 01/26/2021 written by DON revealed . 11am resident was noted in a room with another resident with door open and were immediately separated by CNA. Resident was noted with hypersexual tendency. NP was notified of situation and ordered for resident to be sent to senior care at [hospital]for med adjustment. RP was notified of situation and ordered. 12pm resident was transferred to senior care via van driver. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 08/03/21 at 10:37 AM CNA D stated she was on the secure unit by herself when the incident occurred between Resident #1 and CR#3.on 01/26/21. She was back there by herself at the time. It was the 6am-2pm shift. She remembers hitting the glass to get RN C's attention to come into the secure unit to assist. It is hard when you work the secure unit by yourself. In an interview on 08/05/21 at 12:50 PM RN B stated CR#3 would always make sexual comments about doing dirty sexual stuff. CR#3 would not touch but he would tell staff to come and get into the bed with him while giving medicine. Staff tried to keep an eye on the resident, when he would speak like that staff would redirect him. None of the touch incidents occurred when she was on duty. In an interview on 08/05/21 at 1:53 PM LVN A stated CR#3 was trying to get the nurse aide to get into the bed with him. CR#3 told her he wanted to put something inside of her. He did this several times when he first came to the facility. CR#3 had sexually inappropriate behaviors. He would ask to touch and feel female residents and staff. LVN A was not sure which nurse aide that was but this was during the 10p-06a shift. LVN A said Resident #1 had a history of wandering in other resident's rooms. Resident #1 did not understand what she was doing and she has to be watched. She had seen her walk into other male resident's rooms before. Resident #1 just laughs when spoken to and does not know what was going on. Record review of Resident #3's face sheet revealed she was a [AGE] year old female that was admitted to the facility on [DATE] with a diagnosis of hemiplegia and hemiparesis, muscle wasting atrophy, bipolar disorder, transient ischemic attach, cerebral infarction, Parkinson's disease, heart failure, epilepsy and hypertensive chronic kidney disease. Record review of Resident #3's MDS dated [DATE] revealed she had a BIMS of 8 which meant she had mild cognitive impairment. Observation and interview on 08/04/21 at 11:58 AM revealed Resident #3 was sitting in a wheelchair, resident was in a pleasant mood. Resident #3 stated she did not recall being touched by a male resident at the facility, but she remembered by touched by a family friend at [AGE] years old. Record review of Resident #4's face sheet revealed she was an [AGE] year-old female she was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease, dementia, urinary tract infection, anemia, muscle wasting atrophy, insomnia, and hypothyroidism. Record review of Resident #4's MDS dated [DATE] revealed she did not have a BIMS score. Observation and interview on 08/04/21 at 12:02 PM revealed Resident #4 was sitting in wheelchair, resident in a pleasant mood. Resident could not communicate and answer questions clearly. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 08/02/21 at 12:35 PM RN C stated CNA D told her it was an incident between Resident #1 and CR#3. CR#3 was standing over Resident #1. Resident #1 had BM in brief which was down, CR#3 had no fecal matter on his penis. Resident #1 was lying in CR#3's bed. RN C asked CR#3 what happened but he could not answer. She contacted the DON and NP. Residents were separated. CR#3's briefs was on and he did not have an erection. It was reported to her by a resident that Resident #2 came up to a female resident in dining room and touched her on the hand, she separated the residents and spoke with Resident #2 about the behaviors. She said Resident #2 had another incident, he came in the dining room and touched a female resident on the leg. The residents were separated. She was not sure which incident involved Resident #3 or Resident #4 . One of the incidents occurred on 3/6/21, the other incident occurred on 3/11/21. Resident #4 has dementia and cannot communicate. Resident #3 may not be here anymore. Resident #2 would come from Station #3 and wheel himself to Station #2. He was placed on the secure unit sometime in March or April of 2021. In an interview on 08/07/21 at 7:05 AM the DON stated its important monitor residents with sexual inappropriate behaviors because residents that cannot consent to sexual encounters can become abused, especially in the dementia unit. The facility does not want residents taking advantage of other residents. It made other residents feel uncomfortable. Record review of the facility policy Safety and Supervision of Residents dated December 2007 revealed Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accident are facility-wide priorities Facility-Oriented Approach to Safety .1. Our facility-oriented approach to safety addresses risks for groups of residents. 2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QA&A reviews safety and incident/accident reports; and a facility-wide commitment to safety at all levels of the organization .Systems Approach to Safety 2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. 