Printed: 11/27/2024 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022
NAME OF PROVIDER OR SUPPLIE Avalon Place Kirbyville	ER	STREET ADDRESS, CITY, STATE, ZIP CODE 700 N Herndon Kirbyville, TX 75956	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	and neglect by anybody. **NOTE- TERMS IN BRACKETS IN	AVE BEEN EDITED TO PROTECT Conditional record review the facility failed to erreviewed for abuse. (Resident #s 1, 2, red monitoring and supervision to previewed for abuse.) (Resident #s 1, 2, red monitoring and supervision to previewed for abuse.) (Resident #s 1, 2, red monitoring and supervision to previewed for abuse.) (Resident #2 wandered into Resident #1 and Resident #2, his hand on her shoulent #2. Residents #1 and #2's briefs were and protect Resident #5 from Reside the hovering over Resident #5 yelling at his closed the door and called for the nurse on was identified on 04/14/22 at 3:00 professed the door and called for the nurse on was identified on 04/14/22 at 3:00 professed the door and called for the nurse on was identified on 04/14/22 at 3:00 professed the door and called for the nurse on was identified on 04/14/22 at 3:00 professed the door and called for the nurse on was identified at a potential for more the callity's need to evaluate the effectiveness at risk of abuse, physical harm, men and the door and called for the nurse of compliance at a potential for more the callity's need to evaluate the effectiveness at risk of abuse, physical harm, men and of a professive disorder (moorest), cognitive communication deficit (recommunication	ONFIDENTIALITY** 25115 Insure the right to be free from abuse 4, and 5) Insure the right to be free from abuse 4, and 5) Intent Resident #1 from sexually 1's room. Resident #2 was heard lder, holding his partially erect ere down. Int #4's verbal and physical abuse. Int. The NA B opened the door to 1. The nurse aide left Resident #5 in 1. Int. While the IJ was removed on 1. Int. All and Int. Int. Int. Int. Int. Int. Int. Int.

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

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 675220

If continuation sheet Page 1 of 32

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022
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,		Kirbyville, TX 75956	
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety	Record review of Resident #1's care plan dated 04/11/22 indicated he displayed socially inappropriate behavior and inappropriate sexual gesture with a female resident. Interventions included 15-minute monitoring and sent out to behavioral hospital for evaluation and treatment. There was no previous care for sexually inappropriate behavior available for review.		ntions included 15-minute
Residents Affected - Some	Record review of face sheet dated 04/13/22, indicated Resident #2 was a [AGE] year-old female, admi on [DATE], and her diagnoses included Alzheimer's (a progressive neurologic disorder that causes the to shrink (atrophy) and brain cells to die) and depression (a mood disorder that causes a persistent fee sadness and loss of interest).		ogic disorder that causes the brain
	Record review of MDS dated [DAT impairment), wandered daily, and a	E] indicated Resident #2 had a BIMS s imbulated without assistance.	core of 2 (severe cognitive
	to wandering and significant safety room with verbal cues, notify physi- times will take things out of other re	2/30/21 indicated Resident #2 required awareness due to dementia. Interventician if behavior increases (1/18/22- in assidents' rooms, 2/6/22 altercation with swalker, 4/11/22 victim of inappropriate	ions included assist with location of and out of other residents' rooms, at another resident, 2/11/22
		2 with the Administrator, DON and ADC wo separate camera recordings on 04/	
	At 8:09 a.m. there were no aides of	n the hall, Resident #2 wandered on ha	all and then back into her room.
	Camera error exact time unknown-room.	CNA F went into another resident's roo	om while CNA C was in the shower
	At 8:13 a.m. Resident #2 wandered	I into the hall, then into a resident room	n next to the shower room.
	At 8:14 a.m., CNA C out of shower	to get a wheelchair and then back into	shower room.
	At 8:16 a.m., CNA C opened the sh	nower door and took a resident in a who	eelchair out of the shower.
	CNA C walked past the resident ro	om next to the shower room.	
	CNA C walked into Resident #1's room, escorted Resident #2 out of Resident #1's room and walks back toward Resident #2's room at the opposite end of the hall.		
	At 8:19 a.m. CNA F comes out of o	ther residents' room.	
	Resident #2 scream no don't do that Resident #1 standing behind Resident	04/11/22 at 4:08 p.m., completed by L' at when she entered the room. The doc ent #2. Resident #1 was holding on to sed. Resident #2's pants were down an	or was open and she witnessed Resident #2 with one hand, his
	(continued on next page)		

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AND PLAN OF CORRECTION	675220	A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	olan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES		the DON, indicated CNA C exited ed voice coming Resident #1's in and was standing behind get it'. Resident #2's incontinence #2 and immediately removed it #2 in her room and did not notice as calm at the time of the is to send Resident #1 to behavioral ident #2's daughter was notified. Idented any inappropriate The DON, indicated new ent of incident due to Resident #1's inospital. Officer arrived at facility to ent #2's daughter requested the indicated any inappropriate There was genital injury or results available for review. There was genital injury or results available for review. There was genital injury or results available for review. There was genital injury or results available for review. There was genital injury or results available for review. There was genital injury or results available for review. There was genital injury or results available for review. There was genital injury or results available for review. There was genital injury or results available for review. There was genital injury or results available for review. There was genital injury or results available for review. The deficiency is the sail of the shower room and desident #1 standing behind and Resident #1 standing behind and Resident #1 standing behind and Resident #1 had his penis in his was penetrated. She said psych is ant medication). She said re was a 7 but he was re-assessed are hospital for evaluation/treatment. The hospital for an evaluation, but
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 675220 RAME OF PROVIDER OR SUPPLIER Avalon Place Kirbyville STREET ADDRESS, CITY, STATE, ZIP CODE 700 N Herndon Kirbyville, TX 75956 For information on the nursing home's plan to correct this deficiency, please 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) P 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some During an interview on 04/14/22 at 2:05 p.m., CNA F said a resident came out of his room a required incontinent care. She said she went into the shower room to gather supplies. She working for 2 months and did not see Resident #2 wandering in the hall. She sworking for 2 months and did not recall specific training related to monitoring the residents incident on 04/08/22. During an interview on 04/15/22 at 3:34 p.m. the administrator and DON said they had residucated three staff on 04/13/22 working on hall 300 to have one staff monitoring and the providing care. They said staff were also trained to request help when they need to take ca and they were monitoring the hall. The DON said she was not able locate and there was no record she was trained regarding resident to resident During an interview on 04/15/22 at 1.44 p.m., Psych N J said he received a call from the for the incident with Residents #1 and #2. He said he had worked with Resident #2 as she was wanderit tems from other residents' rooms. He said staff have to monitor, intervene, and divert resid additional psychosis in which a person cannot tell what is real from what is imagined), and anxiety (a dread, and uneasiness). Record review of face sheet dated 04/04/22 indicated Resident #4 had a history of physical behavior, interventions included social services to evaluate and visit, activities staff to visit the behavior, indicated Resident #4 had a histo	
Avalon Place Kirbyville To N Herndon Kirbyville, TX 75956 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) During an interview on 04/14/22 at 2:05 p.m., CNA F said a resident came out of his room a required incontinent care. She said she went into the shower room to gather supplies. She almost finished showering a different resident so she left the shower room and assisted the with his incontinent care. She said she went into the shower room and assisted the with his incontinent care. She said she did not see Resident #2 wandering in the hall. She sworking for 2 months and did not recall specific training related to monitoring the residents incident on 04/08/22. During an interview on 04/15/22 at 3:34 p.m. the administrator and DON said they had re-ineducated three staff on 04/13/22 working on hall 300 to have one staff monitoring and the or providing care. They said staff were also trained to request help when they need to take can and they were monitoring the hall. The DON said she was not able locate any staff training contained the names of the staff that owriced during the incident. She said NA B was not a there was no record she was trained regarding resident to resident During an interview on 04/15/22 at 4:14 p.m., Psych NP J said he received a call from the for the incident with Residents #1 and #2. He said he had worked with Resident #1 for many Resident #1 and #2. He said he had worked with Resident #1 for many Resident #1 and #2. He said he had just recently started seeing Resident #1 as she was wanderif items from other residents' rooms. He said staff have to monitor, intervene, and divert resid to provide a serious mental disorder in which a person cannot tell what is real from what is imagined), and anxiety (a dread, and uneasiness). Record review of MDS dated [DATE] indicated Resident #4 had	RVEY
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 During an interview on 04/14/22 at 2:05 p.m., CNA F said a resident came out of his room a required incontinent care. She said she went into the shower room on gather supplies. She working for 2 months and did not recall specific training related to monitoring the residents incident on 04/08/22. During an interview on 04/15/22 at 3:34 p.m. the administrator and DON said they had re-ireducated three staff on 04/13/22 working on hall 300 to have one staff monitoring and the oproviding care. They said staff were also trained to request help when they need to take can and they were monitoring the hall. The DON said she was not able locate any staff training contained the names of the staff that worked during the incident. She said NA B was not at there was no record she was trained regarding resident to resident During an interview on 04/15/22 at 4:14 p.m., Psych NP J said he received a call from the for the incident with Residents #1 and #2. He said he had worked with Resident #1 for many Resident #1 had multiple hypersexual behaviors in the past that included exposing himself masturbating. He said he had just recently started seeing Resident #2 as she was wanderin items from other residents' rooms. He said staff have to monitor, intervene, and divert resident of [DATE]. His diagnoses included schizophrenia (a serious mental disorder in white interpret reality abnormally), dementia with behaviors, delusional disorders (serious mental psychosis- in which a person cannot tell what is real from what is imagined), and anxiety (a dread, and uneasiness). Record review of MDS dated [DATE] indicated Resident #4 had severe cognitive impairmed every 1 to 3 days. There were no behaviors documented.	
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Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Residents Affected - Some During an interview on 04/15/22 at 3:34 p.m. the administrator and DON said they had re-ineducated three staff on 04/13/22 working on hall 300 to have one staff monitoring and they providing care. They said staff that worked during the incident. She said NA B was not a staff that worked during the incident. She said NA B was not a staff that worked during the incident. She said NA B was not a staff that worked during the incident. She said NA B was not a staff that worked during the incident. She said NA B was not as there was no record she was trained regarding resident to resident During an interview on 04/15/22 at 4:14 p.m., Psych NP J said he received a call from the fof the incident with Residents #1 and #2. He said he had worked with Resident #1 for many Resident #1 had multiple hypersexual behaviors in the past that included exposing himself masturbating. He said he had just recently started seeing Resident #2 as she was wandering items from other residents' rooms. He said staff have to monitor, intervene, and divert resident admitted on [DATE]. His diagnoses included schizophrenia (a serious mental disorder in which a person cannot tell what is real from what is imagined), and anxiety (a dread, and uneasiness). Record review of MDS dated [DATE] indicated Resident #4 had severe cognitive impairment every 1 to 3 days. There were no behaviors documented. Record review of care plan dated 10/08/21 indicated Resident #4 had a history of physical seriors.	
diversional activities, talk in a calm voice when behavior is disruptive, and remove from pubbehavior is disruptive and unacceptable. Record review of care plan dated 04/09/22 indicated Resident #4 exhibited aggressive behavior is disruptive another resident and yelling, threatening and physical aggression direct to diffuse the situation. Interventions included placing Resident #4 in an area for frequent of services to evaluate and visit, activities staff to visit and provide diversional activities, talk in when behavior is disruptive, and remove from public area when behavior is disruptive and usent to behavior hospital for evaluation/treatment. There was no care plan to address the verbal and physical aggression towards his roomma on 03/19/22. (continued on next page)	said CNA C was other resident said she had been prior to the deserviced and other staff re of residents records that certified aide and acility the morning years. He said to others and ng and stealing ents' behaviors. ale who was nich people illness - called a feeling of fear, and wandered aggressive and provide olic area when avior noted by ed at staff trying bservation social a calm voice unacceptable, and

