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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 05/18/21 through 05/21/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaint was investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced {Medicare/Medicaid} abbreviated standard survey was conducted 05/18/21 through 05/21/21. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. 2 complaints were investigated during the survey. The census in this 138 certified bed facility was 77 at the time of the survey. The survey sample consisted of 3 current Resident reviews (Residents #1, #3, #4) and 1 closed record reviews (Resident #2).	F 000		
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, 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-	F 600		6/25/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/17/2021

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

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F 600	Continued From page 1 §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 observations, staff interviews, clinical record reviews and facility documentation reviews the facility staff failed to prevent 1 of 4 residents in the survey sample (Resident #1) from being sexually assaulted on 04/23/2021 which constitutes harm. The findings included: Resident #1 was admitted to the facility on 09/08/2018. Diagnosis included but were not limited to, Dementia, Parkinson's disease and Depression. Resident #1's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 02/28/2021 coded Resident #1 as having severe cognitive impairments. In addition, the Minimum Data Set coded Resident #1 as requiring extensive assistance of 1 staff member for all activities of daily living (ADLs). Resident #2 was admitted to the facility on 02/20/2021 from the community. On 04/23/2021 Resident #2 was discharged from the facility. Diagnosis included but were not limited to, Cirrhosis, Dementia and Other Psychoactive Substance Abuse, Uncomplicated. Resident #2's Quarterly Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 04/23/2021 coded Resident #2 with a BIMS (Brief Interview for Mental Status) score of 13 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #2 as independent with set up help only with meals, requiring supervision with setup help only for bed mobility, transfer,	F 600	1. The sexual assault was reported immediately and resident #2 was placed on 1:1 observation by staff until he was removed from facility by police. Facility will continue to cooperate with outside agencies in regard to the investigation. 2. All residents had the potential to be affected by resident's #2 criminal behavior. After resident interviews, no other alleged assaults had occurred. 3. Facility did educate staff on the facility Abuse policy, Elder Justice Act, and Reporting Requirement timeline. Facility did meet all the reporting requirements at the time of incident. Facility will continue to check potential new admissions via the Registered Sex Offender registry prior to acceptance to facility. Facility will provide education on Abuse Policy, Elder Justice and Reporting requirement timeline to all new hires during orientation, annually, and as needed. 4. Facility Designee will audit employee education files for the completion of education 3 x week for 8 weeks, results of the weekly audits will be submitted to QAPI committee monthly, QAPI committee is responsible for ongoing compliance	

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walk in room, walk in corridor, locomotion off unit, dressing and toilet use and supervision of 1 with personal hygiene and physical help in part of bathing activity of 1 with bathing.

On 05/18/2021 at approximately 11:15 a.m., went to Resident #1's room, on the Warm Unit. When Licensed Practical Nurse (LPN) #1 was asked why Resident #1 on the Warm Unit, LPN #1 stated, "An incident occurred and she is on the unit for close monitoring, observation." LPN #1 stated, "The resident went to the hospital and was readmitted on 04/23/2021 to (room # removed)."

On 05/18/2021 at approximately 11:20 a.m., Resident #1 was observed lying in bed with her arms crossed and her eyes open. The window blinds were open and the light from outside was bright and shining in the room. The room was quiet. Resident #1 looked as if she was squinting her eyes. This surveyor introduced self to Resident #1. When asked if the light from outside was hurting her eyes, Resident #1 stated, "Yes." When asked how she was doing, Resident #1 did not respond. Resident #1 was asked again, how she was doing, Resident #1 did not respond. When asked if she knew where she was, Resident #1 did not respond. When asked if she had ate breakfast this morning, Resident #1 stated, "I don't know." Resident #1 has a low, soft voice and very difficult to understand. After departing the resident's room LPN #1 was made aware of observations made of Resident #1.

On 05/18/2021 at 3:10 p.m., an interview was conducted over the telephone with Certified Nursing Assistant (CNA) #1. When asked if she was Resident #1's CNA on 04/23/2021, CNA #1 stated, "I was the nurse aide that night." When

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F 600	Continued From page 3 asked to review observations with Surveyor regarding Resident #1 and Resident #2, CNA #1 stated, "I was doing my rounds and came to (Residents Name) Resident #1's room to check on her, past 1:00 a.m. I came to her door and the door was open and turned the light on, the resident was on top of (Resident Name) Resident #1. I screamed to come and help and I turned my face to the nurse station and he got up and walked out the room. (Resident Name) Resident #1 had her eyes open, did not say anything. She had her hand in her private area and kind of scratching it or playing with it, diaper wide open. I noticed a black hat on her pillows and he left his gray slippers next to her bed." When asked where Resident #2 went to, CNA #1 stated, "I think he went to his room." When asked if she was the CNA for Resident #2 that night, CNA #1 stated, "Yes. We don't need to help him. I didn't help him with anything that night. I went to his room to pick up trash." When asked when did you go to his room to pick up the trash, CNA #1 stated, "I went before the incident." When asked when did you do your first rounds that night, CNA #1 stated, "I came on around 11:10 p.m., took report, gathered linen and supplies. I go room to room checking to make sure everyone is ok; a walk through." CNA #1 stated, "First rounds were at something after 1:00 a.m." CNA #1 stated, "I found him between 1:15 a.m. and 1:20 a.m." When asked if Resident #1 could tell her what happened, CNA #1 stated, "She can't tell you what happened." When asked had she ever noticed Resident #2 walk into resident rooms, CNA #1 stated, "I only have him every now and then. I've only been to his room once or twice. I see him walk around the hallway a lot every night and stop at the doors. I have not seen him go into rooms."	F 600		

