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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Abbreviated Survey was conducted 05/07/19 through 05/09/19. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey. The census in this 170 certified bed facility was 158 at the time of the survey. The survey sample consisted of 8 resident reviews (Residents #1 through 8).	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		6/18/19

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

Electronically Signed | 05/24/2019

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F 584	Continued From page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure a wheelchair was in good repair and safe operating condition for one of eight residents in the survey sample. Resident #4 was seated in a Broda chair that had torn side cushions and a footrest in disrepair. The findings include: Resident #4 was admitted to the facility on 1/17/19 with diagnoses that included dementia with behaviors, vertigo, hypothyroidism, cerebrovascular disease, anxiety, chronic pain syndrome and constipation. The minimum data set (MDS) dated 4/10/19 assessed Resident #4 with short and long-term memory problems and severely impaired cognitive skills. On 5/7/19 at 11:45 a.m., Resident #4 was observed seated in a Broda wheelchair in the	F 584	F 584 1. The Broda chair identified for Resident #4 has been replaced on 05/8/2019. 2. Quality review will be completed on Broda chairs assigned to residents to ensure equipment is in good repair and safe operating condition by 05/31/2019. 3. Staff re-educated by the Maintenance Director/designee to ensure Broda chairs assigned to residents are in good repair and safe operating condition by 06/18/2019. 4. Maintenance Director/designee to conduct quality monitoring of Broda chairs assigned to residents are in good repair and safe operating condition, 3 times weekly x 2 weeks, weekly x 4 weeks,	

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F 584	Continued From page 2 dining room. The right side cushion below the armrest had a large torn area with interior cushion material visible. On 5/7/19 at 4:05 p.m., Resident #4 was in bed. The resident's Broda chair was inspected again. In addition to the torn right side cushion, torn spots were noted on the left side cushion. The left footrest was cracked where it attached to the support rod. The left footrest was dysfunctional, as it would not stay in the up position. On 5/7/19 at 4:10 p.m., the registered nurse (RN #2) caring for Resident #4 was interviewed about the condition of the Broda chair. RN #2 stated she did not know anything about the chair. RN #2 stated she saw that the footrest would not stay up. RN #2 stated therapy provided the Broda chair. On 5/7/19 at 11:00 a.m., the occupational therapist (OT) was interviewed about Resident #4's Broda chair. The OT stated the resident was provided the Broda chair for improved positioning. The OT stated when the chair was issued, the footrest was not broken and she did not notice the torn cushions. This finding was reviewed with the administrator and director of nursing during a meeting on 5/8/19 at 4:30 p.m.	F 584	then monthly x 3 months. Findings to be reported to QAPI committee monthly by maintenance director and updated as indicated. Quality monitoring schedule modified based on findings. 5. Allegation of Compliance: 06/18/2019	
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property,	F 600		6/21/19

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and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a) The facility must-

§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to ensure two of eight residents were free from sexual abuse. Facility staff failed to provide adequate supervision and implement effective interventions to protect Residents #6 and #7 from sexual abuse by Resident #5 on the dementia care unit. Staff members observed Resident #7, with severe cognitive impairment and wandering behavior, in Resident #5's bed. Resident #5, with a history and ongoing treatments for sexually aggressive behaviors had his hand in Resident #7's pants/brief with his penis exposed. Resident #5 was then observed on top of Resident #7 in his bed while exposed. Three days later, staff observed Resident #5 sexually abusing Resident #6 in the dining room.

The findings include:

1. Resident #5 was originally admitted to the facility on 10/24/2017 and readmitted on 01/26/2019 with diagnoses including, but not limited to: Dementia with Behaviors, Depression, PTSD (post traumatic stress disorder), Seizures,

F 600

Resident #5 discharged from the center on 4/16/2019, the hospital was notified that the resident will not be allowed to readmit to the facility. A head to toe assessment was completed on Resident #6 and #7 with no negative findings noted 5/10/19. A psychosocial evaluation was completed by social services on 5/21/2019 for Resident #6 and #7 with no negative findings.

All residents have the potential to be affected by this deficient practice. The Social Services Director and the Director of Nursing will conduct resident interviews of all interviewable residents to ensure free from sexual abuse by 5/31/2019. The Assistant Director of Nursing will complete head to toe assessments of all non-interviewable residents to ensure no signs/symptoms of abuse by 5/31/2019. Quality Assurance review of other residents with sexual behaviors to be conducted to ensure appropriate

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F 600	Continued From page 4 Legally Blind, Hypertension and Diabetes. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 02/19/19. Resident #5 was assessed as moderately impaired in his cognitive status with a total cognitive score of 10 out of 15. This MDS documented the resident wandered and had behaviors directed toward others almost daily. Resident #5's clinical record was reviewed on 05/08/2019 at approximately 2:00 p.m. Social Service Progress Notes included: 6/27/2018 - "...Behavior Status: Sexually Inapp. (inappropriate). Urinating on floor..." 9/25/2018 - "...Behavior Status: Sexually Inapp. Taking off clothes. Urinating on floor. Sitting self on floor..." 11/21/2018 - "...Sensory/Communication Status...Inappropriate responses at times...Behavior Status: Other behavioral symptoms not directed toward others. Wandering. Standing up on bed/chairs..." 2/19/2019 - "...Behavior Status: Verbal behavioral symptoms directed toward others. Sexually Inapp. Taking Clothes Off..." 3/4/2019 - "...Behavior Status: Taking off clothes. Wandering. Climbing 1/2 wall. Urinating on floor. Sexually Inapp...Resident unable to be in Dayroom at times-refusing to keep clothes on..." Documentation in the "Interdisciplinary Progress Notes" included the following: 12-19-18 at 0500 (5:00 a.m.) "Resident up during	F 600	interventions are in place, to include monitoring of behaviors by nursing staff and using behavioral symptoms Section E 0200 of the Minimum Data Set to determine appropriate interventions are in place and care setting by 5/31/2019. Any identified areas of concern will be addressed in accordance with the facility abuse and neglect policy. Corrective Actions All staff will be educated by Division Clinical Quality Specialist on abuse, types of abuse, training, prevention, identification, investigating, protection, reporting/response, resident's rights, reporting reasonable suspicion of a crime, and Elder Justice Act by 6/15/2019. This included a leadership and department head education conducted by the Vice President of Operations and the Clinical Quality Specialist on 5/13/19, prior to education being conducted with all other staff members. All staff will be required to acknowledge a Freedom from abuse notice to employees in addition to taking an abuse competency exam. This education specifically addressed prevention and protection for residents once an issue has been identified. Facility IDT team to conduct Zone Rounds daily. Rounds include specifically the monitoring for safety, supervision, and monitoring for any potential abuse situation including Involuntary Seclusion. This includes the weekend manager on duty process. Results of Zone rounds	

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F 600	Continued From page 5 entire 11-7 shift. Took brief off multiple times, urinated on floor and bed and took clothes off. Snacks and water given but behaviors continued throughout night." 1-8-19 at 0500 "Resident...sexually inappropriate with staff, pulling his penis out of brief, laying on bed trying to get staff to perform oral sex. Staff redirected him and told him he was inappropriate. Resident didn't respond after that. Continue throughout the night with other behaviors." 1-19-19 at 1400 (2:00 p.m.) "Resident has been walking into other residents room, redirected by staff. Has been making sexual remarks to staff offering to pay money for sex. Assisted to chair at nurse station where he began to pull pants down and expose himself. Assisted back to room..." 1-20-19 at 2100 (9:00 p.m.) "Resident being walked to dinning (sic) room, restless, making unsafe solo transfer OOB (out of bed). On way to dinning (sic) room, resident grabbed both of CNA's (certified nursing assistant) wrist, bent and shook her, required two other staff members to get resident to release her. Given 1:1; snacks and calmed down. Resident again jumps up out of chair, starts swinging for no apparent reason. 1:1; remained calm. Had to recalm resident. MD (physician) called. No medical orders." 1-21-19 at 0700 (7:00 a.m.) "Resident up all night wandering into other rooms, removing his brief constantly and urinating in the floor, sat on night stand and attempted to climb on bed. Unable to redirect most of the night." 2-1-19 at 2:00 p.m. "...Resident ambulating in the	F 600	audits to be submitted to the NHA weekly. NHA to report on results of Zone Rounds audits to QAPI monthly Social Service Director to conduct random interviews of 5 interviewable residents weekly to ensure free from sexual abuse. Assistant director of nursing to conduct 10 head to toe assessments for non-interviewable residents to ensure no signs and symptoms of abuse weekly x 8 weeks. Findings to be reported to QAPI committee monthly and updated as indicated. The Quality Assurance and Performance Improvement (QAPI) Committee is responsible for the on-going monitoring for compliance. Allegation of Compliance: 06/21/2019	

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halls. Making inappropriate responses (sexual) to staff..."

2-8-19 7-3: "Staff came to this writter (sic) and stated that the 'resident was on his knees given oral sex to the chair.' (sic) This writter (sic) removed the resident from the dinning (sic) room where he was at, to his room away from the other residents. Dr. (Name) was called and prescribed Medroxyprogesterone 10 mg (milligrams) daily. Resident would try to grab you while walking him to his room, he came out of his room playing with his nipples..."

2-10-19 7-3: "...Resident asking staff for sex earlier in the shift. Resident redirected to his room..."

2-16-19 3-11: "...Resident was in dining area and was seen by other residents and staff with his hand up another residents shirt. Residents separated, education done with resident about inappropriate behaviors. Resident denied any wrong doing..."

2-25-19 at 0230 (2:30 a.m.) "Resident up during this shift wandering, disrupting other residents who are sleeping and telling female staff that he wants to talk to them about sex. Is not able to be redirected entire night. While sitting in dining room, resident got up from chair and climbed onto the top of the divided wall. Took several minutes to redirect with assistance of one other staff member."

03-08-2018 "IDT (Interdisciplinary Team) met to discuss resident in weekly behavior meeting. Resident cont on Abilify for depression. Resident has behaviors of sitting on floor, sexual

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behaviors, wandering and disrobing..."

3-10-19 7a-3p "Resident has been up wandering in halls and into rooms. Grabbed a female's hand in hallway. Residents separated and redirected."

3-18-19 0600 (6:00 a.m.) "Resident up most of night wandering and disturbing other residents. Unable to redirect, continues to take brief off and urinate in floor multiple times during shift and walks into hallway naked touching his genitals."

3-25-19 at 0640 (6:40 a.m.) "Resident has been awake during entire shift. Disturbing other residents, walking into hallway naked, continues to take off dry briefs and urinate in the floor and unable to redirect entire shift. Resident taken to dining room and he pushed around chairs and tables. When trying to redirect, resident became combative with staff..."

3-30-19 at 1530 (3:30 p.m.) "Resident closed door to room, staff checked resident. Resident observed pulling on fluorescent light above roommate's bed. Light cover, one fluorescent bulb and parts associated in resident's hands and the roommate bed. Resident sat on roommate's bed. Redirected and reoriented to room and safety policies. Resident cont to require frequent checks and redirection."

4-6-19 12:30 p.m. "Resident noted to be sexually inappropriate with staff, attempting to touch them. Very hard to redirect. Wandering the unit. When redirected to his room resident goes through the bathroom into another resident's room in which he keeps coming to the nurse's station asking for someone to get him out. Psych doctor paged and gave new orders to increase

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Medroxyprogesterone to 40 mg Q day (everyday)..."

4-13-19 at 1443 (2:43 p.m.) "Resident with increased sexual behaviors. Redirected and 1:1 offered. Dr. (Name) at (Hospital) notified, verbal order given...Dr. (Name) will follow up with resident on Thursday..." There was no mention of the incident with Resident #7 that happened on this date in Resident #5's clinical record.

4-14-19 at 1630 (4:30 p.m.) "This nurse tried to redirect resident to his room as he was wandering in hallway with shuffling gait. Resident stated, 'I have to be out to fuck.' I stated to resident that was inappropriate and touched his arm to redirect to his room. Resident grabbed this nurses arm with both hands and began twisting it painfully stating 'then lets go to my room and make it a good visit.' I asked the resident to let go, resident twisted harder. I asked again and resident stated 'I like what I see and I need to fuck.' I then yelled for assistance. CNA's took resident off my arm and redirected to room. UM (unit manager) called NP (nurse practitioner) on call (Name) consulted Dr. (Name) to send to ER (emergency room) for eval due to sexual aggression, assault to staff, non-directable behaviors with aggression, for the safety of the resident safety of other residents and staff..." (sic)

4-16-19 2:35 p.m. "Resident s/p (status post) behavior day 3. Resident wandering halls this shift. Resident noted to be taking his clothes off..."

4-16-19 3-11P "At approximately 1630 (4:30 p.m.) resident standing on roommate bed, pulling on light fixtures, this nurse and 2 CNA assisted off

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bed to floor, resident than began touching self. (sic) Redirected and assisted resident to dining area. At approx 1725 (5:25 p.m.) a resident yelled, and this nurse observed resident with one hand in a female resident's pants with other hand on her breast. Resident was redirected, son called to assist in redirection. Several moments later resident repeated behavior with same female resident and became aggressive with 2 CNA's who approached and attempted to redirect. This nurse again assisted in redirection, directed resident to sit at table for dinner. Discussed with UM and MD on call. (Name) City Police arrived, resident displayed no behaviors at that time, and told police nothing happened. After police exited, resident briefly rested in the dining area. Approx 2100 (9:00 p.m.), after resident had returned to room resident exited room and was ambulating unit hall wearing only t-shirt, resident was toileted and cont to ambulate without pants and brief, following this nurse, and was unable to redirect. Resident was assisted to dining room, another brief was put on. Moments later resident at nurse desk without pants and brief. Resident's son called again. Resident sat in chair without pants and brief talking with son. 2153 (9:53 p.m.) (Name) City Police escorted resident out of building."

Behavior Symptom Monitoring Flow Records dated December 2018 through April 16, 2019 showed repeated documentation of Resident #5 wandering, sitting self on floor, standing on bed/chairs, urinating on floors, taking clothes off, sexual inappropriateness, and combativeness. On 4/16/19, the day Resident #5 was removed from the facility by the police, documentation at 4:30 p.m., 5:25 p.m., and 9:10 p.m. included sexual inappropriateness.

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The DON (director of nursing) went before the magistrate on 4/16/19 to obtain an ECO (emergency custody order) to have Resident #5 removed from the facility. The ECO was obtained 4/16/19 at 8:52 p.m.

Geriatric Psychiatry Notes included:
1/31/19 - "...Dementia with behaviors...Staff report increased sexual behaviors over last few months - touching female breasts and making sexual statements. Put his hands down shirt of female residents...Plan: Sexual behaviors may have worsened secondary to decreased SNRI [Serotonin Norepinephrine Reuptake Inhibitor] (Sept. 2018) or decreased Abilify (Dec 2018). Will increase Venlafaxine back to 225, daily to help decrease libido. If no change, consider oral medroxyprogesterone."

2/14/19 - "...dementia with behaviors. Seen 2 weeks ago when Venlafaxine increased for hypersexual behaviors. Staff called me 2/8/19 secondary to pt. performing oral sex on chair leg and continued groping of female staff/residents. Started oral medroxyprogesterone...Plan: Will attempt to reduce aripiprazole to 2.5, daily to reduce parkinsonism. Cont other meds for now."

3/21/19 - "I have seen and evaluated this 61 yo (year old) male for inappropriate sexual behavior. Last seen 2/14/19 when Abilify decreased to reduce EPS (extrapyramidal symptoms). Staff report worse sexual behaviors - he has been wandering into residents rooms, attempting to grope female staff/residents. On exam he denies...Plan: As pt threatening safety of other residents will increase MPA to 20 mg, daily. Will also add prn trazodone for sleep ..."

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Physician Progress Note written by the PA (physician assistant) dated 03/06/2019 included: "...He recently has had increased behaviors of episodes of sexually inappropriate behavior. He is following Dr. (Name) for psych med management..."

Resident #5's CCP (comprehensive care plan) included: "Focus: ...psychosocial well-being problem...Interventions: Consult with: Pastoral care, Social services, Psych services as he or his family requests...When conflict arises, remove (Name) Resident #5 to a calm safe environment and allow to vent/share feelings...Date Initiated: 10/03/2018."

"Focus: (Name) Resident #5 has a behavior problem urinating on floor, wandering, getting up in the middle of the night with confusion, sits self on floor, prefers to be nude, sleeps in others beds, stands up on furniture, sexually inappropriate r/t (related to) vascular dementia...Interventions: ...Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Date Initiated: 10/03/2018."

Resident #7 was admitted to the facility on 5/1/13 with a re-admission on 7/16/15. Diagnoses for Resident #7 included dementia, high blood pressure, psychosis, depression and dysphagia. The minimum data set (MDS) dated 4/25/19 assessed Resident #7 with short and long-term

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memory problems and severely impaired cognitive skills. This MDS listed the resident had wandering behaviors and was rarely and/or never able to make herself understood.

Resident #7's clinical record documented a nursing note dated 4/13/19 stating, "At 1:45 PM, this writer was alerted by CNA's [certified nurses' aides] that resident was observed laying in [Resident #5's] bed. [Resident #5] was observed [with] his hand down this residents pants and had his penis exposed. This resident was immediately redirected and taken to her room. Skin noted to be warm, dry and intact. Resident had no s/s [signs/symptoms] of distress. 15 minute checks implemented. Staff will ensure residents do not ambulate around other residents room, and during mealtimes residents will sit on opposite sides of the dining room while staff monitors the area..." (sic)

The facility's investigation dated 4/16/19 documented, "...After investigation, facility is able to substantiate resident to resident encounter at it was witnessed by staff. Both residents currently reside on [dementia care unit]. The residents were separated immediately; room changes have been refused by responsible parties as both residents exhibit exit seeking behaviors and require a locked unit. No further interactions have occurred between residents..."

The facility's investigation included written witness statements from staff members working at the time of the incident.

A written statement by the housekeeper dated 4/13/19 documented, "I was going to clean [Resident #5's] room and the door was shut so I

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knocked on the door and then opened it. When I opened the door [Resident #5] was standing in front of [Resident #7] with his brief and pants pulled down and [Resident #7] was sitting on the bed. I went to the nurses station to let them know and [CNA #5 and CNA #6] went to the room and when they opened the door [Resident #5] was on top of [Resident #7] with his pants down. They got [Resident #7] out of the room."

CNA #5's written statement dated 4/13/19 documented, "...housekeeper...came and got me & [CNA #6] because [Resident #5] had [Resident #7] on his bed with his hand inside her pants, Also [Resident #5] had his penis exposed...Earlier during lunch he also was trying to touch her in the dinning [dining] room." (sic)

CNA # 6's statement dated 4/13/19 documented, "...were alarted [alerted] by a staff member...of house keeping that resident [#5] had another resident in his room [with] the door closed. Upon arriving to his room [Resident #5] had his pants down on the floor penis exposed with his hand in [Resident #7's] breif [brief]..." (sic)

Resident #7's clinical record documented the resident had a history of wandering about the secured dementia unit. A care plan note dated 3/12/19 documented the resident was oriented to self only, frequently refused to respond and daily walked about the dementia care unit independently. Resident #7's plan of care (revised 3/13/19) listed the resident had wandering and exit seeking behaviors, impaired safety awareness, impaired cognition, garbled speech and impaired decision-making abilities. Interventions to minimize behaviors included, "Anticipate and meet [Resident #7's]

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needs...Explain all procedures...Intervene as necessary to protect the rights and safety of others...Divert attention. Remove from situation and take to alternate location as needed...Monitor behavior episodes and attempt to determine underlying cause...Check placement of wander guard...Distract [Resident #7] from wandering by offering pleasant diversion, structured activities, food, conversation...Identify pattern of wandering..."

On 5/8/19 at 12:30 p.m., the licensed practical nurse (LPN #2) working on the dementia unit on 4/13/19 was interviewed. LPN #2 stated that on 4/13/19 the housekeeper reported a resident was in Resident #5's room. LPN #2 stated she went to Resident #5's room with other staff. LPN #2 stated when she walked in the room Resident #7 was on the bed with Resident #5 standing with his pants/brief down and penis exposed. LPN #2 stated Resident #5 was known to make sexual comments and have sexual behaviors. LPN #2 stated Resident #7 and Resident #5 were independently ambulatory on the unit, with Resident #7 wandering about the unit daily. When asked what interventions were in place to prevent this incident, LPN #2 stated staff members were supposed to monitor the residents and redirect them as needed.

On 5/8/19 at 2:45 p.m., the housekeeper that first witnessed the 4/13/19 incident was interviewed. The housekeeper stated she cleaned rooms routinely on the dementia care unit. The housekeeper stated that on 4/13/19 she went to clean Resident #5's room. The housekeeper stated the door to Resident #5's room was closed so she knocked, got no answer and then entered the room. The housekeeper stated Resident #7

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was sitting on the edge of Resident #5's bed near the head of the bed. The housekeeper stated Resident #5 was standing in front of Resident #7 with his pants/brief down and his penis exposed. The housekeeper stated she went to the nursing station and reported her observation and followed staff back to Resident #5's room. The housekeeper stated when they got back to the room, Resident #5 was on top of Resident #7 in bed. The housekeeper stated Resident #7 had her clothes on but Resident #5's penis was exposed with his pants/brief down. The housekeeper stated she had seen Resident #5 grab another resident's (Resident #8) breast before and grabbed at residents' arms when they went by him in the hallway. The housekeeper stated she did not report the witnessed grabbing of Resident #8's breast because nurses and aides were present at the time and were already aware of the incident.

On 5/9/19 at 10:00 a.m., the director of nursing (DON) and administrator were interviewed about Resident #7's abuse on 4/13/19. The DON stated Resident #5 had a history of sexually aggressive and physical behaviors and had multiple medication changes in attempt to manage behaviors. The DON stated prior to the incident on 4/13/19 with Resident #7, the interventions in place to ensure safety included redirection and separating Resident #5 from inappropriate interactions with other residents. The DON stated they did not want Resident #5 "pulling or hanging onto" other residents or staff members. The DON stated supervision was the main intervention along with attempting to "anticipate things." The DON stated they also tried to provide consistent caregivers for Resident #5.

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These findings were reviewed with the administrator, director of nursing and corporate consultant during a meeting on 5/9/19 at 10:30 a.m.
2. Resident #6 was admitted to the facility on 06/11/2018 with diagnoses including, but not limited to: Alzheimer's Disease, Dementia, Anxiety, Depression, Hypertension and Heart Failure.

The most recent MDS was a quarterly assessment with an ARD of 03/28/2019. Resident #6 was assessed as severely impaired in her short and long term memory and daily decision making skills.

Resident #6's clinical record was reviewed on 05/08/19 at approximately 3:00 p.m. An Interdisciplinary Progress Note dated 4/16/19 included: "Resident involved with another resident who was sexually inappropriate by being observed having one hand in her pants and one hand on her breast in the dining area x2 (times two) this evening..."

A note dated 4/17/19 7p-7a: "Resident rested well with no signs or symptoms of distress or anxiety. Verbally states 'I am okay.' 'No, I am not in pain.'..."

A second note dated 4/17/19 7a-7p: "Resident s/p (status post) incident day #1. No unusual behaviors. No c/o (complaints of) pain/discomfort..." No further documentation was noted in the clinical record.