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	CNA C noted verbal behaviors dire and cursing at others-nurse notified Record review of a face sheet date [DATE], and his diagnoses include striking motor behavior, typically in and agitation), vascular dementia versulting from conditions that affect predominantly positive symptoms of disorder (serious mood disorder), at Record review of an MDS dated [Devery 1 to 3 days. There were no performed Resident Hand Hand Hand Hand Hand Hand Hand Hand	ATE] indicated Resident #5 had severe hysical or verbal behaviors noted. Report dated 04/09/22 at 5:25 a.m. ar sident #5's room and found Resident #4 A separated the residents. Resident #ed. LVN A reached down to assist Resi's upper right arm. Resident #4 yelled I	ers, screaming/yelling at others, bleted. a [AGE] year-old male, admitted on mental disorder characterized by voluntary movement or hyperactivity to memory, thinking, and behavior bid schizophrenia (characterized by and hallucinations), major depressive the cognitive impairment. Wandered the demander of the beautiful demander of the secure unit. Secure of the beautiful demander of the secure unit. Secure of the beautiful demander of the secure unit. Secure of the beautiful demander of the secure unit. Secure of the beautiful demander of the secure unit. Secure of the beautiful demander of the secure unit. Secure of the beautiful demander of the secure unit. Secure of the beautiful demander of the secure unit. Secure of the beautiful demander of the secure unit. Secure of the secure unit. Secure of the secure unit. Secure of the secure of the secure unit. Secure of the secure of the secure unit. Secure of the secure

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	incidents between Residents #4 an reported anything during the morning found standing over Resident #5. S	8:35 a.m. the Administrator said she wid #5. She said she was new to the facing meetings. She said they were roomshe said Resident #4 was recently put objects. She said he was put on 1-1 statuation and treatment.	ility as of January 2022 and no one mates. She said Resident #4 was on Risperdal (antipsychotic
	During an interview on 04/14/22 at 1:54 p.m., The DON said she would have separated Residents #4 and they would not have continued as roommates if she was made aware of the previous incidents. So no one told her of the previous incidents and nothing was reported during morning meeting. During an interview on 04/14/22 at 2:08 p.m., NA B said she realized after she shut the door of Reside and #5 room that she had left Resident #5 in danger. She said she stood right outside of the door until arrived and intervened.		of the previous incidents. She said
	and not shut the door. She said NA training. They said staff were also t LVN A should have documented th	3:34 p.m. the administrator and DON s B was a new aide hired on and she ne rained to request help when they need e prior incident and notified the admini- ne was not able locate staff training rec ident.	eeded more experience and to take care of residents. She said strator (the abuse coordinator
	of aggression from Resident #4. He he received reports from staff if res	4:14 p.m., psych NP J said he was not e said he was in the facility every two w idents had behaviors. He said he would and #5 be separated and not continued	veeks and more as needed. He said d have addressed the aggressions
	shouting from Resident #4's room. Resident #5. Resident #4 was redii	03/19/22 at 2:22 p.m., completed by L'LVN L observed Resident #4 shouting rected to the dining room and offered s for any aggressive behavior towards o	aggressively as he stood over nacks. Resident #4 refused snacks.
	Hall-3 staff are to have safety moni Observe for potential abuse behavi	ng Report dated 09/21/21 indicated the toring of hall at all times. Staff may takiors, wandering, and/or falls and attemplated the names of the LVN A, NA B, C	e turns, being safety monitor. ot to prevent altercations and
	(continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	environment for residents by prohib exploitation and misappropriation of and kicking, shoving, pinching, and sue of oral, written or gestural lang their families, or within their hearing Examples include cursing, yelling, Abuse is defined as non-consensus unnecessary touching or exposure informed consent and with the intention include sexual harassment, sext exhibiting abusive behaviors will be staff will immediately report and proprotection: 1. All residents will be innecessitate assessment and intervione on one supervision. b. transfer member/responsible party. The facility was notified of the Immiprovided the Immediate Jeopardy. The Facility's Plan of Removal for I the following: Facility failed to prevent Resident # yelling please don't no no no Resider shoulder. Resident #1 had a porief was down. Approximately 2-3 was standing between her legs how. There were no interventions put in Facility failed to prevent Resident # 4 was seen standing over Reside interventions were put in place at the context of the see what was happening and the	44 from verbally and physically abusing at #5, while Resident #5 was in bed, ye ne time. novering over Resident #5 yelling at hire closed the door and called for the nuot been trained on dealing with behavior removal:	ling involuntary seclusion, neglect, but is not limited to hitting, slapping, includes but is not limited to the or derogatory terms to residents or by to comprehend, or disability. Ings to frighten a resident. E. Sexual includes but is not limited to any he genitals without voluntary, sire of any person. This definition is invention: 3. Residents identified as instituted in the plan of care. 4. Reservation of abuse has occurred. Regations involving residents will in which may include a. temporary nome or to a family m. and the administrator was wide a Plan of Removal to address of this pants down and his hand on lower of the plan of Resident #2 was heard in his pants down and his hand on lower of the plan of Resident #1's bed. He Resident #5. On 3/19/22 Resident elling aggressively at him. No m. The nurse aide opened the door urse. She did not intervene and