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F 600	Continued From page 4 On 05/18/2021 at 4:30 p.m., an interview was conducted with LPN #2. When asked to provide information as to what she observed on 04/23/2021, LPN #2 stated, "I was at the nurse's station when I heard someone holler. It was the CNA. I went to the room and went directly in the room and (Resident Name) Resident #2 was on top of Resident #1. His shoes were in the floor and his hat was on top of her bed. He was on top of her. I didn't see any penetration at all but he was messing with his zipper on his pants. He had stood up. I redirected him outside of the room. He tried to get his shoes but I told him to get his shoes later. I told him he had to leave out the room. I don't know where he went because I stayed with the patient." When asked how Resident #1 was, LPN #2 stated, "She is non-verbal, she wasn't saying anything." LPN #2 stated, "I asked her if she was ok and she moved her head up and down and then she placed her hands down to her vagina and started masturbating. I kept asking her if she was ok and she kept nodding her head ok." LPN #2 stated, "I asked the CNA to come back in to watch her and asked the other CNA to go down and watch (Resident Name) Resident #2 at all times then I called 911 and then called the Administrative heads." When asked what room Resident #2 was in, LPN #2 stated, "He was on (Unit Name)." LPN #2 stated, "I asked (Resident Name) Resident #2 if he was ok and he kept saying he didn't want to speak to anyone until he spoke to his lawyer." LPN #2 stated, "I called (Resident Name) Resident #2's family and (Resident Name) Resident #1's family and made them aware there was an incident in the facility." LPN #2 stated, "A staff member, CNA, stayed with (Resident Name) Resident #2 and (Resident Name) Resident #1 at	F 600		

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all times."

On 05/18/2021, a review of Resident #1's clinical record revealed the following:

Nursing Progress Note for 04/23/2021 at 01:45 was reviewed and revealed the following: "Note Text: Resident is alert non-verbal. Resident found in room on bed with brief open and male resident in room on top of female resident at 0120. Male patient left his shoes on the side of the bed by the window. Male patient left his hat on top of female bed. Female patient diaper open, patient hand in her vaginal. Patient masturbating at this time. Patient was left in room without touching anything. Notify non emer. (Emergency) police. Notify patient family."

Nursing Progress Note for 04/23/2021 at 02:15 was reviewed and revealed the following: "Note Text: Police and EMS (Emergency Medical Services) at the rehab. (Rehabilitation) center. (Administrator's Name) is present. Police took report about incident. Need family consent. Call five times to family, left messenger and notified (Daughter's Name). Patient remains in her bed with door closed. Will cont. (Continue) to call and notify patient family."

Nursing Progress Note for 04/23/2021 at 03:54 was reviewed and revealed the following: "Note Text: Call and notify (Name of Doctor) Other Staff Name (OTHER) #19 about patient. Other #19 (Name of Doctor), spoke to him about patient no new order. Cont. (Continue) to monitor patient.
Nursing Progress Note for 04/23/2021 at 05:45 was reviewed and revealed the following: "Note Text: Patient POA (Power of Attorney) (Name), return call asking about patient. Will continue to

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F 600	Continued From page 6 monitor patient." Nursing Progress Note for 04/23/2021 at 07:38 was reviewed and revealed the following: "Note Text: Call placed to Resident #2's daughter regarding the detective phone number. Daughter said she will return call after speaking with the Detective." Nursing Progress Note for 04/23/2021 at 07:43 was reviewed and revealed the following: "Note Text: Call placed to the NP (Nurse Practitioner) regarding the information of resident having been found with another resident in her room. NP has stated that resident needs to be sent to the ER for examination and testing. Daughter will be called back and informed of the NP recommendation that it occurs quickly." Nursing Progress Note for 04/23/2021 at 07:59 was reviewed and revealed the following: "Note Text: Call placed to daughter regarding due to the concern of Resident #2 being penetrated or other infections related to having been touched in an area without consent being given." Nursing Progress Note for 04/23/2021 at 08:07 was reviewed and revealed the following: "Note Text: Call placed to NP regarding the matter and concerns related to infections. Awaiting the arrival of ER team as we cannot perform any hygiene care due to matter at hand." Clinical Physician Orders were reviewed and revealed the following: Order Date: 04/23/2021 8:13 Ordered By: OTHER #19 Order Summary: Send patient out stat for rape kit to be done at the ER (Emergency Room) for possible penetration by male resident.	F 600		

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Nursing Progress Note for 04/23/2021 at 08:47 was reviewed and revealed the following: "Note Text: Resident has been picked up and being transferred to the (Hospital Name) for examining, Daughter will be called asap (As Soon As Possible) regarding location of her mother and that (Detective Name) OTHER #16 meet her at the (name of hospital removed)."

Nursing Progress Note for 04/23/2021 at 23:03 was reviewed and revealed the following: "Note Text: Resident returned from hospital with no new orders."

On 05/18/2021 a requested copy of facility investigation for complaint from Administrative Staff Member (ASM) #1 and received.