The Director of Social Services was interviewed at 3:30 p.m. on 5/8/19 regarding any follow-up

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visits with Residents #6 and #7. She stated, "We did not interview either of those ladies. I really can't tell you why. Sometimes the nurses document everything and sometimes we do. If I don't know about it directly, then I don't document. If I do an interview or evaluation then I document it in the record."

At 5:30 p.m. the DON was interviewed regarding expectations of the Social Worker. The DON stated, "There is no policy. It is a reasonable expectation they would do an assessment."

The CCP for Resident #6 did not include any documentation regarding the incident from 4/16/19 or any documentation for emotional or physical distress.

On 5/8/2019 at 2:45 p.m., LPN #1 (licensed practical nurse) and also UM (unit manager) was interviewed regarding if an assessment was completed on Resident #6 on 4/16/19. LPN #6 stated, "LPN #4 did complete a head to toe assessment. It was documented on a skin evaluation sheet. Perineal area was assessed. No issues were noted. She (LPN #4) handed me the assessment when completed and I gave to (Name) DON. There were no changes in her (Resident #6) behavior after the incident."

CNA #1 was interviewed at 2:55 p.m. regarding the incident between Resident #5 and Resident #6 that occurred on 04/16/2019. CNA #1 stated, "I was in the dining room charting. He walked up behind her and put his hand down her shirt. We moved him to the other side of the room. He walked right back over to her and put his hand down the back of her pants. That's when we took him to his room. He was up on his roommate's

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bed after we took him back to his room. I never saw him touch any other residents until (Name) Resident #6. He would touch staff and say sexual things. We would redirect him and he would stop. Some days he wouldn't do or say anything sexual and other days we would take him to his room, give him lotion and tissues and let him go at it."

LPN #2 was interviewed at 3:05 p.m. regarding Resident #5 and his behaviors. LPN #2 stated, "He would walk by and grab your (staff) butt, a firm grab. Prior to (Name) Resident #7 I had not seen him do anything to another resident."

RN #1 (registered nurse) was interviewed at 3:10 p.m. regarding the incident on 4/16/19 that involved Resident #5 and Resident #6. RN #1 stated, "He (Resident #5) put his hand on her breast on the outside of her shirt and put his hand down her pants. She just sat there. She can be verbal, but not appropriately. Actually, another resident yelled out. We redirected him and then he did it again. That is when we removed him from the dining room. (Name) Unit Manager stated there had been another episode over the weekend with another resident. They tried to get him to the ER then. I don't know if he went or not. I was working the Northside of the unit that day and she was on the Southside. I did notice a change in her (Resident #6), but nothing I could put my finger on to document. Like I said, I was working the other side of the unit that day and wasn't directly caring for her. I did ask the UM what the long term plan for him was because he could not be redirected or calmed down. That is when we called and got an order to send him out to the ER."

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LPN #16 was interviewed on 05/09/2019 at 8:40 a.m. regarding an incident on 2/8/19 with Resident #5 and an unidentified resident. LPN #18 stated, "I don't remember anything other than what I wrote there. I called Dr. (Name) and she gave a med order. I gave it at 2:20 p.m. when it came in and then I leave at 3:00. I don't usually work that unit. I believe I was pulled over there that day."

LPN #4 was interviewed at 8:50 a.m. regarding the incident on 4/16/19 with Residents #5 and #6. LPN #4 stated, "I believe I was working the day of (Name) Resident #6. I didn't witness anything. I took him to his room and the other nurse working contacted everybody. I never saw him touching anyone. He never said anything inappropriate to me and I never heard him say anything to anyone else." Regarding Resident #6 and any changes in her behavior or demeanor, LPN #4 stated, "I haven't noticed any changes in behavior for her. I did do a head to toe assessment including the peri area that day. I didn't find anything."

The DON was interviewed at 9:55 a.m. on how Resident #5 's behaviors were handled by staff. The DON stated, "Ongoing monitoring. Re-direct, re-direct, re-direct. Separate him. Med management. He responded very well to one CNA, so we would try to assign that CNA to him. He was really good at redirecting him."

At 10:00 a.m., NP #1 (nurse practitioner) was interviewed regarding the two incidences with Resident #5 and Residents #6 and #7. NP #1 stated, "I wasn't on-call for the first incident (with Resident #7), but talking to (Name) NP #2, from memory the facility called her about this resident (Resident #6). The police refused to take

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Resident #5 without an ECO. We do not go to the magistrate and get an order to ECO somebody. We are on-call for several different places and we can't do that. (Name) NP#2 is working today, but in clinic right now. I will ask her to call you, but I don't know what time that will be."

At 10:25 a.m. the DON was interviewed regarding Resident #5 and the incident with Resident #7 that occurred on 04/13/19 and then the incident with Resident #5 and Resident #6 that occurred on 04/16/19. The DON stated, "We tried to get him out of here on the 13th. APS (adult protective services) was here and the police were here. EMS (emergency medical systems) refused to come and transport him (Resident #5). The police told them (EMS) they were here and he (Resident #5) was sitting in a chair and was calm. APS spoke with EMS also, and they still refused."

Reagarding Resident #5's behaviors and the nursing note from 4/14/19. The DON stated, "The police and APS were here again and EMS refused to come and transport him (Resident #5) again." Regarding if the Medical Director was involved in trying to get Resident #5 out to be evaluated, the DON stated, "I don't know who all they were getting orders from. He was aware of the situation. That's all I can say." Regarding the incident that occurred on 4/16/19, the DON stated, "EMS refused to transport this day also. We had to go to the magistrate and get an ECO. The police then transported the resident to the hospital."

At 12:35 p.m. LPN #15 was interviewed about an incident that occurred on 2/16/19 with Resident

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#5. LPN #15 stated, "I do remember the incident, but I can't remember who the female resident was." Regarding the incident on 4/14/19 involving Resident #5, LPN #15 stated, "I wrote that note. Yes, he grabbed my wrists and tried to pull me in his room. I called the police because he had become aggressive. He had gone over the top. I was going to press charges, but the Commonwealth told me they wouldn't charge him because of his dementia, brain injury and he was on a locked unit. He always had behaviors, coming out of his room nude, making sexually inappropriate comments, touching people. I know they did several medication changes, but other than that, no, I don't think anything was done. The NP on that day was great. She was going to come from (City Name) and have him committed that night. I couldn't get him into (Psych Hospital Name). That is why he wasn't sent out. I was very upset and the nurse coming on was upset also. How was one nurse and one CNA going to handle him? What if there was an emergency on the unit?"

At 1:20 p.m., NP #2 was interviewed. NP #2 stated regarding Resident #5's behaviors on 4/14/19, "I got a call the resident was exhibiting aggressive behaviors. I believe he had grabbed a staff member, causing bruising. Staff were not safe, so I thought, send him to the ER for evaluation. I then got a call that the police couldn't take him because he wasn't homicidal or suicidal and was not exhibiting aggressive behavior at the time. The same thing with EMS. That is when I thought he may could get some good rest that night so I canceled the ER order and ordered an extra dose of Trazodone. I did not get anymore calls that night."

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F 600	Continued From page 22 The facility's policy titled Abuse, Neglect, Exploitation & Misappropriation (revised 11/28/17) documented, "It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property...Employees of the center are charged with a continuing obligation to treat residents so they are free from abuse, neglect, mistreatment, and/or misappropriation of property...Sexual abuse is non-consensual sexual contact of any type with a resident. Sexual abuse includes but is not limited to...Unwanted intimate touching of any kind especially of breast or perineal area...sexual contact is non-consensual if the resident either...Appears to want the contact to occur, but lacks the cognitive ability to consent...The Company recognizes that resident abuse can be committed by other residents, visitors, or volunteers...The center is committed to the prevention of abuse, neglect, misappropriation of resident property...The following systems have been implemented...Monitoring of residents who may be at risk is the responsibility of all facility staff. This includes monitoring residents who are at risk or vulnerable for abuse, for indications of changes in behavior, changes in condition or other non-verbal indications of abuse..." No further information was received by the survey team prior to the exit conference on 05/09/19. This is a complaint deficiency.	F 600		
F 603 SS=G	Free from Involuntary Seclusion CFR(s): 483.12(a)(1)	F 603		6/21/19

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F 603	Continued From page 23 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, facility document review and during the course of a complaint investigation, the facility staff failed to ensure one of 8 resident's were free of abuse; Resident #1 was involuntary confined against her will. Resident #1 was put to bed against her will by a staff member. After the resident told the staff member multiple times, yelling and screaming that she did not want to be put to bed, the staff member proceeded to put the resident to bed against her will and refused to get the resident up. Findings include: Resident #1, was originally admitted to the facility on 09/25/12, with the most current readmission on 06/05/17. Diagnoses for Resident #1 included, but were not limited to: obesity, abnormal posture, muscle weakness, hand contracture, depressive disorder, schizophrenia,	F 603	F 603 Resident #1 no longer resides in the center. Staff member identified was terminated from the facility on 5-24-19 and reported to Department of Health Professions on 6/11/19. All residents have the potential to be affected by this deficient practice. The Social Services Director and the Director of Nursing will conduct resident interviews of all interviewable residents to ensure free from involuntary seclusion by 5/31/2019. NHA interviewed family members of non-interviewable residents to determine if any other residents have been affected by 5/31/2019. For residents without families, interviews will be conducted with staff to determine if they have observed any involuntary seclusion of any resident by 5/31/19.	

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F 603	Continued From page 24 mental retardation, intellectually disabled and anxiety disorder. The resident's most current MDS (minimum data set) was a quarterly assessment dated 01/16/19, and documented the resident was a "9" cognitively, indicating the resident had moderate impairment in daily decision making skills. The resident was assessed as requiring extensive assistance for bed mobility and dressing. The resident was assessed as requiring total assistance for transfers, toileting, eating, and bathing. The resident was assessed as requiring extensive assistance for all other ADL's (activities of daily living). In section G0300. "Balance During Transitions and Walking" the resident was assessed and an "8" [activity did not occur] for moving from seated to standing, walking, turning around, and moving on and off toilet. The resident was assessed as not steady, only able to stabilize with staff assistance for surface to surface transfers. The resident was additionally assessed as having impairment on both sides (right/left) for upper and lower extremities for functional limitations in range of motion. On 05/07/19 at approximately 5:00 PM, the investigation for Resident #1 regarding allegations of abuse for Resident #1 were requested. On 05/08/19 at 9:30 AM, the investigation was presented and reviewed. The investigation documented the following: A facility reported incident was filed and completed on 04/12/19 for an incident that occurred on 04/06/19 regarding Resident #1. The description of the incident documented,	F 603	Corrective Actions All staff will be educated by Division Clinical Quality Specialist on abuse, types of abuse, training, prevention, identification, investigating, protection, reporting/response, resident□s rights, reporting reasonable suspicion of a crime, and Elder Justice Act by 6/15/2019.¿This included a leadership and department head education conducted by the Vice President of Operations and the Clinical Quality Specialist on 5/13/19, prior to education being conducted with all other staff members. All staff will be required to acknowledge a Freedom from abuse notice to employees in addition to taking an abuse competency exam.¿This education specifically addressed Involuntary Seclusion and how to prevent and protect residents from being affected. Facility IDT team to conduct Zone Rounds daily. Rounds include specifically the monitoring for safety, supervision, and monitoring for any potential abuse situation including Involuntary Seclusion. This includes the weekend manager on duty process. Results of Zone rounds audits to be submitted to the NHA weekly. NHA to report on results of Zone Rounds audits to QAPI monthly. Social Services Director will conduct random sample of resident, family, and staff interviews for 5 residents to ensure freedom of abuse to include involuntary seclusion weekly x 8 weeks. Findings to be reported to QAPI committee monthly.	

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F 603	Continued From page 25 "...04/12/19 ...two residents [no names documented] came to the DON's [Director of Nursing] office, ADON [Assistant Director of Nursing] and ED [executive director] were in attendance. The two residents alleged that on Saturday 04/6/19, [Resident #1] was 'mistreated' by staff. Both residents stated [Resident #1] was yelling louder than usual while receiving care...Employee action: None. Investigation completed and no action necessary...Facility internal investigation: Completed on 04/12/19..." The following statements were attached to the above facility investigation: A statement by RN (Registered Nurse) #3 [nurse on duty 4//6/19] documented, "...4/6/19 [Resident #1] was extremely upset, crying and hollering...medicated at 1500...continued to be upset...assessment completed and was negative, vital signs WNL [within normal limits]. [CNA #4] told resident that 'if you don't get it together, I'm putting you to bed.' Subsequently during my medpass, [CNA #4] puts resident in her bed. Resident continues to get even more upset... [Resident #1] expressed to me that she did not want to stay in the bed. I returned to the nurses station and asked [CNA #4] if she could please go and get resident out of bed, she [CNA #4] quickly responded, 'No.' She [CNA #4] said, 'you don't know these residents, I've worked here for three years.' [CNA #4] immediately called the unit manager [LPN/licensed practical nurse #13]...signature of RN [#3] 4/6/19...signature of DON 4/9/19" A statement by CNA #4 [alleged perpetrator], dated 04/24/19 documented, "...I, [Name of CNA #4] was in the process of laying [Resident #1]	F 603	Quality monitoring schedule to be modified based on findings. The QAPI Committee is responsible for the on-going monitoring for compliance. Allegation of Compliance: 06/21/2019	

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down and she began to scream loudly. [Names of 3 residents] came to [Resident #1's] window to she [sic] why she was screaming, I told them 'she was fine' and continued to get her situated I finished cleaning her and laying her down, when I came out her [sic] room the same residents that came to her window were now at her door waiting for me to come out. When I did [Resident #10] said to me 'I [CNA] need to get [Resident #1] back up or he was going to report me for torturing her.' I then said to him that I didn't have to explain anything to him regarding [Resident #1] and walked away. I let the charge nurse [RN #3] what [sic] had just happened, I also notified unit manager and DON of the issue...signature of CNA #4 date: 4/24/19...signature of DON date: 4/24/19."

A typed witness statement by the administrator documented in summary that on 4/12/19 [Name of Resident #9 and Resident #10] made an allegation that Resident #1 was mistreated by a staff member, to which they were unable to name alleged staff member, on 4/8/19. They provided details of the situation and felt the resident was being mistreated. It was determined not to have been mistreatment as the staff were attempting to assess and treat the resident for a change of condition. On 4/12/19 the two residents did not provide any additional details of the occurrence. Once they were finished detailing their concerns, they were assured that the ED and DON were aware of the situation in which they were describing and felt that while their concerns were valid, the resident was not being mistreated based upon firsthand knowledge gained by the DON.

A typed witness statement by the DON

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documented, in summary, that on 4/6/19 at approximately 2:30 PM, the DON received a text message from the unit manager (LPN #13) that there was an issue on the unit between CNA #4 and RN #3. Immediately after the text message, CNA #4 called the DON and stated that something was wrong with Resident #1 and that she had put the resident to bed and RN #3 stated that the resident was fine and she needed to be gotten back up. The DON got off the phone with CNA #4 and called the nurses station to speak with RN #3. RN #3 stated that she had checked the resident's vital signs and they were normal and that the resident wanted to get up but CNA #4 refused for the resident to get up. RN #3 stated that she and CNA #4 had an argument about it and CNA #4 was refusing a work assignment. The DON told RN #3 that she thought CNA #4 was advocating for the resident. Neither the nurse (RN #3) nor CNA #4 received disciplinary action. On 4/12/19 a staff member (not named) came to the DON's office and reported that Resident #9 and Resident #10 were talking about Resident #1 being abused. The DON immediately went to the unit and requested that both residents come to her office. They came the office, the ED was present and stated they believed Resident #1 had been abused. The DON explained to them that she understood their perception.

On 05/08/19 at 9:45 AM, the DON (director of nursing) and administrator were interviewed with the survey team present. The DON was asked if CNA #4 was a current employee. The DON stated that she was and that CNA #4 had worked yesterday. The DON stated that two residents were saying that a CNA (unidentified) was mistreating Resident #1 and that the allegations

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were unsubstantiated because they didn't know who the CNA was and that the residents did not provide a name of the CNA. The DON stated that the resident was in "crises" and that CNA #4 was acting as an advocate. The DON was asked what the crises was and the DON stated that the resident had been complaining of chest pain and right arm pain. The DON stated that the staff had called her regarding the "crises" and they were trying to figure out a treatment option. The DON was asked if this resident was in such a crisis, why the resident was not sent out for evaluation. The DON stated that they do an assessment first and that is why the CNA was putting the resident to bed, to get an assessment. The administrator and DON stated that the residents did not give a name as to which CNA was mistreating or abusing the resident. The administrator and DON stated that they interviewed the two residents and no information was provided to help them identify which CNA it was. The administrator stated that the residents did not provide a name and did not even give a description to help with identification.

Interviews were conducted with Resident #9 and Resident #10, both resident's most current MDS information was reviewed prior to the interviews and revealed that both residents were assessed with a cognitive score of 15, indicating the residents were cognitively intact.

On 05/08/19 at 2:50 PM, Resident #9 was interviewed regarding being a witness to the above incident with Resident #1. Resident #9 stated that it happened in the hall and that she was right outside of her door, and saw the whole thing. The resident stated that she was standing in the hall waiting for her lunch tray, at her room,

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right outside the door [actually standing in the hall]. Resident #9 stated that this occurred around lunch time, because staff were passing out lunch trays and that CNA #4 [named the CNA] had brought a lunch tray to her roommate, but had not brought hers yet and she was standing in the hall waiting on hers. Resident #9 stated that Resident #1 was in her wheelchair heading toward the nurse's station when CNA #4 went up the hall and grabbed her wheelchair by the handles and began pulling her backwards towards the resident's room. Resident #9 stated that she didn't see that Resident #1 was doing anything wrong, but once the CNA grabbed her and started pulling her backwards she began yelling and screaming. Resident #9 stated that Resident #1 was yelling and screaming and saying to the CNA, please don't put me to bed, I don't want to go to bed and kept on repeating that over and over again. The resident stated that the CNA pulled her all the way down the hall backwards and into her room and slammed the door shut. Resident #9 stated that Resident #1 was screaming and yelling the whole time. Resident #9 stated that a short while later around 1:00 PM, she and Resident #10 and another resident went out to smoke. Resident #9 stated that Resident #1 was still screaming and yelling and that the courtyard/smoking area is ground level with this unit and Resident #1's room window was open to the courtyard. Resident #9 stated that she and Resident #10 went toward the resident's window to see if she was ok and that CNA #4 pulled the blind back and asked them, what we were looking at and shut the blind back. Resident #9 stated that they tried to report it, but no one wanted to listen. Resident #9 stated that they told the nurse [named RN #3] and asked, "can't you do something." The resident stated

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that the nurse didn't do much of anything and told them, it was out of her hands. Resident #9 stated that she and Resident #10 went down to speak with the DON and administrator, on either Monday [April 8th] or Tuesday [April 9th]; that she thought it was April 8th because it was after Resident #1 died. The resident stated that DON and administrator didn't want to hear from the residents and stated they told them what was heard and seen, and they told us that CNA #4 was doing exactly what she was supposed to be doing.

On 5/8/19 at 3:05 PM an interview was conducted with Resident #10. Resident #10 stated that CNA #4 [named the CNA] was trying to put Resident #1 to bed in the afternoon and Resident #1 was begging, "No, No I don't want to go to bed." Resident #10 stated that Resident #1 was "screaming for all she was worth" and she just kept yelling and screaming that she did not want to go to bed. Resident #10 stated that he went to the nurse's station and talked to the nurse (named -RN #3) and the nurse told CNA #4 to let Resident #1 stay up and CNA #4 told the nurse that she was putting her to bed and that's that. Resident #10 stated that he looked at RN #3 and she just threw her hands up and stated, "It's out of my hands." Resident #10 stated that after Resident #1 died, either Monday or Tuesday that he and Resident #9 had a meeting with the DON and administrator and told them exactly what CNA #4 had done and the DON and administrator told the residents that CNA #4 was doing exactly what she was supposed to. Resident #10 stated, "We were appalled!" Resident #10 stated that the DON and administrator did not want to hear the residents.

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An interview was conducted with RN #3 on 5/8/19 at 3:50 PM. RN #3 stated that she is an agency nurse, but has worked at the facility for a while and knew Resident #1 well. RN #3 stated that Resident #1 wasn't having a very good day. RN #3 stated that CNA #4 was taking Resident #1 to her room and the resident was screaming and hollering. RN #3 stated that the resident yelling out was not an unusual occurrence for the resident, but on this day CNA #4 told the resident "If you don't get your act together I'm going to put you to bed." RN #3 stated that the resident was saying, "Please don't put me to bed" repeatedly and CNA #4 took her straight down the hall to her room. RN #3 was asked when the CNA took the resident down the hall if she pulled the resident backwards down the hall. RN #3 stated, "Yes, I saw her [CNA #4] pulling her [resident] backwards down the hall." RN #3 stated that she finished what she was doing and she and another CNA went down the hall to check on Resident #1. RN #3 stated that they were trying to get the resident calmed. Resident #1 was asked by RN #3 if she [resident] wanted to stay in bed and resident stated, "No." RN #3 stated that once the resident was talked to she'd [resident] calmed down and RN #3 stated that she went and asked CNA #4 to "Please get Resident #1 out of bed", CNA #4 stated, "No." RN #3 stated that "within minutes" of that conversation CNA #4 went and got on the phone with the unit manager (LPN #13) and then the DON. RN #3 stated that she visually saw CNA #4 pulling the resident backwards down the hall and the resident was yelling and hollering that she did not want to go to bed and CNA #4 put the resident to bed anyway, even after she was told by the RN to leave her up. RN #3 stated that CNA #4 kept doing what she was doing, while the resident was trying to

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resist by pushing her feet down on the floor while CNA #4 pulled her backwards. RN #3 was asked if she thought this was appropriate behavior or treatment of Resident #1 by CNA #4 and the RN stated, "No, but she [CNA #4] got on the phone [to DON and UM] and I felt defeated at that point." RN #3 stated that she let the DON and UM know her feelings about the situation and that she [RN] spoke to the UM herself and that the UM informed her that she [UM] was not surprised and had problems with CNA #4 in the past. RN #3 stated that she did talk to the DON, but stated she honestly didn't remember what she had said and then stated that Resident #10 came to her and she told him, "I'm so sorry." RN #3 stated that she remembered telling Resident #10 that "it was out of her hands" because she felt defeated when she tried to get CNA #4 to get the resident back up and the CNA refused and then called the UM and the DON. RN #3 stated that CNA #4 acted like that was her plan.