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	675220	A. Building B. Wing	04/15/2022
NAME OF PROVIDER OR SUPPLII	L ER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Avalon Place Kirbyville		700 N Herndon Kirbyville, TX 75956	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		ion)
F 0600	2. Notify Regional Director of opera	ations of Immediate Jeopardy status -	
Level of Harm - Immediate jeopardy to resident health or	Onsite 4/14/22@ 3 pm.		
safety	3. Notify facility Medical Director of	Immediate Jeopardy status-	
Residents Affected - Some	Notified via phone by ADON -4/14/	22@ 4pm.	
	/Designee and responsible party w	aced on 1:1 monitoring beginning @ 8: ere notified. Medication orders were re havioral Hospital @3:30 pm on 4/11/22	ceived. He remained on 1:1
	5. Resident #2 was assessed by facility licensed nursing staff on 4/11/22@ 8:21 am with no visible in noted. She was calm. Attending MD /Designee and responsible party were notified. Responsible part called facility and requested she be sent out for exam .MD/Designee were notified of family's request order received to send to ER for evaluation and examination. She was transferred to a hospital on 4/8:30 pm. She returned to the facility on [DATE] @ 3 am. Verbal report was received from nurse at Hc indicating no abrasions, tears or injuries on physical exam, specimens were collected during exam ar pending completion by forensics lab. She has been noted to be in pleasant mood and in no immediat distress or discomfort noted.		e notified. Responsible party later e notified of family's request and insferred to a hospital on 4/11/22 @ s received from nurse at Hospital are collected during exam and are
	Resident #3 has been assessed on numerous occasions for the past 3 weeks with no noted skin issues obvious discomfort observed.		weeks with no noted skin issues or
	7. Resident #4 was placed on 15-minute interval monitoring beginning 4/9/22 @ 6am. Attending MD/Designee were notified. Order received to transfer to behavioral hospital. Resident remaine 15-minute monitoring until transferred to Behavioral Hospital on 4/9/22 @4:45 pm. He remains a Behavioral Hospital at the time of this report.		ital. Resident remained on
		ensed nursing staff on 4/9/22 with no i 9/22 @ 6 am and monitoring was disco	
		cure unit have had skin assessments of d concerns with none identified. Initiate Treatment Nurse.	
		ecure unit were evaluated for any physi x. 4:30 pm and Completed 4/14/22@ 5	
	Care plans for Residents #1, 2 , 4 & reviewed .	& 5 were updated to reflect identified ev	vent and interventions were
	11. Facility staff were provided edu	cation by DON/Designee on:	
	11a) Inappropriate Resident to Re	sident touching. Reporting procedures	discussed.
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022
NAME OF PROVIDER OR SUPPLIER Avalon Place Kirbyville		STREET ADDRESS, CITY, STATE, ZI 700 N Herndon Kirbyville, TX 75956	P CODE
For information on the nursing home's	plan to correct this deficiency, please con		agency.
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)	
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Initiated 4/13/22@ 12:30 pm, Follow attendees on 4/13/22-51 Subseque 4/14/22 -Total attendees 11. Follow Total Attendees 29. 11b) Supervision and Monitoring of facilitate monitoring of unit. Staff we hallway on Hall 3 while care is bein with these roles and to notify the nutlan, Follow up sessions @ 2:30 Subsequent sessions on 4/14/22@ beginning 4/15/22@ 6 am completed 11c) Abuse -Content Abuse Coord 4/13/22@10:30 am, Follow up sessions attendees 63 Subsequent sessions attendees Follow up sessions on 4/12. Facility staff were provided edu 12a) Behavior Assessment, Interve 5:30 pm, Completed @ 5:50 pm on completed by 945 am. Total attendes 12b) Unmanageable Residents - co 6:00 pm on 4/14/22 Attendees 35 Fortal attendees 29. 13. Facility were provided education including reporting procedures, intercompleted at 945 am. Total attendees 14. Staff who were not on duty will staff will be allowed to work on the 15a, and 15b.	w up sessions @2:30 pm and 6pm Corent sessions on 4/14 /22@beginning @ v up sessions conducted @ 4/15/22 be of Hall 3/Secure Unit. Content discussedere educated that one staff would be many general by the other staff member. The surse if additional monitoring assistance pm. and 6:00 pm. Completed @ 6:30 pm. and 6:00 pm. Completed @ 6:30 pm. and 6:00 pm. Total attendees 29. In am, Completed @ 10:30 am. 12 attended @ 945 am. Total attendees 29. In attended @ 945 am. Total attendees 29. In any Completed @ 4/14/22 beginning @10 am, Completed & 4/14/22 beginning at 6am completed at 9/15/22 beginning	mpleted @ 6:30pm on 4/13/22 Total at 10am, Completed @ 10:30 am on ginning @ 6am completed by 9am. Id and procedures discussed to conitoring Residents and the Staff were instructed to take turns is needed. Initiated 4/13/22@ om on 4/13/22. Total attendees 50 tendees Follow up sessions See Prohibition Guideline. Initiated @ 6:30 pm on 4/13/22. Total ed @ 10:30 am on 4/14/22- 17 945 am. Total attendees 29. Id facility policy. Initiated 4/14/22@ cion on 4/15/22 beginning at 6 am at 6 am completed at 945 am. Iddent-resident altercations, content ures. Initiated 4/15/22 at 6 am ducation by the DON/designee. No ed for items #13, #14a, #14b, #14c,

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022
NAME OF PROVIDER OR SUPPLIE Avalon Place Kirbyville	700 111 1		P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is accidents. **NOTE- TERMS IN BRACKETS Hased on observation, interview, a supervision to prevent abuse for 4 1. The facility staff did not provide south 1/22. Resident #2 wandered in found behind Resident #2, his hand Resident #2. Residents #1 and #2/22. The facility staff did not separate abuse of Resident #4. On 04/9/22 Bopened the door to see what was Resident #5 in imminent harm. An Immediate Jeopardy (IJ) situation 04/15/22, the facility remained out identified as a pattern due to the fact the fact the fact of the fact the fact the fact or change in a person's life), Parking walking, balance, and coordination feeling of sadness and loss of intersomeone uses language), and schabnormally). Record review of MDS dated [DAT impairment), he wandered every 1-1. Record review of Resident #1's carbehavior and inappropriate sexual	AVE BEEN EDITED TO PROTECT Condition of the residents (Resident #s 1, 2, 4, and supervision to prevent Resident #1 from the Resident #1's room. Resident #2 was don her shoulder, holding his partially as briefs were down. The resident #4 was found hovering over F is happening and then closed the door as the resident #4 was found hovering over F is happening and then closed the door as the resident #4 was found hovering over F is happening and then closed the door as the resident #4 was found hovering over F is happening and then closed the door as the resident #4 was found hovering over F is happening and then closed the door as the resident #4 was found hovering over F is happening and then closed the door as the resident #4 was found hovering over F is happening and then closed the door as the resident #4 was found hovering over F is happening and then closed the door as the resident #1 was a finally as a finally	les adequate supervision to prevent ONFIDENTIALITY** 25115 Issure residents received adequate d 5) reviewed for supervision. In sexually abusing Resident #2 on as heard yelling. Resident #1 was erect penis while thrusting toward This continued verbal and physical resident #5 yelling at him. The NA and called for the nurse. NA B left Im. While the IJ was removed on an minimal harm with a scope ss of the corrective systems. In all anguish, emotional distress, and [AGE] year-old male, admitted on avioral reaction to a stressful event asking, stiffness, and difficulty with order that causes a persistent lifficulty with thinking and how in which people interpret reality In was 7 (severe cognitive ever ever no behaviors noted. In played socially inappropriate intions included 15-minute