On 05/18/2021 at approximately 1:30 p.m., review of facility investigation packet revealed the following: Discharge information Discharge Date/Time 04/23/2021 1727 Discharge Disposition Nursing Home/custodial care Discharge Summary.................. (Name of Hospital) EMERGENCY DEPARTMENT Time of Arrival: 04/23/21 0909 (Y09) Alleged assault - sexual Detective was called by daughter and SANE (Sexual Assault
Nurse Examiner) nurse to eval (Evaluate). 10:23 AM SANE nurse at bedside. 1:45 PM Spoke to (SANE Nurse Name); vaginal abrasion/redness. Daughter declines GC/chlamydia testing; declines HIV (Human Immunodeficiency Virus) testing and empiric treatment as she wants to talk to other siblings. All questions sought and answered with daughter; shared decision making with daughter on disposition; at this time feels comfortable going back to nursing home. Advised on what

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signs/symptoms to return immediately to the ER (Emergency Room). At time of d/c (Discharge), pt (Patient) appears well hydrated, nontoxic and in no acute distress. The patient/family agree with the plan and is stable for d/c to home. Nurse to discharge pt with written paperwork. Case reviewed, evaluated and treated patient under the supervision of (Name of Doctor) (OTHER #15).

On 05/18/2021 requested copy of police report and lab results from test conducted at hospital on 04/23/2021. ASM #1 (Administrator) stated, "I don't have them."

On 05/18/2021 a request was made for the room numbers of Resident #1 and Resident #2 on 04/23/2021 and was received. Observation of room numbers provided revealed that the resident's rooms were located on the same unit.

An interview was conducted with ASM #2 (Director of Nursing) on 05/18/2021 at 3:05 p.m. When asked if Forensics was in to see Resident #1 last week, ASM #2 stated, "Last Wednesday, later in the afternoon, Other #21 (Forensics Staff) were in the resident's room and we were present, Administrator and myself, and they obtained photos and conducted an exam." When asked if they (the facility) have received a report, ASM #2 stated, "No." When ASM #1 was asked if she knew the last name of the SANE nurse, ASM #1 stated, "I don't know her name. She is with (Name of Forensics)." ASM #1 provided name and contact information for the Director of Forensics. ASM #1 stated, "I reached out to (Name of Detective) and asked if she had a report and she said that when she gets the report she will let me know." ASM #1 provided name and contact information of the Detective who

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F 600	Continued From page 9 investigated the sexual assault on 04/23/2021. When asked why Resident #2 was in 3 different rooms since admission to the facility in February 2021, ASM #1 explained that the resident was admitted from the community to (Unit Name) for quarantine then moved to (Unit Name) then to (Unit Name). The resident walked a lot in the halls on (Unit Name), he was a smoker and had COPD so they moved him to a room closer to Administration, (room # removed), so they could watch him and he would be closer to the smoking area. On 05/18/2021 review of Resident #2's Clinical Record revealed the following: Review of Nurse Practitioner Progress Note with DOS (Date of Service): 3/19/2021 revealed the following: Progress Note General Type of Visit: Initial Evaluation Room: (room # removed) Reason for Follow-up: PCP (Primary Care Physician)/Staff request Psychiatric evaluation Chief Complaint / Nature of Presenting Problem: Depression, anxiety, easily irritated. History of Present Illness: Staff report patient is easily irritated, argumentative. Patient is seen today for initial psych eval. Currently taking Sertraline for Depression. Recommendations: Monitor behavior for safety concerns and redirect as needed............. Nursing Progress Note for 04/07/2021 at 06:50 was reviewed and revealed the following: "Note Text: Client has been awake and ambulating within building with the help of wheelchair for support. Observed client in the door way of room (room # removed) twice and told him to not enter the room. He became very offended with some animosity and walked away. The room door was	F 600		

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closed at this time and client was checked frequently as far as his location on unit."

Nursing Progress Note for 04/07/2021 at 14:39 was reviewed and revealed the following: "Note Text: Writer observed pt (Patient) at room door (room # removed) "Asking pt if she wants a sandwich." Pt in room (room # removed) NPO (Nothing by Mouth) status. Writer educated (Resident Name) Resident #2, on pt privacy and to check with nurses before offering other residents food. (Resident Name) Resident #2 thankful. Will continue to monitor."

Nursing Progress Note for 04/09/2021 at 06:18 was reviewed and revealed the following: "Note Text: Found client in room (room # removed). Client states that he was looking for coffee. He left the room screaming "We do get coffee at 5:30! We do!" He is now in his room. This nurse explained to him that if he wasn't invited into the room then he is invading their privacy. He said he was invited into the room. This nurse made him aware that the staff knows this to be untrue. Will continue to monitor and observe."

Nursing Progress Note for 04/11/2021 at 00:06 was reviewed and revealed the following: "Note Text: Found client in room (room # removed). Observed client coming out of room and closing the door. This nurse once again told the client that he should not be in any other room except his own. (Resident Name) Resident #2, then shouted "I was not in that room!" Will continue to monitor and observe client's behaviors.

Nursing Progress Note for 04/12/2021 at 13:48 was reviewed and revealed the following: "Note Text: ED, Maintenance and SW (Social Worker)

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spoke with resident regarding going in and out of residents rooms. He stated that he likes to offer the other resident's snacks and to read the newspaper with the resident. Personal space and boundaries were also discussed and resident expressed understanding. Resident will speak with his nurse before entering another resident's room."