On 05/08/19 at 4:15 PM CNA #4 was interviewed with the survey team present. CNA #4 was asked to describe the events that took place with Resident #1 on 04/06/19. CNA #4 stated that she had gotten Resident #1 up that morning around 4:30 AM and later in the day the resident started complaining that her arms and legs were hurting. The CNA stated, "I kept telling her if you are hurting I'm going to lay you down." CNA #4 stated that it was reported that the resident had been down in the lobby earlier that day screaming. CNA #4 stated that she laid the resident down around 1:00 PM and that the resident's window was open, which is open to the court yard/smoking area. CNA #4 stated that the resident was screaming and yelling and that it was echoing throughout the courtyard and that

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three residents came over to the window to see what was going on. CNA #4 stated that she told the residents, "I'm doing what is necessary, I said I don't have to explain a reason." CNA #4 stated that she put the blind down in the resident's room and told the agency nurse [RN #3] that "she [resident] needs time to herself."
CNA #4 stated that the residents were accusing her [CNA #4] of abuse and she went immediately to the nurse's station and called the UM [LPN #13] and called the DON. CNA #4 was asked why she called LPN #13 and the DON, what was going on that she felt the need to call upper management. CNA #4 stated, "...because they were accusing me." CNA #4 was asked what the UM said in response to being accused of abuse. CNA #4 stated, "Didn't say a lot, thanked me." CNA #4 was asked what the DON said regarding the allegation of abuse. CNA #4 stated, "The same thing, not much." CNA #4 was asked for clarification as to what the DON said in response to the allegation of abuse. CNA #4 stated that "she didn't say much, she thanked me too." CNA #4 was asked again what was the reason for the immediate phone call to the UM and the DON and the CNA stated, "I called because I was being accused of abuse." CNA #4 was asked if that was the only reason for the phone calls to the UM and DON and the CNA stated, "Yes." CNA #4 was asked why she continued to take the resident to her room if she was screaming and yelling that she did not want to lay down or go to bed. CNA #4 stated that the resident will often lay down and rest and went on to say that the resident had been up since 4:30 AM and she was yelling. CNA #4 was asked if the resident told her that she did not want to go to bed or that she did not want to lay down. CNA #4 stated, "Yes, she did say that." CNA #4 was asked again why she took the

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resident against her will and laid her down, when it was evident that the resident did not want to be in the bed. CNA #4 stated, "That's the thing, she would have been fine." CNA #4 was made aware that the resident did not want to be in bed and did not want to go to bed, but was put in her to bed anyway, against her will. CNA #4 stated that when Resident #1 acts like that the staff normally put her to bed. CNA #4 was asked where did that come from and was asked if that was part of the resident's care plan. CNA #4 stated that she did not know if this was part of the Resident #1's care plan, that it is just what was done. CNA #4 was asked if she pulled the resident down the hall backwards to her room and the CNA stated, "No that sounds like a horror movie [laughed]."

The resident's CCP [comprehensive care plan] was reviewed and documented, "....behavior problem...yelling out when needs aren't met...frequently crying, curses at staff...depression, anxiety, ineffective coping skills...anticipate and meet needs...explain all procedures before starting and allow her time to adjust...intervene as necessary to protect the rights and safety...approach/speak in a calm manner...remove from situation and take to alternate location as needed...monitor behavior..."

On 5/8/19 at 4:50 PM, the administrator and DON were again interviewed in a meeting with the survey team. The DON stated that they report immediately and that they did not feel this was abuse or mistreatment, that they did a 100 % audit and did not reveal any abuse. The DON stated again that the resident was in "crises" and that CNA #4 was being an advocate. The DON stated that the resident has these behaviors and screams and yells and it is common to lay her

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down to get her to calm. The DON was made aware that the resident's comprehensive care plan did not identify that Resident #1 was to be put to bed for behaviors. The DON was made aware of the investigation that included interviews from witnesses and staff that were involved, which did not reveal the resident was in crises, but revealed the resident did not want to be put to bed and was done so against the resident's will. The DON was made aware that the resident repeatedly told the CNA, no and the CNA put the resident to bed and the resident had no way of getting up due to the fact the resident was totally dependent upon staff. The DON was made aware that residents have the right to refuse and choose and that no means no. The DON stated, "I hear what you are saying. The DON stated, "It's not like they described to me." The DON and administrator were made aware of the above interviews and that the information was not matching up and that there was no information and/or documentation that the resident was in "crises" and that the information gathered did not match what the DON and administrator were saying. The DON stated, "It doesn't sound like it."

On 5/8/19 at 6:10 PM, the UM [LPN #13] was interviewed via telephone. The UM stated that on 4/6/19 she received a call from CNA #4 regarding an "issue with the agency nurse." The UM stated that CNA #4 told her that the RN #3 told her to get Resident #1 back and that CNA #4 told the RN, "No" and that CNA #4 had just put her to bed. The UM stated that she told CNA #4 that if the resident is asking to get up, then CNA#4 needs to get her back up. The UM stated that the CNA then told her that "this nurse doesn't know her [resident]." The UM stated that she had a conversation with CNA #4 a week before

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regarding this same thing. The UM stated that she was in her office and that she overheard CNA #4 tell Resident #1 that if she didn't stop yelling she was going to put her to bed. The UM stated that she immediately left her office and confronted CNA #4 and told her that she could not do that and that the CNA again responded to the UM, "if she keeps yelling like that, I'm putting her to bed." The UM stated that CNA #4 did not put Resident #1 to bed that day after this conversation. The UM stated that she got a call from RN #3 after the conversation with CNA #4 and RN #3 had asked CNA #4 to get the resident up and the CNA refused. The UM stated that she reported this information to the DON via phone and had also let the DON know about what had transpired a week prior with CNA #4 wanting to put the resident to bed and stated that the DON responded back that the situation had been taken care of. The UM stated that she did not receive any follow up as to what happened as a result of her reporting this information to the DON. The UM stated that the staff don't get follow up and don't get any information regarding investigations on things like this.

The facility abuse policy [Abuse, Neglect, Exploitation, & Misappropriation] was reviewed and documented, "...Employees of the center are charged with a continuing obligation to treat residents so they are free from abuse, neglect, mistreatment...willful infliction...unreasonable confinement...willful...individual must have acted deliberately...used as a means to correct or control behavior...humiliation, intimidation, fear, shame, agitation or...isolating a resident from social interaction or activities...Neglect...failure to take precautionary measures to protect the health and safety of a resident...failure to report

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observed or suspected abuse, neglect...involuntary seclusion...separation of a resident from other residents or...confinement to his/her room [with or without roommates] against the resident's will...seclude the resident...leaving and closing the door...Acts of abuse directed against residents are absolutely prohibited...All employees have a duty to respect the rights of all resident's to treat them with dignity and to prevent others from violating their rights...any...who witnesses or has knowledge of an act of abuse or allegation of abuse, neglect...is obligated to report such information immediately, but no later than 2 hours...any employee shall be deemed to have violated this obligation...fails to report...abuse witnessed or known...makes a false or misleading or incomplete report of abuse...the abuse coordinator or designee shall investigate all reports...immediately the suspect shall be segregated from residents pending the investigation...any suspect who is an employee or contract service provider identified, will be suspend pending the investigation...once an allegation is reported the executive director is responsible for ensuring that the reporting is completed timely and appropriately...protect the rights of residents...report the results of all investigations to the ED [executive director]...any employee who is found to have committed an act of resident abuse shall be discharged from employment..."

On 05/09/19 at 10:00 AM, a meeting with the DON, administrator and facility quality specialist, was conducted with the survey team. The facility staff were informed of concerns regarding abuse and neglect of Resident #1 by CNA #4. The DON and administrator stated that they did not know of this allegation until 4/12/19, even though the

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F 603	Continued From page 38 interview with CNA #4 revealed that CNA #4 reported the allegation of abuse herself to the DON and the UM via phone on 4/6/19. No further information and/or documentation was presented prior to the exit conference to evidence that CNA #4 did not abuse Resident #1 by putting the resident in involuntary confinement.	F 603		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, facility document review and during the course of a complaint investigation, the facility staff failed to implement policies and procedures that prevent abuse, investigate allegations of abuse, and report abuse, for three of 8 resident's; Resident #1, Resident #7 and Resident #8. 1. Resident #1 was put to bed against her will by a staff member, the act was witnessed and reported to facility management, but the staff member was allowed to continue working with	F 607	F 607 Resident #1 no longer resides in the center. Resident #5 and #7 incidents reported to state agency on 4-15-19. Resident # 5 and #8 incidents reported to the state 5-8-19. For resident #7, resident # 5 no longer resides in the center, and resident # 7 provided with psychosocial evaluation on 5/24/2019 with no negative findings. For resident #8, resident # 5 no longer resides in the center. The allegation was reported and investigated,	6/21/19

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residents and was not suspended while an investigation was conducted. The facility staff failed to implement policies and procedures for investigating abuse and the investigation was not conducted within the specified time frames.

2. Facility staff failed to follow their abuse prevention policies for timely reporting of abuse to the state agency. Staff witnessed sexual abuse of Resident #7 by Resident #5 on 4/13/19 at 1:45 p.m. This incident was not reported to the state agency until 4/15/19, two days after the incident.

3. A housekeeper and nursing staff failed to report the administrator, an observation of Resident #5 grabbing/touching Resident #8's breasts.

Findings include:

1. Resident #1 was originally admitted to the facility on 09/25/12, with the most current readmission on 06/05/17. Diagnoses for Resident #1 included, but were not limited to: obesity, abnormal posture, muscle weakness, hand contracture, depressive disorder, schizophrenia, mental retardation, intellectually disabled and anxiety disorder.

The resident's most current MDS (minimum data set) quarterly assessment dated 01/16/19 was reviewed and documented the resident was a "9" cognitively, indicating the resident had moderate impairment in daily decision making skills. The resident was assessed as requiring extensive assistance for bed mobility and dressing. The resident was assessed as requiring total assistance for transfers, toileting, eating, and bathing. The resident was assessed as required

and the housekeeper was provided one on one education regarding our abuse policies and procedures.

All residents have the potential to be affected by this deficient practice. The Social Services Director and the Director of Nursing will conduct resident interviews of all interviewable residents to ensure free from abuse by 5/31/2019. Family members of non-interviewable residents interviewed to determine if any other residents have been affected by 5/31/2019. For residents without families, interviews will be conducted with staff to determine if they have observed any form of abuse of any resident by 5/31/19.

Corrective Actions

All staff will be educated by Division Clinical Quality Specialist on abuse, types of abuse, training, prevention, identification, investigating, protection, reporting/response, resident's rights, reporting reasonable suspicion of a crime, and Elder Justice Act by 6/18/2019. This included a leadership and department head education conducted by the Vice President of Operations and the Clinical Quality Specialist on 5/13/19, prior to education being conducted with all other staff members. All staff will be required to acknowledge a Freedom from abuse notice to employees in addition to taking an abuse competency exam. This education specifically addressed timely reporting of incidents as required by the Elder Justice Act, Facility policy of

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F 607	Continued From page 40 extensive assistance for all other ADL's (activities of daily living). In section G0300. "Balance During Transitions and Walking" the resident was assessed and an "8" for moving from seated to standing, walking, turning around, and moving on and off toilet, indicating the activity did not occur. The resident was assessed as not steady, only able to stabilize with staff assistance for surface to surface transfers. The resident was additionally assessed as having impairment on both sides (right/left) for upper and lower extremities for functional limitations in range of motion. On 05/07/19 at approximately 5:00 PM, the investigation for Resident #1 regarding allegations of abuse for Resident #1 were requested. On 05/08/19 at 9:30 AM, the investigation was presented and reviewed. The investigation documented the following: A facility reported incident was filed and completed on 04/12/19 for an incident that occurred on 04/06/19 regarding Resident #1. The description of the incident documented, "...04/12/19 ...two residents [no names documented] came to the DON's [Director of Nursing] office, ADON [Assistant Director of Nursing] and ED [executive director] were in attendance. The two residents alleged that on Saturday 04/6/19, [Resident #1] was 'mistreated' by staff. Both residents stated [Resident #1] was yelling louder than usual while receiving care...Employee action: None. Investigation completed and no action necessary...Facility internal investigation: Completed on 04/12/19..."	F 607	employees not being allowed to work while being investigated of abuse allegation or witnessed event, and timely investigating of allegations of abuse. Facility IDT team to conduct Zone Rounds daily. Rounds include specifically the monitoring for safety, supervision, and monitoring for any potential abuse situation including Involuntary Seclusion. This includes the weekend manager on duty process. Results of Zone Rounds reviewed daily at Daily Leadership Stand up. Zone rounds are submitted to and maintained by the NHA. NHA to report results of Zone Rounds audit to QAPI Committee monthly. Social Services Director will conduct random sample of resident, family, and staff interviews for 5 residents to ensure freedom of abuse to include involuntary seclusion weekly x 8 weeks. Findings to be reported to QAPI committee monthly. Quality monitoring schedule to be modified based on findings. The QAPI Committee is responsible for the on-going monitoring of compliance. Allegation of Compliance: 06/21/2019	

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The following statements were attached to the above facility investigation:

A statement by RN (Registered Nurse) #3 [nurse on duty 4//6/19] documented, "...4/6/19 [Resident #1] was extremely upset, crying and hollering...medicated at 1500...continued to be upset...assessment completed and was negative, vital signs WNL [within normal limits]. [CNA #4] told resident that 'if you don't get it together, I'm putting you to bed.' Subsequently during my medpass, [CNA #4] puts resident in her bed. Resident continues to get even more upset... [Resident #1] expressed to me that she did not want to stay in the bed. I returned to the nurses station and asked [CNA #4] if she could please go and get resident out of bed, she [CNA #4] quickly responded, 'No.' She [CNA #4] said, 'you don't know these residents, I've worked here for three years.' [CNA #4] immediately called the unit manager [LPN/licensed practical nurse #13]...signature of RN [#3] 4/6/19...signature of DON 4/9/19"

A statement by CNA #4 [alleged perpetrator], dated 04/24/19 documented, "...I, [Name of CNA #4] was in the process of laying [Resident #1] down and she began to scream loudly. [Names of 3 residents] came to [Resident #1's] window to she [sic] why she was screaming, I told them 'she was fine' and continued to get her situated I finished cleaning her and laying her down, when I came out her [sic] room the same residents that came to her window were now at her door waiting for me to come out. When I did [Resident #10] said to me 'I [CNA] need to get [Resident #1] back up or he was going to report me for torturing her.' I then said to him that I didn't have to explain anything to him regarding [Resident #1]

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and walked away. I let the charge nurse [RN #3] what [sic] had just happened, I also notified unit manager and DON of the issue...signature of CNA #4 date: 4/24/19...signature of DON date: 4/24/19."

A typed witness statement by the administrator documented in summary that on 4/12/19 [Name of Resident #9 and Resident #10] made an allegation that Resident #1 was mistreated by a staff member, to which they were unable to name alleged staff member, on 4/8/19. They provided details of the situation and felt the resident was being mistreated. It was determined not to have been mistreatment as the staff were attempting to assess and treat the resident for a change of condition. On 4/12/19 the two residents did not provide any additional details of the occurrence. Once they were finished detailing their concerns, they were assured that the ED and DON were aware of the situation in which they were describing and felt that while their concerns were valid, the resident was not being mistreated based upon first hand knowledge gained by the DON.

A typed witness statement by the DON documented, in summary, that on 4/6/19 at approximately 2:30 PM, the DON received a text message from the unit manager (LPN #13) that there was an issue on the unit between CNA #4 and RN #3. Immediately after the text message, CNA #4 called the DON and stated that something was wrong with Resident #1 and that she had put the resident to bed and RN #3 stated that the resident was fine and she needed to be gotten back up. The DON got off the phone with CNA #4 and called the nurses station to speak with RN #3. RN #3 stated that she had checked

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the resident's vital signs and they were normal and that the resident wanted to get up but CNA #4 refused for the resident to get up. RN #3 stated that she and CNA #4 had an argument about it and CNA #4 was refusing a work assignment. The DON told RN #3 that she thought CNA #4 was advocating for the resident. Neither the nurse (RN #3) nor CNA #4 received disciplinary action. On 4/12/19 a staff member (not named) came to the DON's office and reported that Resident #9 and Resident #10 were talking about Resident #1 being abused. The DON immediately went to the unit and requested that both residents come to her office. They came the office, the ED was present and stated they believed Resident #1 had been abused. The DON explained to them that she understood their perception.

On 05/08/19 at 9:45 AM, the DON (director of nursing) and administrator were interviewed with the survey team present. The DON was asked if CNA #4 was a current employee. The DON stated that she was and that CNA #4 had worked yesterday. The DON stated that two residents were saying that a CNA (unidentified) was mistreating Resident #1 and that the allegations were unsubstantiated because they didn't know who the CNA was and that the residents did not provide a name of the CNA. The DON stated that the resident was in "crises" and that CNA #4 was acting as an advocate. The DON was asked what the crises was and the DON stated that the resident had been complaining of chest pain and right arm pain. The DON stated that the staff had called her regarding the "crises" and they were trying to figure out a treatment option. The DON was asked if this resident was in such a crisis, why was the resident not sent out for evaluation.

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The DON stated that they do an assessment first and that is why the CNA was putting the resident to bed, to get an assessment. The administrator and DON stated that the residents did not give a name as to which CNA was mistreating or abusing the resident. The administrator and DON stated that they interviewed the two residents and no information was provided to help them identify which CNA it was. The administrator stated that the residents did not provide a name and did not even give a description to help with identification.

Interviews were conducted with Resident #9 and Resident #10, both resident's most current MDS information was reviewed prior to the interviews and revealed that both residents were assessed with a cognitive score of 15, indicating the residents were cognitively intact.

On 05/08/19 at 2:50 PM, Resident #9 was interviewed regarding being a witness to the above incident with Resident #1. Resident #9 stated that it happened in the hall and that she was right outside of her door, and saw the whole thing. The resident stated that she was standing in the hall waiting for her lunch tray, at her room, right outside the door [actually standing in the hall]. Resident #9 stated that this occurred around lunch time, because staff were passing out lunch trays and that CNA #4 [named the CNA] had brought a lunch tray to her roommate, but had not brought hers yet and she was standing in the hall waiting on hers. Resident #9 stated that Resident #1 was in her wheelchair heading toward the nurse's station when CNA #4 went up the hall and grabbed her wheelchair by the handles and began pulling her backwards towards the resident's room. Resident #9 stated

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that she didn't see that Resident #1 was doing anything wrong, but once the CNA grabbed her and started pulling her backwards she began yelling and screaming. Resident #9 stated that Resident #1 was yelling and screaming and saying to the CNA, please don't put me to bed, I don't want to go to bed and kept on repeating that over and over again. The resident stated that the CNA pulled her all the way down the hall backwards and into her room and slammed the door shut. Resident #9 stated that Resident #1 was screaming and yelling the whole time. Resident #9 stated that a short while later around 1:00 PM, she and Resident #10 and another resident went out to smoke. Resident #9 stated that Resident #1 was still screaming and yelling and that the courtyard/smoking area is ground level with this unit and Resident #1's room window was open to the courtyard. Resident #9 stated that she and Resident #10 went toward the resident's window to see if she was ok and that CNA #4 pulled the blind back and asked them, what we were looking at and shut the blind back. Resident #9 stated that they tried to report it, but no one wanted to listen. Resident #9 stated that they told the nurse [named RN #3] and asked, "can't you do something." The resident stated that the nurse didn't do much of anything and told them, it was out of her hands. Resident #9 stated that she and Resident #10 went down to speak with the DON and administrator, on either Monday [April 8th] or Tuesday [April 9th]; that she thought it was April 8th because it was after Resident #1 died. The resident stated that DON and administrator didn't want to hear from the residents and stated they told them what was heard and seen, and they told us that CNA #4 was doing exactly what she was supposed to be doing.

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ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24402

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On 5/8/19 at 3:05 PM an interview was conducted with Resident #10. Resident #10 stated that CNA #4 [named the CNA] was trying to put Resident #1 to bed in the afternoon and Resident #1 was begging, "No, No I don't want to go to bed." Resident #10 stated that Resident #1 was "screaming for all she was worth" and she just kept yelling and screaming that she did not want to go to bed. Resident #10 stated that he went to the nurses station and talked to the nurse (named -RN #3) and the nurse told CNA #4 to let Resident #1 stay up and CNA #4 told the nurse that she was putting her to bed and that's that. Resident #10 stated that he looked at RN #3 and she just threw her hands up and stated, "It's out of my hands." Resident #10 stated that after Resident #1 died, either Monday or Tuesday that he and Resident #9 had a meeting with the DON and administrator and told them exactly what CNA #4 had done and the DON and administrator told the residents that CNA #4 was doing exactly what she was supposed to. Resident #10 stated, "We were appalled!" Resident #10 stated that the DON and administrator did not want to hear the residents.

An interview was conducted with RN #3 on 5/8/19 at 3:50 PM. RN #3 stated that she is an agency nurse, but has worked at the facility for a while and knew Resident #1 well. RN #3 stated that Resident #1 wasn't having a very good day. RN #3 stated that CNA #4 was taking Resident #1 to her room and the resident was screaming and hollering. RN #3 stated that the resident yelling out was not an unusual occurrence for the resident, but on this day CNA #4 told the resident "If you don't get your act together I'm going to put you to bed." RN #3 stated that the resident was

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saying, "Please don't put me to bed" repeatedly and CNA #4 took her straight down the hall to her room. RN #3 was asked when the CNA took the resident down the hall if she pulled the resident backwards down the hall. RN #3 stated, "Yes, I saw her [CNA #4] pulling her [resident] backwards down the hall." RN #3 stated that she finished what she was doing and she and another CNA went down the hall to check on Resident #1. RN #3 stated that they were trying to get the resident calmed. Resident #1 was asked by RN #3 if she [resident] wanted to stay in bed and resident stated, "No." RN #3 stated that once the resident was talked to she'd [resident] calmed down and RN #3 stated that she went and asked CNA #4 to "Please get Resident #1 out of bed", CNA #4 stated, "No." RN #3 stated that "within minutes" of that conversation CNA #4 went and got on the phone with the unit manager (LPN #13) and then the DON. RN #3 stated that she visually saw CNA #4 pulling the resident backwards down the hall and the resident was yelling and hollering that she did not want to go to bed and CNA #4 put the resident to bed anyway, even after she was told by the RN to leave her up. RN #3 stated that CNA #4 kept doing what she was doing, while the resident was trying to resist by pushing her feet down on the floor while CNA #4 pulled her backwards. RN #3 was asked if she thought this was appropriate behavior or treatment of Resident #1 by CNA #4 and the RN stated, "No, but she [CNA #4] got on the phone [to DON and UM] and I felt defeated at that point." RN #3 stated that she let the DON and UM know her feelings about the situation and that she [RN] spoke to the UM herself and that the UM informed her that she [UM] was not surprised and had problems with CNA #4 in the past. RN #3 stated that she did talk to the DON, but stated

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she honestly didn't remember what she had said and then stated that Resident #10 came to her and she told him, "I'm so sorry." RN #3 stated that she remembered telling Resident #10 that "it was out of her hands" because she felt defeated when she tried to get CNA #4 to get the resident back up and the CNA refused and then called the UM and the DON. RN #3 stated that CNA #4 acted like that was her plan.