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022
NAME OF PROVIDER OR SUPPLII Avalon Place Kirbyville	ER	STREET ADDRESS, CITY, STATE, ZI 700 N Herndon Kirbyville, TX 75956	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICE	CIENCIES full regulatory or LSC identifying informati	on)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety	on [DATE], and her diagnoses incl	04/13/22, indicated Resident #2 was a uded Alzheimer's (a progressive neurol o die) and depression (a mood disorde	ogic disorder that causes the brain
Residents Affected - Some	Record review of MDS dated [DAT impairment), wandered daily, and a	E] indicated Resident #2 had a BIMS sambulated without assistance.	core of 2 (severe cognitive
	to wandering and significant safety room with verbal cures, notify phys at times will take things out of othe	2/30/21 indicated Resident #2 required awareness due to dementia. Interventician if behavior increases (1/18/22- in residents' rooms, 2/6/22 altercation we swalker, 4/11/22 victim of inappropriate	ons included assist with location of and out of other residents' rooms, ith another resident, 2/11/22
		2 with the Administrator, DON and AD0 two separate camera recordings on 04/	
	At 8:09 a.m. there were no aides o	n the hall, Resident #2 wandered on ha	all and then back into her room.
	Camera error exact time unknown-room.	CNA F went into another resident's roo	m while CNA C was in the shower
	At 8:13 a.m. Resident #2 wandered	d into the hall, then into a resident room	n next to the shower room.
	At 8:14 a.m., CNA C out of shower	to get a wheelchair and then back into	shower room.
	At 8:16 a.m., CNA C opened the sl	nower door and took a resident in a who	eelchair out of the shower.
	CNA C walked past the resident ro	om next to the shower room.	
	CNA C walked into Resident #1's r toward Resident #2's room at the c	oom, escorted Resident #2 out of Residence and of the hall.	dent #1's room and walks back
	At 8:19 a.m. CNA F comes out of c	other residents' room.	
	Resident #2 scream no don't do the Resident #1 standing behind Resident	04/11/22 at 4:08 p.m., completed by L' at when she entered the room. The doc lent #2. Resident #1 was holding on to sed. Resident #2's pants were down a	or was open and she witnessed Resident #2 with one hand, his
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022
NAME OF PROVIDER OR SUPPLIER Avalon Place Kirbyville		STREET ADDRESS, CITY, STATE, ZI 700 N Herndon Kirbyville, TX 75956	P CODE
For information on the nursing home's plan to correct this deficiency, please contact the nursing h		tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of nurse note dated 04/11/22 at 4:18 p.m., completed by the DON, indicated CNA C exited the shower room at approximately 8:15 a.m. and heard Resident #2's raised voice coming Resident #1's room. CNA C entered the room and noted Resident #2 had his pants down and was standing behind Resident #2. Resident #1 had his penis in his hand and was saying 'get it, get it'. Resident #2's incontinence protective wear and pants were down. CNA C separated Resident #1 and #2 and immediately removed Resident #2 from the room. DON and Treatment nurse examined Resident #2 in her room and did not notice any redness or drainage to rectal or perineal/vaginal area. Resident #2 was calm at the time of the examination. No injuries noted. The physician was notified and new orders to send Resident #1 to behavioral hospital for evaluation and treatment. The administrator was notified. Resident #2's daughter was notified. Psych services was notified. Record review of NP E's visit report dated 04/11/22 indicated Resident #1 denied any inappropriate behaviors occurred. Resident #1's BIMS was assessed and scored at 15. Record review of Resident #1's behavior monitoring from 01/01/22 through 04/08/22 indicated no behaviors were documented. Record review of Resident #2 behavior monitoring from 01/01/22 through 04/08/22 indicated there were 79 incidents of wandering into other residents' rooms and the nurse was notified. During an interview on 04/13/22 at 8:35 a.m. the Administrator said CNA C came out of the shower room and heard Resident #2 say 'stop'. She said the door was open and she saw Resident #1 standing behind Resident #2. She said both residents' pants and briefs were down. She said Resident #1 had his penis in his hand. She said Resident #2 was assessed and it was not determined she was penetrated. She said psych services was contacted and increased Resident #1's Zoloft (an antidepressant medication). She said		
	Resident #1 denied the allegations. She said Resident #1's last BIMS score was a 7 but he was re-assessed and it was 15. She said Resident #1 had previous sexually inappropriate behaviors and would masturbate on the porch. She said he was easily re-directed. During an interview on 04/13/22 at 9:10 a.m., CNA C said she was previously trained on abuse and neglect prevention. She said approximately 2 or 3 weeks prior she had previously caught Resident #1 with another resident sitting on his bed. She said Resident #1 was standing between the other resident's legs as she was sitting on his bed. She said both residents were fully dressed. She said Resident #1 stepped back and said he was trying to help the other resident. She said she thought she told LVN G of the incident. She said the most recent incident occurred after breakfast at approximately 8:15 a.m. She said was in the shower room when heard Resident #2 scream No don't do that no no no. She said she brought the other resident out of the shower room and walked to Resident #1's room. She said both Resident #1 and Resident #2's pants were down. She said Resident #1 had his penis in his hand and was holding Resident #2's left shoulder as he was telling Resident #1 to get it, get it as he was thrusting. She said Resident #1 sat down on his bed when he walked into the room. She said Resident #2 was crying. She said she dressed Resident #2 and walked her out of the room. She said she and CNA F were working the secure unit together. She said they had cell phones to call the nurse if there as an emergency. During an interview on 04/13/22 at 9:47 a.m., the DON said she had heard of the incident of another resident being in Resident #1's room but she was not told the incident was sexual.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022
NAME OF PROVIDER OR SUPPLIER Avalon Place Kirbyville		STREET ADDRESS, CITY, STATE, ZI 700 N Herndon Kirbyville, TX 75956	P CODE
For information on the nursing home's	or information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.		agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 04/13/22 at 11:35 a.m., LVN I said she had witnessed an incident approximately 2 - 3 months prior where another resident had taken off her clothes in her room and her roommate had opened the door as Resident #1 walked by. She said he stopped and stared, and when asked why he did that he said because he could. She said she had heard of the incident where he stood over the same resident while she sat on his bed. During an interview on 04/13/22 at 11:53 a.m., LVN G said she had not noticed Resident #1 having inappropriate sexual behaviors. She said Resident #1 did stare at the resident that was found sitting on his		
	inappropriate sexual behaviors. She said Resident #1 did stare at the resident that was found sitting or bed. During an interview on 04/14/22 at 10:15 a.m., the DON said she was not able to locate LVN A, NA B, CNA C's training for sexually inappropriate behaviors or resident abuse. During an interview on 04/14/22 at 1:30 p.m., the Administrator said she was not aware of any previou incidents related to inappropriate sexual behavior. She said she was not aware LVN A, NA B, or CNA not trained. She said she became the new Administrator in January 2022 and was not aware staff was trained. She said she and the DON or designee were responsible for ensuring staff was trained. During an interview on 04/14/22 at 1:54 p.m., the DON said both aides on the secure unit should not b providing resident care at the same time. She said one of the aides was supposed to monitor and supe the other residents and the hall to ensure residents do not wander or to be able to intervene for resider safety. She said she was not able to locate training records to indicate the staff had been trained. She she or designee were responsible for ensuring staff was trained. She could not say why the staff were trained or she could not locate the training records. During an interview on 04/14/22 at 2:05 p.m., CNA F said a resident came out of his room and the resirequired incontinent care. She said she went into the shower room to gather supplies. She said CNA C almost finished showering a different resident so she left the shower room and assisted the other resid with his incontinent care. She said she with the shower room to gather supplies. She said CNA C almost finished showering a different resident so she left the shower room and assisted the other resid with his incontinent care. She said she with the shower room to gather supplies. She said CNA C almost finished showering a different resident so she left the shower room and assisted the other resid with his incontinent care. She said she will not see Resident #2 wandering in the hall.		vas not aware of any previous aware LVN A, NA B, or CNA C were and was not aware staff was not uring staff was trained. If the secure unit should not be upposed to monitor and supervise able to intervene for resident as taff had been trained. She said do not say why the staff were not are out of his room and the resident her supplies. She said CNA C was and assisted the other resident in the hall. She said had been ing the residents prior to the said they had re-inserviced and onitoring and the other staff yn need to take care of residents any staff training records that INA B was not a certified aide and ssion. If a call from the facility the morning sident #1 for many years. He said exposing himself to others and she was wandering and stealing

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building	(X3) DATE SURVEY COMPLETED 04/15/2022	
	675220	B. Wing	04/13/2022	
NAME OF PROVIDER OR SUPPLI	NAME OF PROVIDER OR SUPPLIER		P CODE	
Avalon Place Kirbyville		700 N Herndon	. 332	
Kirbyville, TX 75956				
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)	
F 0689	2.			
Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of face sheet dated 04/04/22 indicated Resident #4 was a [AGE] year-old male who was admitted on [DATE]. His diagnoses included schizophrenia (a serious mental disorder in which people interpret reality abnormally), dementia with behaviors, delusional disorders (serious mental illness - called a psychosis- in which a person cannot tell what is real from what is imagined), and anxiety (a feeling of fear, dread, and uneasiness).			
	Record review of MDS dated [DAT every 1 to 3 days. There were no b	E] indicated Resident #4 had severe coehaviors documented.	ognitive impairment and wandered	
	Record review of care plan dated 10/08/21 indicated Resident #4 had a history of physical aggressive behavior. Interventions included social services to evaluate and visit, activities staff to visit and provide diversional activities, talk in a calm voice when behavior is disruptive, and remove from public area when behavior is disruptive and unacceptable.			
	Record review of care plan dated 04/09/22 indicated Resident #4 exhibited aggressive behavior noted by staff standing over another resident and yelling, threatening and physical aggression directed at staff trying to diffuse the situation. Interventions included placing Resident #4 in an area for frequent observation social services to evaluate and visit, activities staff to visit and provide diversional activities, talk in a calm voice when behavior is disruptive, and remove from public area when behavior is disruptive and unacceptable, as sent to behavior hospital for evaluation/treatment.			
	There was no care plan to address 03/19/22.	verbal and physical aggression toward	ds his roommate that occurred on	
	CNA C noted verbal behaviors dire	w of a face sheet dated 04/04/22 indicated Resident #5 was a [AGE] year-old male, admitted on his diagnoses included catatonic schizophrenia (rare severe mental disorder characterized by behavior, typically involving either significant reductions in voluntary movement or hyperactivity, vascular dementia with behavioral disturbances (changes to memory, thinking, and behavior in conditions that affect the blood vessels in the brain), paranoid schizophrenia (characterized by ly positive symptoms of schizophrenia, including delusions and hallucinations), major depressive		
	shouting from Resident #4's room. Resident #5. Resident #4 was redi			
	[DATE], and his diagnoses include striking motor behavior, typically in and agitation), vascular dementia v resulting from conditions that affect			
	Record review of an MDS dated [D every 1 to 3 days. There were no p	ATE] indicated Resident #5 had severe hysical or verbal behaviors noted.	e cognitive impairment. Wandered	
	(continued on next page)			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022
NAME OF PROVIDER OR SUPPLIER Avalon Place Kirbyville		STREET ADDRESS, CITY, STATE, ZI 700 N Herndon Kirbyville, TX 75956	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	NA B entered Resident #4 and Resident #4 was yelling at Resident #5. LVN sat on the floor by the foot of his be #4 swung his fist and struck LVN A Resident #5 was moved to a differed During an interview on 04/13/22 at #4 and #5's room. She said she op Resident #5 lay in his bed. She said not know why she did not intervened She said she was not trained on he Resident #4 to his bed. She said R CNA K was on shift with her. Record review of CNA K's undated told her she heard shouting and rule opened the door and LVN A, CNA #4 was standing over Resident #5 Resident #5. Resident #4 started to LVN A directed CNA K to get LVN picked up a shoe. LVN A moved R. During an interview on 04/13/22 at He said he was not aware of any s Resident #5 then he would calm do say why he did not document the in the top of his lungs at Resident #5 got between the residents. He said did not have any marks on his back. Record review of nurse note dated to Resident #4 and Resident #5 sr yelling. LVN A directed Resident #4 but Resident #4 hit LVN A on the rimoved Resident #5 to another room was no visible injury. Resident #5 to another room was no visible injury. Resident #5 to another room was no visible injury. Resident #5 to another room was no visible injury. Resident #5 to another room was no visible injury. Resident #5 to another room was no visible injury. Resident #5 to another room was no visible injury. Resident #5 to another room was no visible injury. Resident #5 to another room was no visible injury. Resident #5 to another room was no visible injury. Resident #5 to another room was no visible injury. Resident #5 to another room was no visible injury. Resident #5 to another room was no visible injury. Resident #5 to another room was no visible injury. Resident #5 to another room was no visible injury. Resident #5 to another room was no visible injury. Resident #5 to another room was no visible injury.	t Report dated 04/09/22 at 5:25 a.m. ar sident #5's room and found Resident #1 A separated the residents. Resident #2 ad. LVN A reached down to assist Resident room. 2:08 p.m., NA B said she heard voices ened the door and saw Resident #4 stated she shut the door and told the other see. She said she was not a certified aide to we to redirect residents. She said LVN desident #4 went toward his bed and sate statement included in the ongoing fact mbling in the room and for her (CNA K). C and CNA K walked into Resident #4 hitting him and cursing at him. LVN A was swing and curse at LVN A. Resident #4 and esident #5 to another room. All staff lef 4:27 p.m., LVN A said he was not train pecific care plans for Resident #4. He said was able to redirect him. He said was 104/09/22 at 10:47 a.m., completed by oom at 5:25 a.m. LVN A found Resident 4 to sit on his bed but he sat on the floor gift upper arm and started to yell he was not resident. Resident #5 stated Resident #4 to a behavioral was resting in a safe bed. Notified on-cing to send Resident #4 to a behavioral	4 bent over Resident #5. Resident 44 sat at the foot of his bed. LVN A dent #4 from the floor and Resident he was going to kill LVN A. 5 and yelling and went to Residents anding over Resident #5 while staff to get LVN A. She said she did and was not trained on behaviors. A came to the room and directed id, I'll fucking kill you. She said 6 lity's investigation indicated CNA C to to go and get LVN A. LVN A and Resident #5's room. Resident was able to get Resident #4 off #4 fell on the floor as he swung. I he started cursing at LVN A and it Resident #4's room for their safety. 7 In the said there were other incidents of the incidents of the incident #4 was not able to see' the or an incident report. He could not not, Resident #5 when he (LVN A) in the back. He said Resident #5 matized for the next day or two. 8 LVN A, indicated LVN A was called and the said the said Resident #5, or LVN A attempted to help him up as going to kill LVN A. LVN A and the hit him in the back. There all ADON, and the ADON notified