Nursing Progress Note for 04/12/2021 at 15:39 was reviewed and revealed the following: "Note Text: Resident transferred to room (room # removed). All belongings transfer to room "

Review of Nurse Practitioner Progress Note with DOS: 4/15/2021 revealed the following: Progress Note General Chief Complaint / Nature of Presenting Problem: Combative behavior towards residents. History of Present Illness: Patient is seen today at request of nursing for increased behavioral concerns. Staff reports another resident stated patient tried to attack them, causing them to dodge punch thrown by patient. Patient currently under the care of psych provider, taking Sertraline for depression and anxiety. Patient noted to be easily agitated and verbally aggressive at times ... .

Medication Administration Record for the period of 4/1/2021 - 4/30/2021 was reviewed and revealed the following documentation: Sertraline HCI Tablet 50 MG (Milligram) Give 50 mg by mouth in the morning for depression Start Date-02/11/2021; Nitrofurantoin Microcrystal Capsule 100 MG by mouth two times a day for UTI (Urinary Tract Infection) for 7 Days Start Date-04/20/2021 2100; Buspirone HCI Tablet 7.5 MG Give 1 tablet by mouth two times a day for Anxiety Start Date-04/23/2021 1700.

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Review of Nursing Progress Note dated 4/23/2021 01:48 revealed and is documented in part, as follows: "Note Text: Patient at nursing station asking for food. Patient was told we don't have any food. Patient then went rolling around in the hall way. Patient was then found in another female patient room. Patient family was notify about was an accident and police was call. Patient now in and out his door to his room. Patient is been watch at all time. Will cont. to monitor."

Review of Nurse Practitioner Progress Note with DOS: 4/23/2021 revealed the following: Progress Note General Chief Complaint / Nature of Presenting Problem: Depression, anxiety, easily irritated, refusing medications.
History of Present Illness: Patient seen today at request of staff. Report patient refusing medication, easily irritated............ Nurse informed me that patient was involved in an incident, alleged assault of another resident in the early morning hours..............

Nursing Progress Note dated 4/23/2021 15:00 was reviewed and revealed the following: "Note Text: Resident discharged to the custody of the (Name of Police Department.)

Review of Nursing Progress Note dated 4/23/2021 17:38 revealed and is documented in part, as follows: "Note Text: 1401-- Authorities arrived to speak with the resident and had a warrant presented for testing and to have him be removed from the premises."

Resident #2's Gate's Wandering Assessment was reviewed and revealed the following: Date: 02/10/2021 Description: Admission Category:

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F 600	Continued From page 13 Low Risk Score: 4.0 Care Plan with a Review Start Date: 2/19/2021 and a Target Completion Date: 2/26/2021 was reviewed and revealed the following: Focus: Resident #2 uses antidepressant medication r/t (Related To) Depression Goals: Resident #2 will be free from discomfort or adverse reactions related to antidepressant therapy through the review date. Interventions: Monitor/document/report to MD prn ongoing s/sx (Signs/Symptoms) of depression unaltered by antidepressant meds (Medications): Sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, neg. (Negative) mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance. Review of care plan did not evidence Resident #2's behaviors of easily irritated, argumentative and combative behavior towards residents as being addressed in care plan. Behaviors were evidenced in review of Nurse Practitioner Progress note dated 03/19/2021 and 04/15/2021, Review of care plan did not evidence Resident #2's behavior of walking into resident rooms. An interview was conducted with ASM #1 on 05/18/2021 at approximately 5:00 p.m. When asked why Resident #2 was in 3 different rooms since admission to the facility in February 2021, ASM #1 explained that the resident was admitted from the community to (Unit Name) for quarantine then moved to (Unit Name) then to (Unit Name). The resident walked a lot in the halls on (Unit	F 600		

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Name), he was a smoker and had COPD so they moved him to a room closer to Administration, (room # removed), so they could watch him and he would be closer to the smoking area.

On 05/19/2021 at 4:05 p.m., attempted to contact Other Staff Member (OTHER) #3 by telephone, no answer. Left a voice message to return my call.

On 05/19/2021 at 4:10 p.m., conducted an interview by telephone with OTHER #1 (Police Detective) and made her aware of investigating complaint at (Facility Name) concerning Resident #2. OTHER #1 stated, "I did that investigation." When asked what needed to be done to request a copy of the police report, OTHER #1 stated, "I should be able to do that. I will check with my supervisor and get back to you."

On 05/19/2021 at 4:30 p.m., received telephone call from OTHER #3 (Forensics Director). An interview was conducted. When asked for the last name of SANE (Sexual Assault Nurse Examiner) nurse (First Name given), OTHER #3 stated, "(SANE nurse name) (OTHER #2) no longer works at the company." OTHER #3 did provide SANE nurse last name. Made OTHER #3 aware trying to obtain lab results of a resident that OTHER #2 examined that lived at (Facility Name). OTHER #3 stated, "(Resident Name) (Resident #1).
Surveyor stated, "Yes." OTHER #3 stated, "Initial exam was done at (Hospital Name), evidence collection." OTHER #3 stated, "We do forensic evidence by swab, was obtained. Results are turned over to law enforcement (Police Department Name) (OTHER #17), OTHER #1 did investigation." OTHER #3 stated, "There was