On 05/08/19 at 4:15 PM CNA #4 was interviewed with the survey team present. CNA #4 was asked to describe the events that took place with Resident #1 on 04/06/19. CNA #4 stated that she had gotten Resident #1 up that morning around 4:30 AM and later in the day the resident started complaining that her arms and legs were hurting. The CNA stated, "I kept telling her if you are hurting I'm going to lay you down." CNA #4 stated that it was reported that the resident had been down in the lobby earlier that day screaming. CNA #4 stated that she laid the resident down around 1:00 PM and that the resident's window was open, which is open to the court yard/smoking area. CNA #4 stated that the resident was screaming and yelling and that it was echoing throughout the courtyard and that three residents came over to the window to see what was going on. CNA #4 stated that she told the residents, "I'm doing what is necessary, I said I don't have to explain a reason." CNA #4 stated that she put the blind down in the resident's room and told the agency nurse [RN #3] that "she [resident] needs time to herself."
CNA #4 stated that the residents were accusing her [CNA #4] of abuse and she went immediately to the nurse's station and called the UM [LPN #13] and called the DON. CNA #4 was asked why she called LPN #13 and the DON, what was

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going on that she felt the need to call upper management. CNA #4 stated, "...because they were accusing me." CNA #4 was asked what the UM said in response to being accused of abuse. CNA #4 stated, "Didn't say a lot, thanked me." CNA #4 was asked what the DON said regarding the allegation of abuse. CNA #4 stated, "The same thing, not much." CNA #4 was asked for clarification as to what the DON said in response to the allegation of abuse. CNA #4 stated that "she didn't say much, she thanked me too." CNA #4 was asked again what was the reason for the immediate phone call to the UM and the DON and the CNA stated, "I called because I was being accused of abuse." CNA #4 was asked if that was the only reason for the phone calls to the UM and DON and the CNA stated, "Yes." CNA #4 was asked why she continued to take the resident to her room if she was screaming and yelling that she did not want to lay down or go to bed. CNA #4 stated that the resident will often lay down and rest and went on to say that the resident had been up since 4:30 AM and she was yelling. CNA #4 was asked if the resident told her that she did not want to go to bed or that she did not want to lay down. CNA #4 stated, "Yes, she did say that." CNA #4 was asked again why she took the resident against her will and laid her down, when it was evident that the resident did not want to be in the bed. CNA #4 stated, "That's the thing, she would have been fine." CNA #4 was made aware that the resident did not want to be in bed and did not want to go to bed, but was put in her to bed anyway, against her will. CNA #4 stated that when Resident #1 acts like that the staff normally put her to bed. CNA #4 was asked where did that come from and was asked if that was part of the resident's care plan. CNA #4 stated that she did not know if this was part of the Resident #1's care

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plan, that it is just what was done. CNA #4 was asked if she pulled the resident down the hall backwards to her room and the CNA stated, "No, that sounds like a horror movie [laughed]."

On 5/8/19 at 4:50 PM the administrator and DON were again interviewed in a meeting with the survey team. The DON stated that they report immediately and that they did not feel this was abuse or mistreatment, that they did an 100 % audit and did not reveal any abuse. The DON stated again that the resident was in "crises" and that CNA #4 was being an advocate. The DON stated that Resident #1 has these behaviors and screams and yells and it is common to lay her down to get her to calm. The DON was made aware that there was no information on the resident's comprehensive care plan regarding this type of behavior or any interventions related to this type of behavior. The DON was made aware of the investigation that included interviews from witnesses and staff that were involved, which did not reveal the resident was in crises, but revealed the resident did not want to be put to bed and was done so against the resident's will. The DON was made aware that the resident repeatedly told the CNA, no and the CNA put the resident to bed and the resident had no way of getting up due to the fact the resident was totally dependent upon staff. The DON was made aware that residents have the right to refuse and choose and that no means no. The DON stated, "I hear what you are saying." The DON stated, "It's not like they described to me." The DON and administrator were made aware of the above interviews and that the information was not matching up and that there was no information and/or documentation that the resident was in "crises" and that the information gathered did not match what the DON

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and administrator were saying. The DON stated, "It doesn't sound like it." The DON was made aware that CNA #4 stated that she had called on 4/6/19 to report her being accused of abuse. The DON had no comment.

On 5/8/19 at 6:10 PM, the UM [LPN #13] was interviewed via telephone. The UM stated that on 4/6/19 she received a call from CNA #4 regarding an "issue with the agency nurse." The UM stated that CNA #4 told her that the RN #3 told her to get Resident #1 back and that CNA #4 told the RN, "No" and that CNA #4 had just put her to bed. The UM stated that she told CNA #4 that if the resident is asking to get up, then CNA#4 needs to get her back up. The UM stated that the CNA then told her that "this nurse doesn't know her [resident]" The UM stated that she had a conversation with CNA #4 a week before regarding this same thing. The UM stated that she was in her office and that she overheard CNA #4 tell Resident #1 that if she didn't stop yelling she was going to put her to bed. The UM stated that she immediately left her office and confronted CNA #4 and told her that she could not do that and that the CNA again responded to the UM, "if she keeps yelling like that, I'm putting her to bed." The UM stated that CNA #4 did not put Resident #1 to bed that day after this conversation. The UM stated that she got a call from RN #3 after the conversation with CNA #4 and RN #3 had asked CNA #4 to get the resident up and the CNA refused. The UM stated that she reported this information to the DON via phone and had also let the DON know about what had transpired a week prior with CNA #4 wanting to put the resident to bed and stated that the DON responded back that the situation had been taken care of. The UM stated that she did not receive

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any follow up as to what happened as a result of her reporting this information to the DON. The UM stated that the staff don't get follow up and don't get any information regarding investigations on things like this.

On 05/09/19 at 10:00 AM, a meeting with the DON, administrator and facility quality specialist was conducted with the survey team. The facility staff were informed of concerns regarding abuse and neglect of Resident #1 by CNA #4 and that the facility staff allowed CNA #4 to continue working and that an investigation was not completed until 4/12/19. The staff were made aware that CNA #4's statement was dated 4/24/19 and that this investigation did not reveal that the facility's policy and procedures were followed. The DON and administrator stated that they did not know of this allegation until 4/12/19, even though the interview with CNA #4, revealed that she called the UM and DON immediately upon being accused of abuse to report the allegations to the DON and UM.

No further information and/or documentation was presented prior to the exit conference to evidence that the facility staff followed their policies and procedures for ensuring residents are free from further abuse after an allegation is made and failed to follow policies and procedure for investigating allegations of abuse and neglect.
2. Resident #7's clinical record documented a nursing note dated 4/13/19 stating, "At 1:45 PM, this writer was alerted by CNA's [certified nurses' aides] that resident was observed laying in [Resident #5's] bed. [Resident #5] was observed [with] his hand down this residents pants and had his penis exposed. This resident was immediately redirected and taken to her room.

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Skin noted to be warm, dry and intact. Resident had no s/s [signs/symptoms] of distress. 15 minute checks implemented. Staff will ensure residents do not ambulate around other residents room, and during mealtimes residents will sit on opposite sides of the dining room while staff monitors the area..." (sic)

A facility reported incident regarding the 4/13/19 sexual abuse of Resident #7 was faxed to the state agency two days later on 4/15/19.

On 5/9/19 at 10:00 a.m., the director of nursing (DON) was interviewed about reporting of the 4/13/19 sexual abuse incident to the state agency. The DON stated adult protective services and the police were notified immediately of the incident. The DON stated she was not sure why the incident was not faxed in a timely manner. The DON stated the staff members were "caught up in the safety issue" of the events and notifying the state agency was left out.

These findings were reviewed with the administrator and director of nursing during a meeting on 5/9/18 at 10:30 a.m.

3. Resident #8 was admitted to the facility on 7/17/17 with diagnoses that included dementia with behaviors, heart failure, major depression, atrial fibrillation and high blood pressure. The minimum data set (MDS) dated 3/27/19 assessed Resident #8 with short and long-term memory loss and severely impaired cognitive skills.

On 5/8/19 at 2:45 p.m., the housekeeper that witnessed Resident #7's sexual abuse by Resident #5 on 4/13/19 was interviewed. The housekeeper was asked during this interview if

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she had ever seen Resident #5 have sexual contact with any other residents on the dementia unit. The housekeeper stated she saw Resident #5 grab and touch Resident #8's breasts when in the dining room on the dementia unit. The housekeeper stated she did not report the incident because nurses and aides were in the dining room at the time and witnessed the incident. The housekeeper stated since the nurses were aware, she did not feel she needed to report the incident.

Resident #8's clinical record documented no incidents of any sexual contact with Resident #5. December 2018 notes made no mention of the incident. Resident #8's clinical record had no nursing notes documented from January 2019 through 3/25/19.

On 5/8/19 at 4:50 p.m., the director of nursing (DON) and administrator were interviewed about any reported sexual incidents involving Resident #8 and Resident #5. The DON and administrator stated they did not receive a report from housekeeping or nursing regarding Resident #5 touching and/or grabbing Resident #8's breasts. The administrator and DON stated they had no knowledge of the incident. Concerning Resident #8's clinical record with no documented nursing notes from January 2019 through 3/25/19, the DON stated, "That's all we have." The DON stated all employees were required to report any suspected abuse and had annual training regarding abuse and reporting requirements.

On 5/9/19 at 7:30 a.m., the housekeeper was interviewed again, about when she observed Resident #5 grabbing Resident #8's breasts. The housekeeper stated she did not remember the

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exact date but it was "several months ago." The housekeeper stated, "I think it was around December [2018] or January [2019]."

The facility abuse policy, Abuse, Neglect, Exploitation, & Misappropriation, was reviewed and documented, "...Employees of the center are charged with a continuing obligation to treat residents so they are free from abuse, neglect, mistreatment...willful infliction...unreasonable confinement...willful...individual must have acted deliberately...used as a means to correct or control behavior...humiliation, intimidation, fear, shame, agitation or...isolating a resident from social interaction or activities...Neglect...failure to take precautionary measures to protect the health and safety of a resident...failure to report observed or suspected abuse, neglect...involuntary seclusion...separation of a resident from other residents or...confinement to his/her room [with or without roommates] against the resident's will...seclude the resident...leaving a closing the door...Acts of abuse directed against residents are absolutely prohibited...All employees have a duty to respect the rights of all resident's to treat them with dignity and to prevent others from violating their rights...any...who witnesses or has knowledge of an act of abuse or allegation of abuse, neglect...is obligated to report such information immediately, but no later that 2 hours...any employee shall be deemed to have violated his obligation...fails to report...abuse witnessed or known...makes a false or misleading or incomplete report of abuse...the abuse coordinator or designee shall investigate all reports...A social services rep may be offered in the role of resident advocate during nay questioning or or interviewing of residents...Preliminary Investigation: Immediately

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F 607	Continued From page 56 upon an allegation of abuse or neglect, the suspects shall be segregated from residents pending the investigation...the DON shall perform and document a thorough nursing evaluation, an notify attending...incident report shall be filed by the individual in charge who received the report in conjunction with the person who reported the abuse, the report shall be filed as soon as possible in order to provide the most accurate information in a timely fashion, and submitted to the abuse coordinator...abuse coordinator and/or DON shall take statements from the victim, the suspect and all possible witnesses including all other employees in the vicinity...upon completion of the investigation, a detailed report shall be prepared...any suspect who is an employee or contract service provider has been identified, will be suspended pending the investigation...the resident will be evaluated for any signs of injury including a physical exam or psychosocial assessment, if needed...once an allegation is reported the executive director is responsible for ensure that the reporting is completed timely and appropriately...protect the rights of residents...report the results of all investigations to the ED [executive director]...any employee who is found to have committed an act of resident abuse shall be discharged from employment..." This finding was reviewed with the administrator and director of nursing during a meeting on 5/8/19 at 4:30 p.m.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		6/21/19

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F 609	Continued From page 57 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, facility document review and during the course of a complaint investigation, the facility staff failed to report an allegation of abuse in a timely manner to the state agency regarding three of 8 resident in the survey sample: Resident #1, Resident #7 and Resident #8. 1. Resident #1 was put to bed against her will by a CNA [certified nursing assistant] #4, the resident was yelling repeatedly telling the staff	F 609	F 609 Resident #1 no longer resides in the center. Resident #5 and #7 incidents reported to state agency on 4-15-19. Resident # 5 and #8 incidents reported to the state 5-8-19. For resident #7, resident # 5 no longer resides in the center, and resident # 7 provided with psychosocial evaluation on 5/24/2019 with no negative findings. For resident #8, resident # 5 no longer resides in the center. The	

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member that she did not want to be put to bed, the staff member proceeded to put the resident to bed and refused to get the resident up. This allegation was reported by two residents [Resident #9 and Resident #10], an RN (registered nurse #3) and by CNA #4 (perpetrator) but was not reported to the state agency in a timely manner.

2. Facility staff failed to report witnessed abuse of Resident #7 to the state agency in a timely manner. Staff witnessed sexual abuse of Resident #7 by Resident #5 on 4/13/19 at 1:45 p.m. This incident was not reported to the state agency until 4/15/19, two days after the incident.

3. Facility staff failed to report to the administrator a witnessed incident of abuse of Resident #8 by Resident #5. A housekeeper and nursing staff failed to report an observation of Resident #5 grabbing/touching Resident #8's breasts on the dementia care unit to the administrator.

Findings include:

1. Resident #1, was originally admitted to the facility on 09/25/12, with the most current readmission on 06/05/17. Diagnoses for Resident #1 included, but were not limited to: obesity, abnormal posture, muscle weakness, hand contracture, depressive disorder, schizophrenia, mental retardation, intellectually disabled and anxiety disorder.

The resident's most current MDS (minimum data set) was a quarterly assessment dated 01/16/19, and documented the resident was a '9' cognitively, indicating the resident had moderate impairment in daily decision making skills. The

allegation was reported and investigated, and the housekeeper was provided one on one education regarding our abuse policies and procedures to include abuse reporting. The Director of Nursing and Executive Director were re-educated on abuse policies and procedures, prevention, resident rights and mandated reporting by the Regional Vice President on 5/13/2019.

All residents have the potential to be affected by this deficient practice. The Social Services Director and the Director of Nursing will conduct resident interviews of all interviewable residents to ensure free from abuse by 5/31/2019. Family members of non-interviewable residents interviewed to determine if any other residents have been affected by 5/31/2019. For residents without families, interviews will be conducted with staff to determine if they have observed any form of abuse of any resident by 5/31/19.

Corrective Actions

All staff will be educated by Division Clinical Quality Specialist on abuse, types of abuse, training, prevention, identification, investigating, protection, reporting/response, resident's rights, reporting reasonable suspicion of a crime, and Elder Justice Act by 6/15/2019. This included a leadership and department head education conducted by the Vice President of Operations and the Clinical Quality Specialist on 5/13/19, prior to education being conducted with all other

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resident was assessed as requiring extensive assistance for bed mobility and dressing. The resident was assessed as requiring total assistance for transfers, toileting, eating, and bathing. The resident was assessed as requiring extensive assistance for all other ADL's (activities of daily living). In section G0300. 'Balance During Transitions and Walking' the resident was assessed and an '8' [activity did not occur] for moving from seated to standing, walking, turning around, and moving on and off toilet. The resident was assessed as not steady, only able to stabilize with staff assistance for surface to surface transfers. The resident was additionally assessed as having impairment on both sides (right/left) for upper and lower extremities for functional limitations in range of motion.

On 05/07/19 at approximately 5:00 PM, the investigation for Resident #1 regarding allegations of abuse for Resident #1 were requested.

On 05/08/19 at 9:30 AM, the investigation was presented and reviewed. The investigation documented the following:

A facility reported incident was filed and completed on 04/12/19 for an incident that occurred on 04/06/19 regarding Resident #1. The description of the incident documented, "...04/12/19 ...two residents [no names documented] came to the DON's [Director of Nursing] office, ADON [Assistant Director of Nursing] and ED [executive director] were in attendance. The two residents alleged that on Saturday 04/6/19, [Resident #1] was 'mistreated' by staff. Both residents stated [Resident #1] was yelling louder than usual while receiving

staff members. All staff will be required to acknowledge a Freedom from abuse notice to employees in addition to taking an abuse competency exam. This education specifically addressed timely reporting of incidents as required by the Elder Justice Act, Facility policy of employees not being allowed to work while being investigated of abuse allegation or witnessed event, and timely investigating of allegations of abuse.

Facility IDT team to conduct Zone Rounds daily. Rounds include specifically the monitoring for safety, supervision, and monitoring for any potential abuse situation including Involuntary Seclusion. This includes the weekend manager on duty process. Results of Zone Rounds reviewed daily at Daily Leadership Stand up. Zone rounds are submitted to and maintained by the NHA. Results of Zone Rounds audits to be reported monthly to QAPI Committee.

Social Services Director will conduct random sample of resident, family, and staff interviews for 5 residents to ensure freedom of abuse weekly x 8 weeks. Findings to be reported to QAPI committee monthly. Quality monitoring schedule to be modified based on findings.

The QAPI Committee is responsible for the on-going monitoring for compliance.

Allegation of Compliance: 06/21/2019

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care...Employee action: None. Investigation completed and no action necessary...Facility internal investigation: Completed on 04/12/19..."

The following statements were attached to the above facility investigation:

A statement by RN (Registered Nurse) #3 [nurse on duty 4//6/19] documented, "...4/6/19 [Resident #1] was extremely upset, crying and hollering...medicated at 1500...continued to be upset...assessment completed and was negative, vital signs WNL [within normal limits]. [CNA #4] told resident that 'if you don't get it together, I'm putting you to bed.' Subsequently during my medpass, [CNA #4] puts resident in her bed. Resident continues to get even more upset... [Resident #1] expressed to me that she did not want to stay in the bed. I returned to the nurses station and asked [CNA #4] if she could please go and get resident out of bed, she [CNA #4] quickly responded, 'No.' She [CNA #4] said, 'you don't know these residents, I've worked here for three years.' [CNA #4] immediately called the unit manager [LPN/licensed practical nurse #13]...signature of RN [#3] 4/6/19...signature of DON 4/9/19"

A statement by CNA #4 [alleged perpetrator], dated 04/24/19 documented, "...I, [Name of CNA #4] was in the process of laying [Resident #1] down and she began to scream loudly. [Names of 3 residents] came to [Resident #1's] window to she [sic] why she was screaming, I told them 'she was fine' and continued to get her situated I finished cleaning her and laying her down, when I came out her [sic] room the same residents that came to her window were now at her door waiting for me to come out. When I did [Resident #10]

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said to me 'I [CNA] need to get [Resident #1] back up or he was going to report me for torturing her.' I then said to him that I didn't have to explain anything to him regarding [Resident #1] and walked away. I let the charge nurse [RN #3] what [sic] had just happened, I also notified unit manager and DON of the issue...signature of CNA #4 date: 4/24/19...signature of DON date: 4/24/19."

A typed witness statement by the administrator documented in summary that on 4/12/19 [Name of Resident #9 and Resident #10] made an allegation that Resident #1 was mistreated by a staff member, to which they were unable to name alleged staff member, on 4/8/19.

A typed witness statement by the DON documented, in summary, that on 4/6/19 at approximately 2:30 PM, the DON received a text message from the unit manager (LPN #13) that there was an issue on the unit between CNA #4 and RN #3. On 4/12/19 a staff member (not named) came to the DON's office and reported that Resident #9 and Resident #10 were talking about Resident #1 being abused. The DON immediately went to the unit and requested that both residents come to her office. They came the office, the ED was present and stated they believed Resident #1 had been abused. The DON explained to them that she understood their perception.

On 05/08/19 at 9:45 AM, the DON (director of nursing) and administrator were interviewed with the survey team. The DON was asked if CNA #1 was a current employee. The DON stated that she was and that CNA #1 had worked yesterday. The DON stated that two residents were saying

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that a CNA (unidentified) was mistreating Resident #1 and that the allegations were unsubstantiated because they didn't know who the CNA was. The administrator and DON stated that the residents did not give a name as to which CNA was mistreating or abusing the resident so the allegation was unsubstantiated. The administrator and DON stated that they interviewed the two residents on 4/12/19, six days after the incident. The administrator stated that the residents did not give us a name and did not even give a description to help with identification.

Interviews were conducted with Resident #9 and Resident #10, both resident's most current MDS information was reviewed prior to the interviews and revealed that both residents were assessed with a cognitive score of 15, indicating the residents were cognitively intact.

On 05/08/19 at 2:50 PM, Resident #9 was interviewed regarding being a witness to the above incident with Resident #1. Resident #9 stated that it happened in the hall and that she was right outside of her door, and saw the whole thing. The resident stated that she was standing in the hall waiting for her lunch tray, at her room, right outside the door [actually standing in the hall]. Resident #9 stated that this occurred around lunch time, because staff were passing out lunch trays and that CNA #4 [named the CNA] had brought a lunch tray to her roommate, but had not brought hers yet and she was standing in the hall waiting on hers. Resident #9 stated that Resident #1 was in her wheelchair heading toward the nurse's station when CNA #4 went up the hall and grabbed her wheelchair by the handles and began pulling her backwards towards the resident's room. Resident #9 stated

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that she didn't see that Resident #1 was doing anything wrong, but once the CNA grabbed her and started pulling her backwards she began yelling and screaming. Resident #9 stated that Resident #1 was yelling and screaming and saying to the CNA, please don't put me to bed, I don't want to go to bed and kept on repeating that over and over again. The resident stated that the CNA pulled her all the way down the hall backwards and into her room and slammed the door shut. Resident #9 stated that Resident #1 was screaming and yelling the whole time. Resident #9 stated that a short while later around 1:00 PM, she and Resident #10 and another resident went out to smoke. Resident #9 stated that Resident #1 was still screaming and yelling and that the courtyard/smoking area is ground level with this unit and Resident #1's room window was open to the courtyard. Resident #9 stated that she and Resident #10 went toward the resident's window to see if she was ok and that CNA #4 pulled the blind back and asked them, what we were looking at and shut the blind back. Resident #9 stated that they tried to report it, but no one wanted to listen. Resident #9 stated that they told the nurse [named RN #3] and asked, "can't you do something." The resident stated that the nurse didn't do much of anything and told them, it was out of her hands. Resident #9 stated that she and Resident #10 went down to speak with the DON and administrator, on either Monday [April 8th] or Tuesday [April 9th]; that she thought it was April 8th because it was after Resident #1 died. The resident stated that DON and administrator didn't want to hear from the residents and stated they told them what was heard and seen, and they told us that CNA #4 was doing exactly what she was supposed to be doing.

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An interview was conducted with RN #3 on 5/8/19 at 3:50 PM. RN #3 stated that she is an agency nurse, but has worked at the facility for a while and knew Resident #1 well. RN #3 stated that Resident #1 wasn't having a very good day. RN #3 stated that CNA #4 was taking Resident #1 to her room and the resident was screaming and hollering. RN #3 stated that the resident yelling out was not an unusual occurrence for the resident, but on this day CNA #4 told the resident "If you don't get your act together I'm going to put you to bed." RN #3 stated that the resident was saying, "Please don't put me to bed" repeatedly and CNA #4 took her straight down the hall to her room. RN #3 was asked when the CNA took the resident down the hall if she pulled the resident backwards down the hall. RN #3 stated, "Yes, I saw her [CNA #4] pulling her [resident] backwards down the hall." RN #3 stated that she finished what she was doing and she and another CNA went down the hall to check on Resident #1. RN #3 stated that they were trying to get the resident calmed. Resident #1 was asked by RN #3 if she [resident] wanted to stay in bed and resident stated, "No." RN #3 stated that once the resident was talked to she'd [resident] calmed down and RN #3 stated that she went and asked CNA #4 to "Please get Resident #1 out of bed", CNA #4 stated, "No." RN #3 stated that "within minutes" of that conversation CNA #4 went and got on the phone with the unit manager (LPN #13) and then the DON. RN #3 stated that she visually saw CNA #4 pulling the resident backwards down the hall and the resident was yelling and hollering that she did not want to go to bed and CNA #4 put the resident to bed anyway, even after she was told by the RN to leave her up. RN #3 stated that CNA #4 kept doing what

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she was doing, while the resident was trying to resist by pushing her feet down on the floor while CNA #4 pulled her backwards. RN #3 was asked if she thought this was appropriate behavior or treatment of Resident #1 by CNA #4 and the RN stated, "No, but she [CNA #4] got on the phone [to DON and UM] and I felt defeated at that point." RN #3 stated that she let the DON and UM know her feelings about the situation and that she [RN] spoke to the UM herself and that the UM informed her that she [UM] was not surprised and had problems with CNA #4 in the past. RN #3 stated that she did talk to the DON, but stated she honestly didn't remember what she had said and then stated that Resident #10 came to her and she told him, "I'm so sorry." RN #3 stated that she remembered telling Resident #10 that "it was out of her hands" because she felt defeated when she tried to get CNA #4 to get the resident back up and the CNA refused and then called the UM and the DON.