AND PLAN OF CORRECTION IDENTIFIC 675220 NAME OF PROVIDER OR SUPPLIER Avalon Place Kirbyville For information on the nursing home's plan to correct (X4) ID PREFIX TAG SUMMAR (Each defict F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some During an and they no one to During an and #5 ro arrived ar During an and not sign they said LVN A sh and/or de the staff ti			
Avalon Place Kirbyville For information on the nursing home's plan to correct (X4) ID PREFIX TAG SUMMAR (Each defice) F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some During an and they wan on one to During an and #5 ro arrived ar During an and not sign they said LVN A she and/or de the staff to	VIDER/SUPPLIER/CLIA CATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022
(X4) ID PREFIX TAG F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some During an and they no one to During an and #5 ro arrived ar During an and not si They said LVN A sh and/or de the staff ti			P CODE
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some During an and they no one to During an and #5 ro arrived ar During an and not start the staff to t	et this deficiency, please con	tact the nursing home or the state survey	agency.
Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some During an and #5 ro arrived ar During an and not start to a least to a l	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
of aggres Residents Record re Hall-3 sta Observe f incidents. Record re safety and target inte supervisic interventic supervisic supervisic Hazards . Record re indicated and beha behavior s			ras not aware of any previous dility as of January 2022 and no one mates. She said Resident #4 was on Risperdal (antipsychotic ffing with 15-minute monitoring and ave separated Residents #4 and #5 of the previous incidents. She said morning meeting. It is she shut the door of Residents #4 right outside of the door until LVN A right outside of the door until LVN A said NA B should have intervened ed more experience and training. Care of residents. The DON said strator (the abuse coordinator fords that contained the names of the strator (the abuse coordinator fords that contained the names of the strator (the abuse coordinator fords that contained the names of the strator (the abuse coordinator fords that contained the names of the strator (the abuse coordinator fords that contained the names of the strator (the abuse coordinator fords that contained the names of the strator (the abuse coordinator fords that contained the names of the strator (the abuse coordinator fords that contained the names of the strator (the abuse coordinator fords that contained the names of the strator (the abuse coordinator fords that contained the names of the strator (the abuse coordinator fords that contained the names of the strator (the abuse coordinator fords that contained the names of the strator (the abuse coordinator fords that contained the names of the strator (the abuse coordinator fords that contained the names of the strator (the abuse coordinator fords that contained the names of the strator (the abuse coordinator fords that contained the names of the strator (the abuse coordinator fords that contained the names of the strator (the abuse coordinator fords that contained the names of the strator (the abuse coordinator fords that contained the names of the strator (the abuse coordinator fords that contained the names of the strator (the abuse coordinator fords that contained the names of the strator (the abuse coordinator fords that contained the names of the strator fords that contained the strator fords that contained t

Printed: 11/27/2024 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022
NAME OF PROVIDER OR SUPPLIER Avalon Place Kirbyville		STREET ADDRESS, CITY, STATE, ZI 700 N Herndon Kirbyville, TX 75956	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	I tact the nursing home or the state survey	agency.
			on)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) The facility was notified of the Immediate Jeopardy on 04/14/22 at 3:00 p.m. ar provided the Immediate Jeopardy template. The facility was asked to provide a the Immediate Jeopardy. The Facility's Plan of Removal for Immediate Jeopardy was accepted on 04/15 the following: Facility failed to prevent Resident #1 from sexually abusing Resident #2. On 4/1 yelling please don't no no no Resident #1 was found behind Resident #2. his pher shoulder. Resident #1 had a partially erect pents and was thrusting toward brief was down. Approximately 2-3 weeks earlier Resident #3 was found sitting was standing between her legs hovering over her. Both were fully clothed. There were no interventions put in place. Facility failed to prevent Resident #4 from verbally and physically abusing Resil #4 was seen standing over Resident #5, while Resident #5 was in bed, yelling interventions were put in place at the time. On 4/9/22 Resident #4 was found hovering over Resident #5 yelling at him. The to see what was happening and then closed the door and called for the nurse. separate the Residents. She had not been trained on dealing with behaviors. Please accept the following plan of removal: 1. Notify V.P. of Clinical Operations of immediate Jeopardy status - On site 4/14/22@ 3 pm. 3. Notify Regional Director of operations of Immediate Jeopardy status - Onsite 4/14/22@ 3 pm. 4. Resident #1 was immediately placed on 1:1 monitoring beginning @ 8:30 an /Designee and responsible party were notified. Medication orders were receive monitoring until transferred to a Behavioral Hospital @3:30 pm on 4/11/22. He Hospital at time of this report. 5. Resident #2 was assessed by facility licensed nursing staff on 4/11/22@ 8:2 noted. She was calm. Attending MD /Designee and responsible party were notified. Medication orders were receive monitoring on abrasions, tears or injuries on physical exam, specimens were co pending co		On 4/11/22 Resident #2 was heard his pants down and his hand on oward resident #2. Resident #2's sitting on Resident #1's bed. He helling aggressively at him. No The nurse aide opened the door arse. She did not intervene and ors. Resident #3. On 3/19/22 Resident helling aggressively at him. No The nurse aide opened the door arse. She did not intervene and ors. Resident #5. On 3/19/22 Resident helling aggressively at him. No The nurse aide opened the door arse. She did not intervene and ors. Resident #5. On 3/19/22 Resident helling aggressively at him. No The nurse aide opened the door arse. She did not intervene and ors. Resident #5. On 3/19/22 Resident helling aggressively at him. No The nurse aide opened the door arse. She did not intervene and ors. Resident #5. On 3/19/22 Resident helling aggressively at him. No The nurse aide opened the door arse. She did not intervene and ors.