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F 600	Continued From page 15 some findings in the vaginal area. When something is found we always go back and reassess. I went with (SANE Nurse Name) (OTHER #2) to the facility to assist to reassess. No swab, just observation on reassessment." On 05/20/2021 at approximately 10:00 a.m. conducted an interview with ASM #3. When asked to provide the room numbers and dates that Resident #2 was transferred to, ASM #3 stated, "Admitted 02/10/2021 to Room (room # removed) (quarantine unit), transferred to (room # removed) on 02/24/2021 and moved to Room (room # removed) on 04/12/2021." A telephone call was placed to OTHER #1 on 05/20/2021 at 12:15 p.m. and no answer. A voice message was left to return call. On 05/20/2021 at 12:40 p.m., received return telephone call from OTHER #1. OTHER #1 stated, "I spoke to my supervisor and he didn't know what they could provide to me due to the case still being open. Going to run it by the Commonwealth Attorney's Office. Other #22 (name withheld) is the Commonwealth Attorney." When asked if I could get the results from the test done by the SANE nurse, OTHER #1 stated, "The SANE exam - physical evidence collected goes to the lab and could be couple months before the results can be obtained. The PERK (Physical Evidence Recovery Kit) goes to the lab and also take a couple of months to get results." OTHER #1 stated, "SANE test was done on Resident #1 and Resident #2." OTHER #1 stated, "Police get a written report if anything was on the resident, what the SANE nurse observed, if any injuries or if any DNA (Deoxyribonucleic Acid) samples was collected, but no test results." When asked if	F 600		

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Resident #2 was in jail, OTHER #1 stated, "Yes, still in jail."

On 05/20/2021 at 12:20 p.m., placed a telephone call to LPN #3, no answer. Left a voice message to return call. On 05/20/2021 at 1:00 p.m., placed a telephone call to OTHER #13 (APS Worker), no answer. Left a voice message to return call.
On 05/20/2021 at approximately 1:00 p.m., an interview was conducted with LPN #6. Reviewed with LPN #6 that 04/15/2021 Nurse Practitioner note revealed that Resident #2 had combative behavior towards resident. When asked if she knew anything about that incident, LPN #6 stated, "The staff monitoring the smokers reported to me that (Resident Name) (Resident #2) and another resident was out in the smoke area. It was raining and the other resident was trying to push another resident out of the rain and (Resident Name) (Resident #2) would not move.
There was room to get past (Resident Name) (Resident #2) and (Resident Name) (Resident #2) swung at the other resident but did not hit him. LPN #6 stated, "That is what was told to me." LPN #6 stated, "I told the staff, (Staff Name) (CNA #2) to let the Administrator know." When asked were you Resident #2's nurse that day, LPN #6 stated, "Yes." When asked did you document what the CNA reported to you, LPN #6 stated, "No, I did not witness it."

An interview was conducted on 05/20/2021 at approximately 1:00 p.m. with LPN #6. When asked did Resident #2 wander when in Room (room # removed), LPN #6 stated, "No, not really." Did you observe him walk into other resident rooms, LPN #6 stated, "No." When asked are you the nurse on the Fine Unit, LPN #6 stated, "On the front side."

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On 05/20/2021 at 1:20 p.m. an interview was conducted with ASM #4. When asked did Resident #2 wander, ASM #4 stated, "He walked up and down the hallways like the other residents." When asked did Resident #2 go into other resident rooms, ASM #4 stated, "From my understanding he did go and visit the other residents." When asked did you consider his walking up and down the halls or going into other resident rooms inappropriate, ASM #4 stated, "No." Reviewed Nursing Progress Note dated 04/12/2021 13:48. When asked why did you have a conversation with Resident #4 on 04/12/2021 concerning going into other resident rooms, ASM #4 stated, "Most of the residents do visit. I reviewed the nurse notes, because the nurses were concerned about him going into other resident rooms." When asked did you consider Resident #2 a wanderer, ASM #4 stated, "No." When asked if a resident is identified as a wanderer or wandering, are the residents evaluated, ASM #4 stated, "Yes, I think nursing does." When asked do you think Resident #2 needed to be evaluated for wandering, ASM #4 stated, "No." When asked what you can tell me about the incident on 04/23/2021 regarding Resident #2, ASM #4 stated, "I know that the incident is under investigation, can I get back to you?" Surveyor stated, "Yes."

An interview was conducted with LPN #4 on 05/20/2021 at 3:15 p.m. When asked did Resident #2 wander, "Yea, he walked around." When asked did you ever see him go into resident rooms, LPN #4 stated, "No ma'am."
On 05/20/2021 at approximately 4:00 p.m., an interview was conducted with LPN #5. When asked did Resident #2 wander, LPN #5 stated,

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F 600	Continued From page 18 "(Resident Name) walked." When asked was he deliberate in where he was going, LPN #5 stated, "Yes." LPN #5 stated, "He didn't wander aimlessly." When asked did you ever see him going into resident rooms, LPN #5 stated, "Me personally, no." LPN #5 stated, "(Resident Name) Resident #2 is not a wanderer." When asked what happened on 04/23/2021, LPN #5 stated, "Got a text and phone call, in a patient room." LPN #5 stated, "I went to (Resident Name) Resident #2's room with the Administrator and he said not going to tell you anything without a lawyer. We walked out." On 05/21/2021 at approximately 10:15 a.m., an interview was conducted over the telephone with OTHER #13. When asked when you were made aware of the incident of 04/23/2021 at (Facility Name), OTHER #13 stated, "I was made aware on 04/23/2021. I know the incident occurred in the early morning. I received the report at 1:30 p.m. in the afternoon." When asked how did you receive the report, OTHER #13 stated, "Came through via FRI (Facility Reported Incident) in the fax system." When asked was anything wrong with their fax machine on 04/23/2021, OTHER #13 stated, "Not that I'm aware of." OTHER #13 stated, "What was reported in the FRI was not actually accurate as to what happened." When asked what was not accurate, OTHER #13 stated, "FRI stated the resident was found in room with his pants down but the resident was on top of the resident." When asked how did you find out that the FRI was not accurate, "OTHER #13 stated, "I spoke to the POA, law enforcement, daughter and Detective, gave me a full picture. The Administrator was not forth coming with me." OTHER #13 stated, "There is a case with the Commonwealth Attorney regarding this matter."	F 600		