3. The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment (such as construction) or if there is a change in the resident's condition . An Immediate Jeopardy was identified on 08/04/21 11:35 AM and the DON was informed of IJ in the area of accidents/supervision and the IJ template was provided to him via email at 11:51 AM and a plan of removal was requested. The plan of removal was accepted on 08/06/21 at 8:32 AM and included: .PLAN OF REMOVAL Name of facility: [facility name] Date: August 4, 2021 Immediate action: Resident #2 was discharged from the facility on 7/20/21 at 5:00 PM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #1 was assessed at the time of the incident without any concerns. Resident #1 was re-assessed on 8/4/21 by the Director of Nursing and found to be without distress with good food intakes and hydration per normal for the resident. Resident #1s care plan was reviewed and revised to show supervision and monitoring and communicate any changes in the plan of care prior to staff starting their shift through direct report. The C.N.A. profile will be update appropriately to reflect any changes in care. On 8/4/21 at 12:45, The nursing administrative team assessed the residents who reside on the secured unit by completing wandering assessments and supervision needs as well as changes in their usual activities of daily living. Behavior tracking logs and care plans were reviewed and revised as needed. No concerns were revealed. On 8/4/21 the Director of Nursing re-evaluated the staffing for the secured unit so that there would always be two (2) staff assigned on the schedule for the day and evening shift to give care appropriate within their scope of practice. The facility secured a contract with a nursing agency on 1/7/2021 to fulfill any needs resulting in not being able to staff the facility. If agency staff is required on the secured unit, they will receive the same training as regular facility staff, prior to working on the secured unit. There are currently no residents residing on the secured unit who require the assist of two (2) staff however if a resident becomes a two (2) person assist, they will be re-assessed by the Director of Nursing/designee for continued residency on the unit. If a resident required two (2) person assist because of illness or other situation, the staff will be instructed to ask staff outside the unit for assistance so that residents are always monitored by a staff. On 8/4/21 the Director of Nursing began a direct-staff in-service regarding the monitoring and safety of residents including sexual behaviors and re-direction of residents with aggressive behaviors using crisis prevention intervention (CPI) training utilizing a power point. The regional nurse consultant educated the Director of Nursing regarding this training. Also included in this training is the procedure for relieving staff for breaks so that the two (2) staff criteria are not broken as well as seeking assistance should a resident require a two (2) person assist. Direction was given to staff to monitor for residents wandering into another resident's room's and to re-direct following CPI training strategies. Staff will routinely round the secured unit to identify concerns and huddle at change of shift to give report on shift occurrences. If any concerns with resident behavior are identified, sexual or otherwise, the staff will separate residents and keep on 1:1 monitoring of any resident with sexual inappropriate behavior or otherwise until a sufficient intervention implemented under the direction of the Director of Nursing. The charge nurse will notify the administrator and Director of Nursing immediately for any concerns with any resident with sexual inappropriate behavior or otherwise. Any concerns with any resident with sexual inappropriate behavior or otherwise will be reviewed in the morning Clinical Meeting, behavior tracking will be updated, and plan of care reviewed and revised as needed. Nursing administration will communicate any findings to the staff on the secured unit and the Resident Profile (C.N.A. plan of care) will be updated. This training will be completed by end of day 8/5/21. Any staff not receiving this education by end of day 8/4/21 will be required to receive it before beginning their next assigned shift. Facilities Plan to ensure compliance quickly (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Director of Nursing will be responsible for monitoring the daily staffing schedules to validate there are two (2) staff scheduled for the day and evening shift for the secured unit. Staffing agency will be utilized if needed to staff this unit. If staffing agency is not available, then administrative staff will assist in staffing the secured unit. The administrator/designee will bring all concerns to the monthly quality assurance performance improvement meeting for tracking, trending, and further interdisciplinary team (IDT) review . Surveyor Verification of Plan of Removal was as follows: Observation on 08/04/21 at 12:50 PM on the memory care unit revealed the facility had 2 staff on unit. Observation on 08/05/21 at 1:40 PM on the memory care unit revealed the facility had 2 staff on unit. Observation on 08/06/21 at 12:45 PM on the memory care unit revealed the facility had 3 staff on unit. Observation on 08/07/21 at 6:00 AM on the memory care unit revealed the facility had 2 staff on unit. Interviews were started on 08/06/21 at 1:07 PM and continued through 08/07/21 at 7:05 AM with 31 staff across all three shifts, including weekdays, weekends, and