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID:

If continuation sheet Page 18 of 32

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022		
NAME OF PROVIDER OR SUPPLII	NAME OF PROVIDER OR SUPPLIER		P CODE		
Avalon Place Kirbyville		700 N Herndon Kirbyville, TX 75956			
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	6. Resident #3 has been assessed obvious discomfort observed. 7. Resident #4 was placed on 15-m MD/Designee were notified. Order 15-minute monitoring until transferr Behavioral Hospital at the time of the second stream	on numerous occasions for the past 3 minute interval monitoring beginning 4/9 received to transfer to behavioral hospited to Behavioral Hospital on 4/9/22 @mis report. Seensed nursing staff on 4/9/22 with no in 3/22 @ 6 am and monitoring was discontructed to a many monitoring was discontructed with a many monitoring and 6 minutes and 6 minutes with a many monitoring and 6 minutes a	weeks with no noted skin issues or 1/22 @ 6am. Attending ital. Resident remained on 4:45 pm. He remains at a 1/2/2 may be remained an an injuries noted. He was placed on a notinued on 4/12/22 may with no 1/2/2 may be remained an arrive staff of 4/13/22 may be remained and aggressive behaviors with none and interventions were 1/2/2 may be remained and interventions were 1/2/2 may be		
	(continued on next page)				

			No. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022
NAME OF PROVIDER OR SUPPLIER Avalon Place Kirbyville		STREET ADDRESS, CITY, STATE, Z 700 N Herndon Kirbyville, TX 75956	IP CODE
For information on the nursing home's	plan to correct this deficiency, please con	Lact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		ion)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	5:30 pm, Completed @ 5:50 pm or completed by 945 am. Total attended 12b) Unmanageable Residents - cc 6:00 pm on 4/14/22 Attendees 35 F Total attendees 29. 13. Facility were provided education including reporting procedures, intercompleted at 945 am. Total attended 14. Staff who were not on duty will staff will be allowed to work on the 15a, and 15b. Administrator, DON, and MDS Coordinating to a phone and texts. Not a phone	content included facility policy. Initiated follow up sessions on 4/15/22 beginning in by DON/Designee on resident to reserventions and documentation procedures 27. be notified, to come to the facility for endicator until education has been completed and the decent of the facility for endicator and HR Director will conduct audit red education. Staff are being notified obtifications started on 4/14/22 @ 3:30 predinator will continue to audit, notify, a quirement. For Residents on the secure unit and refunction on the secure unit and refunction of the secure and Completed 4/14/22@8:20 through: For Reports and Medical record review in the secure actions taken for identification and the secure actions taken for identification of the secure actions to the secure action of the secure actions to the secure action of the secure action	A/14/22@ 5:30 pm Completed @ ng at 6 am completed at 945 am. A/14/22@ 5:30 pm Completed @ ng at 6 am completed at 945 am. A/14/22@ 5:30 pm Completed @ ng at 6 am completed at 945 am. A/14/22@ 5:30 pm Completed @ ng at 6 am completed at 945 am. A/14/22@ 5:30 pm Completed @ ng at 6 am completed at 945 am. A/14/22@ 5:30 pm Completed @ ng at 6 am completed at 945 am. A/15/22 at 6 am. A/15/24 at 945 am.

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(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICE (Each deficiency must be preceded by f		CIENCIES full regulatory or LSC identifying informati	on)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observations, interviews, and recording and included 9 residents, 6 nurses aides, activity director, activity coording were on duty during this time. Staff	emoval occurred on 04/15/22 and included reviews were conducted on 04/15/22 including charge nurses, treatment nur dinator, BOM, housekeeping, dietary swere able to identify inappropriate resident supervision and	2 from 12:00 p.m. through 4:35 p.m. rse, MDS nurse, 6 certified nurse taff, and the ADON and DON that dent to resident touching and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022	
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Avalon Place Kirbyville			P CODE	
Avaion Flace Kirbyville		700 N Herndon Kirbyville, TX 75956		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)	
F 0726	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a wa that maximizes each resident's well being.			
Level of Harm - Immediate jeopardy to resident health or safety	**NOTE- TERMS IN BRACKETS F	HAVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 25115	
Residents Affected - Some	Based on observation, interview and record review, the facility failed to ensure nursing staff demonstrated competencies and skill sets necessary to care for resident needs for 4 of 11 residents (Resident #s 1, 2, 4, and 5) reviewed for competent nursing staff.			
	The facility did not ensure LVN A, I with behaviors.	NA B and CNA F were trained to super	vise and intervene for residents	
	The facility did not provide required monitoring and supervision to prevent Resident #1 from sexually abun Resident #2 on 04/11/22. Resident #2 wandered into Resident #1's room. Resident #2 was heard yelling Resident #1 was found behind Resident #2, his hand on her shoulder, holding his partially erect penis with thrusting toward Resident #2. Residents #1 and #2's briefs were down.			
	The facility staff did not intervene and protect Resident #5 from Resident #4's verbal and physical abuse 4/9/22 Resident #4 was found hovering over Resident #5 yelling at him. The NA B opened the door to se what was occurring and then closed the door and called for the nurse. NA B left Resident #5 in imminent harm.			
	An Immediate Jeopardy (IJ) situation was identified on 04/14/22 at 3:00 p.m. While the IJ was remove 04/15/22, the facility remained out of compliance at a potential for more than minimal harm with a scidentified as a pattern due to the facility's need to evaluate the effectiveness of the corrective system			
	These failures placed residents at needed skills and competencies.	risk of receiving supervision and interve	entions from staff without the	
	Findings included:			
	Record review of face sheet dated 04/13/22, indicated Resident #1 was a [AGE] year-old male, admitted on [DATE] and his diagnoses included adjustment disorder (emotional or behavioral reaction to a stressful event or change in a person's life), Parkinson's (a brain disorder that leads to shaking, stiffness, and difficulty with walking, balance, and coordination), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), cognitive communication deficit (difficulty with thinking and how someone uses language), and schizophrenia (a serious mental disorder in which people interpret reality abnormally).			
	Record review of MDS dated [DATE], indicated Resident #1's BIM score was 7 (severe cognitive impairment), he wandered every 1-3 days, ambulated with a walker. There were no behaviors noted.			
Record review of Resident #1's care plan dated 04/11/22 indicated he displayed socially inap behavior and inappropriate sexual gesture with a female resident. Interventions included 15-r monitoring and sent out to behavioral hospital for evaluation and treatment. There was no prefor sexually inappropriate behavior available for review.			ntions included 15-minute	
	(continued on next page)			

			No. 0936-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022	
NAME OF PROVIDER OR SUPPLIER Avalon Place Kirbyville		STREET ADDRESS, CITY, STATE, ZI 700 N Herndon Kirbyville, TX 75956	P CODE	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)			
F 0726 Level of Harm - Immediate jeopardy to resident health or safety	Record review of face sheet dated 04/13/22, indicated Resident #2 was a [AGE] year-old female, admitted on [DATE], and her diagnoses included Alzheimer's (a progressive neurologic disorder that causes the brain to shrink (atrophy) and brain cells to die) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).			
Residents Affected - Some	Record review of MDS dated [DAT impairment), wandered daily, and a	E] indicated Resident #2 had a BIMS sambulated without assistance.	core of 2 (severe cognitive	
	Record review of care plan dated 12/30/21 indicated Resident #2 required placement on the secure unit due to wandering and significant safety awareness due to dementia. Interventions included assist with location or room with verbal cues, notify physician if behavior increases (1/18/22- in and out of other residents' rooms, times will take things out of other residents' rooms, 2/6/22 altercation with another resident, 2/11/22 attempted to take another residents walker, 4/11/22 victim of inappropriate sexual gesture). The care plan did not address supervision.			
	Observation conducted on 04/14/22 with the Administrator, DON and ADON, who verified the identity of the staff and residents, of the facility's two separate camera recordings on 04/08/22 from 7:30 a.m. through 8:30 a.m. indicated:			
	At 8:09 a.m. there were no aides o	n the hall, Resident #2 wandered on ha	all and then back into her room.	
	Camera error exact time unknown-CNA F went into another resident's room while CNA C was in the shower room.			
	At 8:13 a.m. Resident #2 wandered	d into the hall, then into a resident roon	n next to the shower room.	
	At 8:14 a.m., CNA C out of shower	to get a wheelchair and then back into	shower room.	
	At 8:16 a.m., CNA C opened the sh	nower door and took a resident in a wh	eelchair out of the shower.	
	CNA C walked past the resident ro	om next to the shower room.		
	CNA C walked into Resident #1's r toward Resident #2's room at the c	oom, escorted Resident #2 out of Resi opposite end of the hall.	dent #1's room and walks back	
	At 8:19 a.m. CNA F comes out of c	other residents' room.		
	Resident #2 scream no don't do the Resident #1 standing behind Resident	04/11/22 at 4:08 p.m., completed by L at when she entered the room. The doctent #2. Resident #1 was holding on to used. Resident #2's pants were down as	or was open and she witnessed Resident #2 with one hand, his	
	(continued on next page)			