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F 600	Continued From page 19 OTHER #13 stated, "This AP (Alleged Perpetrator) had criminal history that should have precluded him from being accepted by this facility. I don't know how this gentleman was admitted." When asked what criminal history did he have, OTHER #13 stated, "I would love to tell you that." OTHER #13 stated, "(Name) (OTHER #1) informed me that when the police asked had this AP ever been found in another person's room, the Administrator at first said no but after speaking to staff it was found out that he had about a week prior." When asked did the Administrator admit to that, "OTHER #13 stated, "Yes." OTHER #13 stated, "I spoke with (Name) (OTHER #1) on 04/26/2021." OTHER #13 stated, "I met with the Administrator on 04/27/2021. I asked the Administrator if the AP had been in another resident's room and she said no, this was the only incident since his admission." When asked was there any information , had anything occurred when he was found in the other residents room, OTHER #13 stated, "I don't know, (Name) (OTHER#1) would have to speak on that." When asked if she had anything else to tell me, OTHER #13 stated, "Somewhat concerning to me, the police and I asked to view video footage and we were told they didn't have video footage of rooms in that direction. And there were quite a few rooms." OTHER #13 stated, "I did ask the Administrator if she did a criminal history background check and the Administrator stated that she did and nothing came back and I asked for proof of that and she said she would have to speak to corporate. I never heard anything else regarding that since. Based on what I saw from the court records, how he was admitted and nothing came up." A telephone interview was conducted with LPN #3	F 600		

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F 600	Continued From page 20 on 05/21/2021 at approximately 10:35 a.m. When asked what do you remember concerning Resident #2, LPN #3 stated, "(Resident Name) was a patient and he liked to stay up all night and I thought he was going to smoke cigarettes, thought it was innocent but then I noticed he was coming out of female rooms. My first initial verbal encounter was "You don't need to go into female resident rooms at night. I'm letting you know you should not go into resident rooms at night when they are sleeping and you have not been invited." When asked were the female residents sleeping, LPN #3 stated, "Yes. The females in the room were non-verbal." When asked how many times did you observe Resident #2 go into the female resident's room, LPN #3 stated, "I think I saw him come out of the room twice. I never saw him go in a room, only saw him coming out of room (room # removed). I would stop him before he got to where he was going. He maybe did that twice. He may have did it more frequently, can only say for what I saw." When asked did you go in and observe the residents in room (room # removed) after he left out, LPN #3 stated, "Yes ma'am I did." When asked did you notice anything out of the way, LPN #3 stated, "No nothing out of the way, the sheets were straight." When asked when he went into Room (room # removed) who was he going into see, or was he just walking in, LPN #3 stated, "I don't know who he was going in to see, I just assumed it was bed A because bed B always kept her curtain pulled. I only saw him when he was coming out." LPN #3 stated, "I work night shift. I've noted him up in the hall at 3:00 a.m. At first he was not defensive. He use to just go through the unit to go out to smoke. He started yelling after being told to stay out of the room." When asked what unit you work on, LPN	F 600		

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F 600	Continued From page 21 #3 stated, "Work on Homer Unit." LPN #3 stated, "After the Unit Manager was made aware of incidents he was transferred to another unit and actually it was to his benefit because he was moved to a room next to where he could go out and have a cigarette." When asked was Resident #2 confused, LPN #3 stated, "I don't think so, I don't know. In the beginning I thought he was but in the end I thought it was more manipulation than confusion." On 05/21/2021 at 1:00 p.m., received a telephone call from OTHER #1 and she stated, "We cannot release copy of police report since it is going to trial." OTHER #1 was asked if Resident #2 was a registered sex offender. OTHER #1 stated, "He is not a registered sex offender. He is a registered felon. He was convicted of multiple felonies in the past." On 05/21/2021 the following information was obtained from the (Name of General District Court) Online Case Information System. Review of information revealed the following: Case/Defendant Information Name: Resident #2; Filed Date: 04/26/2021; Status: Custody; Charge Information Charge: ATTEMPT RAPE VICTIM HELPLESS Offense Date: 04/23/2021; Case Type: Felony; Hearing Information Date 04/26/2021 Time 02:00 PM Result Continued Hearing Type Arraignment; Date 06/24/2021 Time 08:30 AM Hearing Type Preliminary On 05/21/2021 at 2:30 p.m., an interview was conducted with OTHER #14 (Resident #1's Responsible Party) by telephone. When asked to recall what she knew occurred regarding Resident #1, OTHER #14 stated, "I received a call that my mom was sexually assaulted by a	F 600		

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gentleman and they were taking her to the ER (Emergency Room) to do a Rape Kit." OTHER #14 stated, "I was involved in the whole situation." When asked did they do the Rape Kit, OTHER #14 stated, "Yes and the gentleman is in jail." OTHER #14 stated, "I did appreciate that the facility notified me." OTHER #14 stated, "I left my phone downstairs that night and didn't hear the phone. Got the messages that morning. They did tell me mom was assaulted." OTHER #14 stated, "My mother was in 2 other facilities and they separated the men and women. When she first got there they were all on the same wing. With this I feel they probably should change this. Apparently they did not have enough camera feed so it could see when the gentleman walked into the room so that needs to be addressed."