On 05/08/19 at 4:15 PM CNA #4 was interviewed with the survey team present. CNA #4 was asked to describe the events that took place with Resident #1 on 04/06/19. CNA #4 stated that she had gotten Resident #1 up that morning around 4:30 AM and later in the day the resident started complaining that her arms and legs were hurting. The CNA stated, "I kept telling her if you are hurting I'm going to lay you down." CNA #4 stated that it was reported that the resident had been down in the lobby earlier that day screaming. CNA #4 stated that she laid the resident down around 1:00 PM and that the resident's window was open, which is open to the court yard/smoking area. CNA #4 stated that the resident was screaming and yelling and that it was echoing throughout the courtyard and that

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three residents came over to the window to see what was going on. CNA #4 stated that she told the residents, "I'm doing what is necessary, I said I don't have to explain a reason." CNA #4 stated that she put the blind down in the resident's room and told the agency nurse [RN #3] that "she [resident] needs time to herself." CNA #4 stated that the residents were accusing her [CNA #4] of abuse and she went immediately to the nurse's station and called the UM [LPN #13] and called the DON. CNA #4 was asked why she called LPN #13 and the DON, what was going on that she felt the need to call upper management. CNA #4 stated, "...because they were accusing me." CNA #4 was asked what the UM said in response to being accused of abuse. CNA #4 stated, "Didn't say a lot, thanked me." CNA #4 was asked what the DON said regarding the allegation of abuse. CNA #4 stated, "The same thing, not much." CNA #4 was asked for clarification as to what the DON said in response to the allegation of abuse. CNA #4 stated that "she didn't say much, she thanked me too." CNA #4 was asked again what was the reason for the immediate phone call to the UM and the DON and the CNA stated, "I called because I was being accused of abuse." CNA #4 was asked if that was the only reason for the phone calls to the UM and DON and the CNA stated, "Yes."

On 5/8/19 at 4:50 PM, the administrator and DON were again interviewed in a meeting with the survey team. The DON stated that they report immediately and that they did not feel this was abuse or mistreatment, that they did a 100 % audit and did not reveal any abuse. The DON was asked why this was not reported in a timely manner to the state agency and the DON stated again that the resident was in "crises" and that

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CNA #4 was being an advocate and not being abusive. The DON and administrator were both made aware that the CNA #4 stated that she called the UM and DON to report that she was being accused of abuse, not to report any type of crisis. The DON stated we reported when we found out about it on 4/12/19. The DON was asked if the allegation and the investigation was done all on the same day 4/12/19. The DON stated, it was not all done in one day. CNA #4's statement was dated 4/24/19.

The DON stated, "It's not like they described to me." The DON and administrator were made aware of the above interviews and that the information was not matching up regarding reporting of this allegation of abuse. The DON stated, "It doesn't sound like it."

On 5/8/19 at 6:10 PM, the UM [LPN #13] was interviewed via telephone. The UM stated that on 4/6/19 she received a call from CNA #4 regarding an "issue with the agency nurse." The UM stated that CNA #4 told her that the RN #3 told her to get Resident #1 back and that CNA #4 told the RN, "No" and that CNA #4 had just put her to bed. The UM stated that she told CNA #4 that if the resident is asking to get up, then CNA#4 needs to get her back up. The UM stated that the CNA then told her that "this nurse doesn't know her [resident]." The UM stated that she had a conversation with CNA #4 a week before regarding this same thing. The UM stated that she was in her office and that she overheard CNA #4 tell Resident #1 that if she didn't stop yelling she was going to put her to bed. The UM stated that she immediately left her office and confronted CNA #4 and told her that she could not do that and that the CNA again responded to

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the UM, "if she keeps yelling like that, I'm putting her to bed." The UM stated that CNA #4 did not put Resident #1 to bed that day after this conversation. The UM stated that she got a call from RN #3 after the conversation with CNA #4 and RN #3 had asked CNA #4 to get the resident up and the CNA refused. The UM stated that she reported this information to the DON via phone and had also let the DON know about what had transpired a week prior with CNA #4 wanting to put the resident to bed and stated that the DON responded back that the situation had been taken care of. The UM stated that she did not receive any follow up as to what happened as a result of her reporting this information to the DON. The UM stated that the staff don't get follow up and don't get any information regarding investigations on things like this.

On 05/09/19 at 10:00 AM, a meeting with the DON, administrator and facility quality specialist was conducted with the survey team. The facility staff were informed of concerns regarding reporting allegations of abuse and neglect in a timely manner. The DON and administrator stated that they did not know of this allegation until 4/12/19, even though through multiple interviews as documented above reported that the DON was made aware of the allegations on the day of the incident (4/8/19) and the administrator was made aware of the allegations on 4/8/19.

No further information and/or documentation was presented prior to the exit conference 5/9/19 to evidence that the facility reported an allegation of abuse regarding Resident #1 in a timely manner.
2. Resident #7's clinical record documented a nursing note dated 4/13/19 stating, "At 1:45 PM,

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this writer was alerted by CNA's [certified nurses' aides] that resident was observed laying in [Resident #5's] bed. [Resident #5] was observed [with] his hand down this residents pants and had his penis exposed. This resident was immediately redirected and taken to her room. Skin noted to be warm, dry and intact. Resident had no s/s [signs/symptoms] of distress. 15 minute checks implemented. Staff will ensure residents do not ambulate around other residents room, and during mealtimes residents will sit on opposite sides of the dining room while staff monitors the area..." (sic)

A facility reported incident regarding the 4/13/19 sexual abuse of Resident #7 was faxed to the state agency two days later on 4/15/19.

On 5/9/19 at 10:00 a.m., the director of nursing (DON) was interviewed about reporting of the 4/13/19 sexual abuse incident to the state agency. The DON stated adult protective services and the police were notified immediately of the incident. The DON stated she was not sure why the incident was not faxed in a timely manner. The DON stated the staff members were "caught up in the safety issue" of the events and notifying the state agency was left out.

These findings were reviewed with the administrator and director of nursing during a meeting on 5/9/18 at 10:30 a.m.

3. Resident #8 was admitted to the facility on 7/17/17 with diagnoses that included dementia with behaviors, heart failure, major depression, atrial fibrillation and high blood pressure. The minimum data set (MDS) dated 3/27/19 assessed Resident #8 with short and long-term memory

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loss and severely impaired cognitive skills.

On 5/8/19 at 2:45 p.m., the housekeeper that witnessed Resident #7's sexual abuse by Resident #5 on 4/13/19 was interviewed. The housekeeper was asked during this interview if she had ever seen Resident #5 have sexual contact with any other residents on the dementia unit. The housekeeper stated she saw Resident #5 grab and touch Resident #8's breasts when in the dining room on the dementia unit. The housekeeper stated she did not report the incident because nurses and aides were in the dining room at the time and witnessed the incident. The housekeeper stated since the nurses were aware, she did not feel she needed to report the incident.

Resident #8's clinical record documented no incidents of any sexual contact with Resident #5. December 2018 notes made no mention of the incident. Resident #8's clinical record had no nursing notes documented from January 2019 through 3/25/19.

On 5/8/19 at 4:50 p.m., the director of nursing (DON) and administrator were interviewed about any reported sexual incidents involving Resident #8 and Resident #5. The DON and administrator stated they did not receive a report from housekeeping or nursing regarding Resident #5 touching and/or grabbing Resident #8's breasts. The administrator and DON stated they had no knowledge of the incident. Concerning Resident #8's clinical record without documented nursing notes for almost three months, the DON stated, "That's all we have." The DON stated all employees were required to report any suspected abuse and had annual training regarding abuse

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F 609	Continued From page 71 and reporting requirements. The facility's policy titled Abuse, Neglect, Exploitation & Misappropriation (revised 11/28/17) documented the following concerning reporting of abuse, "Any employee or contracted service provider who witnesses or has knowledge of an act of abuse or an allegation of abuse...to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation involve abuse or result in serious bodily injury...to the Administrator and to other officials in accordance with State law...Once an allegation of abuse is reported, the Executive Director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations...Facility staff should be aware of and comply with their individual requirements and responsibilities for reporting as required by law..." These findings were reviewed with the administrator and director of nursing during a meeting on 5/9/18 at 10:30 a.m.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		6/21/19

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F 610	Continued From page 72 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to implement adequate corrective interventions to protect one of eight residents in the survey sample following an incident of abuse. There were no effective corrective interventions implemented to ensure protection of Resident #7 and other residents on the dementia care unit following the sexual abuse by Resident #5. Staff members observed Resident #7, with severe cognitive impairment and wandering behavior, in Resident #5's bed. Resident #5, with a history and ongoing treatments for sexually aggressive behaviors had his hand in Resident #7's pants/brief with his penis exposed. Resident #5 was then observed on top of Resident #7 in his bed while exposed. Resident #7 remained on the same unit with Resident #5 following this abuse, with staff unable to effectively manage and/or redirect Resident #5's aggressive, sexual behaviors. Three days later, staff members observed Resident #5 sexually abuse another resident (Resident #6) in the dining room. The findings include: Resident #7 was admitted to the facility on 5/1/13 with a re-admission on 7/16/15. Diagnoses for	F 610	F 610 Resident #5 no longer resides in the center, was taken into custody Emergency Custody Order (ECO) and emergency discharged on 4/16/2019. A psychosocial evaluation was completed 5/21/2019 by social services for Resident #6 and #7 with no negative findings. All residents have the potential to be affected by this deficient practice. The Social Services Director and the Director of Nursing will conduct resident interviews of all interviewable residents to ensure free from sexual abuse by 5/31/2019. The Assistant Director of Nursing will complete head to toe assessments of all non-interviewable residents to ensure no signs/symptoms of abuse by 5/31/2019. Quality Assurance review of other residents with sexual behaviors to be conducted to ensure appropriate interventions are in place, to include monitoring of behaviors by nursing staff and using behavioral symptoms Section E 0200 of the Minimum Data Set to determine appropriate interventions are in place and care setting by 6/7/19. Any	

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Resident #7 included dementia, high blood pressure, psychosis, depression and dysphagia. The minimum data set (MDS) dated 4/25/19 assessed Resident #7 with short and long-term memory problems and severely impaired cognitive skills. This MDS listed the resident had wandering behaviors and was rarely and/or never able to make herself understood.

Resident #7's clinical record documented a nursing note dated 4/13/19 stating, "At 1:45 PM, this writer was alerted by CNA's [certified nurses' aides] that resident was observed laying in [Resident #5's] bed. [Resident #5] was observed [with] his hand down this residents pants and had his penis exposed. This resident was immediately redirected and taken to her room. Skin noted to be warm, dry and intact. Resident had no s/s [signs/symptoms] of distress. 15 minute checks implemented. Staff will ensure residents do not ambulate around other residents room, and during mealtimes residents will sit on opposite sides of the dining room while staff monitors the area..." (sic)

The facility's investigation of this incident dated 4/16/19 documented, "...After investigation, facility is able to substantiate resident to resident encounter at it was witnessed by staff. Both residents currently reside on [dementia care unit]. The resident were separated immediately; room changes have been refused by responsible parties as both residents exhibit exit seeking behaviors and require a locked unit. No further interactions have occurred between residents..."

The facility's investigation included written witness statements from staff members. A written statement by the housekeeper dated 4/13/19 identified areas of concern or identified with be addressed in accordance with the facility abuse and neglect policy.

Corrective Actions

All staff will be educated by Division Clinical Quality Specialist on abuse, types of abuse, training, prevention, identification, investigating, protection, reporting/response, resident□s rights, reporting reasonable suspicion of a crime, and Elder Justice Act by 6/15/2019.¿This included a leadership and department head education conducted by the Vice President of Operations and the Clinical Quality Specialist on 5/13/19, prior to education being conducted with all other staff members. All staff will be required to acknowledge a Freedom from abuse notice to employees in addition to taking an abuse competency exam.¿This education specifically addressed the process for residents exhibiting inappropriate/aggressive behaviors to include sexual behaviors that have the ability to cause harm to self or others to place resident on 1 to 1, notify DON/ED until psychiatrist/MD can address and when an involuntary discharge cannot be obtained.

Facility IDT team to conduct Zone Rounds daily. Rounds include specifically the monitoring for safety, supervision, and monitoring for any potential abuse situation. This includes the weekend manager on duty process. Results of Zone Rounds reviewed daily at Daily

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F 610	Continued From page 74 documented, "I was going to clean [Resident #5's] room and the door was shut so I knocked on the door and then opened it. When I opened the door [Resident #5] was standing in front of [Resident #7] with his brief and pants pulled down and [Resident #7] was sitting on the bed. I went to the nurses station to let them know and [CNA #5 and CNA #6] went to the room and when they opened the door [Resident #5] was on top of [Resident #7] with his pants down. The got [Resident #7] out of the room." CNA #5's statement dated 4/13/19 documented, "...housekeeper...came and got me & [CNA #6] because [Resident #5] had [Resident #7] on his bed with his hand inside her pants, Also [Resident #5] had his penis exposed...Earlier during lunch he also was trying to touch her in the dinning [dining] room." (sic) CNA # 6's statement dated 4/13/19 documented, "...were alarted [alerted] by a staff member...of house keeping that resident [#5] had another resident in his room [with] the door closed. Upon arriving to his room [Resident #5] had his pants down on the floor penis exposed with his hand in [Resident #7's] breif [brief]..." (sic) Resident #7's clinical record documented the resident had a history of wandering about the dementia unit. A care plan note dated 3/12/19 documented the resident was oriented to self only, frequently refused to respond and daily walked about the dementia care unit independently. Resident #7's plan of care (revised 3/13/19) listed the resident had wandering and exit seeking behaviors, impaired safety awareness, impaired cognition, garbled speech and impaired decision-making abilities.	F 610	Leadership Stand up. Zone rounds are submitted to and maintained by the NHA. NHA to report results of Zone Rounds audits to reported monthly to QAPI Committee. Social Services Director will conduct random sample of resident, family, and staff interviews for 5 residents to ensure they are free of abuse weekly x 8 weeks. Findings to be reported to QAPI committee monthly. Quality monitoring schedule to be modified based on findings. The QAPI Committee is responsible for the on-going monitoring for compliance. Allegation of Compliance: 06/21/2019	

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Interventions to minimize behaviors included, "Anticipate and meet [Resident #7's] needs...Explain all procedures...Intervene as necessary to protect the rights and safety of others...Divert attention. Remove from situation and take to alternate location as needed...Monitor behavior episodes and attempt to determine underlying cause...Check placement of wander guard...Distract [Resident #7] from wandering by offering pleasant diversion, structured activities, food, conversation...Identify pattern of wandering..."

Resident #5 had an ongoing history of aggressive physical and sexual behaviors directed toward others. Resident #5 was admitted to the facility on 10/24/17 and readmitted on 01/26/19 with diagnoses that included PTSD (post-traumatic stress disorder), depression, vascular dementia with behaviors, seizures, hypertension and diabetes. The most recent MDS dated 2/19/19 assessed Resident #5 with moderately impaired cognitive skills (total cognitive score of 10 out of 15). This MDS documented the resident wandered and had behaviors almost daily directed toward others.

Resident #5's clinical record included documentation of sexual inappropriateness on a social service progress review dated 6/27/2018. Exacerbation of his verbal and sexual behaviors was documented starting December 2018 through April 2019. This documentation was included in physician progress notes, nursing progress notes, behavior monitoring flow sheets, social service progress notes, and physician orders.

Resident #5's plan of care (revised 12/26/18)

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listed the resident had behaviors that included urinating in the floor, wandering, getting up in the middle of the night with confusion, a preference for nudity, sleeping in other residents' beds, standing on furniture and sexually inappropriate behaviors. Interventions to reduce behaviors included, "Intervene as necessary to protect the right and safety of others," approach/speak in a calm manner, divert attention, remove from situation and take to alternate location as needed, monitor behavior episodes and attempt to determine underlying cause considering location, time of day, persons involved and situations and document behavior and causes.

Resident #5's plan of care (revised 12/26/18) and Resident #7's plan of care (revised 3/13/19) made no mention of the sexual incident on 4/13/19 or of any interventions or plan implemented for resident protection following the incident.

Three days later on 4/16/19, Resident #5 physically attacked Resident #6 in the dining room. A facility reported incident form dated 4/16/19 documented Resident #5 was unable to be redirected and sexually assaulted Resident #6 while in the dining area. Police removed Resident #5 from the facility on 4/16/19.

On 5/8/19 at 12:30 p.m., the licensed practical nurse (LPN #2) working on the dementia unit on 4/13/19 was interviewed about any interventions put in place following the incident to protect Resident #7 and other residents from abuse. LPN #2 stated staff members were supposed to redirect Resident #7 if she went near Resident #5's room and to keep them away from each other when in the dining room. LPN #2 stated no

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residents on the unit were placed on constant, one to one supervision.

On 5/9/19 at 10:00 a.m., the director of nursing (DON) and administrator were interviewed about Resident #7's abuse on 4/13/19 and any interventions put in place following the incident to protect residents. The DON stated the nurse practitioner gave an order on 4/13/19 to send Resident #5 to the emergency room because of the aggression and threat to other residents. The DON stated the police and adult protective services came to the facility and the police refused for to remove Resident #5 because he was no longer aggressive. The DON stated emergency services refused to come because the police refused to remove the resident. The DON stated the nurse practitioner discontinued the discharge order because police and emergency services refused to take the resident out of the facility. When asked what was done next, the DON stated the psychiatrist was contacted who ordered medication changes for Resident #5. The DON stated they placed a Velcro stop sign across Resident #5's door to deter wandering residents from entering his room. The DON stated staff were supposed to monitor Resident #5 and other residents and intervene as needed. The DON stated there was no one to one supervision of Resident #5 or any other residents implemented after the abuse incident. The DON stated on 4/16/19 Resident #5, in the dining room with other residents and staff, got up and grabbed Resident #6. The DON stated she went to the magistrate on 4/16/19 and got an emergency order for Resident #5's discharge to the emergency room. When asked about any room changes, the administrator stated Residents #5 and #7 needed to stay on the

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locked dementia unit, as they were both at risk for elopement. When asked why there was no constant supervision of Resident #5 or any other plan to ensure protection of other residents, the DON stated, "He [Resident #5] would overpower you." When asked if the medical director was involved in developing any plans to manage Resident #5's behaviors for protection of others, the DON stated, "No."

The facility's policy titled Abuse, Neglect, Exploitation & Misappropriation (revised 11/28/17) documented, "...The Company recognizes that resident abuse can be committed by other residents, visitors, or volunteers...The center is committed to the prevention of abuse, neglect, misappropriation of resident property...The following systems have been implemented...Monitoring of residents who may be at risk is the responsibility of all facility staff. This includes monitoring residents who are at risk or vulnerable for abuse, for indications of changes in behavior, changes in condition or other non-verbal indications of abuse..." This policy documented concerning protection of residents following an abuse allegation, "...Increased supervision of the alleged victim and residents...Room or staffing changes, if necessary, to protect the resident (s) form [from] the alleged perpetrator...Protection from retaliation...Provide the resident with emotional support and counseling during and after the investigation, if needed."

These findings were reviewed with the administrator, director of nursing and corporate consultant during a meeting on 5/9/19 at 10:30 a.m.

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F 656	Continued From page 79	F 656		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656		6/21/19

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F 656	Continued From page 80 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and in the course of a complaint investigation, facility staff failed to develop a CCP (comprehensive care plan) for three of eight residents in the survey sample, Residents #6, #1, and #4. 1. Facility staff failed to develop a CCP for Resident #6 to include sexual abuse that occurred involving another resident. 2. Facility staff did not develop a sexual behavior care plan for Resident #1. 3. Facility staff failed to develop a care plan for the use of a Broda chair for Resident #4. Findings included: 1. Resident #6 was admitted to the facility on 06/11/2018 with diagnoses including, but not limited to: Alzheimer's Disease, Dementia, Anxiety, Depression, Hypertension and Heart Failure. The most recent MDS was a quarterly assessment with an ARD of 03/28/2019. Resident #6 was assessed as severely impaired in her short and long term memory and daily decision making skills. Resident #6's clinical record was reviewed on	F 656	F 656 Resident #6 comprehensive care plan updated on 5/24/2019 to reflect behaviors. Resident #1 no longer resides in the facility. Resident # 4 comprehensive care plan has been updated to reflect use of broda chair on 5/8/2019. All resident with behaviors have the potential to be affected. Behaviors are monitored through weekly behavior meetings and behavior flow sheets to track and trend frequency and type. Care plans are updated during weekly meeting and as needed for accuracy. A review of care plans for identified residents with behaviors will be conducted by the Assistant Director of Nursing and IDT committee to ensure care plan accuracy and implementation by 6/7/2019. A review of residents with patient care devices will be conducted to ensure care plans reflect the device used. Licensed staff, social services and MDS will be re-educated by Corporate Clinical Quality Specialist on developing and implementing person centered comprehensive care plans by 6/18/19. Director of Nursing to conduct quality	

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F 656	Continued From page 81 05/08/19 at approximately 3:00 p.m. An Interdisciplinary Progress Note dated 4/16/19 included: "Resident involved with another resident who was sexually inappropriate by being observed having one hand in her pants and one hand on her breast in the dining area x2 (times two) this evening..." A note dated 4/17/19 7p-7 documented: "Resident rested well with no signs or symptoms of distress or anxiety. Verbally states 'I am okay.' 'No, I am not in pain.'..." A second note dated 4/17/19 7a-7p: "Resident s/p (status post) incident day #1. No unusual behaviors. No c/o (complaints of) pain/discomfort..." No further documentation was noted in the clinical record. The CCP for Resident #6 was reviewed and did not include any documentation regarding the incident from 4/16/19 or any documentation for emotional or physical distress. The DON (director of nursing) was interviewed on 5/9 /19 at 10:10 a.m. regarding the current care plan for Resident #6. The DON stated, "Yes, I would agree the care plan needs to be more specific." The Administrator stated, "We don't put specific incidents on the care plan." No further information was received by the survey team prior to the exit conference on 05/09/19. This is a complaint deficiency. 2. Resident #1 was originally admitted to the facility on 09/25/12, with the most current	F 656	monitoring on the development of comprehensive care plans of 5 residents with behaviors to ensure care plan accurate per week x 8 weeks. Findings to be reported to QAPI committee monthly and updates as indicated. Quality monitoring schedule modified based on findings. Allegation of Compliance 6/21/19.	