			No. 0936-0391
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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some			ne DON, indicated CNA C exited sed voice coming Resident #1's m and was standing behind , get it'. Resident #2's incontinence if #2 and immediately removed int #2 in her room and did not notice as calm at the time of the sto send Resident #1 to behavioral ident #2's daughter was notified. If denied any inappropriate idenied any inappropriate in 04/08/22 indicated no behaviors 04/08/22 indicated there were 79 fied. C came out of the shower room and desident #1 standing behind and Resident #1 had his penis in his exast penetrated. She said psych is sant medication). She said one was a 7 but he was re-assessed behaviors and would masturbate on the caught Resident #1 with another ne other resident's legs as she was esident #1 stepped back and said in G of the incident. She said the She said she was in the shower dishe brought the other resident out sident #1 and Resident #2's pants ing Resident #2's left shoulder as esident #1 sat down on his bed
		10:15 a.m., the DON said she was not propriate behaviors or resident abuse. S	

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	CNA C were not trained. She said staff was not trained. She said she During an interview on 04/14/22 at providing resident care at the same the other residents and the hall to esafety. She said she could not local were responsible for ensuring staff could not locate the training record. During an interview on 04/14/22 at required incontinent care. She said almost finished showering a differe with his incontinent care. She said working for 2 months and did not reincident on 04/08/22. During an interview on 04/15/22 at educated staff working on hall 300 staff were also trained to request hall. The DON said she was not ab that worked during the incident. She trained regarding resident-to-reside During an interview on 04/15/22 at residents' behaviors. 2. Record review of face sheet dated admitted on [DATE]. His diagnoses interpret reality abnormally), demer psychosis- in which a person cannod dread, and uneasiness). Record review of MDS dated [DAT every 1 to 3 days. There were no be Record review of care plan dated 1 behavior. Interventions included so	2:05 p.m., CNA F said a resident came she went into the shower room to gath nt resident so she left the shower room she did not see Resident #2 wandering scall specific training related to monitor 3:34 p.m. the administrator and DON sto have one staff monitoring and the ot lep when they need to take care of resile locate any staff training records that e said NA B was not a certified aide and the aggression prior to the incident between the said NA B was not a certified aide and the staff training records that e said NA B was not a certified aide and the said that aggression prior to the incident between the said that the said the said that the said the said the said	anuary 2022 and was not aware asible for ensuring staff was trained. The secure unit should not be upposed to monitor and supervise able to intervene for resident the unit. She said she or designee as staff were not trained or she are out of his room and the resident the supplies. She said CNA C was and assisted the other resident and assisted the other resident and the residents prior to the said they had re-inserviced staff and ther staff providing care. They said dents and they were monitoring the contained the names of the staff and there was no record she was even Resident #4 and Resident #5. It o monitor, intervene, and divert [AGE] year-old male who was not all disorder in which people is (serious mental illness - called a dd), and anxiety (a feeling of fear, opgnitive impairment and wandered sistory of physical aggressive vities staff to visit and provide

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. Building	COMPLETED	
	675220	B. Wing	04/15/2022	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
Avalon Place Kirbyville 700 N Herndon Kirbyville, TX 75956				
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)		
F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of care plan dated 04/09/22 indicated Resident #4 exhibited aggressive behavior noted by staff standing over another resident and yelling, threatening and physical aggression directed at staff trying to diffuse the situation. Interventions included placing Resident #4 in an area for frequent observation social services to evaluate and visit, activities staff to visit and provide diversional activities, talk in a calm voice when behavior is disruptive, and remove from public area when behavior is disruptive and unacceptable, and sent to behavior hospital for evaluation/treatment. There was no care plan to address the verbal and physical aggression towards his roommate that occurred on 03/19/22. Record review of Resident #4's behavior monitoring from 01/01/22 through 04/09/22 indicated on 04/05/22 CNA C noted verbal behaviors directed at others included threatening others, screaming/yelling at others,			
	and cursing at others-nurse notified. There were no additional dates completed. Record review of nurse note dated 03/19/22 at 2:22 p.m., completed by LVN L, indicated LVN L heard shouting from Resident #4's room. LVN L observed Resident #4 shouting aggressively as he stood over Resident #5. Resident #4 was redirected to the dining room and offered snacks. Resident #4 refused snack LVN L notified CNAs to be on alert for any aggressive behavior towards other residents. Resident #5 had r apparent injuries and denied pain.			
	[DATE], and his diagnoses included striking motor behavior, typically in and agitation), vascular demential variable from conditions that affect predominantly positive symptoms of	wiew of a face sheet dated 04/04/22 indicated Resident #5 was a [AGE] year-old male, admitted or not his diagnoses included catatonic schizophrenia (rare severe mental disorder characterized by otor behavior, typically involving either significant reductions in voluntary movement or hyperactivity cion), vascular dementia with behavioral disturbances (changes to memory, thinking, and behavior from conditions that affect the blood vessels in the brain), paranoid schizophrenia (characterized by antly positive symptoms of schizophrenia, including delusions and hallucinations), major depressive serious mood disorder), and anxiety. Eview of an MDS dated [DATE] indicated Resident #5 had severe cognitive impairment. Wandered of 3 days. There were no physical or verbal behaviors noted.		
	NA B entered Resident #4 and Res #4 was yelling at Resident #5. LVN sat on the floor by the foot of his be	t Report dated 04/09/22 at 5:25 a.m. ar sident #5's room and found Resident #4 I A separated the residents. Resident #ed. LVN A reached down to assist Resid's upper right arm. Resident #4 yelled lent room.	4 bent over Resident #5. Resident 4 sat at the foot of his bed. LVN A dent #4 from the floor and Resident	
	#4 and #5's room. She said she op Resident #5 lay in his bed. She sai not know why she did not intervene She said she was not trained on ho	2:08 p.m., NA B said she heard voices sened the door and saw Resident #4 stad she shut the door and told the other se. She said she was not a certified aide by to redirect residents. She said LVN aresident #4 went toward his bed and sa	anding over Resident #5 while staff to get LVN A. She said she did and was not trained on behaviors. A came to the room and directed	
	(continued on next page)			

			No. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2022
NAME OF PROVIDER OR SUPPLIER Avalon Place Kirbyville		STREET ADDRESS, CITY, STATE, ZIP CODE 700 N Herndon Kirbyville, TX 75956	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	ion)
F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	told her she heard shouting and rui opened the door and LVN A, CNA #4 was standing over Resident #5 Resident #5. Resident #5. Resident #4 started to LVN A directed CNA K to get LVN picked up a shoe. LVN A moved R. During an interview on 04/13/22 at He said he was not aware of any s Resident #4 yelling at Resident #5 Resident #5 then he would calm do say why he did not document the ir the top of his lungs at Resident #5. got between the residents. He said did not have any marks on his back. Record review of nurse note dated to Resident #4 and Resident #5's r yelling. LVN A directed Resident #5 but Resident #4 hit LVN A on the rimoved Resident #5 to another roor was no visible injury. Resident #5 with DON. DON stated she was goil. During an interview on 04/14/22 at and #5 room that she had left Resiarrived and intervened. During an interview on 04/15/22 at and not shut the door. The DON sat The DON said staff were also trainsaid she was not able locate staff to During an interview on 04/15/22 at of aggression from Resident #4. He Residents #4 and #5 be separated.	I statement included in the ongoing facing mbling in the room and for her (CNA K) C and CNA K walked into Resident #4 hitting him and cursing at him. LVN A volume of swing and curse at LVN A. Resident #1. LVN I tried to talk to Resident #4 and esident #5 to another room. All staff lef 4:27 p.m., LVN A said he was not trair pecific care plans for Resident #4. He shown. He said he did not do a nurse not encident. He said the most recent incide. He said Resident #4 continued to yell. Resident #5 said Resident #4 hit him is. He said Resident #4 was pretty traur 04/09/22 at 10:47 a.m., completed by soom at 5:25 a.m. LVN A found Residen 4 to sit on his bed but he sat on the flooght upper arm and started to yell he was resting in a safe bed. Notified oncome to send Resident #4 to a behavioral 2:08 p.m., NA B said she realized after dent #5 in danger. She said she stood 3:34 p.m. the administrator and DON said NA B was a new aide and she needed to request help when they need to training records for LVN A, NA B and C 4:14 p.m., psych NP J said he was not be said he would have addressed the again and not continued their status as room 1/09/21), NA B (DOH 04/01/22) and CN as of training or competency checks for	on to go and get LVN A. LVN A and Resident #5's room. Resident was able to get Resident #4 off #4 fell on the floor as he swung. It he started cursing at LVN A and it Resident #4's room for their safety. The do not dementia for the secure unit. It is aid there were other incidents of it if resident #4 was not able to see' the or an incident report. He could not not not, Resident #4 was screaming at at Resident #5 when he (LVN A) in the back. He said Resident #5 matized for a day or two. LVN A, indicated LVN A was called not #4 standing over Resident #5, or. LVN A attempted to help him up as going to kill LVN A. LVN A ent #4 hit him in the back. There all ADON, and the ADON notified hospital. The shut the door of Residents #4 right outside of the door until LVN A said NA B should have intervened led more experience and training. The above the sidents and recommended in mates. A F (DOH 02/01/22)'s personnel