On 05/21/2021 at approximately 2:45 p.m. at pre-exit meeting the Administrator and Director of Nursing was informed of the findings.

No further information was provided.

The facility policy titled - Abuse, Neglect and Exploitation

Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.

Definitions: "Sexual Abuse" is non-consensual sexual contact of any type with a resident.

Complaint Deficiency

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F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based a complaint investigation, medical record review, hospital record review, resident interview and staff interviews the facility staff failed to ensure a safe discharge on 11/5/2020 for 1 of 4 residents in the survey sample, Resident #3. The findings included: Resident #3 was admitted to the facility on 10/7/21 with diagnoses to include but not limited to Type 2 Diabetes Mellitus, Morbid Obesity, End Stage Renal Disease and Fracture of Right Lower Leg. Resident #3 was discharged from the facility on 11/5/2020. The most recent Minimum Data Set (MDS) was a Discharge Assessment with an Assessment Reference Date (ARD) of 11/5/2020. Resident #3's Brief Interview for Mental Status was coded as a 15 out of a possible 15 which indicates the resident is cognitively intact and capable of daily decision making. Resident #3's progress notes were reviewed and is documented in part, as follows:	F 624	1. Resident #3 is no longer at facility. 2. All residents that discharge from facility have the potential to be affected by this deficient practice. 3. Facility will ensure all DME is in place at time of discharge. Rehab will provide SW with recommendations via checklist. SW will submit DME request to DME provider and validate scheduled delivery DME with resident, responsible party, or vendor prior to discharge of resident. SW will conduct a post discharge follow up call to assure all needs have been met. SW or facility Designee (s) will provide staff education on new process. 4. Facility will audit discharged residents for a safe discharge plan to home daily x 4 weeks, results of the weekly audits will be submitted to the QAPI committee monthly. QAPI committee is responsible for the ongoing monitoring for compliance.	6/25/21

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10/23/2020 11:29 a.m. Social Service Progress Note: SW (Social Worker) and BOM (Business Office Manager) spoke with resident regarding his financial obligation and discharge plans. Resident stated that he cannot afford to pay the copay on day 21 and is choosing to return home with services. Resident requires assistance upon discharge. SW will set up home health services for the resident and also DME (Durable Medical Equipment). Resident is a dialysis patient and will resume dialysis upon discharge. SW will work to put a safe plan in place.

11/5/2020 06:41 a.m. Nursing Progress Note: Resident departed facility via medical transport to dialysis with personal belongings and medication that was brought from home. No c/o (complaint of) pain or discomfort voiced. Will continue to monitor.

Resident #3's Discharge Planning Review at Admission dated 10/9/2020 completed by the Director of Social Services was reviewed and is documented in part, as follows:

A. 1. Anticipated Length of Stay: 20 days.
B. Home Environment: 4. Does the resident have family or a support network to provide assistance post-discharge? No.
C. Treatment Care/Needs: 2. Additional home care supports required? DME (Durable Medical Equipment), home health care.
D. Overall Summary of Potential For/Discharge: Resident was admitted for snf (skilled nursing facility). Resident will return home with home health services.

Resident #3's Physical Therapy (PT) Discharge Summary dated 11/4/2020 was reviewed and is

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documented in part, as follows:

Discharge Recommendations: Environmental modifications, 24 hour care, Home Health services, and In-home aide, Lifeline for safety, Meals on wheels, Hospital bed, sliding board and wheelchair.

Resident #3's Discharge Physician Orders dated 11/3/2020 were reviewed and are documented in part, as follows:

1. Discharge: Stable for discharge.
2. Hospital Bed with railings.
3. Bedside Commode 3 in 1.
4. Standard Wheelchair with cushion and leg rests.
5. Home Health Services: skilled nursing for medication management, wound care, home health aide for activities of daily living assistance, physical and occupational therapy evaluate and treat.

On 5/18/2021 at 10:00 A.M. a phone interview was conducted with the Adult Protective Services (APS) Worker that was in charge of Resident #3. The APS Worker was asked to explain what happened with Resident #3 on 11/5/2020 after being discharged from the facility. The APS Worker stated, "His dialysis center called APS while he was at dialysis concerned about Name (Resident #3) going home and that they felt it was an unsafe discharge. This was escalated to an emergency level and I went to his house that afternoon. When I arrived he was sitting in a lazy boy recliner, there was no bed, no bedside commode, no wheelchair and no food in the home. Name (Resident #3) had a hospital gown on, a brace on his leg and he could not walk. I