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readmission on 06/05/17. Diagnoses for Resident #1 included, but were not limited to: obesity, abnormal posture, muscle weakness, hand contracture, depressive disorder, schizophrenia, mental retardation, intellectually disabled and anxiety disorder.

The resident's most current MDS (minimum data set) quarterly assessment dated 01/16/19 was reviewed and documented the resident was a "9" cognitively, indicating the resident had moderate impairment in daily decision making skills.

Resident #1's progress notes were reviewed from September 2018 to present [May 2018].

The progress notes documented throughout that the resident had inappropriate sexual behaviors that included aggression, responses, statements, and acts. None of the notes were specific regarding the sexual behaviors.

A progress note dated 11/16/18 documented, "...schizophrenia...anxiety...has behaviors of aggression, inappropriate response to verbal communication, wandering, disruptive sounds, sexual behaviors, socially inappropriate acts and hypervigilance..."

A progress dated 11/25/18 documented, "2:45 PM Resident was seen performing oral sex on another resident today. Resident educated on sexual activities being done in private and not in public...signature of LPN #12"

The resident's CCP (comprehensive care plan) was reviewed and did not document anything other than, "...behavior problem...yelling out for staff/visitors to push her...yelling out when needs

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aren't met...crying...takes leg rest out bag..resistive to care...sexually inappropriate..." This was the only place in the resident's CCP that documented sexual behaviors. The CCP did not specifically identify what the sexually inappropriate behaviors were and there were no specific interventions regarding sexually inappropriate behaviors.

On 5/8/19 at 4:50 PM, the DON (director of nursing), the administrator and ADON (assistant director of nursing) were interviewed regarding the above nursing note. The DON, administrator, and ADON all stated that this was the first they had heard of this. The DON stated that she knew of resident's sexual behaviors and that the resident was a stripper and a prostitute when she was young and the resident carried those behaviors with her. The DON stated that the resident was known to have sexual behaviors and would offer exchanges of sexual favors to residents and/or visitors for Pepsi, chips or money. The DON stated that the resident would make offers to engage in oral sex or give a "hand job" for 5 dollars. The DON stated that it has been going on as long as she (DON) has been at the facility. The administrative staff were informed that there was not a CCP for this resident regarding this information, nor was there an assessment to ensure that the resident was capable of making such decisions.

On 5/9/19 at 7:30 AM, LPN #12 was interviewed regarding the nursing note. The LPN stated that a staff member told her about this incident. The LPN stated that the incident occurred downstairs near the snack machines. LPN #12 stated that she told the residents they needed to do that in private. LPN #12 stated that she reported that to

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LPN #11 and LPN #11 then in turn notified the DON. LPN #12 stated that she spoke to the residents and their BIMS score was high enough for them to make that decision, told them it needed to be done in private, not in the halls where others could see. LPN #12 was asked if she thought that was a sound decision on Resident #1's part, considering that the resident was assessed as a 9 cognitively. LPN #12 stated, "I don't know how to answer that...she's made her own decisions as long as I've known her...I've never known her do that in public, I believe if she had sexual behaviors it was in private...I thought she was care planned for sexual behaviors."

On 5/9/19 at 7:45 AM, LPN #11 was interviewed. LPN #11 stated that it happened on the weekend and she was not here, she was taking call. LPN #11 stated that LPN #12 called her and told her what had happened and stated that she contacted the DON, who said their BIMS score was high enough. LPN #11 was asked if she felt like an assessment should have been completed on Resident #1. LPN #11 stated that they were consenting adults and we put it in their behavior book and that the sexual behaviors are care planned. LPN #11 was made aware that those behaviors were not care planned. LPN #11 was asked if she felt like an assessment should have been completed on Resident #1. LPN #11 stated that she did not think an assessment needed to be completed.

On 5/9/19 at 10:30 AM, the survey team met with the DON, administrator and quality specialist regarding Resident #1's sexual behaviors and that the resident was not assessed or care planned for such behaviors. The DON was

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asked again if she had knowledge of the incident. The DON stated, "Originally, I said I didn't have knowledge, but I'd like to take that back." The DON stated that it was reported, as per the above interviews, and that it was discussed and they were consenting adults. The DON was asked if she felt like Resident #1 could make a safe, sound, reasonable decision about such sexual acts. The DON stated, "Yes, I do feel like she could make that decision." The DON then stated, "I agree that an assessment should have been done and it should have been care planned." The DON stated that she didn't think she had told the administrator about this incident when it happened and didn't feel like that was a reportable event. The administrator stated, "I just found out about it yesterday."

No further information and/or documentation was presented prior to the exit conference on 5/9/19 to evidence Resident #1 was assessed or that the resident had a CCP developed for sexually explicit behaviors and acts.

3. Resident #4 was admitted to the facility on 1/17/19 with diagnoses that included dementia with behaviors, vertigo, hypothyroidism, cerebrovascular disease, anxiety, chronic pain syndrome and constipation. The minimum data set (MDS) dated 4/10/19 assessed Resident #4 with short and long-term memory problems and severely impaired cognitive skills.

On 5/7/19 at 11:45 a.m., Resident #4 was observed seated in a Broda wheelchair in the dining room.

Resident #4's plan of care (revised 1/28/19) included no problems, goals and/or interventions regarding use of the Broda chair.

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F 656	Continued From page 86 On 5/7/19 at 4:10 p.m., the registered nurse (RN #2) caring for Resident #4 was interviewed the Broda chair. RN #2 stated she did not know anything about the chair. RN #2 stated therapy provided the Broda chair. On 5/7/19 at 11:00 a.m., the occupational therapist (OT) was interviewed about Resident #4's Broda chair. The OT stated the resident was provided the Broda chair for better wheelchair positioning. The OT stated the resident had been in the chair for approximately two weeks and in-service education was provided to the nursing and aide staff regarding use of the chair. On 5/8/19 at 11:15 a.m., the licensed practical nurse unit manager (LPN #8) was interviewed about a plan of care regarding the Broda chair. LPN #8 stated therapy did not notify nursing about use of the chair. LPN #8 reviewed the in-service education book and stated no education information had been provided for the nursing staff about the Broda chair and there was nothing added to the care plan. On 5/8/19 at 11:30 a.m., LPN #10, responsible for MDS and care plans was interviewed about Resident #4's Broda chair. LPN #10 stated there was no care plan about the Broda chair because she was not aware the resident used a Broda chair. This finding was reviewed with the administrator and director of nursing during a meeting on 5/8/19 at 4:30 p.m.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		6/21/19

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F 657	Continued From page 87 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and during the course of a complaint investigation the facility staff failed to review and revise the CCP (comprehensive care plan) for three of 8 residents in the survey sample, Resident #1, Resident #3 and Resident #5. 1. The facility staff failed to review and revise the CCP for Resident #1 in the area of falls.	F 657	F 657 Resident #1 no longer resides in the center. Resident # 3 comprehensive care plans has been updated to reflect falls from 11/1/2018, 2/2/2019, and 4/13/2019 on 5/24/2019. Resident # 5 no longer resides in the center.	

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F 657	Continued From page 88 2. Resident #3 had an unwitnessed/unsupervised fall on 11/1/18. The resident had a fall on 2/2/19. The resident had a fall on 4/13/19 that unwitnessed and unsupervised. The resident's CCP was not reviewed and revised related to these falls. 3. Facility staff failed to review and revise Resident #5's care plan for increased verbal and sexual behaviors. Findings include: 1. Resident #1, was originally admitted to the facility on 09/25/12, with the most current readmission on 06/05/17. Diagnoses for Resident #1 included, but were not limited to: obesity, abnormal posture, muscle weakness, hand contracture, depressive disorder, schizophrenia, mental retardation, intellectually disabled and anxiety disorder. The resident's most current MDS (minimum data set) quarterly assessment dated 01/16/19 was reviewed and documented the resident was a "9" cognitively, indicating the resident had moderate impairment in daily decision making skills. The resident was assessed as requiring extensive assistance for bed mobility, dressing, hygiene, and locomotion on and off the unit. The resident was assessed as requiring total assistance for transfers, toileting, eating, and bathing. In section G0300. "Balance During Transitions and Walking" the resident was assessed and an "8" [indicating the activity did not occur] for moving from seated to standing, walking, turning around, and moving on and off toilet. The resident was assessed as not steady, only able to stabilize with	F 657	All resident have the potential to be affected. Behaviors are monitored through weekly behavior meetings and behavior flow sheets to track and trend frequency and type. Care plans are updated during weekly meeting and as needed for accuracy. A review of care plans for identified residents with behaviors will be conducted to ensure care plan accuracy and implementation by 6/7/19. A fall risk assessment is completed upon admission, quarterly, and with a significant change in condition. Care plans are updated accordingly and with each fall with new interventions in place. A review to be completed on comprehensive care plans for residents with falls in past thirty days with behaviors and falls to ensure they are accurate in reflecting falls and behaviors by Assistant Director of Nursing by 6/7/19. Licensed nurses/MDS Coordinator re-educated by the Corporate Clinical Quality Specialist related to care plan timing and revision, care plan is to be reviewed and revised by the interdisciplinary team as indicated including both the comprehensive and quarterly review assessments, care plans are to be updated with new Physician orders as indicated to include fall interventions and accurately reflects residents behavior by 6/18/2019. Director of Nursing to conduct quality monitoring on the development of comprehensive care plans of 5 residents with behaviors to ensure care plan	

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F 657	Continued From page 89 staff assistance for surface to surface transfers. The resident was additionally assessed as having impairment on both sides (right/left) for upper and lower extremities for functional limitations in range of motion. An annual MDS dated 4/4/19 documented that the resident had one fall with injury (not major). Resident #1's most current physician's orders were reviewed and included: "Hoyer lift for all transfers every shift [10/17/18] and high back w/c when out of bed." A fall risk assessment dated 4/5/19 documented, "Total score of 10 or above deems resident at risk" Resident #1 was documented with a fall risk score of "14" indicating the resident was a high fall risk. Progress notes for this resident were reviewed and documented: 2/13/19 - "CNA [certified nursing assistant] reported resident found on floor next to bed at 6:30 AM...unwitnessed...bruise to left outer thigh, no head injuries notes...alert and verbal...complained of left arm and left leg pain...assisted to bed with mechanical lift, dressed and assisted to w/c [wheelchair]..." 2/13/19 - "...discuss residents fall from 2/13/19...found on floor in room beside bed, bruise to ...thigh...staff implemented neuro checks, safety checks and resident on early riser list..." 2/13/19 - "...total lift for transfers. May porch sit with staff or family supervision...enjoys going out to smoke..."	F 657	accurate per week x 8 weeks. Findings to be reported to QAPI committee monthly and updates as indicated. Quality monitoring schedule modified based on findings. Allegation of Compliance: 06/21/2019	

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2/14/19 - "...no obvious signs of pain or trauma...mood swings...bouts of crying...difficult to redirect..."

2/15/19 - "...able to voice needs...earlier in shift resident yelling out continuously, extensive assist with ADL's, incontinent...extensive assist with bed mobility...Is fed by staff, Transfers with hoyer lift X 2..."

A quarterly data collection assessment dated 4/5/19 documented, "...memory problem, verbally abusive, resists care, inappropriate/disruptive behavior...does the resident smoke: No...Functional: tremors, spasms, shaking of upper extremities: Yes...Contractures: fingers, hands, wrist, elbow, shoulder or dominant side/non dominant side: Yes...Strength: weakness, paresis, paralysis of upper extremity: Yes...Posture: Unable to maintain trunk control or upright posture: Yes..."

Resident #1's CCP dated 2/13/19 documented the only update to the care plan was safety check for 72 hours, neuro checks, and placed on the early riser list. No other interventions were implemented. No safety checks were found, nor were neuro checks found in the resident's clinical record.

The resident then had a fall with major injury on 4/8/19, which resulted in severe injury and death, as a result of the fall.

On 5/8/19 at 10:00, the DON (Director of Nursing), administrator and ADON (assistant director of nursing) were made aware that the interventions for fall prevention for Resident #1,

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after an actual fall occurred, did not evidence any interventions were implemented to prevent further falls for this resident. The ADON stated that the facility changed over to a new system or "notebook" in the computer system for care plans. The ADON stated that this was done on 11/19/18. This new system made it look as though interventions were started and revised on 11/19/18, but the interventions were actually the same interventions that had been in place before 11/19/18.

No further information and/or documentation was presented prior to the exit conference on 5/9/19 to evidence the resident's CCP was reviewed and revised for the prevention of falls.

This is a complaint deficiency.

2. Resident #3 was admitted to the facility on 5/26/17. Diagnoses for this resident included, but were not limited to: high blood pressure, cancer lesion on left forehead, anxiety disorder, depression, dementia, vitamin d deficiency, muscle weakness, disorder of the bone, history of falls, and history of wandering.

The most current MDS (minimum data set) was a quarterly assessment dated 3/4/19. This MDS assessed the resident with a cognitive score of 3, indicating the resident had severe impairment with daily decision making skills. The resident was also assessed as requiring limited assistance of one with transfers, and ambulation. The resident was assessed as requiring extensive assistance for total assistance for bathing and was assessed as not steady, only able to stabilize with human assistance for moving from seated to standing, walking, turning

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around, moving on and off toilet, and surface to surface transfers. The resident was assessed as wandering on this MDS. The resident's mode of transportation was a wheelchair.

The resident's annual MDS assessment with CAAS [care area assessment summary] dated 11/13/18 was reviewed for comparison. The resident was assessed as having one fall without injury in the look back period. The resident's mode of transportation was a wheelchair.

Resident #3's clinical records were reviewed. The resident's nursing notes revealed the following:

11/1/18 "...resident fell while in shower room with aide, hard bump on right arm with no complaints of pain, X-ray completed this PM."

11/2/18 "...post day 1 related to fall...has been up in w/c [wheelchair] today and propels self around on unit, continues to stand up without assistance, reminded resident to have assistance when getting up..."

11/5/18 "...met to discuss resident...fell in shower...Interventions are safety and staff education on always supervising residents while in shower..."

2/2/19 - "this nurse administering medications when [name of employee] ran down the hall and stated that [name of resident] had fallen out of her w/c...went down hall to find resident in prone position in front of her w/c...evaluated...assisted back to w/c x 2...no obvious injuries...She did hit her head as this was witnessed fall...going forward we are offering an earlier bedtime...all

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safety measures in place..."

4/13/19 - "...observed sitting in the floor in an upright position at 4 PM with her w/c behind her...open area to forehead was noted to be bleeding and swelling to nose/eye area, pressure applied...bleeding controlled...applied ice to nose as resident will allow...resident did complaint of headache at 5:30 PM...no further complaints of pain...safety checks and neuro checks...no new orders...DON notified...resident propelling self on unit at this time..."

4/15/19 - "...all safety measures in place..."

4/15/19 - "...neuro checks, safety checks, and dycem [mat to help prevent slipping] to w/c..."

4/16/19 - "...neuro checks, safety checks, and dycem to w/c..."

Resident #3 was observed on 5/7/19 and 5/8/19 without dycem to the resident's wheelchair for safety.

On 5/8/19 at approximately 10:20 AM, the DON (director of nursing) and the administrator were asked for any fall investigations for Resident #3.

A fall investigation was presented for Resident #3 regarding the fall in the shower room on 11/1/18. The investigation documented implemented interventions were: "assistance to transfer and walk, w/c - ambulation, gripper socks..."

A fall investigation was presented for Resident #3 regarding the fall in the hall on 4/13/19. The investigation documented, "...4/13/19 4:00 PM...dementia...found on floor, injuries

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observed...propels self in w/c on unit...resident observed sitting in the floor with her w/c beside her...interventions implemented 15 minute checks, 12 hours charting, ice as needed..."

Resident #3's CCP was reviewed and did not reveal that the above interventions were added to the resident's CCP.

On 5/8/19 at 10:00, the DON, administrator and ADON (assistant director of nursing) were made aware that the interventions for fall prevention for Resident #3, after actual falls occurred, were not added to the CCP and were not implemented. The ADON stated that the facility changed over to a new system or "notebook" in the computer system. The ADON stated that this was done on 11/19/18. The resident's current, resolved and canceled CCP's were reviewed. The care plan that the ADON was referring to made it look like all new interventions were initiated and started on 11/18/18, but all that had changed were the dates, the interventions were the same.

No further information and/or documentation was presented prior to the exit conference on 5/9/19 to evidence the resident's CCP was reviewed and revised for falls.

This is a complaint deficiency.

3. Resident #5 was originally admitted to the facility on 10/24/2017 and readmitted on 01/26/2019 with diagnoses including, but not limited to: Dementia with Behaviors, Depression, PTSD (post traumatic stress disorder), Seizures, Legally Blind, Hypertension and Diabetes.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment

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reference date) of 02/19/19. Resident #5 was assessed as moderately impaired in his cognitive status with a total cognitive score of 10 out of 15.

Resident #5's CCP (comprehensive care plan) was reviewed on 5/8/19 at 2:30 p.m. and included: "Focus: ...psychosocial well-being problem...Interventions: Consult with: Pastoral care, Social services, Psych services as he or his family requests...When conflict arises, remove (Name) Resident #5 to a calm safe environment and allow to vent/share feelings...Date Initiated: 10/03/2018."

"Focus: (Name) Resident #5 has a behavior problem urinating on floor, wandering, getting up in the middle of the night with confusion, sits self on floor, prefers to be nude, sleeps in others beds, stands up on furniture, sexually inappropriate r/t (related to) vascular dementia...Interventions: ...Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Date Initiated: 10/03/2018."

There was no mention of specific incidences regarding inappropriate verbal or sexual behaviors. There was also no mention of exacerbations in Resident #5's behaviors and any changes in treatment that were implemented due to his increased behaviors as documented in his clinical record.

The DON (director of nursing) was interviewed on

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F 657	Continued From page 96 5/9 /19 at 10:10 a.m. regarding the current care plan for Resident #5. The DON stated, "Yes, I would agree the care plan needs to be more specific. There is some work needed on care plans for sure." The Administrator stated, "We don't put specific incidents on the care plan." No further information was received by the survey team prior to the exit conference on 05/09/19. This is a complaint deficiency.	F 657		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, visitor interview, facility document review, clinical record review and complaint investigation, the facility staff failed to provide supervision and safety devices to prevent accidents for four of eight residents in the survey sample. Three of these accidents resulted in resident harm. 1. Resident #2, legally blind with severe cognitive impairment and wandering behaviors, was found in the stairwell of the facility on 2/17/19 at 3:10 a.m. with a laceration to her forehead. The	F 689	F 689 Resident #2's call bell was placed in residents reach on 5/8/2019 and the door alarm was changed on 3 New West stairwell door that leads to front lobby on 2/17/19, Maintenance staff/Manager on Duty will check functionality of door alarms daily and increased checks to be completed by 3 New West nurse each shift to validate functionality of alarms. Resident #2's care plan was updated to	6/21/19

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resident was last seen on her living unit in bed on 2/17/19 at 1:15 a.m. The stairwell door alarm to alert staff of any entrances to the stairwell malfunctioned and was not sounding at the time of the incident. The resident was diagnosed with a subdural hematoma and swelling/bruising/pain of the right hand/wrist as a result of the fall. Resident #2 was also observed in bed during the current survey without access to her call bell as required in her plan of care for safety.

2. Resident #4, with a history of frequent falls and severe cognitive impairment, fell on the dementia unit while unsupervised, resulting in a laceration to the back of her head requiring closure with three staples.

3. While unsupervised, Resident #1 exited the facility in her wheelchair, rolled down a hill, fell from the wheelchair, and sustained traumatic injury. The resident was sent to the hospital, emergently airlifted to higher level of care hospital and subsequently expired two days later, as result of the injuries sustained during this fall.

4. Resident #3 fell while unsupervised in the shower room on the dementia care unit. Resident #3 did not have a Dycem anti-slip device in her wheelchair as documented in her clinical record for fall prevention/safety.

The findings include:

1a) Resident #2 was admitted to the facility on 8/30/18 with diagnoses that included intellectual disability, legal blindness, diabetes, muscle weakness, failure to thrive and high blood pressure. The minimum data set (MDS) dated 3/8/19 assessed Resident #2 with severely

include supervision to prevent falls with the following interventions; monitoring call light placement, staff awareness of visual impairment, med review, non skid strips at bedside, bowel and bladder program, staff education, and landing strip at bedside. The staff member responsible for supervision during Resident # 3's fall 11/1/2018 is no longer employed at the center. Resident # 3's care plan was updated to include supervision to prevent falls, with the following interventions; monitor placement of Dycem, supervision during showers, dump w/c seat, offer earlier bed time as resident allows and Dycem to wheel chair. Resident #3's Dycem placed in chair on 5/9/2019. Resident #4's care plan was updated to include supervision to prevent falls, with the following interventions; med review, aroma therapy for calming, med review due to new medication, bowel and bladder program and landing strip at bedside. Front doors will be locked at 8pm by receptionist and verified by the nurse on 2 North South.

Residents with visual impairment, cognitive deficit, wandering behavior and history of falls have the potential to be affected. A quality review will be completed by the Assistant Director of Nursing on 6/19/19, for residents with visual impairment, cognitive deficit, wandering behavior and falls in last 30 days to ensure appropriate supervision and interventions are in place to prevent accidents including location awareness for visually impaired residents, call bell

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F 689	Continued From page 98 impaired cognitive skills, severely impaired vision and as requiring limited assistance of one person for ambulation. Resident #2's clinical record documented a nursing note dated 2/17/19 stating, "Resident was directed to her room and put to bed about 01:15 [a.m.]. Staff from another unit escorted patient to dining room & reported that resident was found in stairwell @ 0310 [3:10 a.m.]. Resident had bloodied area to right forehead no actively bleeding. Area and a resident mental status & pain level assessed. [Physician] notified @0315 and ordered send out via rescue squad to the emergency room for evaluation and treatment..." (sic) The emergency room report dated 2/17/19 documented, "...Staff reported to EMS [emergency medical services] found patient at bottom of stairs. Not able to report how many steps she may have fallen. Went missing from unit somewhere between 0115 and 0310. Has hematoma/bleeding to right forehead. Pain and swelling/bruising to right hand...is legally blind." (sic) This emergency room report listed the resident was diagnosed with a subdural hematoma and a 2 centimeter laceration to her right forehead area repaired with staples. The resident was referred to a university neurological center for further evaluation of the subdural hematoma. The university hospital report dated 2/17/19 documented, "...went missing from her nursing facility room...at 01:00 this morning, and she was found several hours later at the bottom of the staircase after apparently suffering a fall...originally complained of neck pain and right	F 689	placement, adaptive equipment and fall precautions in place, secured exit doors and a clean home like environment. Fall risk assessment will be completed on all active residents to ensure appropriate measures are in place to prevent falls and appropriate supervision is achieved by 6/20/18. Care plans and Kardex's will be updated to reflect outcome of the quality review and assessments. Nursing staff to be re-educated by Corporate Clinical Quality Specialist on supervision of "at risk" residents, reading care plans and Kardex's as it relates to supervision of residents to prevent falls, monitor behavior, monitor location, monitor exits and other appropriate interventions, including call bells being in place by 6/20/19. All staff to be re-educated by Divisional Executive Director or Corporate Clinical Quality Specialist on improved process for stairwell and front door alarm system monitoring by 6/20/19. Director of Nursing will conduct quality monitoring of 5 residents with falls, visual impairment or wandering behavior to ensure root cause analysis complete, supervision and intervention in place weekly for 8 weeks. Executive Director/Maintenance staff/Manager on duty will conduct quality monitoring of door functionality 5x per week for 4 weeks, 3x per week for 4 weeks, and then 2x weekly for 2 months and monthly thereafter. Facility IDT team to conduct Zone Rounds daily. Rounds include specifically the	

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F 689	Continued From page 99 wrist pain...noted to have a head laceration and bruising to her right wrist upon examination... CT head performed...visualized an SDH [subdural hematoma] 4.5 mm [millimeters] in thickness...On further our position with the nursing home, patient fell at approximately 3:00 a.m. and picked herself up and sat on the stairs without any help...She is also noted to be blind at baseline." (sic) The resident had a repeat CT scan of her head and discharged back to the facility on 2/17/19 with no surgical intervention required. The facility's investigation of Resident #2's fall in the stairwell documented the alert/alarm system on the stairwell door was not functioning properly at the time of the incident. Witness statements documented staff caring for Resident #2 last saw the resident at 1:15 a.m. in bed. An employee from another unit found Resident #2 in the stairwell on 2/17/19 at 3:10 a.m. Certified nurse's aide (CNA) #7's written statement dated 2/17/19 documented, "At 1:15 [a.m.] I seen Resident [#2] in her bed. @ 3:10 [a.m.] another staff member brought her back to the unit from the stairwell." CNA #8, who found Resident #2 in the stairwell, wrote a statement on 2/17/19 stating, "Reporting witness used the side stair way to clock at approx. 2:57 A [a.m.] when staff returned to the stairway to exit the building, slight noises and shuffling were heard. Reporting witness walked up the stairs to find out what the noises were, and found Resident [#2] sitting on the stairs with her head in her hands covered in blood. There was a small golf ball sized opening on her head. There was also blood on the floor...assisted resident back to her unit...Reporting witness and other	F 689	monitoring for safety and supervision. This includes the weekend manager on duty completing Zone Rounds for the building on weekends. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. Allegation of Compliance: 06/21/2019	

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aide assisted resident to the dinning [dining] room to sit down. She, the resident made several comments about feeling pain w/ [with] her head..."