multiple departments. The staff were interviewed regarding the plan of removal: MA D, CNA E, CNA F, Medical Records, LVN A, RN C, CNA G, ADON A, MDS Coordinator A, MDS Coordinator B, ADON B, CNA C, CNA H, RN A, Maintenance Director, Social Worker, CNA J, Activity Aide, RN D, Dietary Cook, Floor Tech, CNA J, DON, CNA K, Laundry Aide, PTA, CNA L, CNA M, MA D, CNA D, and Transportation. Staff were able to verbalize the plan of removal. Record review of the behavior tracking logs for memory care residents revealed no concerns with behavior monitoring. Record review of the care plans for 11 of 11 memory care residents revealed no concerns with care plan updates. Record review of the facility contracts revealed the facility had contracts with 2 staffing agencies dated 5/27/20 and 6/22/21. Record review of the facility C.N.A. profile revealed the facility updated care plans were in the kiosk for memory care residents with wandering behaviors. Record review of the facility staffing sheets dated 08/04/21, 08/05/21, 08/06/21 and 08/07/21 revealed the facility had 2 staff members assigned to the 6a-2p and 2p-10p shifts. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility in-service sheets dated 08/04/21 revealed staff on from multiple department including (Nursing Department, Housekeeping, Activities, Dietary, Maintenance, Transportation, Business Office, Social Services, Laundry) were in-serviced on sexual inappropriate behaviors, sexual triggers, de-escalation, reporting incidents to administration immediately, 2 staff on the memory care unit, supervision on the secure unit, swapping out staff for breaks and lunch, and calling out from work on the secure unit. While the DON was informed that the Immediate Jeopardy was removed on 08/07/21 at 7:05 AM, the facility remained out of compliance at severity of no actual harm with potential for more than minimal harm with a scope of isolation due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective s [TRUNCATED]

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34463 Based on observation, interview and record review, the facility failed to provide services by sufficient numbers of staff on a 24 hour basis to provide nursing care to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care for 5 of 9 residents (Resident #1, #2,,#3, #4 and CR#3) reviewed for sufficient staff, in that; The facility staffing on the memory care unit was not adequate to supervise and monitor the residents on the locked unit with wandering and sexual inappropriate behaviors. Resident #2 was found in the Resident #1's room (a confused female resident) sitting on her bed with his pants down touching her thigh while she was uncovered with her pants down. The facility did not provide adequate supervision for CR#3 who had a history of sexual inappropriate behaviors. CR#3 was found sexually abusing Resident #1. The facility did not ensure they had sufficient staff to prevent Resident #2 who was known to have inappropriate sexual behavior towards resident from inappropriately touching Resident #3 and resident #4. These failures could place residents on the secure unit at risk of a diminished quality of life abuse, neglect, and severe injury. Findings Included: Record review of the daily staffing sheet dated 01/26/21 revealed the facility census was 97. There were 2 RN's, 8 CNA's, 2 MA's listed needed for the 6am-2pm shift. Record review of the staffing sign-in sheet dated 01/26/21 for the 6a-2p shift revealed the memory care unit had 1 CNA on duty. Record review of the daily staffing sheet dated 07/17/21 revealed there were 2 RN's 1 LVN, 8 CNA's and 3 MA's needed for the 2 pm-10 pm shift. Record review of the staffing sign-in sheet dated 07/17/21 for the 2pm-10pm shift revealed the memory care unit had 1 CNA on duty. 1 MA was scheduled to come to the memory care unit at 8PM. Record review of the Resident Roster dated 07/20/21 revealed there were 11 residents that resided on the memory care unit. Record review of the list of Residents with wandering behaviors dated 08/03/21 revealed the facility had 11 residents with wandering behaviors on the secure unit. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/20/21 at 1:26 PM, CNA A stated on 07/17/21 CNA B was the only aide on duty in the memory care unit, and RN A and LVN A were behind the nurses' station located outside of memory care unit. In an interview on 07/20/21 at 2:13 PM, CNA B stated on 07/17/21 she was in the dining room watching the other residents when she heard a CNA A say, what are you doing. CNA B stated when she got up Resident #2 was already walking toward his room. She stated she was on the memory care unit by herself and RN A went back and forth to the unit periodically. In an interview on 07/20/21 at 12:37 PM, the DON said the facility typically had two staff assigned to the memory care area. The nurse was usually in the hallway during the evening and the aide was in the dayroom or helping residents. In an interview on 07/20/21 at 2:45 PM, RN A stated there was one nurse aide assigned to the memory care unit. MA B was assigned to that unit but was scheduled to come in at 8 PM. MA B passed the 8 PM medications and she passed the 4PM medications on the memory care unit. RN A said the memory care unit was part of station #3 but the nurse aide for station #3 did not work on the memory care unit. Staff on the memory care unit had to get staff from station #3 to help with transfers