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F 624	Continued From page 26 sent him to the hospital because it was unsafe for him to remain in the home without the proper equipment and assistance. When he (Resident #3) was discharged from the hospital we had to pay his rent for a month and bring food boxes in for him." On 5/18/21 at 11:53 A.M. a phone interview was conducted with Resident #3 regarding his facility discharge on 11/5/2020. Resident #3 stated, "Before I left the facility the nurse went over my discharge papers and then I left with the ambulance drivers to go dialysis then they took me home. At dialysis I started getting worried about going home and not being able to take care of myself so they called APS. I can't get around at home by myself because I have an external fixator on my leg and can't walk. I was told by the facility Social Worker that all of my equipment would be at my apartment when I got there. My equipment never showed up and no one called me from the Equipment Company or home health until the next day when I was back in the hospital. APS came to my apartment a couple hours after the transport people left me in my lazy boy chair. She (APS Worker) said I needed to go to the hospital because I had no equipment, I couldn't take care of myself and it was not safe for me to stay there." On 5/18/2021 at 1:04 P.M. a phone interview was conducted with the Director of Social Services who arranged Resident #3's discharge on 11/5/2020. The Director of Social Services was asked about what was put in place for Resident #3's discharge on 11/5/2020. The Director of Social Services stated, "I set up home health and DME (durable medical equipment) for him. I ordered a hospital bed, a wheelchair, and a	F 624		

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bedside commode. The DME Company called him while he was at dialysis on the day he discharged to get the roommate to open the door so the equipment could be delivered. He (Resident #3) never answered the phone when the DME Company called on 11/5/2020. The family sets up the drop off time for the equipment."

On 5/18/2021 at 3:39 P.M. a phone interview was conducted with the Office Manager at the DME Company used for Resident #3's discharge on 11/5/2020. The Office Manager was asked what equipment was ordered by the facility Social Worker, when was the equipment to be delivered and how does that process take place. The Office Manager stated, "On 11/3/2020 we received an order for a hospital bed, a bedside commode and a wheelchair. We usually make contact with the resident or family the day before the discharge and setup a time to deliver the equipment. We try to deliver the equipment to the home the day before the discharge date." The Office Manager was asked what was the discharge date they had received from the facility for Resident #3. The Office Manager stated, "We only received the orders, I have no notes of us receiving a discharge date. We first called him (Resident #3) on 11/6/2020 and he told us he was in the hospital. We placed another call out to him on 11/9/2020 but he did not answer. We log all of our calls whether they answer or not. Usually when the facility sends us the orders they will send us the discharge date, but we never received it for him. That's why we called him on the 6th (11/6/2020) because we hadn't heard anything."

Resident #3's ED (Emergency Department)

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Provider Note dated 11/5/2020 at 17:29 (5:29) P.M. was reviewed and is documented in part, as follows:

Assessment /Differential Diagnosis: This patient is about 5 weeks status post a bad fracture which was surgically repaired. He is not ambulatory. He lives alone. It does not seem that his discharge plan was a feasible one.

Chief Complaint: This morning when he was taken to dialysis he was taken immediately to his home without any of his DME or medication set up. He was struggling at home but realized he did not have a bed, wheelchair, or bedside commode, he called the social worker at dialysis who called Adult Protective Services who then called 911.

Resident #3's ED (Emergency Department) Provider Note dated 11/6/2020 at 6:39 A.M. was reviewed and is documented in part, as follows:

Discharged from SNF (Skilled Nursing Facility) without hospital bed, wheelchair or bedside commode.

On 5/19/2021 at 1:37 P.M. this surveyor received a phone call from the facility Nurse Practitioner that discharged Resident #3 on 11/5/2020. The Nurse Practitioner stated, "I was told to call you about (Name) Resident #3's discharge not being safe. I feel like I prepared for all of his needs. I gave orders for a hospital bed, a wheelchair, a bedside commode, home health, gave prescriptions for his medications and made sure he had a follow-up appointment with his orthopedic provider. I even kept him an extra week because of knee pain." At this point I made

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the Nurse Practitioner aware of the APS emergency visit, that no equipment had been delivered to the home for the resident and also that there was no food in the home when he arrived. The Nurse Practitioner was then asked if she was aware of these findings and if she still felt Resident #3 was provided a safe discharge. The Nurse Practitioner stated, "I did not know all of that, no it was not safe then. Usually the Social Worker calls me and lets me know that the equipment has been delivered."

On 5/19/2021 at 4:08 P.M. a phone interview was conducted with the Director of Social Services. The Director of Social Services was made aware that the DME company stated that they had never receive the discharge date for Resident #3 in order for the equipment to be dropped of the day before the actual discharge. The Director of Social Services was asked if she had made the DME Company aware of the 11/5/2020 discharge date for Resident #3. The Director of Social Services stated, "No, I can't recall that information. That was almost a year ago."

The facility policy titled "Transfer and Discharge" revised 10/22/20 was reviewed and is documented in part, as follows:

9. Anticipated Transfers or Discharges:
a. Obtain physicians' orders for transfer or discharge and instructions or precautions for ongoing care.
c. Orientation for transfer or discharge must be provided and documented to ensure safe and orderly transfer or discharge from the facility, in a form and manner that the resident can understand.

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F 624	Continued From page 30 On 5/19/2021 at 4:15 P.M. a pre-exit debriefing phone interview was held with the Administrator where the above information was shared. The Administrator was asked what are her expectations for safe resident discharges from the facility. The Administrator stated, "I expect that all services are put in place to ensure the resident's safety to include all needed equipment, home health services, medications and follow-up appointments. It appears there was a communication issue." Prior to exit no further information was shared. This is a COMPLAINT DEFICIENCY	F 624		