Resident #2's plan of care (revised 9/21/18) documented the resident was at risk for falls due to blindness, wandering and gait/balance problems. Interventions to minimize injury included, anticipating and meeting resident needs, call light within reach, appropriate footwear and therapy to evaluate as needed. Multiple nursing notes in December 2018 documented the resident wandered about the unit and sometimes mistakenly went into other resident rooms. Resident #2's CNA Kardex sheet (undated) listed the resident as blind and to require the assistance of one person for ambulation.

On 5/7/19 at 1:30 p.m., the licensed practical nurse unit manager (LPN #6) was interviewed about Resident #2's fall in the stairwell. LPN #6 stated Resident #2 went out of the unit into the stairwell and fell. LPN #6 stated the door alarm was not functioning properly and did not alert staff when the resident entered the stairwell. LPN #6 stated Resident #2 was blind and frequently ambulated on the unit following the handrail. LPN #6 stated the resident at times went into other resident rooms, as she was confused and visually impaired.

On 5/7/19 at 4:15 p.m., a certified nurse's aide (CNA #3) that routinely care for Resident #2 was interviewed about Resident #7. CNA #3 stated the resident ambulated on the unit, usually following the handrail. CNA #3 stated the resident required the assistance of one person for walking, as she was unsteady on her feet and

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had difficulty finding her room due to blindness.

On 5/7/19 at 4:50 p.m., the administrator and director of nursing (DON) were interviewed about Resident #2's fall in the stairwell. The DON stated CNA #8 went down the stairwell from the third floor to clock out and leave work on 2/17/19 at 2:57 a.m. The DON stated CNA #8 reported she did not see the resident in the stairwell at that time. The DON stated when CNA #8 went back into the stairwell to go home, she heard and found Resident #2 on the stairs, bleeding from her head. The administrator stated their investigation found the alarm on the stairwell door was not functioning properly at the time of the fall. The administrator stated when they tested the alarm after the accident, the alarm sounded but only for a few seconds. The administrator stated that stairwell doors in the facility were not locked but only had alarms that sounded when the door was opened. The DON stated CNA #8 reported there was no alarm sounding when she found Resident #2 in the stairwell. The DON stated the resident was blind, ambulated on the unit, usually following the handrail and sometimes went into others' rooms. The DON stated the "big issue" with this accident was the malfunctioning alarm on the stairwell door. The DON stated the maintenance director reported the "motherboard" was bad on the door alarm unit.

On 5/7/19 at 5:30 p.m., the registered nurse (RN #2) caring for Resident #2 at the time of the incident was interviewed by telephone. RN #2 stated she was passing medications and doing "rounds" when a CNA from another unit brought Resident #2 from the stairwell to the dining room. RN #2 stated she assessed the resident who had a laceration on her forehead. RN #2 stated she

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assumed the resident opened the door and went into the stairwell. RN #2 stated she did not see Resident #2 walking in the hall prior to the incident. RN #2 stated she heard no alarm sounding on the shift indicating anyone had entered the stairwell. RN #2 stated there was no door alarm sounding when the resident was found. RN #2 stated Resident #2 ambulated independently, usually following the handrail.

On 5/7/19 at 6:00 p.m., the maintenance director was interviewed about the malfunctioning alarm. The maintenance director stated the alarm was supposed to sound until a staff person entered a code to stop the alarm. The maintenance director stated there were no locks on the stairwell doors, only alarms. The maintenance director stated when he checked the alarm after the incident, it alarmed for only a few seconds and stopped. The maintenance director stated his department performed daily checks on the alarm. The maintenance director presented a checklist indicating the alarm was last checked prior to the accident on 2/15/19.

These findings were reviewed with the administrator and director of nursing during a meeting on 5/8/19 at 4:30 p.m.

1b) On 5/7/19 at 11:30 p.m., Resident #2 was observed in bed. Her call bell was located on the floor on top of a pile of personal items located between the bed and the bedside table. The call bell was out of the resident's reach. Resident #2 was observed again on 5/7/19 at 1:20 p.m. in bed. The call bell was in the floor between the bed and the bedside table.

Resident #2's plan of care (revised 9/21/18)

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documented the resident was at risk for falls due to blindness, wandering and gait/balance problems. Interventions to minimize injury included, "...Call light within reach..."

On 5/7/19 at 4:50 p.m., the director of nursing (DON) was interviewed about safety interventions for Resident #2. The DON stated the call bell was supposed to be kept within the resident's reach. The DON stated the resident used the call bell but not always consistently.

On 5/8/19 at 9:00 a.m., the licensed practical nurse (LPN #5) caring for Resident #2 was interviewed about the call bell. LPN #5 stated the call bell was supposed to be within the resident's reach when in bed. LPN #5 stated the call bell was usually attached to the side rail near the head of the bed. LPN #5 stated the resident was blind so they tried to keep the call bell and her personal items within reach.

This finding was reviewed with the administrator and director of nursing during a meeting on 5/8/19 at 4:30 p.m.

2. Resident #4 was admitted to the facility on 1/17/19 with diagnoses that included dementia with behaviors, vertigo, hypothyroidism, cerebrovascular disease, anxiety, chronic pain syndrome and constipation. The minimum data set (MDS) dated 4/10/19 assessed Resident #4 with short and long-term memory problems, severely impaired cognitive skills and to require the extensive assistance of one person for ambulation.

Resident #4's clinical record documented a nursing note dated 4/13/19 stating, "At

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approximately 1600 [4:00 p.m.], I was exiting the nurses station towards the dining room when a visitor alerted me that Resident had fallen. I approached Resident, she was alert and lying on her back on the ground. resident was responding to questions. Resident had blood pooling underneath her head. 911 call was initiated..."

The emergency room report dated 4/13/19 documented, "Received...following a fall. She has a lac [laceration] to the back of her head, bleeding controlled..." The report documented the resident was assessed with a 3 centimeter linear laceration on the back of her head. The report documented the laceration was repaired with three staples to be removed after 5 days. The resident was discharged back to the facility with orders for wound care.

The facility's investigation of Resident #4's fall on 4/13/19 documented the fall/injury was reported by a visitor and not witnessed by any staff members. The investigation report dated 4/13/19 documented the resident required the assistance of one person for ambulation and stated the resident was found by a visitor in the floor in the dining room hallway with another resident in the floor next to her. A written witness statement dated 4/13/19 by the registered nurse working at the time of the incident documented, "...a visitor alerted me that two residents had fallen. As I approached, [Resident #4] was lying on the ground on her back. Patient was alert, moaning. Patient had a pool of blood underneath her head. I immediately told staff to call 911. I was informed that the call had already been initiated by a visitor...The second patient was [Resident #3] whom was sitting upright, alert..." (sic)

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Written statements from three CNA's working on the unit at the time of the incident documented they were providing care to other residents and did not see the incident or know what happened.

Resident #4's clinical record documented the resident ambulated/wandered on the dementia unit and had experienced seven prior falls since her admission on 1/17/19. A fall risk assessment completed on 4/3/19 documented the resident as a high risk for falls.

Resident #2's plan of care at the time of the fall (revised 1/28/19) listed the resident was at risk of falls due to confusion, gait/balance problems, poor safety awareness and use of psychoactive medications. Interventions to minimize falls/injury included anticipating resident needs, call light within reach, proper footwear, therapy evaluation as needed and safety checks following any fall.

On 5/7/19 at 4:10 p.m., an interview was conducted by telephone with the visitor that found Resident #4 on 4/13/19. The visitor stated that the incident occurred on 4/13/19 between 3:00 p.m. and 5:00 p.m. The visitor stated he was visiting in the common area on the dementia unit when he heard two loud thumps and a commotion. The visitor stated he found two women in the floor and they were unable to get up. The visitor stated one of the women was on top of the other, with the one on top bleeding from the front of her head and the one on the floor bleeding from the back of her head. The visitor stated blood was pooling on the floor with both women bleeding profusely. The visitor stated no staff were in the hall or in the common area when all of this occurred. The visitor stated he went to the nurse's station and told the nurse at the desk.

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The visitor stated the nurse was not able to see the residents from the station. The visitor stated he called 911 and was concerned because no staff members were there when these women fell.

On 5/8/19 at 11:15 a.m., the licensed practical nurse unit manager (LPN #8) was interviewed about Resident #4's fall/injury. LPN #8 stated staff members did not witness Resident #4's fall. LPN #8 stated staff were busy passing out meal trays and attending to other residents at the time of the fall. LPN #8 stated she did not know what happened with the two residents or the circumstances of the fall as no staff were present when it happened.

On 5/8/19 at 11:20 a.m., LPN #2, working on the dementia unit at the time of the incident, was interviewed. LPN #2 stated she was on the telephone with adult protective services about an abuse incident at the time of the fall. LPN #2 stated the fall was "weird" as she did not see Resident #4 walking in the hall prior to the incident. LPN #2 stated another staff member reported to her the residents were in the floor. LPN #2 stated when she went to the dining hall area, Resident #3 and #4 were in the floor. LPN #2 stated Resident #4's wheelchair was still in her room so she must have ambulated to the area. LPN #2 stated she saw Resident #4 in bed on 4/13/19 at approximately 3:30 p.m. LPN #2 stated she did not know what happened or how the resident fell as she was on the telephone.

On 5/8/19 at 11:50 a.m., the director of nursing (DON) was interviewed about Resident #4's fall on 4/13/19. The DON stated, "There was a lot going on that day." The DON stated staff

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members were present on the unit but probably not watching Residents #3 and #4. The DON stated this fall occurred on the same afternoon as an abuse incident and staff members were focused on other things.

This finding was reviewed with the administrator and director of nursing during a meeting on 5/8/19 at 4:30 p.m.

3. Resident #1, was originally admitted to the facility on 09/25/12, with the most current readmission on 06/05/17. Diagnoses for Resident #1 included, but were not limited to: obesity, abnormal posture, muscle weakness, hand contracture, depressive disorder, schizophrenia, mental retardation, intellectually disabled and anxiety disorder.

The resident's most current MDS (minimum data set) quarterly assessment dated 01/16/19 was reviewed and documented the resident was a "9" cognitively, indicating the resident had moderate impairment in daily decision making skills. The resident was assessed as requiring extensive assistance for bed mobility, dressing, hygiene, and locomotion on and off the unit. The resident was assessed as requiring total assistance for transfers, toileting, eating, and bathing. In section G0300. "Balance During Transitions and Walking" the resident was assessed and an "8" [indicating the activity did not occur] for moving from seated to standing, walking, turning around, and moving on and off toilet. The resident was assessed as not steady, only able to stabilize with staff assistance for surface to surface transfers. The resident was additionally assessed as having impairment on both sides (right/left) for upper and lower extremities for functional limitations in range of motion.

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A complaint investigation was conducted on 5/7/19 through 5/919. An allegation within the complaint alleged that Resident #1 was found outside of the facility on 4/8/19 by staff, fell from the wheelchair and sent to the hospital and later expired as result of the injuries. The resident's room was located on the 3rd floor, indicating the resident would have used the elevator to get to the lobby and exit the building.

Resident #1's most current physician's orders were reviewed. The resident had orders for: "Hoyer lift for all transfers every shift [10/17/18] and high back w/c when out of bed."

A fall risk assessment dated 4/5/19 documented, "Total score of 10 or above deems resident at risk." Resident #1 was documented with a fall risk score of "14" indicating the resident was a high fall risk.

An elopement risk assessment was completed dated 1/3/19 and 2/25/19 both documented that the resident is not at risk for elopement, but did document the following: "...Resident has poor decision making related to MR [mental retardation], has...anxiety, schizoaffective disorder and depression, is able to propel in w/c [wheelchair] [documented the same for both dates].

An eye exam dated 3/29/19 documented: "... [name of Resident #1]...glaucoma both eyes, cataracts right greater than left...poor historian...depression...Neuro: Oriented to person, time, place: No..."

Progress notes for this resident were reviewed

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and documented:

7/18/18 - "...resident is up daily in w/c...she is able to propel self..is alert and oriented X 2 and able to voice wants...will bring herself down to lobby and scream 'Help!' at the top of her lungs, non compliant with smoking policy...disruptive behaviors...signature of SW."

8/22/18 - "...up daily in w/c...able to propel self...alert and oriented X 2...propels throughout facility...does yell out disruptively...SW."

8/22/18 - "...hoyer lift for transfers, and may porch sit dependently with staff/family supervision...SW."

11/28/19 - "...able to propel self...will frequently yell out disruptively, curse, cry and ask others to push her in her w/c...scream 'help' when she doesn't get what she wants right away...goes out to smoke, to vending machines...SW."

2/13/19 - "...up out of bed daily, dressed and able to propel self...is a smoker...behaviors of yelling out, crying, asking visitors to push her in w/c, hitting hands on walls, sexually inappropriate...scream "Help Me"...often found at vending machines, buying snacks and drinks...SW."

2/13/19 - "...total lift for transfers. May porch sit with staff or family supervision...enjoys going out to smoke..."

2/22/19 A consult documented, "...70 year old woman with MR and schizophrenia is a resident here due to mental illness and physical debility...have fits of emotional liability but doesn't

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harm other residents or staff...requires a lot of hands on attention and reassurance...will sneak foods and frequently get snack foods in the vending machine...non compliant with her tobacco cessation recommendations...alert and awake, crying in the common area and yelling unitellibly..."

3/30/19 - "...propels self most of time, also pushed by staff..."

A Occupational Therapy evaluation dated 2/13/18 documented, "...schizophrenia, muscle weakness, generalized abdominal pain, abnormal posture...exacerbation of impaired postural alignment and impaired w/c positing indicating the need for OT to facilitate tolerance and postural control...resident is long term care...history of poor positioning in w/c with multiple referrals to therapy...has history of upper abdominal hernia which she reports is painful when sitting upright...and leaning to her right side...has been treated multiple times for positioning and w/c mobility...has been altered or changed several times to facilitated her best positioning with poor results overall...Precautions: fall risk, poor positioning, anxiety...able to self propel her w/c...total care with all...ADL's...has had multiple falls from her w/c due to not using leg rests, having other residents propel her chair for her, and sliding from the chair due to weakness in her core...bilateral leg rests of which she often uses either none or left only...sometimes uses her right lower extremity to assist with propulsion and steering of the chair though not often to say she equally uses both upper extremity and lower extremity; Propulsion in room = Needs supervision; Propulsion in facility = Needs supervision...Propulsion Outdoors = Needs

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supervision; Negotiating obstacles = needs physical assist, Negotiating Curbs and Ramps = Needs physical assist...Wheelchair...management = Needs physical assist...Brakes = Needs physical assist...she has demonstrated poor control of her trunk even with extensive therapy services...unable to reposition self...she will ask for assistance at times but is not always aware of her postural deficits...uses her right lower extremity to assist at times with mobility holding her left lower extremity in extension and raised from the floor though cannot use this extremity functionally...Underlying impairments: Cognition, body awareness, insight, judgement, limitations in ROM [range of motion], joint mobility, pain, postural alignment/control, static and dynamic balance, vision loss, fine motor coordination...decreased safety awareness and coordination...Right upper extremity ROM = impaired; Left upper extremity ROM = Impaired right/left lower extremity ROM = Impaired (poor mobility of BLE [bilateral lower extremities] with right knee valgus deformity) Right shoulder ROM = impaired...left hand ROM = impaired ...summary of coordination impairments: decreased should flexion/abduction limits her overall coordination along with limited ROM in her left hand/fingers...oriented to: self...Problem solving: Severe impairment...Follow directions: Mild impairment...Safety awareness: Severe impairment...Insight and Judgement: Severe impairment...patient with mental illness along with MR limits her higher level of reasoning skills and prevents her from having adequate insight, problem solving skills, and safety awareness. She has a general awareness of the sensation of falling though this awareness does not affect her behaviors that put her at risk of falls..."

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The resident's CCP [comprehensive care plan] documented, "...[11/19/18] has had an actual fall related to poor balance...PT [physical therapy] consult for strength and mobility...vital signs as ordered and as needed...[2/13/19] safety checks x 72 hours, neuro checks placed on early riser get up list...[11/19/18] Is at risk for falls related to Unaware of Safety Needs...call light within reach...bed in low potion...wearing appropriate footwear...provide services to improve abilities (PT, OT, ST, psych, etc.)...needs assistance with ADLs...needs assistance/escort to activity functions...high back w/c...totally dependent on 2 staff for repositioning and turning...dressing...toilet use...transferring...mechanical lift...anticipate and meet resident's needs...Impaired cognitive function...impaired thought processes related to schizoaffective disorder and ID [intellectual disability]...cue, reorient and supervise as needed...may porch sit with staff/family supervision...Monitor [name of resident] after administration of antianxiety medication for safety...meds which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia and increased risk of falls...opioid pain medication...monitor for increased risk of falls...has visual impairments related to cataracts..."

On 5/8/19 at approximately 9:00 AM, the DON [director of nursing] and the administrator were asked for the investigation on Resident #1's fall outside of the facility.

The investigation was presented, along with a binder that the administrator stated was a 4 point

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plan that he wanted to share to show what all the facility has done.

The information was reviewed and documented in summary that on 4/8/19 at approximately 7:30 AM the resident had a fall from her wheelchair outside of the facility. It was documented that the resident had a laceration right temporal area and swelling of the right arm and "other injury" to right temporal side and right elbow. A fall root cause analysis report was included, that documented, "locomotion status: independent...w/c...propelling self in w/c...INTERNAL/RESIDENT CONTRIBUTING FACTORS: Wandering, anxiety, agitation, restlessness...last dose of medications given at 6:00 AM (narcotics)... (antidepressant)...(antianxiety)...Diagnoses: Neurological disease, depression...sent to ER at 7:40 AM...resident observed on ground outside..."

A witness statement dated 4/8/19 by CNA #9 documented "[name of CNA #9] came from up stairs got report and [name of resident #1] was singing I asked her to stay up here breakfast was coming and I would feed her soon, and went to give a resident a shower. last time saw [name of resident #1] was at 7:10 AM (CNA signature 4/8/19)."

A witness statement dated 4/8/19 by CNA #10 documented "[name of CNA #10] I clocked out at 7:17 am, when I was going to my car that was parked in the visitors parking lot I seen resident come out of staff ed room singing and was in lobby when I when [sic] out to leave (signature of CNA #10 4/8/19)."

A witness statement by CNA #2 documented "[Name of NA#2] I got here around 7:10 AM to

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7:15 AM and came in through the side door from employee parking lot. Becky the receptionist was at the desk at some point between 7:15 AM and 7:30 AM. [name of resident #1] was downstairs and came into the classroom next to the lobby. She went out of the classroom singing around 7:20 AM (signature 4/8/19)

A statement by the medical records coordinator, OS [other staff] #10 documented "[name of OS #10] coming to work @ [at] 7:20 saw [name of resident #1] laying in driveway. Went inside to get help, had [name] call her nurse, [name of resident] up against curb on ground w/c had turned & [and] flipped her out laying on side (Right) head bleeding @ temple, had knot, Right arm cut & bleeding. restorative aides & transportation came out to help. Nurse out to assess - sent resident to emergency room (signature of OS #10 4/8/19)."

The ADON "witness statement" documented that the ADON interviewed a resident, "...at approximately 2:00 PM, resident frequently assisted [name of Resident #1] by pushing her in her w/c to the lobby...[resident] stated he had not pushed the resident to the lobby that morning."

No further information was included with this investigation to determine how how the resident got downstairs to the lobby, and how the resident was able to leave the facility without staff present or providing supervision.

The resident's MARs (medication administration records) were reviewed and documented that the resident received all 6:00 AM medications, which included, but not limited to: Clonazepam 1.5 mg [milligrams], aspirin 81 mg, Celexa 40 mg,

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Depakote 500 mg, and hydrocodone 5/325 mg. It was documented that the resident received a Risperdal 50 mg injection on 04/07/19.

On 5/7/19 at 6:00 PM the maintenance director was interviewed regarding the doors to the facility and concerns regarding Resident #1 were expressed. The maintenance director stated that the front doors are now locked manually with a key and that if a resident has a wanderguard on, the door would lock, or if the door was already open it would alarm. The maintenance director stated that people could walk in anytime, but not come between the hours of 8 PM and 8 AM. The maintenance director stated that the receptionist is here usually by 7:30 AM, but their hours start at 8 AM. The maintenance director stated we have locked the doors down manually and we have installed a camera in the lobby at the door and one outside at the door.

On 5/8/19 at approximately 5:30 PM the DON and administrator and were made aware of concerns regarding this resident and the fall with injury. The DON and administrator stated that the resident was ambulatory throughout the facility in her wheelchair without supervision. The DON and administrator were made aware of the concerns surrounding this that the resident had an expansive history of behaviors and poor judgment and safety awareness. The DON stated that the resident had a BIMS score of "9" and the resident was able to make decisions on her own. The administrator stated that the resident had never attempted to leave the facility that they were aware of and that the main entrance doors were fixed to prevent residents from leaving the facility. The administrator stated that before this happened, all staff and all

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residents and anyone inside the facility could go to the main entrance door and the doors would open, anytime day or night. The doors were locked on the outside to prevent anyone from coming in form the outside between the hours of 8:00 PM until 8:00 AM and after that the doors were open for entry or exit from the outside or inside during those hours. The administrator stated that anyone could leave the facility anytime day or night if they were inside, there was no locking mechanism in place to prevent residents from exiting the building.

A fall policy was requested at this time.

The fall policy was presented and documented, "...residents who have had a fall in the last 60 days...new residents...appropriateness of intervention and care plan..reduction of psychotropic medications...least restrictive restraints...Plan of care...utilize fall prevention POC [plan of care], individualize interventions, review and revise interventions...Fall- assess for injury and treat, notify...complete incident report...chart...investigate to determine cause...staff meeting to determine cause...complete fall response action plan...establish interventions on POC after each fall...implement interventions on POC after each fall...supervisor to review investigation and verify all steps followed...falling star program, falls-incidents-response, fall interventions for preventions, fall care plan, adopt a resident...Check: psychotropic drug reduction/interactions, number of medications resident is receiving...nutrition, hydration, need for othodics...toileting...timeliness answering call bells..."

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Hospital records from 4/8/19 were reviewed. The records documented, "...8:04 AM...pt [patient] from [name of nursing home] pt fell out of w/c on to face. Hematoma to right forehead and right forearm. Approx 1/4" laceration to temple. Hx [history] of MR pt is at baseline per EMS, Pt takes aspirin...sent from nursing home after she fell off of...chair today...intellectually disabled and unable to give history...pt is alert...Acute right sided axial hematoma likely to be subdural in location...significant mass effect as described...additional small area of intracranial hemorrhage as described...CT scan of head was obtained...results are subdural hematoma...female presents after falling out of her w/c...initially she was at baseline...found to have subdural hematoma...during transfer patient became more unresponsive, right pupil became dilated, no longer following commands...intubated [10:17 AM]...accepted pt for higher level of care...transferred to other facility [10:25 AM]." The resident was airlifted to a higher level of care hospital.

Records from the receiving higher level care hospital documented, "...trauma mechanism ground level fall from w/c...taken to [name of first hospital] and found to have right frontal subdural hematoma with 8 mm [millimeter] midline shift...intubated...bradycardic event...transferred...via air medical transport...trauma department consulted by...Alpha trauma alert...trauma occurred this morning...GCS [glascow coma score] 3 [scale is 3-15, 15 indicating the best score; a score of 3 indicates the patient is totally unconscious and indicating severe brain injury] no corneal or gag reflex...some spontaneous movement in bilateral lower and left upper extremity, no response to

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painful stimuli...left leg appears shortened, ecchymosis [bruising]...IMPRESSION: large acute right convexity subdural hematoma 2.1 cm [centimeter] max thickness with internal hypodense component likely representing ongoing active bleeding...marked mass effect causing 14 mm or right to left midline shift and severe right uncal herniation...entrapment of temporal horn of the left lateral ventricle...trace sulcal subarachnoid hemorrhage in the bilateral frontal lobes...right frontal scalp laceration and subgaleal hematoma...critical results...fell out of w/c and struck her head at her nursing home...sent via helicopter...GCS 13 but acutely declined to have a blown right pupil prior to leaving (likely GCS 5 per report...)...the patient is a full code...family wishes to proceed with surgery despite knowing poor prognosis and likely need for trach/peg...ICU [intensive care unit]...take the patient emergently to the OR for craniotomy and subdural hematoma evacuation...significant ecchymosis over right eye...right arm...intellectually disability, extensive psychiatric history, history of hip fracture...discharge summary: 4/10/19 ...primary diagnosis: Subdural bleeding...Secondary diagnosis: thrombocytopenia, hypotension or shock, acute respiratory failures secondary to devastating neurological injury, coma...complications: None...Expected patient death...exam declined and pupils were fixed with no cough, gag, or corneals...after discussion with family...DNAR-C...extubated and was pronounced dead at 3:40 AM on 4/10/19..."

On 5/9/19 at approximately 9:30 the administrator, DON and quality specialist were made aware of concerns regarding harm with Resident #1 related to the fall, which occurred

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outside of the facility. The administrator stated that the facility fixed the door and presented a plan of action. The presented plan of action was reviewed, which documented interventions regarding the doors now being locked and the cameras being installed. The plan of action did not address actual resident supervision, specifically of residents, such as Resident #1 with known tendencies and a history of poor decision making, poor judgement, insight and poor safety awareness. Concerns were raised and expressed to the administrative staff during this meeting regarding the lack of supervision for this resident; the resident's CCP identified and documented specific problems and/or interventions for Resident #1 that indicated that this resident had poor balance, had a history of falls, was unaware of her own safety needs, needed extensive to total assistance for all ADL's, needed assistance/escort for activities of her choice, staff needed to anticipate and meet the residents needs, the resident was not a safe smoker, the resident needed to be cued, oriented and supervised as needed, the resident was allowed to porch sit with supervision, the resident did take and was prescribed antianxiety, antidepressant, antipsychotic, and opioid medications, which increased safety concerns, increased confusion, amnesia, increased loss of balance, increased cognitive impairment and increased the risk for falls, and the resident also had visual impairments. The facility staff were made aware of the serious concerns regarding lack of supervision for Resident #1, which resulted in harm.

No further information and/or documentation was presented prior to the exit conference on 5/9/19 to evidence that the facility staff provided

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adequate supervision and/or interventions for the prevention of accidents for Resident #1, which led to the resident exiting the facility without supervision and resident rolled and fell out of her w/c landing on the curb in front of the facility, which subsequently resulted in death of the resident related to the extensive injuries incurred.

This is a complaint deficiency.

4.a. Resident #3 was admitted to the facility on 5/26/17. Diagnoses for this resident included, but were not limited to: high blood pressure, cancer lesion on left forehead, anxiety disorder, depression, dementia, vitamin d deficiency, muscle weakness, and disorder of the bone.

The most current MDS (minimum data set) was a quarterly assessment dated 3/4/19. This MDS assessed the resident with a cognitive score of 3, indicating the resident had severe impairment with daily decision making skills. The resident was also assessed as requiring limited assistance of one with transfers, and ambulation. The resident was assessed as requiring extensive assistance for total assistance for bathing and was assessed as not steady, only able to stabilize with human assistance for moving from seated to standing, walking, turning around, moving on and off toilet, and surface to surface transfers. The resident was assessed as wandering on this MDS. The resident's mode of transportation was a wheelchair.

During a complaint investigation conducted 5/7/19 through 5/9/19 the resident's clinical records were reviewed. The resident's nursing notes revealed the following:

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11/1/18 "...resident fell while in shower room with aide, hard bump on right arm with no complaints of pain, X-ray completed this PM."

11/2/18 "...post day 1 related to fall...has been up in w/c [wheelchair] today and propels self around on unit, continues to stand up without assistance, reminded resident to have assistance when getting up..."

11/5/18 "...met to discuss resident...fell in shower witnessed. Interventions are safety and staff education on always supervising residents while in shower..."

On 5/8/19 at approximately 10:20 AM, the DON (director of nursing) and the administrator were asked for any fall investigations for this resident.

A fall investigation was presented for Resident #3 regarding the fall in the shower room on 11/1/18.

The investigation was reviewed and documented, "Fall Root Cause Investigation Report...11/1/18 4:15 PM shower room...fall inside of facility building...no injury...long term memory loss, alert with periods of confusion...stood to walk without assistance [contributing factors]...impulse control...resident was finished with shower, socks were on, aide turned to get gown, resident stood up to walk and fell on buttocks and arm..Staff education."

The next page of this investigation documented, "resident name, 11/1/18...Resident/staff/visitor [circle one] Description or Statement regarding the cause: [Resident was circled, but there was no information and/or a statement or description as to what happened]." The was signed by LPN

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(licensed practical nurse) #14.

The "determination of unavoidable accident" form documented, "...intervention implemented, including adequate supervision and/or assistive devices, to reduce risk of an accident...assistance to transfer/walk...w/c-ambulation...gripper socks...care plan revision: staff education..."

There were three witness/employee statements attached. Two statements were from CNA (certified nursing assistant) #1, CNA #11, both of which documented, that neither were with this resident and did not witness this fall. One witness statement was from LPN #14 that documented, she was working at the nurse's station and did not witness this resident's fall.

On 5/8/19 at 12:35 PM, LPN #14 was interviewed regarding the above. LPN #14 stated that she did complete the investigation and was asked who was in the shower room with the resident. LPN #14 stated, "At this point, I wouldn't know." LPN #14 was asked how she knew that a CNA was in the shower room with the resident. LPN #14 stated, "I was told by the CNA that she was." LPN #14 was asked for clarification, that she (LPN) was told by the CNA that was actually in the shower room with the resident that the resident had fallen. LPN #14 stated, "Yes." LPN #14 was asked, who that CNA was. LPN #14 stated, "With her at this point, I don't remember." LPN #14 was asked who she "educated" in regards to this fall, as it was documented that staff education was provided (it was documented on the investigation who was educated but no names were provided). LPN #14 stated, "Oh do you want me to start putting names?" LPN #14 was made aware that this was not a complete

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and accurate investigation if everyone involved isn't identified. LPN #14 then stated, "I generally ask for statements, but I don't always get them before I leave, I work 7 [am] to 7 [PM]."

On 5/8/19 at 12:40 PM, in a meeting with the survey team, the DON (Director of Nursing) and administrator were made aware of the above concerns regarding this resident falling and that it did not appear that the resident had any supervision. The DON stated that she would look for any other statements and also stated that she would look at the schedule to see who was working during that time. The DON and administrator were both asked if staff education was completed, would there be a record of that. The DON stated that they would have a record and that anytime staff are educated the facility keeps a record.

On 5/8/19 at 12:50 PM, the DON and administrator returned and stated that no other witness statements or other information was found. The DON was asked about staff education. The DON stated that the CNA involved was no longer an employee and was terminated in February due to an unrelated event. The DON stated, "She [LPN #14] gave verbal education and that won't fly now." The administrator stated that he could provide a schedule. A schedule of staff working on that day on that unit, along with time punch information was requested at that time.

A fall policy was requested and presented. The policy documented, "...residents who have had a fall in the last 60 days...appropriateness of intervention and care plan..reduction of psychotropic medications...least restrictive

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restraints...Plan of care...utilize fall prevention POC [plan of care], individualize interventions, review and revise interventions...Fall- assess for injury and treat, notify...complete incident report...chart...investigate to determine cause...staff meeting to determine cause...complete fall response action plan...establish interventions on POC after each fall...implement interventions on POC after each fall...supervisor to review investigation and verify all steps followed...falling star program, falls-incidents-response, fall interventions for preventions, fall care plan, adopt a resident...Check: psychotropic drug reduction/interactions, number of medications resident is receiving...nutrition, hydration, need for othodics...toileting...timeliness answering call bells..."

Resident #3's fall risk assessments were reviewed and documented [Complete quarterly and with significant change, if total score is 10 or greater, the resident should be considered at high risk for potential falls...].

Resident #3 had a fall score assessment completed on 1/27/18, with a score of 5. Resident #3 did not have another fall risk assessment until 11/1/18, which assessed the resident with a fall score of 9 (indicating the resident was still not a fall risk, after the fall on 11/1/18). This fall assessment was not accurately calculated and should have scored the resident with a fall score of 11, indicating high risk for falls.

The resident's CCP (comprehensive care plan) in effect for the time frame of the above fall documented, "...ADL deficit...limited mobility, confusion, unable to bath, dress groom, ambulate

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... without assistance...Bathing- keep needed items in easy reach...use verbal cues...provide full assistance to bathe daily and as needed...dressing...keep needed items in easy reach...anticipate and meet the resident's needs...ensure appropriate footwear...falls related to gait/balance problems...cue, reorient and supervise as needed..."

An Occupation Therapy evaluation dated 11/8/19 documented, "...dementia...fall...history of falling...need for assistance with personal care...Reason for referral: ...due to recent fall in shower room while standing without assistance in relation to impaired cognitive skills, impaired functional activity tolerance and falls...sustained a ground level fall without injuries while in the shower room, she was unattended and unassisted and stood from seated position...reason for standing without assistance is unknown due to cognitive impairment...requires extensive assistance of 1 trained caregiver for basic ADL completion...demonstrates with poor auditory attention secondary to what appears to be HOH [hard of hearing]...demonstrates with decreased visual attention when in a busy and more distracting environment..."

No further information and or documentation was presented prior to the exit conference to evidence that Resident #3 was supervised or was provided assistance in the shower to prevent a fall.

b. Resident # 3's nursing notes revealed the following:

12/18/18 - 9:00 PM "...history of wandering, exit seeking, and refusing care..."

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2/2/19 - "this nurse administering medications when [name of employee] ran down the hall and stated that [name of resident] had fallen out of her w/c...went down hall to find resident in prone position in front of her w/c...evaluated...assisted back to w/c x 2...no obvious injuries...She did hit her head as this was witnessed fall...going forward we are offering an earlier bedtime...all safety measures in place..."

4/13/19 - "...observed sitting in the floor in an upright position at 4 PM with her w/c behind her...open area to forehead was noted to be bleeding and swelling to nose/eye area, pressure applied...bleeding controlled...applied ice to nose as resident will allow...resident did complaint of headache at 5:30 PM...no further complaints of pain...safety checks and neuro checks...no new orders...DON notified...resident propelling self on unit at this time..."

4/14/19 - "...no new falls...Tylenol given for swelling and headache...resident is noted to have facial swelling around eyes and nose, red bruises under each eye and a small bruise on chin..."

4/15/19 - "...all safety measures in place..."

4/15/19 - "...neuro checks, safety checks, and dycem [mat to help prevent slipping] to w/c..."

4/16/19 - "...neuro checks, safety checks, and dycem to w/c..."

A visitor in the facility on 4/13/19 gave a witness statement via telephone on 5/7/19 at 4:10 PM. The witness stated, in summary: On 4/13/19 a Saturday, he was visiting a relative of his in the common area of the 3rd floor locked unit. The

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visitor stated that two loud thumps were heard and a commotion; he got up and went to see and saw two residents laying in the floor one resident [identified as Resident #3] laying on top of the other resident. Resident #3 was bleeding from the front of the face per the visitor and the other resident was bleeding from the back of the head, that resident was laying on her back with her head on the floor and blood was pooling around the woman's head. The visitor stated that no one was around during this time. The visitor stated he ran to the nurses station and began repeating, "hey someone fell, someone fell"; he returned to the area and called 911 himself and explained that the two women were bleeding profusely. The visitor stated that staff finally came to assist and he left the unit to meet EMS downstairs and when they arrived they came to the unit and took the other resident [not Resident #3] to the hospital for treatment. The visitor stated that he was very concerned that no staff were around anywhere when this happened.

Resident #3 was observed on 5/7/19 and 5/8/19 without dycem to the resident's wheelchair for safety.

On 5/8/19 at approximately 10:20 AM, the DON (director of nursing) and the administrator were asked for any fall investigations for this resident.

A fall investigation was presented for Resident #3 regarding the fall in the hall on 4/13/19.

The investigation documented, "...4/13/19 4:00 PM...dementia...found on floor, injuries observed...treatment required: yes...fall inside facility...swelling, bruising...previous head wound bleeding, nose swollen, below eye bruising...eye

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area...propels self in w/c on unit...resident observed sitting in the floor with her w/c beside her...interventions implemented 15 minute checks, 12 hours charting, ice as needed..."

A statement by LPN #2 dated 4/13/19 documented that this LPN was on the phone when another nurse [unnamed] care around the corner stating she needed help right away. When the nurses rounded the corner Resident #3 was sitting on floor in an upright position and another resident was lying on the floor flat on her back. This statement did not document witnessing the fall.

On 5/8/19 at 11:20 a.m., LPN #2, working on the dementia unit at the time of the incident, was interviewed. LPN #2 stated she was on the telephone with adult protective services about an abuse incident at the time of the fall. LPN #2 stated another staff member reported to her the residents were in the floor. LPN #2 stated when she went to the dining hall area, Resident #3 and #4 were in the floor. LPN #2 stated she did not know what happened or how the resident fell as she was on the telephone.

Six CNA statements were obtained on 4/13/19, none of the CNAs witnessed the fall, all were either assisting other resident or not in that immediate area at the time.

Three additional LPN statements were obtained on 4/13/19, no staff members witnessed this fall.

Resident #3 was observed again on 5/8/19 at 2:40 PM, no dycem was observed in this resident's chair. LPN #2 was asked to assist with this resident to ensure the resident did not have

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F 689	Continued From page 129 dycem in the seat of the wheelchair. LPN #2 assisted the resident to a standing position and no dycem was present. LPN #2 stated that she did not know this resident was supposed to have dycem to the chair. CNA #12 asked what we were looking for and the LPN told her "dycem" the CNA stated that the resident takes stuff out of her chair. LPN #2 was asked where interventions of like this would be documented to ensure a resident is receiving. LPN #2 stated that she was not sure. The resident's MARs/TARs (medication administration records/treatment administration records) were reviewed and did not reveal this intervention. Point of care documentation was reviewed and did not reveal this intervention. The resident's CCP (comprehensive care plan) was reviewed and did not reveal that this intervention was ever listed on the resident's plan of care. No further information and/or documentation was presented prior to the exit conference on 5/9/19 to evidence that the facility staff provided adequate supervision and/or interventions for the prevention of accidents for Resident #3. The resident has a known history of falls without adequate supervision or safety interventions. This is complaint deficiency.	F 689		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document	F 745	F 745	6/21/19

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F 745	Continued From page 130 review, clinical record review, and in the course of a complaint investigation, facility staff failed to ensure two of eight residents received social service assessments after sexual assault incidences, Residents #6 and #7. 1. The social work staff failed to evaluate Resident #6 after a documented incident of sexual abuse on 04/16/19. 2. Resident #7 was not assessed or offered any follow up by social services after being a victim sexual abuse on the dementia care unit. Findings included: 1. Resident #6 was admitted to the facility on 06/11/2018 with diagnoses including, but not limited to: Alzheimer's Disease, Dementia, Anxiety, Depression, Hypertension and Heart Failure. The most recent MDS was a quarterly assessment with an ARD of 03/28/2019. Resident #6 was assessed as severely impaired in her short and long term memory and daily decision making skills. Resident #6's clinical record was reviewed on 05/08/19 at approximately 3:00 p.m. An Interdisciplinary Progress Note dated 4/16/19 included: "Resident involved with another resident who was sexually inappropriate by being observed having one hand in her pants and one hand on her breast in the dining area x2 (times two) this evening..." A note dated 4/17/19 7p-7a: "Resident rested well with no signs or symptoms of distress or	F 745	Resident # 6 and #7 provided psychosocial assessment by social services on 5/21/2019. No negative findings noted from psychosocial assessment for residents #6 and #7. All residents have the potential to be affected. A Quality Review will be completed on Facility Reported Incidents involving abuse in the last 30 days to ensure psychosocial assessments and support is provided to affected residents by 6/07/2019. Any findings will be followed up with resident and/or family member as indicated. Corporate Clinical Quality Specialist will educate social services on patients need for psychosocial intervention and on-going support for residents who were affected by traumatic incidents/abuse by 6/20/19. Executive Director will conduct quality monitoring on residents who are involved in facility reported incidents involving abuse to ensure psychosocial assessments and support are provided, 5 times per week for 8 weeks. Findings to be reported to the QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. Allegation of Compliance: 06/21/2019	

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	495243	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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anxiety. Verbally states 'I am okay.' 'No, I am not in pain.'..."

A second note dated 4/17/19 7a-7p: "Resident s/p (status post) incident day #1. No unusual behaviors. No c/o (complaints of) pain/discomfort..." No further documentation noted in the clinical record.

Review of Social Work notes did not include any documentation regarding the incident that occurred on 04/16/2019 involving Resident #5 and Resident #6. There were no follow-up assessments located in clinical record either.

The Director of Social Services was interviewed on 05/08/19 at 3:30 p.m. regarding no documentation for Resident #6. The SW stated, "We did not interview either of those ladies. I really can't tell you why. Sometimes the nurse's document everything and sometimes we do. If I don't know about it directly, then I don't document. If I do an interview or evaluation then I document it in the record."

The DON (director of nursing) was interviewed at 5:30 p.m. regarding expectations of the Social Worker. The DON stated, "There is no policy. It is a reasonable expectation they would do an assessment."

A job description for the Social Worker was requested and received from the Administrator. The job description was non-specific, but did include. "...Job Functions:...Responsible for providing services to respond to the emotional needs of the residents and their families..."

No further information was received from the

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facility prior to the exit conference on 05/09/19.

This is a complaint deficiency.
2. Resident #7 was admitted to the facility on 5/1/13 with a re-admission on 7/16/15. Diagnoses for Resident #7 included dementia, high blood pressure, psychosis, depression and dysphagia. The minimum data set (MDS) dated 4/25/19 assessed Resident #7 with short and long-term memory problems and severely impaired cognitive skills. This MDS listed the resident had wandering behaviors and was rarely and/or never able to make herself understood.

Resident #7's clinical record documented a nursing note dated 4/13/19 stating, "At 1:45 PM, this writer was alerted by CNA's [certified nurses' aides] that resident was observed laying in [Resident #5's] bed. [Resident #5] was observed [with] his hand down this residents pants and had his penis exposed. This resident was immediately redirected and taken to her room. Skin noted to be warm, dry and intact. Resident had no s/s [signs/symptoms] of distress. 15 minute checks implemented. Staff will ensure residents do not ambulate around other residents room, and during mealtimes residents will sit on opposite sides of the dining room while staff monitors the area..." (sic)

Resident #7's clinical record documented no assessment and/or interventions from social services following Resident #7's sexual abuse on 4/13/19. There was no assessment or visit by social services following the incident. Nursing documented on 4/15/19 and 4/16/19 the resident had no signs of distress and a skin assessment was performed on 4/13/19 following the incident. There was no mention of the resident's emotional

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state following the abuse incident.

A social service progress note dated 4/25/19 made no mention the resident had been a victim of sexual abuse by another resident. This social service note listed the resident's behavior status as "exit seeking" and "pushing others in w/c [wheelchair]." The psychosocial/well-being status of Resident #7 was listed as "passive [with] activities, wanders the hall." There was no assessment by social services of the resident's emotional and/or psychosocial response to the sexual abuse incident of 4/13/19.

Resident #7's care plan (revised 3/13/19) made no mention of the incident and included no revisions regarding emotional and/or psychosocial needs of the resident following the 4/13/19 sexual abuse.

On 5/8/19 at 3:30 p.m., the director of social services was interviewed about any assessment or follow up care offered and/or provided for Resident #7 following the sexual abuse on 4/13/19. The social worker director stated she nor her assistance interviewed or assessed Resident #7 following the incident on 4/13/19. The social worker director stated she was aware of the incident but did not know why social services failed to assess the resident following the incident. The social services director stated if she had direct contact with the resident, she would have entered a note in the clinical record.

The facility's job description for the manager of social services included under job functions, "Responsible for providing services to respond to the emotional needs of the residents and their families...Conduct and document a social

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F 745	Continued From page 134 services evaluation, including identification of resident problems/needs..." This finding was reviewed with the administrator and director of nursing during a meeting on 5/8/19 at 4:30 p.m.	F 745		