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	facility will not use any individual as other basis unless: a. That individual That person has completed a trainity evaluation program approved by the S483.150) and (b) of the Requirem aide who has worked less than 4 material as tate-approved training and compatisfactory participation in a state-has been deemed competent as participation in a state-has deemed compet	#4 from verbally and physically abusing nt #5, while Resident #5 was in bed, ye ne time. **novering over Resident #5 yelling at hir en closed the door and called for the not been trained on dealing with behavior	s full-time, temporary, per diem, or nursing related services; and b. n program, or a competency deemed competent as provided in not sue any induvial as a nurse time employee and participating in demonstrated competence through betency evaluation program; or c. quirements of Participation. topic was safety monitoring-Hall-3: e turns, being safety monitor. of to prevent altercations and to CNA F. m. and the administrator was yide a Plan of Removal to address 04/15/22 at 1:55 p.m. and reflected On 4/11/22 Resident #2 was heard in his pants down and his hand on loward resident #2. Resident #2's sitting on Resident #1's bed. He Resident #5. On 3/19/22 Resident elling aggressively at him. No m. The nurse aide opened the door urse. She did not intervene and ors.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. Notify facility Medical Director of Notified via phone by ADON -4/14/4. Resident #1 was immediately pla /Designee and responsible party w monitoring until transferred to a Be Hospital at time of this report. 5. Resident #2 was assessed by fa noted. She was calm. Attending MI called facility and requested she be order received to send to ER for ev 8:30 pm. She returned to the facility indicating no abrasions, tears or inj pending completion by forensics la distress or discomfort noted. 6. Resident #3 has been assessed obvious discomfort observed. 7. Resident #4 was placed on 15-m MD/Designee were notified. Order 15-minute monitoring until transferr Behavioral Hospital at the time of the second stream of the s	Immediate Jeopardy status- 22@ 4pm. aced on 1:1 monitoring beginning @ 8: ere notified. Medication orders were re havioral Hospital @3:30 pm on 4/11/22 cility licensed nursing staff on 4/11/22 cility licensed nursing am. Verbal report was trained as the second of the past of the	30 am on 4/11/22. Attending MD ceived. He remained on 1:1 2. He remains at the Behavioral 2. 8:21 am with no visible injuries e notified. Responsible party later e notified of family's request and insferred to a hospital on 4/11/22 @ s received from nurse at Hospital re collected during exam and are not mood and in no immediate weeks with no noted skin issues or 1/22 @ 6am. Attending ital. Resident remained on 4:45 pm. He remains at a njuries noted. He was placed on not included on 4/12/22@ 7am with no completed by licensed nursing staff of 4/13/22 @t 11 am and cal aggressive behaviors with none is:30 pm by ADON. I and interventions were discussed. Impleted @ 6:30pm on 4/13/22 Total and no completed @ 10:30 am on
	(continued on next page)		

F 0726 Level of Harm - Immediate hypopardy to resident health or safety (E	UMMARY STATEMENT OF DEFICE ach deficiency must be preceded by 11b) Supervision and Monitoring of acilitate monitoring of unit. Staff we allway on Hall 3 while care is bein vith these roles and to notify the nu	CIENCIES full regulatory or LSC identifying informati f Hall 3/Secure Unit. Content discussedere educated that one staff would be mig delivered by the other staff member.	agency. on) d and procedures discussed to
(X4) ID PREFIX TAG F 0726 Level of Harm - Immediate jeopardy to resident health or safety 1	UMMARY STATEMENT OF DEFICE ach deficiency must be preceded by 11b) Supervision and Monitoring of acilitate monitoring of unit. Staff we allway on Hall 3 while care is bein vith these roles and to notify the nu	tact the nursing home or the state survey. CIENCIES full regulatory or LSC identifying informati f Hall 3/Secure Unit. Content discusser ere educated that one staff would be m g delivered by the other staff member.	on) d and procedures discussed to
(X4) ID PREFIX TAG F 0726 Level of Harm - Immediate jeopardy to resident health or safety 1	UMMARY STATEMENT OF DEFICE ach deficiency must be preceded by 11b) Supervision and Monitoring of acilitate monitoring of unit. Staff we allway on Hall 3 while care is bein vith these roles and to notify the nu	CIENCIES full regulatory or LSC identifying informati f Hall 3/Secure Unit. Content discussedere educated that one staff would be mig delivered by the other staff member.	on) d and procedures discussed to
Level of Harm - Immediate jeopardy to resident health or safety fa h w 1	acilitate monitoring of unit. Staff we allway on Hall 3 while care is bein vith these roles and to notify the nu	ere educated that one staff would be m g delivered by the other staff member.	
4 a a a a 1 1 1 5 c c 1 1 6 T 1 ir c c 1 1 s 1 A A ir c c A e e 1 1 fa Ir R	subsequent sessions on 4/14/22@eginning 4/15/22 @ 6 am complet 11c) Abuse -Content Abuse Coord 1/13/22@10:30 am, Follow up sessittendees 63 Subsequent sessions ttendees Follow up sessions on 4/2. Facility staff were provided edu 2a) Behavior Assessment, Interversion pm, Completed @ 5:50 pm on completed by 945 am. Total attended 2b) Unmanageable Residents - corologo pm on 4/14/22 Attendees 35 For 10cluding reporting procedures, interversion pm, attended 29. 3. Facility were provided education coulding reporting procedures, interversion pm, and 15b am. Total attended 4. Staff who were not on duty will taff will be allowed to work on the 5a, and 15b am. Administrator, DON, and MDS Coordinary and 15b among the staff of the second policies of the secon	ention and Monitoring - content included 4/14/22 Attendees 32. Follow up sess ees 22. Content included facility policy. Initiated 4 Follow up sessions on 4/15/22 beginning in by DON/Designee on resident to residence and documentation procedures 27. The benotified, to come to the facility for each floor until education has been complete ardinator will monitor for employee complete and HR Director will conduct audits and education. Staff are being notified to diffications started on 4/14/22 @ 3:30 perdinator will continue to audit, notify, are	is needed. Initiated 4/13/22@ m on 4/13/22. Total attendees 50 tendees Follow up sessions se Prohibition Guideline. Initiated @ 6:30 pm on 4/13/22. Total ed @ 10:30 am on 4/14/22- 17 ed 5 am. Total attendees 29. difficulty policy. Initiated 4/14/22@ ion on 4/15/22 beginning at 6 am. difficulty policy. Initiated 4/14/22@ ion on 4/15/22 beginning at 6 am. dent-resident altercations, content res. Initiated 4/15/22 at 6am. ducation by the DON/designee. No ed for items #13, #14a, #14b, #14c, eletion of required education topics and to report to facility for education m and are continuing on 4/15/22. Indiginal provide education items until all eside in the facility in the session of the session in the facility in the session items and all education items until all eside in the facility in the session in t

F 0726 16. Level of Harm - Immediate jeopardy to resident health or safety The Residents Affected - Some 16th August 17. Mo Ob and		1	04/15/2022	
(X4) ID PREFIX TAG F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some 16t Auc 17. mo Mo Ob and			STREET ADDRESS, CITY, STATE, ZIP CODE 700 N Herndon Kirbyville, TX 75956	
F 0726 16. Level of Harm - Immediate jeopardy to resident health or safety The Residents Affected - Some 16th August 17. Mo Ob and	correct this deficiency, please con	l tact the nursing home or the state survey a	agency.	
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jeopardy to resident health or safety The Residents Affected - Some 16t Auc 17. mo Mo Ob	16. Compliance will be monitored through:			
werep obs Sta Sta adr pro Sta fac Sta inte Re: Re: Re:	ministrator during Clinical meeting DON and administrator will control of Pindings will submitted to the dits and corrective actions if indifferent procedures by V.P. Of Control of the facility Administrator and the Entitoring procedures by V.P. Of Control of the facility's plan or reservations, interviews, and record included 9 residents, 6 nurses es, activity director, activity coording procedures. Staff provide the facility the Abusting procedures. Staff provides the requirement of the facility the Abustinistrator and were able to give examples of the facility assessment procedures. If were able to identify the Abustinistrator and were able to give examples of the facility assessment procedures. If were able to give examples of the facility assessment procedures. If were able to identify Unmana of the facility assessment procedures. If were able to give examples of the facility assessment procedures. If were able to administration procedure and documentation p	ON were provided education on completinical Operations. emoval occurred on 04/15/22 and included reviews were conducted on 04/15/22 including charge nurses, treatment nurdinator, BOM, housekeeping, dietary si were able to identify inappropriate resid appropriate resident supervision and red supervision and monitoring of Hall e Coordinator, indicated reporting was example of physical, verbal, sexual absolute to residents and indicated appropriate resident to resident altercation rocedures. Fireident to resident-resident altercation rocedures. Fireident to recall the incident. Fireident to recall the incident. Fireident to recall the incident.	this will be an ongoing process. additional iance and ded the following: 2 from 12:00 p.m. through 4:35 p.m. se, MDS nurse, 6 certified nurse taff, and the ADON and DON that dent to resident touching and redirection. There were no 3/Secure Unit. immediate to the charge nurse or ouse and immediate intervention on, appropriate notification, and oriate facility policy. ns, reporting procedures,	
Re:	sident #5 did not recall the incid	ent and displayed no signs of anxiety.		

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