when needed. In an interview on 07/20/21 at 3:34 PM, the DON stated the facility usually had two people assigned to the memory care unit. The nurse had a camera at the desk of station #3 so she could see what was going on the memory care unit. In an interview on 08/03/21 at 10:37 AM CNA D stated she had worked on the secure unit by herself the 6am-2pm shift. When an incident occurred between two residents CR#3 and Resident #1. She remembers hitting the glass to get RN C's attention to come into the secure unit to assist. She said it was hard when you work the secure unit by yourself. Record review of Resident #1's face sheet revealed Resident #1 was a [AGE] year-old female, admitted to the facility on [DATE] with a diagnoses of Alzheimer's disease, wandering, abnormalities of gait, lack of coordination, and muscle weakness. Record review of Resident #1's MDS dated [DATE] revealed she had a BIMS of 99 which meant she was unable to complete the interview. Record review of Resident #1's Care Plan dated 10/20/20 revealed Resident #1 experienced wandering, moved with no rational purpose, and was seemingly oblivious to her needs or safety. The interventions are for staff to remove the resident from other resident's rooms and unsafe situations, when resident begins to wander, provide comfort measures for basic needs. Observation and interview on 07/20/21 at 10:07 AM revealed Resident #1 was sitting in a chair in dayroom. Resident #1 did not respond to questions, just laughed when questioned. Record review of Resident #2's face sheet revealed Resident #2 was a [AGE] year old male that was admitted to the facility on [DATE] with a diagnoses of Parkinson's disease, psychosis, muscle wasting atrophy, anxiety disorder, vitamin D deficiency, muscle weakness, abnormality of gain and mobility, lack of coordination, hallucinations, pain, benign prostate hyperplasia, hyperlipidemia, anemia, vitamin B deficiency, depressive disorders, irritable bowel syndrome, and constipation . (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's MDS dated [DATE] revealed Resident #2 had a BIMS of 11 of 15 which meant he had moderate cognitive impairment. Record review of Resident #2's Care Plan dated 04/15/21 revealed Resident #2 experienced wandering, moved with no rational purpose, seemingly oblivious to needs or safety, and goes into other resident rooms. The interventions indicated staff are to remove resident from other resident's rooms and unsafe situations and staff are to provide comfort measures for basic needs. The resident care plan indicated Resident #2 had episodes of adverse behavior verbally aggressive-cursing, racial slurs, yelling/screaming, fabricate facts, unreliable history, manipulates staff, had inappropriate behavior of disrobing in common areas, urinates in public, masturbates in public, and verbally entices other conflicts related to psychosis. Interventions are for staff to anticipate resident behavior and re-direct the resident when in close proximity to others that might invoke aggression, asses for triggers that may contribute / prompt behaviors, and attempt to redirect resident to safe area when increased behavior noted. Record review of CR#3's face sheet revealed he was an [AGE] year-old male that was admitted to the facility on [DATE] and discharged on [DATE] with a diagnosis of psychosis, fever, pain, neuromuscular dysfunction of bladder, constipation, bipolar disorder, Alzheimer's disease, and repeated falls. Record review of CR#3's MDS dated [DATE] revealed he had a BIMS of 3 which meant he had severe cognitive impairment. Record review of CR#3's care plan dated 051/0415/21 revealed CR#3 resided on the secure unit due to risk of exit seeking and risk for injury from wandering related to dementia as evidence by impaired cognition and safety awareness. CR#3 was at risk for injury from others while residing in secure unit due to altered cognition. Staff approaches are to monitor and discuss activity preference, allow resident to choose activity inside and outside that don't pose a safety risk, call resident by name when giving care, involve in care as much as possible, explain procedures using terms/gestures resident can understand, and keep environment free from possible hazards. Record review of Resident #3's face sheet revealed she was a [AGE] year old female that was admitted to the facility on [DATE] with a diagnosis of hemiplegia and hemiparesis, muscle wasting atrophy, bipolar disorder, transient ischemic attach, cerebral infarction, Parkinson's disease, heart failure, epilepsy and hypertensive chronic kidney disease. Record review of Resident #3's MDS dated [DATE] revealed she had a BIMS of 8 which meant she had mild cognitive impairment. Record review of Resident #4's face sheet revealed she was an [AGE] year-old female she was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease, dementia, urinary tract infection, anemia, muscle wasting atrophy, insomnia, and hypothyroidism. Record review of Resident #4's MDS dated [DATE] revealed she did not have a BIMS score . (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy Staffing dated April 2007 revealed Our facility provides adequate staffing to meet needed care and services for our resident population .Policy Interpretation and Implementation 1. Our facility maintains adequate on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services. 2. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan