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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 11/9/2022 through 11/14/2022. Six complaints were investigated during the survey. Complaint VA00055387 was unsubstantiated. Complaint VA00056079 was substantiated with deficient practice. Complaint VA00056397 was substantiated with deficient practice. Complaint VA00056686 was substantiated with deficient practice. Complaint VA00056732 was substantiated with deficient practice. Complaint VA00056747 was substantiated with deficient practice. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 180 certified bed facility was 168 at the time of the survey. The survey sample consisted of thirteen current resident reviews and three closed record reviews.	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.	F 600		12/22/22

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

Electronically Signed | 12/07/2022

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F 600	Continued From page 1 §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, facility document review, clinical record review and complaint investigation, the facility staff failed to protect the residents' right to be free from sexual and/or mental abuse by a staff member (identified by the facility as CNA #4) for four of sixteen residents (Residents #2, #8, #13, and #15) in the survey sample, which resulted in Resident #8 sustaining trauma to the perineal/vaginal area. This constitutes harm. The findings include: 1. Resident #8 sustained unwanted sexual touching/penetration to her perineal/vaginal area by a staff member the facility identified as CNA #4 and was found subsequently to have vaginal abrasion with bleeding upon assessment. The 11/1/22 facility reported incident, that was forwarded to the state agency, documented that Resident #8 had reported to the occupational therapist (OT) that she had been raped a few nights ago by a short African-American CNA, identified by the facility as CNA #4. The report documented that Resident #8 reported that the CNA had put his fingers in Resident #8's vagina when changing her brief and then left the room. According to the 11/1/22 FRI, the resident was assessed with findings that included blood in her brief and on her labia/vaginal area and was sent	F 600	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F600 1. Resident #2 and 15 continue to reside in the facility and social services and psych providers will follow-up with residents for any psychosocial needs as needed. Resident #8 and #13 is no longer a resident at the facility. 2. Current residents have the potential to be affected. 3.) The Administrator/Designee will educate facility staff on the Abuse/Neglect/Misappropriation/Crime Policy and appropriate reporting protocol to include immediate notification of questionable incidents that occur in the facility to the Administrator and with an emphasis that all employees are mandated reporters. 4.) The Administrator/Designee will perform weekly random interviews with 10 residents concerning abuse and care in	

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F 600	Continued From page 2 to the emergency room for evaluation. The facility's investigation included a statement from the occupational therapist (other staff #1) stating during a therapy session on 11/1/22, Resident #8 stated, "...I think that foreign man that works here raped me. I'm traumatized." When questioned...patient stated event occurred, 'the night before last' and it was the 'short African man who works here' and it occurred, 'while he was changing my brief.'..." The investigation also included the 11/1/22 resident interview by the administrator and DON, which documented that the Resident #8 reported she was "raped", and that the CNA put his fingers in her vagina. The interview documented the resident reported the incident the next morning. The facility's investigation also documented a statement from CNA #4 stating he took care of Resident #8 on Monday night (10/31/22) until Tuesday morning (11/1/22). CNA #4 wrote, "...at six o'clock...I was giving that resident a small bed bath and dressed her for her physical therapy...When I was undressing her brief I smelled bad other coming from that bottom and I was thinking that she did a BM [bowel movement] but unfortunately it wasn't a BM. then I used the wipes to wipe here there five times because until the wipes were moving dirty from that delicate part of her body I showed her all the wipes which were really black and yellow of dirty to make her be sure that not only she was really dirty, but I cleaned her very good. After that I dressed her properly...Saying that i abused her sexually is not true. because all gestures I did was only to clean her very good without any sexual intention or violence. And during all the time I performed that task, she didn't stopped me for any reason..."	F 600	the facility to ensure the abuse policy is followed and any allegations reported timely. During monthly resident council meetings resident rights will be discussed with emphasis on abuse and the need for residents to inform staff if they feel uncomfortable during any situation upon happening. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis. 6.Date of Compliance 12/22/22	

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A review of the clinical record included an 11/1/22 skin assessment, which was performed by the assistant director of nursing (RN #2) and RN #3, after the reported allegation. This assessment documented, "...Blood was noted in resident's brief and on her genitalia, bleeding was near her clitoris, bleeding did not appear to be vaginal. No bruising or swelling was noted to breasts, thighs, buttocks, or genitalia. There was no blood noted under her fingernails..."

Resident #8 was evaluated at the emergency department on 11/1/22 in response to the rape allegations. The emergency department report dated 11/1/22 documented, "...presents with alleged sexual assault. On 10/30/2022 a caregiver was helping to change her briefs...She states that the male staff member put his fingers in her vagina. Patient did not consent to this. There was no intercourse. No rectal penetration..." The physician assistant's examination documented, "Positive for vaginal bleeding. Negative for dysuria, urgency, frequency, hematuria and flank pain...does not bruise/bleed easily..." The report listed the resident's mental status as "alert" and that the resident "appeared anxious."

A family nurse practitioner (other staff #10) assessed Resident #8 on 11/2/22 and documented, "...Today, vaginal abrasion visualized and unchanged...continue to monitor daily..."

According to the clinical record, the psychiatric nurse practioner (other staff #5) assessed Resident #8 on 11/3/22. The psychiatric NP

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documented that when asked if she was getting along with the staff and other residents, resident #8 replied "...I was raped by a foreigner..." This entry also documented that the psychiatric NP assessed the resident as " ...not overly agitated or emotional."

The 11/8/22 facility investigation report that was sent to the state survey agency documented that the facility was unable to substantiate Resident #8's allegations because the rape evaluation requested by police was pending and that CNA #4 was no longer employed with the facility.

On 11/9/22 at 2:43 p.m., Resident #8 was interviewed about her allegations made on 11/1/22. Resident #8 stated the short man with dark complexion and foreign accent stuck his fingers in her vagina. Resident #8 stated she did not know the staff member's name but she had seen him before in the hallway. Resident #8 stated this staff person came in her room during the night shift and asked if she needed changing. Resident #8 stated that she said yes and the staff person put his fingers into her vagina while he was changing her. Resident #8 stated that she told him to stop and he did then put a clean brief on her and left the room. Resident #8 stated that she reported the incident the next morning to a therapist. Resident #8 stated she had some vaginal bleeding after the incident and was initially sore. Resident #8 stated that the staff person talked with a foreign accent but made no sexual comments to her. Resident #8 stated that she routinely required help from staff for brief changes.

On 11/9/22 at 3:18 p.m., the occupational therapist (OT - other staff #1) was interviewed

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about Resident #8. The OT stated on the morning of 11/1/22 that Resident #8 told him a foreign man had raped her "night before last" during a brief change. The OT stated he immediately reported it to his supervisor and then the administrator.

On 11/10/22 at 7:30 a.m., the ADON (RN #2) was interviewed about the allegations made by Resident #8. RN #2 stated she and RN #3 got Resident #8 from the therapy room on 11/1/22 after the resident reported the incident and performed a head-to-toe skin assessment. RN #2 stated when Resident #8's brief was pulled back there was blood noted on the brief and on the resident's labia. RN #2 stated the resident's fingernails were clean and the brief was dry. RN #2 stated she saw nothing and found no other explanation for the bleeding and the resident had no history of self-injurious behaviors. RN #2 stated the staff person Resident #8 described was identified as CNA #4 as he was the only male aide with a foreign accent and dark complexion that worked nights. RN #2 stated in response to Resident #8's allegations, all cognitively intact residents were interviewed about any concerns with CNA #4. RN #2 stated during these interviews, Resident #13 stated a short, dark complexion male aide had been rough with her during a brief change.

On 11/10/22 at 10:35 a.m., the administrator, DON and ADON (RN #2) were interviewed about the allegations of sexual abuse made by Resident #8. The administrator stated when Resident #8 was interviewed she described a short, African man that stuck his fingers in her vagina. The administrator stated they reviewed the schedule and nobody else fit the resident's description.

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The administrator stated CNA #4 was the only male CNA with a foreign accent. When questioned, the administrator and DON had no other explanation for the resident #8's genital trauma. The DON stated interviews done with other staff members caring for Resident #8 revealed no previous reports of blood in the resident's brief or perineal area. The administrator stated based on allegations from multiple residents, as APS made him aware that similar concerns about CNA #4 had been reported from other facilities in the area, the administrator stated CNA #4's agency was contacted about the allegations and that CNA #4 was no longer allowed to work in the facility.

A review of the comprehensive care plan (dated 11/7/22) documented that Resident #8 had episodes of bladder/bowel incontinence and required staff assistance for toileting and hygiene.

2. Resident #2 was subjected to unwanted touching of her perineal/vaginal area and unwelcomed sexual remarks by certified nurses' aide the facility identified as CNA #4.

During the complaint investigation, a review of the facility reported incident form (FRI) dated 10/24/22 revealed that Resident #2 had reported to the facility staff that a certified nurses' aide (CNA #4) had wiped her for an inappropriate length of time in her perineal area and made her uncomfortable. The facility's investigation of that incident documented an interview with Resident #2 by the director of nursing (DON) dated 10/24/22. This interview documented, "... [Resident #2] told me that months ago that a short, black CNA asked to check her brief during the night shift. She said he wiped her for 10

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minutes and she got a bad vibe from him...continued to say that when she was...being isolated for Covid he was her aide again. She said he was performing incontinent care and she asked him to stop. She said he replied with, 'I don't know why you don't like this because my girlfriend does'..." (Sic) The facility's investigation also included an interview by the administrator, dated 10/24/22, which documented that Resident #2 stated CNA #4 wiped her for a " ...very long time, approximately 10 minutes" and that she was concerned about how rough she was wiped. This interview documented that the resident was not sure of the date this occurrence but that it was while she was isolated on the COVID unit.

A review of the facility's investigation documented a written statement from Resident #2's routine CNA (#3) dated 10/24/22 stating, "On Wednesday night/Thursday morning [10/19/22 - 10/20/22] ...Resident #2 made a complaint to me about an aide [CNA #4] wiping her inappropriately and saying 'that's how my girlfriend likes it'. I reported it to the nurse on duty and gave her my statement. [Resident #2] also stated that she had reported this incident to the APS [adult protective service] person that had been in to see her during the day...informed my nurse [licensed practical nurse #2] Agency." (Sic)

The facility investigation included an interview by the director of nursing (DON) with CNA #1, dated 10/26/22, which documented, "... [CNA #1] stated that when [Resident #2] was isolating for Covid...she told her that she did not like [CNA #4] because of the way he wiped her during incontinent care."

The facility investigation included an interview by

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the DON with registered nurse (RN) #1, which documented, "... [RN #1] stated that [Resident #2] told her months ago that she did not like the way [CNA #4] wiped her during incontinent care and that he used too many wipes. [RN #1] stated that [Resident #2] did not act like the incident was a big deal at the time and did not give her any reason to believe it was anything but her not liking the way he did ADL care."

The facility investigation included the undated written statement by CNA #4 denying the allegations and stating he had never worked in [Resident #2's] room.

On 11/9/22 at 11:30 a.m., Resident #2 was interviewed about her care in the facility and the allegations regarding CNA #4. Resident #2 stated that approximately 3 to 4 months ago, CNA #4 came in her room around 2:00 a.m. and said he wanted to check her brief to see if she was wet. Resident #2 stated she told CNA #4 that she was "ok", but CNA #4 then stated he needed to check her anyway because that was his job. Resident #2 stated CNA #4 "wiped me for 10 minutes" using cleansing wipes. Resident #2 stated she watched the clock and he cleaned her for 10 minutes continually wiping her perineal area. Resident #2 stated CNA #4 "was down there a long time" and she was very uncomfortable with the continued wiping. Resident #2 stated she told her usual nurse (registered nurse #1) about the incident when she next worked and requested that CNA #4 not provide care for her anymore. Resident #2 stated registered nurse (RN) #1 agreed to not assign CNA #4 to her and she did not see CNA #4 again until she was moved to another unit after getting COVID-19. When questioned, Resident #2

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stated she did not recall the exact date but she had been moved to the COVID unit in September (2022) for isolation and while on that unit, CNA #4 came in her room and stated he wanted to check/change her brief. Resident #2 stated that she told CNA #4 that he was not supposed to be in her room or to provide care for her. Resident #2 stated that CNA #4 said he needed to check her and began wiping her buttock area. Resident #2 stated she told CNA #4 that he had done enough wiping, but he then started wiping her vaginal area. Resident #2 stated she told CNA #4 to "stop" and that's when CNA #4 told her that he did not understand why she did not like it because his girlfriend liked it. Resident #2 stated, "I was scared of him." Resident #2 stated that CNA #1 had come into her room and she told her that CNA #4 was not supposed to be providing care for her and that he kept wiping her "pretty hard." Resident #2 stated that CNA #1 later said that she had reported the incident to the nurse, but Resident #2 was not aware of the nurse's name. Resident #2 stated, "I was fighting him off. Told him he'd done enough wiping ... I was only wet." When questioned, Resident #2 stated that CNA #4 had not provided her routine care and she only encountered him on those two occasions. When questioned further, Resident #2 stated that she was upset about the incident. "I was shocked that it happened again because I had reported him [CNA #4] to [redacted name - RN #1] several months ago and thought the issue was taken care of." When questioned if she had reported the incident to anyone else, Resident #2 stated that when she returned to her previous unit/room after COVID, she told her regular CNA (CNA #3) about the incident on the COVID unit. When asked what specifically she had reported, Resident #2 replied that she had reported that

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CNA #4 had touched her inappropriately and made her uncomfortable twice, once several months ago, which she had reported to RN #1, and then about the incident on the COVID unit, which she had reported to CNA #1 and CNA #3. When questioned further, Resident #2 stated, "I had trouble sleeping for a few days after the last incident ... was tearful when I had to talk with the police ... but I feel better now that he [CNA #4] no longer works here."

On 11/9/22 at 4:10 p.m., CNA #1 was interviewed about the allegations made by Resident #2. Stating that she did not remember the exact date of the incident, CNA #1 stated, "that day, me and CNA #4 worked on the COVID unit." CNA #1 stated that shortly after shift change at 11:00 p.m., Resident #2's call light was on. CNA #1 stated that when she responded to the light and entered the room, CNA #4 was putting on gloves and pulling the curtain around Resident #2. CNA #1 stated Resident #2 told her that CNA #4 was not supposed to be in her room or care for her. CNA #1 stated she left the room and told the nurse working the unit that Resident #2 did not want CNA #4 caring for her. CNA #1 stated that he nurse she reported this to was an agency employee and she did not know her name, but added that CNA #4 was moved to the West unit after her report.

On 11/10/22 at 6:00 a.m., RN #1 was interviewed about Resident #2. RN #1 stated she routinely cared for Resident #2 on the night shift (11:00 p.m. until 7:00 a.m.). RN #1 stated Resident #2 told her " ...several months ago" that she did not like the way CNA #4 wiped her during incontinence care and had requested that he not care for her anymore. RN #1 stated that since

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that report she had not assigned CNA #4 to care for Resident #2. When asked if she had asked Resident #2 to elaborate on why she did not want care by CNA #4, RN #1 stated, "No." When asked if she had reported the concern, RN #1 stated that she interpreted the issue to be about "mechanics" and had not reported the issue to supervision or administration.

On 11/10/22 at 6:15 a.m. CNA #3, who routinely cared for Resident #2, was interviewed. CNA #3 stated during the night shift, starting at 11:00 p.m. on 10/19/22 until 7:00 a.m. on 10/20/22, Resident #2 had reported to her that CNA #4 had cleaned her perineal area for a long time while she was on the COVID unit. CNA #3 stated that Resident #2 had told her that she was scared of CNA #4 because CNA #4 kept wiping her peri-area, even after she told him to stop and had made a comment to her that she should like it because his girlfriend liked it. CNA #3 stated the resident had " ...acted a little scared of him." When asked if the comments had been reported, CNA #3 stated that she immediately went to the nursing station and reported Resident #2's concern to licensed practical nurse (LPN) #2. CNA #3 stated that she also wrote a statement about what the resident said and gave it to LPN #2. CNA #3 stated that when she came back to work on Saturday (10/22/22), CNA #4 was working on the unit. CNA #3 stated that she told the agency nurse working that she was uncomfortable with him (CNA #4) on the unit because she had reported an issue with Resident #2 earlier in the week that regarded [CNA #4]. CNA #3 stated CNA #4 worked on Resident #2's unit that shift but was not assigned to Resident #2. CNA #3 stated the next shift she worked was on Monday (10/24/22), but CNA #4 was still scheduled to

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work. CNA #3 stated that she did not understand why he had not been suspended, when she had reported what Resident #2 had said. When questioned further, CNA #3 stated that she had cared for Resident #2 routinely for almost two years and that the resident had never reported any concerns with staff members or problems with ADL care until the issue with CNA #4.

On 11/10/22 at 8:50 a.m., LPN #2 was interviewed by telephone about CNA #3's report of Resident #2's allegations. LPN #2 stated she was not made aware of Resident #2's inappropriate care. LPN #2 stated she heard "over-talking" by CNA #3 and some other CNAs mentioning CNA #4's name, but she did not know what the discussion was about. LPN #2 denied that CNA #3 told her about Resident #2's allegations of inappropriate touching and stated she never received a written statement from CNA #3 about the incident. LPN #2 stated she was not aware of the allegations until the DON asked her about them on 10/24/22. LPN #2 stated again that CNA #2 "did not directly report" to her Resident #2's allegation regarding CNA #4.

On 11/10/22 at 9:00 a.m., CNA #3 was interviewed again about reporting Resident #2's allegations regarding CNA #4 on 10/20/22. CNA #3 stated, "I was standing in front of her [LPN #2] when I told her." CNA #3 stated she wrote a statement on her own and gave it to LPN #2. CNA #3 stated that she was later told that her original statement was lost and so she wrote it again.

A review of the clinical record documented that resident #2 was moved from her usual room to the COVID isolation unit on 9/22/22 and returned

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to her previous room/unit on 10/2/22. Resident #2's clinical record documented a skin assessment on 10/24/22 with no impairments noted. Nursing notes from 9/21/22 through 11/8/22 made no mention of the resident #2's allegations or any changes in condition. The comprehensive care plan, revised on 10/31/22, documented that resident #2 had frequent bladder incontinence due to diuretics and required assistance from staff for hygiene after incontinence.

On 11/10/22 at 10:35 a.m., the administrator, DON, and assistant director of nursing (RN #2) were interviewed about Resident #2's allegations of inappropriate touching, along with staff and reporting of the resident's complaints/concerns about CNA #4 by RN #1, CNA #1 and CNA #3. The administrator stated that he was first advised of the allegations by adult protective services (APS) on 10/24/22, after an APS worker met with Resident #2 about another issue. The administrator stated no staff members had reported any allegations or concerns of Resident #2 regarding CNA #4. The DON responded that she interviewed Resident #2, who had reported inappropriate wiping in her peri-area and that the resident reported she had previously told CNA #1 and CNA #3 about the incident that occurred on the COVID unit. The DON stated when she talked with CNA #3 she stated she reported the allegations to LPN #2, but that LPN #2 stated CNA #3 did not report the allegations directly to her. The DON stated she was not aware that Resident #2 had requested not to have CNA #4 provide her care or that RN #1 was routinely not assigning CNA #4 to Resident #2. The DON stated that she had not been made aware of the

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reported concerns about CNA #4 made to RN#1, which should have been reported to her or the administrator. The administrator repeated that RN #1 should have reported to her supervisor about the resident not wanting care by CNA #4. During this interview, the administrator also stated that his staff interviewed other residents that were assigned to CNA #4 and found no other concerns following this incident. The administrator stated he was unable to "firmly conclude" that the allegations happened. The administrator stated he reviewed the abuse policy with CNA #4 and had been allowed to return to work on 10/26/22.

3. Resident #13 was subjected to non-consensual touching of the perineal/vaginal area by a staff member, that the facility identified as CNA #4.

The 11/3/22 facility reported incident form sent to the state agency documented that Resident #13 reported to the ADON that she had been "fingered" by a "dark skinned, short man" and that she had not reported the incident when it happened, but probably should have. The facility identified the employee involved as CNA #4.

A review of Resident #13's clinical record included a note written by the ADON dated 11/3/22 documenting, " ... this nurse spoke with resident regarding care needs, resident states she is comfortable with male staff members...resident states she has only had a problem with one male staff member...resident stated, 'I don't know his name, but he has dark skin, is short, and he hasn't been here for a few days.' This nurse again asked if resident was comfortable with female and/or male staff

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member assisting her with care, resident [resident] stated, 'yes, just not that one man'."

On 11/9/22 at 2:20 p.m., Resident #13 was interviewed about her allegations. Resident #13 stated a dark-skinned man with a foreign accent came into her room "just that one night" and when changing her brief started "fondling" in her vaginal area. Resident #13 stated the man put his fingers in her vagina and she asked him to stop. Resident #13 stated he then stopped and put her brief back in place and left the room. Resident #13 stated that she did not report the incident to anyone when it happened because she was " ...scared to talk about private stuff." Resident #13 stated that was the only time he had provided her any care. Resident #13 stated, "It bothered me. I didn't want him to do it to someone else." Resident #13 stated she reported the incident to the ADON when she interviewed her about any concerns with staff. Resident #13 stated she did not remember the exact date but that it had occurred " ... shortly before [CNA #4] was fired."

On 11/10/22 at 10:35 a.m., the administrator, DON and ADON (RN #2) were interviewed about the allegation made by Resident #13. RN #2 stated Resident #13 had initially reported to the social worker that a male CNA had been "rough" with her during a brief change but did not mention inappropriate touching. RN #2 stated that when she went back and talked with the resident, she described a short, dark complexion man and said he stuck his fingers in her during a brief change.

4. Resident #15 had unwanted touching to her upper thigh, but thwarted efforts by a staff

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member to gain further access to her perineal area. The facility identified the staff member as CNA #4.

During the facility investigation following Resident #8's allegations of non-consensual sexual touching, the staff conducted interviews with all cognitively intact residents. The ADON (RN #2) documented an interview with Resident #15 dated 11/1/22, which stated, "...I asked [Resident #15] if any staff member had touched her inappropriately. [Resident #15] stated, 'No but I am afraid of that man who works at night'... [Resident #15] stated, 'I don't know his name, but he is short, dark complexion, with an accent, he worked last night'...[Resident #15] stated, 'He came into my room and said he needed to change me, I told him I did not wear a brief, but he would not listen, he said he needed to make sure I was clean, I again told him "No, that I did not wear a brief...he then checked his paper and said oh, I need to check your roommate, and he left me alone..." (Resident #15's roommate at this time was Resident #8).

A review of the clinical record documented a social worker (SW) note dated 11/2/22 documenting that resident #15 stated she was "inappropriately touched and 'made to feel very uncomfortable..." The social worker note documented that Resident #15 was told that the perpetrator was currently suspended from the facility and that she declined services by the psychiatric nurse practitioner about the incident.

There was no facility reported incident form sent to the state survey agency regarding Resident #15's comments/allegations regarding the unwanted touching by a staff member identified

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by the facility as CNA #4.

On 11/14/22 at 11:55 a.m., Resident #15 was interviewed about her allegations regarding CNA #4. Resident #15 described the staff member as dark with a foreign accent that was not her usual CNA. Resident #15 stated that she did not remember the exact date, but she " ... woke up one morning and he [CNA #4] was standing beside my bed and said he was there to change me." Resident #15 stated that she did not wear a diaper or pull-up, but that this staff person insisted stating, "Let me see." Resident #15 stated that he then put his hand under her upper thigh and said again he needed to check to see if she was wet. Resident #15 stated that she told him again that she wore underwear, not a brief, but the staff member went to the closet and stated, "Let me see." Resident #15 stated that he went to the roommate's closet instead of her closet. Resident #15 stated he kept insisting and she told him she was calling the nurse. Resident #15 stated that she pushed the call bell several times and each time the male CNA turned off the call light and said he was the nurse. Resident #15 stated that she told him he was not the nurse and to get out of her room, but he then went to her roommate (Resident #8) and pulled the curtain around her. Resident #15 stated that she did not see what care he provided for the roommate, but that he left the room, and she did not see him again. When questioned further, Resident #15 stated that when the male CNA put his hand under her leg, she had pushed him away. Resident #15 stated that the male CNA did not touch her groin or perineal area but did reach under her leg against her wishes. Resident #15 stated that she was unable to go back to sleep that morning after the incident and " ... still

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wondered if he would be able to return to the building." Resident #15 stated, "I'm sure he realizes why he was let go. He's scary. I was able to take care of myself, but it makes you wonder what he may have done to other residents." When questioned if she had told anyone about the incident, Resident #15 stated that she had told a night nurse, who she described as "blonde with an accent", but she did not know her name.

Resident #15's comprehensive care plan (revised 9/26/22) documented the resident as able to transfer to the toilet with limited assistance of one person and included a toileting intervention to provide an unobstructed path to the bathroom. The minimum data set (MDS - a cms assessment tool) dated 10/14/22 assessed Resident #15 as cognitively intact, always continent of bowel/bladder elimination, and as requiring limited assistance of one person for toileting.

On 11/14/22 at 12:30 p.m., the administrator and DON were interviewed about Resident #15's allegation. The administrator stated he did not initiate a facility reported incident form and formal investigation about Resident #15's allegation because the resident reported that she was not physically touched. The DON stated no nurses had reported to her Resident #15's allegations about CNA #4 and she was not aware of a blonde night shift nurse with an accent mentioned by the resident.

A review of facility records revealed that CNA #4 was originally suspended on 10/24/22 and returned to work on 10/26/22, with his last day worked in the facility listed as 10/31/22. Records also show that Residents #8, #13 and #15

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F 600	Continued From page 19 resided on the same unit around the time of the allegations. A review of the work schedules documented that CNA #4 worked on these residents' unit during the night shift (11:00 p.m. to 7:00 a.m.) on 10/26/22, 10/27/22 and 10/31/22. The facility's policy titled Abuse/Neglect/Misappropriation/Crime (1/23/20) documented, "There is zero tolerance for mistreatment, abuse, neglect, misappropriation of property, or any crime against a patient...Patients of the Center have the legal right to be free from verbal, sexual, mental and physical abuse, corporal punishment, involuntary seclusion...Any employee and/or covered agent of the Center, who willfully abuses...will be immediately subjected to corrective action..." This policy documented that sexual abuse included sexual harassment, inappropriate touching, sexual coercion, sexual assault or inciting any of these actions. This policy described psychological/emotional (mental) abuse to include humiliation, harassment, malicious teasing and threats of punishment or deprivation. These findings were reviewed with the administrator, DON, regional director of clinical services on 11/10/22 at 10:35 a.m. and on 11/14/22 at 1:10 p.m. No further information was provided prior to the exit conference. This was a complaint deficiency.	F 600		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that:	F 607		12/22/22

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F 607	Continued From page 20 §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, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to follow their abuse prevention policies for reporting allegations of sexual and/or mental abuse for three of sixteen residents in the survey sample (Residents #2, #13 and #15). The findings include: 1. Resident #2's allegations regarding unwanted	F 607	F607 1) CNA #1 & #2, LPN #1 & #2, and RN #1, were educated on the Abuse/Neglect/Misappropriation/Crime policy on and timely reporting of any allegations on 11/1/22. 2) Current facility residents have the potential to be affected. 3) The Administrator/Designee will educate facility staff on the Abuse/Neglect/Misappropriation/Crime	

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F 607	Continued From page 21 touching to the perineal/vaginal area by a staff member, along with unwelcomed sexual remarks, were not immediately reported to the administrator as required by the facility's abuse prevention policies. The administrator failed to report Resident #2's allegations against certified nurses' aide (CNA) #4 of unwanted touching to the department of health professions as required in the facility abuse prevention policy. A review of the facility reported incident (FRI) form dated 10/24/22 documented that Resident #2 reported to the facility staff that a certified nurses' aide (identified by the facility as CNA #4) had wiped her for an inappropriate length of time in her perineal area and made her uncomfortable. This FRI also documented that the resident reported CNA #4 made the comment while wiping her that he did not understand why she did not like it because "that's how his girlfriend likes it." This report documented no report of the allegations to the department of health professions regarding CNA #4. The facility's investigation documented an interview with Resident #2 by the director of nursing (DON) dated 10/24/22. This interview documented, "...[Resident #2] told me that months ago a short, black CNA asked to check her brief during the night shift. She said he wiped her for 10 minutes and she got a bad vibe from him...continued to say that when she was...being isolated for Covid he was her aide again. She said he was performing incontinent care and she asked him to stop. She said he replied with, 'I don't know why you don't like this because my girlfriend does'..." (Sic) The administrator documented an interview with Resident #2 dated 10/24/22 stating the resident stated CNA #4	F 607	Policy and appropriate reporting protocol with an emphasis on sexual abuse. 4) The Administrator/Designee will perform weekly random interviews with 10 residents concerning abuse and care in the facility to ensure the abuse policy is followed and any allegations reported timely. 5) Results of the audit will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, audits will be conducted on a random basis 6) Date of Compliance: 12/22/22	

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wiped her for a "very long time, approximately 10 minutes" and that she was concerned about how rough she was wiped. This documented interview stated the resident was not sure of the dates this occurred but that it happened while she was isolated on the COVID unit.

The facility's investigation documented a written statement from Resident #2's routine CNA (#3) dated 10/24/22 stating, "On Wednesday night/Thursday morning [10/19/22 - 10/20/22]...Resident #2 made a complaint to me about an aide [CNA #4] wiping her inappropriately and saying 'that's how my girlfriend likes it' I reported it to the nurse on duty and gave her my statement. [Resident #2] also stated that she had reported this incident to the APS [adult protective service] person that had been in to see her during the day...informed my nurse [licensed practical nurse #2] Agency." (Sic)

The facility's investigation documented an interview by the DON with CNA #1 dated 10/26/22. This interview documented, "...[CNA #1] stated that when [Resident #2] was isolating for Covid...she told her that she did not like [CNA #4] because of the way he wiped her during incontinent care. [CNA #1] stated that [Resident #2] did not act like the incident was a big deal at the time or did not give any reason to believe it was anything but her not liking the way he did ADL [activities of daily living] care." (Sic)

The facility's investigation documented an interview by the DON with registered nurse (RN) #1. This interview documented, "...[RN #1] stated that [Resident #2] told her months ago that she did not like the way [CNA #4] wiped her during incontinent care and that he used too many

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wipes. [RN #1] stated that [Resident #2] did not act like the incident was a big deal at the time and did not give her any reason to believe it was anything but her not liking the way he did ADL care."

On 11/9/22 at 11:30 a.m., Resident #2 was interviewed about her care in the facility and the allegations regarding unwanted touching. Resident #2 stated that approximately 3 to 4 months ago, CNA #4 came in her room around 2:00 a.m. and said he wanted to check her brief to see if she was wet. Resident #2 stated she told CNA #4 that she was "ok" and CNA #4 then stated he needed to check her anyway because that was his job. Resident #2 stated CNA #4 "wiped me for 10 minutes" using cleansing wipes. Resident #2 stated she watched the clock and he cleaned her for 10 minutes continually wiping her perineal area. Resident #2 stated CNA #4 "was down there a long time" and she was very uncomfortable with the continued wiping. Resident #2 stated she told her usual nurse (registered nurse #1) about the incident when she next worked and requested that CNA #4 not provide care for her anymore. Resident #2 stated registered nurse (RN) #1 agreed to not assign CNA #4 to her and she did not see CNA #4 again until she was moved to another unit after getting COVID-19. Resident #2 stated she was moved to the COVID unit in September (2022) for isolation and while on that unit, CNA #4 came in her room and again stated he wanted to check/change her brief. Resident #2 stated she told CNA #4 that he was not supposed to be in her room or provide care for her. Resident #2 stated CNA #4 stated he needed to check her and began wiping her buttock area. Resident #2 stated she told CNA #4 that he had done enough

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wiping and then he went to wiping her vaginal area. Resident #2 stated she told CNA #4 to "stop" and that's when CNA #4 told her he did not understand why she did not like it because his girlfriend liked it. Resident #2 stated, "I was scared of him." Resident #2 stated CNA #1 came in the room and she reported to her that CNA #4 was not supposed to be providing care for her and that he kept wiping her "pretty hard." Resident #2 stated CNA #1 said she reported the incident to the nurse but she was not aware of the nurse's name. Resident #2 stated that when she returned to her previous unit/room after COVID, she told her regular CNA (#3) about the incident on the COVID unit. Resident #2 stated she reported that CNA #4 had touched her inappropriately and made her uncomfortable twice, once several months ago to RN #1 and then to CNA #1 and CNA #3 about the incident while on the COVID unit.

On 11/9/22 at 4:10 p.m., CNA #1 was interviewed about the allegations made by Resident #2. Stating that she did not remember the exact date of the incident, CNA #1 stated, "...that day, me and CNA #4 worked on the COVID unit." CNA #1 stated that shortly after shift change at 11:00 p.m., Resident #2's call light was on. CNA #1 stated that when she responded to the light and entered the room, CNA #4 was putting on gloves and pulling the curtain around Resident #2. CNA #1 stated Resident #2 told her that CNA #4 was not supposed to be in her room or care for her. CNA #1 stated she left the room and told the nurse working the unit that Resident #2 did not want CNA #4 caring for her. CNA #1 stated that he nurse she reported this to was an agency employee and she did not know her name, but added that CNA #4 was moved to the West unit

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after her report.

On 11/10/22 at 6:00 a.m., RN #1 was interviewed about Resident #2. RN #1 stated she routinely cared for Resident #2 on the night shift (11:00 p.m. until 7:00 a.m.). RN #1 stated Resident #2 told her "several months ago" the she did not like the way CNA #4 wiped her during incontinence care and that she requested that he not care for her anymore. RN #1 stated since that report she had not assigned CNA #4 to care for Resident #2. RN #1 stated it was "generally known" and "common knowledge" to not assign CNA #4 to Resident #2. RN #1 stated, "We knew not to assign him [CNA #4] to [Resident #2]." When asked if she asked Resident #2 to elaborate on why she did not want care by CNA #4, RN #1 stated, "No." RN #1 stated she did not view Resident #2 not wanting CNA #4's care as a complaint. RN #1 stated the resident's complaint was more about the length of time he cleaned her and not about touching her and that the resident did not elaborate on what CNA #4 had done. RN #1 stated she interpreted the issue to be about "mechanics" and she did not report the issue to supervision or administration. RN #1 stated if the resident had been more specific about what CNA #4 had done she would have reported the concern to her supervisor or administration.

On 11/10/22 at 6:15 a.m. CNA #3 that routinely cared for Resident #2 was interviewed. CNA #3 stated during the night shift starting at 11:00 p.m. on 10/19/22 until 7:00 a.m. on 10/20/22, Resident #2 reported to her that CNA #4 had cleaned her perineal area for a long time while she was on the COVID unit. Resident #2 stated the resident told her she was scared of CNA #4. CNA #3 stated the resident reported that CNA #4 kept wiping her

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peri-area even after she told him to stop and made a comment to her that she should like it because his girlfriend liked it. CNA #3 stated the resident "acted a little scared of him." CNA #3 stated she immediately went to the nursing station and reported Resident #2's concern to licensed practical nurse (LPN) #2. CNA #3 stated she wrote a statement about what the resident said and gave it to LPN #2. CNA #3 stated when she came back to work on 10/22/22, CNA #4 was working on the unit. CNA #3 stated she told the agency nurse working that she was uncomfortable with him on the unit because she had reported an issue with Resident #2 earlier in the week. CNA #3 stated CNA #4 worked on Resident #2's unit that shift but was not assigned to Resident #2. CNA #3 stated she returned to work next on Monday 10/24/22 and CNA #4 was still scheduled to work and she did not understand why he had not been suspended regarding the allegations with Resident #2 that she reported on 10/20/22 to LPN #2.

On 11/10/22 at 8:50 a.m., LPN #2 was interviewed by telephone about CNA #3's report of Resident #2's allegations. LPN #2 stated she was not made aware of Resident #2's inappropriate care. LPN #2 stated she heard "over-talking" by CNA #3 and some other CNAs mentioning CNA #4's name but she did not know what the talking was about. LPN #2 denied that CNA #3 told her about Resident #2's allegations of inappropriate touching and stated she never received a written statement from CNA #3 about the incident. LPN #2 stated she was not aware of the allegations until the DON asked her about them on 10/24/22. LPN #2 stated again that CNA #2 "did not directly report" to her Resident #2's allegation regarding CNA #4.

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On 11/10/22 at 9:00 a.m., CNA #3 was interviewed again about reporting Resident #2's allegations regarding CNA #4 on 10/20/22. CNA #3 stated, I was standing in front of her [LPN #2] when I told her." CNA #3 stated she wrote a statement on her own and gave it to LPN #2. CNA #3 she was later told her original statement was lost and she wrote it again.

On 11/10/22 at 8:17 a.m., the licensed practical nurse unit manager (LPN #1) was interviewed about Resident #2's allegations regarding CNA #4. LPN #1 stated she was not aware that CNA #4 was not assigned to Resident #2 due to an expressed concern about his care. LPN #1 stated none of Resident #2's concerns/allegations regarding CNA #4's inappropriate wiping and comments were reported to her by any staff members.

On 11/10/22 at 10:35 a.m., the administrator, DON and ADON (RN #2) were interviewed about Resident #2's allegations and reporting of the resident's complaints/concerns about CNA #4 by RN #1, CNA #1 and CNA #3. The administrator stated APS advised him of the allegations on 10/24/22 after an APS worker met with Resident #2 about another issue. The administrator stated no staff members reported any allegations or concerns about Resident #2 regarding CNA #4. The DON stated she interviewed Resident #2 and the resident reported inappropriate wiping in her peri-area and that the resident reported she had previously told CNA #1 and CNA #3 about the incident that occurred on the COVID unit. The DON stated when she talked with CNA #3 she stated she reported the allegations to LPN #2 and LPN #2 stated CNA #3 did not report the

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allegations directly to her. The DON stated she was not aware that Resident #2 had requested not to have CNA #4 provide her care or that RN #1 was not routinely assigning CNA #4 to Resident #2. The DON stated the reports of concern about CNA #4 made to RN#1 should have been reported to her or the administrator. The DON stated she was not aware Resident #2 expressed concerns about CNA #4 several months ago. The administrator stated RN #1 should have reported to her supervisor about the resident not wanting care by CNA #4. The DON stated it sounded like RN #1 and Resident #2 worked out a plan but the plan was not communicated. The DON stated CNA #3 and LPN #2 should have reported the allegations about the incident on the COVID unit immediately to her and that CNA #4 would have been suspended earlier if reported.

2. Allegations of unwanted touching to the perineal/vaginal area made by Residents #13 against certified nurses' aide (CNA) #4 were not reported to the state's department of health professions as required in the facility's abuse prevention policy.

Resident #13 was admitted to the facility with diagnoses that included anemia, liver cirrhosis, gastrointestinal hemorrhage, depression, gastritis and protein-calorie malnutrition. The minimum data set (MDS) dated 9/14/22 assessed Resident #13 as cognitively intact, frequently incontinent of bladder and as requiring extensive assistance of one person for toileting.

A facility reported incident form to the state agency dated 11/3/22 documented Resident #13

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reported to the ADON that she had been "fingered" by a "dark skinned, short man" and she had not reported the incident when it happened but probably should have. The facility identified the employee involved as CNA #4. This form documented no notification to the department of health professions.

On 11/14/22 at 12:30 p.m., the administrator was interviewed about reporting of allegations against CNA #4 involving Residents #2, #13 and #15. The administrator stated Resident #2's allegation against CNA #4 were not reported to the department of health professions (DHP) because he found nothing at the time putting CNA #4 with Resident #2 for care. The administrator stated he had reported allegations about CNA #4 touching Resident #8 and when the DHP investigator called him he would let them know about the other allegations involving Residents #2, #13 and #15. The administrator stated he was not aware that their policy required reporting to DHP within 24 hours.

3. Resident #15 had unwanted touching of the upper thigh, but thwarted repeated attempts by a staff member to gain further access to her perineal area. The facility identified the staff member as CNA #4. These allegations were not reported to the state agency, adult protective services, or the department of health professions.

Resident #15 was admitted to the facility with diagnoses that include end stage renal disease, diabetes, anemia and hypothyroidism. The minimum data set (MDS) dated 10/14/22 assessed Resident #15 as cognitively intact, always continent of bowel/bladder and as

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requiring limited assistance of one person for toileting.

The assistant director of nursing (registered nurse #2) documented an interview with Resident #15 dated 11/1/22 stating, "...I asked [Resident #15] if any staff member had touched her inappropriately. [Resident #15] stated, 'No but I am afraid of that man who works at night'... [Resident #15] stated, 'I don't know his name, but he is short, dark complexion, with an accent, he worked last night'...[Resident #15] stated, 'He came into my room and said he needed to change me, I told him I did not wear a brief, but he would not listen, he said he needed to make sure I was clean, I again told him no that I did not wear a brief...he then checked his paper and said oh, I need to check your roommate, and he left me alone..."

Resident #15's clinical record documented a social worker (SW) note dated 11/2/22 documenting the resident stated she was "inappropriately touched and 'made to feel very uncomfortable..." The social worker note documented he explained that the perpetrator was currently suspended from the facility.

There was no facility reported incident form sent to the state survey agency, no notification to adult protective services or the department of health professions regarding Resident #15's comments/allegations regarding the attempted brief change and inappropriate touching by a staff member identified by the facility as CNA #4.

On 11/14/22 at 12:30 p.m., the administrator was interviewed about Resident #15. The administrator stated he did not initiate a facility

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reported incident form and make notification to protective agencies about Resident #15 because the resident reported that she was not physically touched.

The facility's policy titled Abuse/Neglect/Misappropriation/Crime (10/24/22) documented, "A licensed nurse will immediately respond to all allegations and/or reasonable suspicions of staff to patient, patient to patient, and/or visitor to patient, abuse, neglect, mistreatment...All alleged violations involving abuse, neglect...are to be reported immediately but (a) no later than 2 hours after the allegation is made if the event that cause the allegation involves abuse...Any staff observing or suspecting abuse, neglect or mistreatment will remove the patient from danger immediately and report to their immediate supervisor...A licensed nurse will notify the Administrator and/or Director of Nursing immediately..."

The facility's policy titled Reporting Requirements/Investigations (1/23/20) documented, "The Administrator will ensure the timely reporting, investigation, and follow up reporting of incidents of alleged/suspected patient abuse, neglect, mistreatment, exploitation, or crime against a patient to the State Agency and any other appropriate authorities...Notify within 24 hours the Department of Health Professions (DHP) for incidences involving nurse aides, RNs, LPNs, Physicians, or other licensed or certified by DHP..."

These findings were reviewed with the administrator, director of nursing and regional director of clinical services during a meeting on

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F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §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, facility document review, clinical record review and complaint investigation, the facility staff failed to immediately report allegations of abuse to the	F 609	F609 1) CNA #1 & #3, LPN #1 & #2, and RN #1, were educated on the Abuse/Neglect/Misappropriation/Crime	12/22/22

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administrator and/or the state survey agency for two of sixteen residents in the survey sample. Facility staff failed to immediately report to the administrator allegations by Resident #2 of inappropriate touching by a certified nurses' aide. Resident #15's attempts to stop a CNA from accessing her perineal area were not reported to the state survey agency or adult protective services.

The findings include:

1. Resident #2's allegations/concerns involving unwanted touching of the perineal/vaginal area by a staff member, along with unwelcomed sexual remarks, were not immediately reported to the administrator.

Resident #2 was admitted to the facility with diagnoses that included anxiety, sleep apnea, major depressive disorder, heart failure, restless leg syndrome, overactive bladder, chronic respiratory failure, insomnia, hypertension and Parkinson's disease. The minimum data set (MDS) dated 10/7/22 assessed Resident #2 as cognitively intact, as always incontinent of bladder and as requiring the extensive assistance of one person for toileting.

A facility reported incident form dated 10/24/22 documented Resident #2 reported to the facility staff that a certified nurses' aide (CNA #4) had wiped her for an inappropriate length of time in her perineal area and made her uncomfortable. The resident reported CNA #4 made the comment while wiping her that he did not understand why she did not like it because "that's how his girlfriend likes it." This report documented no report of the allegations to the

policy on and timely reporting of any allegations on 11/1/22.

Regional Director of Clinical Services educated facility Administrator and Director of Nursing on facility incidents that need to be reported to the state survey agencies and APS and the timeframe in which to do so on 11/14/22.
2) Current facility residents have the potential to be affected.
3) The Administrator/Designee will educate facility staff on the Abuse/Neglect/Misappropriation/Crime Policy and appropriate reporting protocol to include immediate notification of questionable incidents that occur in the facility to the Administrator.
4) The Administrator/Designee will perform weekly random interviews with 10 residents concerning abuse and care in the facility to ensure the abuse policy is followed and any allegations reported timely.
5) Results of the audit will be presented to the QAPI committee for review and recommendations. Once the QAPI committee determines the problem no longer exists, audits will be conducted
6) Date of Compliance: 12/22/22

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department of health professions.

The facility's investigation documented an interview with Resident #2 by the director of nursing (DON) dated 10/24/22. This interview documented, "...[Resident #2] told me that months ago a short, black CNA asked to check her brief during the night shift. She said he wiped her for 10 minutes and she got a bad vibe from him...continued to say that when she was...being isolated for Covid he was her aide again. She said he was performing incontinent care and she asked him to stop. She said he replied with, 'I don't know why you don't like this because my girlfriend does'..." (Sic) The administrator documented an interview with Resident #2 dated 10/24/22 stating the resident stated CNA #4 wiped her for a "very long time, approximately 10 minutes" and that she was concerned about how rough she was wiped. This interview stated the resident was not sure of the dates this occurred but that it happened while she was isolated on the COVID unit.

The facility's investigation documented a written statement from Resident #2's routine CNA (#3) dated 10/24/22 stating, "On Wednesday night/Thursday morning [10/19/22, 10/20/22]...Resident #2 made a complaint to me about an aide [CNA #4] wiping her inappropriately and saying 'that's how my girlfriend likes it' I reported it to the nurse on duty and gave her my statement [Resident #2] also stated that she had reported this incident to the APS [adult protective service] person that had been in to see her during the day...informed my nurse [licensed practical nurse #2] Agency." (Sic)

The facility's investigation documented an

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(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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interview by the DON with CNA #1 dated 10/26/22. This interview documented, "...[CNA #1] stated that when [Resident #2] was isolating for Covid...she told her that she did not like [CNA #4] because of the way he wiped her during incontinent care. [CNA #1] stated that [Resident #2] did not act like the incident was a big deal at the time or did not give any reason to believe it was anything but her not liking the way he did ADL [activities of daily living] care."

The facility's investigation documented an interview by the DON with registered nurse (RN) #1. This interview documented, "...[RN #1] stated that [Resident #2] told her months ago that she did not like the way [CNA #4] wiped her during incontinent care and that he used too many wipes. [RN #1] stated that [Resident #2] did not act like the incident was a big deal at the time and did not give her any reason to believe it was anything but her not liking the way he did ADL care."

On 11/9/22 at 11:30 a.m., Resident #2 was interviewed about her care in the facility and the allegations regarding CNA #4. Resident #2 stated approximately 3 to 4 months ago, CNA #4 came in her room around 2:00 a.m. and said he wanted to check her brief to see if she was wet. Resident #2 stated she told CNA #4 that she was "ok" and CNA #4 then stated he needed to check her anyway because that was his job. Resident #2 stated CNA #4 "wiped me for 10 minutes" using cleansing wipes. Resident #2 stated she watched the clock and he cleaned her for 10 minutes continually wiping her perineal area. Resident #2 stated CNA #4 "was down there a long time" and she was very uncomfortable with the continued wiping. Resident #2 stated she told

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her usual nurse (registered nurse #1) about the incident when she next worked and requested that CNA #4 not provide care for her anymore. Resident #2 stated registered nurse (RN) #1 agreed to not assign CNA #4 to her and she did not see CNA #4 again until she was moved to another unit after getting COVID-19. Resident #2 stated she was moved to the COVID unit in September (2022) for isolation and while on that unit, CNA #4 came in her room and again stated he wanted to check/change her brief. Resident #2 stated she told CNA #4 that he was not supposed to be in her room or provide care for her. Resident #2 stated CNA #4 stated he needed to check her and began wiping her buttock area. Resident #2 stated she told CNA #4 that he had done enough wiping and then he went to wiping her vaginal area. Resident #2 stated she told CNA #4 to "stop" and that's when CNA #4 told her he did not understand why she did not like it because his girlfriend liked it. Resident #2 stated, "I was scared of him." Resident #2 stated CNA #1 came in the room and she reported to her that CNA #4 was not supposed to be providing care for her and that he kept wiping her "pretty hard." Resident #2 stated CNA #1 said she reported the incident to the nurse but she was not aware of the nurse's name. Resident #2 stated when she returned to her previous unit/room after COVID, she told her regular CNA (#3) about the incident on the COVID unit. Resident #2 stated she reported that CNA #4 had touched her inappropriately and made her uncomfortable twice, once several months ago to RN #1 and then to CNA #1 and CNA #3 about the incident while on the COVID unit.

On 11/9/22 at 4:10 p.m., CNA #1 was interviewed

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about the allegations made by Resident #2. Stating that she did not remember the exact date of the incident, CNA #1 stated, "that day, me and CNA #4 worked on the COVID unit." CNA #1 stated that shortly after shift change at 11:00 p.m., Resident #2's call light was on. CNA #1 stated that when she responded to the light and entered the room, CNA #4 was putting on gloves and pulling the curtain around Resident #2. CNA #1 stated Resident #2 told her that CNA #4 was not supposed to be in her room or care for her. CNA #1 stated she left the room and told the nurse working the unit that Resident #2 did not want CNA #4 caring for her. CNA #1 stated that he nurse she reported this to was an agency employee and she did not know her name, but added that CNA #4 was moved to the West unit after her report.

On 11/10/22 at 6:00 a.m., RN #1 was interviewed about Resident #2. RN #1 stated she routinely cared for Resident #2 on the night shift (11:00 p.m. until 7:00 a.m.). RN #1 stated Resident #2 told her "several months ago" the she did not like the way CNA #4 wiped her during incontinence care and that she requested that he not care for her anymore. RN #1 stated since that report she had not assigned CNA #4 to care for Resident #2. RN #1 stated it was "generally known" and "common knowledge" to not assign CNA #4 to Resident #2. RN #1 stated, "We knew not to assign him [CNA #4] to [Resident #2]." When asked if she asked Resident #2 to elaborate on why she did not want care by CNA #4, RN #1 stated, "No." RN #1 stated she did not view Resident #2 not wanting CNA #4's care as a complaint. RN #1 stated the resident's complaint was more about the length of time he cleaned her and not about touching her and that the resident

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did not elaborate on what CNA #4 had done. RN #1 stated she interpreted the issue to be about "mechanics" and she did not report the issue to supervision or administration. RN #1 stated if the resident had been more specific about what CNA #4 had done she would have reported the concern to her supervisor or administration.

On 11/10/22 at 6:15 a.m., CNA #3 that routinely cared for Resident #2 was interviewed. CNA #3 stated during the night shift starting at 11:00 p.m. on 10/19/22 until 7:00 a.m. on 10/20/22, Resident #2 reported to her that CNA #4 had cleaned her perineal area for a long time while she was on the COVID unit. Resident #2 stated the resident told her she was scared of CNA #4. CNA #3 stated the resident reported that CNA #4 kept wiping her peri-area even after she told him to stop and made a comment to her that she should like it because his girlfriend liked it. CNA #3 stated the resident "acted a little scared of him." CNA #3 stated she immediately went to the nursing station and reported Resident #2's concern to licensed practical nurse (LPN) #2. CNA #3 stated she wrote a statement about what the resident said and gave it to LPN #2. CNA #3 stated when she came back to work on 10/22/22, CNA #4 was working on the unit. CNA #3 stated she told the agency nurse working that she was uncomfortable with him on the unit because she had reported an issue with Resident #2 earlier in the week. CNA #3 stated CNA #4 worked on Resident #2's unit that shift but was not assigned to Resident #2. CNA #3 stated she returned to work next on Monday 10/24/22 and CNA #4 was still scheduled to work and she did not understand why he had not been suspended regarding the allegations with Resident #2 that she reported on 10/20/22 to LPN #2.

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On 11/10/22 at 8:50 a.m., LPN #2 was interviewed by telephone about CNA #3's report of Resident #2's allegations. LPN #2 stated she was not made aware of Resident #2's inappropriate care. LPN #2 stated she heard "over-talking" by CNA #3 and some other CNAs mentioning CNA #4's name but she did not know what the talking was about. LPN #2 denied that CNA #3 told her about Resident #2's allegations of inappropriate touching and stated she never received a written statement from CNA #3 about the incident. LPN #2 stated she was not aware of the allegations until the DON asked her about them on 10/24/22. LPN #2 stated again that CNA #2 "did not directly report" to her Resident #2's allegation regarding CNA #4.

On 11/10/22 at 8:17 a.m., the licensed practical nurse unit manager (LPN #1) was interviewed about Resident #2's allegations regarding CNA #4. LPN #1 stated she was not aware that CNA #4 was not assigned to Resident #2 due to an expressed concern about his care. LPN #1 stated none of Resident #2's concerns/allegations regarding CNA #4's inappropriate wiping and comments were reported to her by any staff members. LPN #1 stated she was made aware of the allegations on 10/24/22 by the DON.

On 11/10/22 at 9:00 a.m., CNA #3 was interviewed again about reporting Resident #2's allegations regarding CNA #4 on 10/20/22. CNA #3 stated, I was standing in front of her [LPN #2] when I told her." CNA #3 stated she wrote a statement on her own and gave it to LPN #2. CNA #3 stated she was later told her original statement was lost and she wrote it again.

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On 11/10/22 at 10:35 a.m., the administrator, DON and ADON (RN #2) were interviewed about Resident #2's allegations and reporting of the resident's complaints/concerns about CNA #4 by RN #1, CNA #1 and CNA #3. The administrator stated APS advised him of the allegations on 10/24/22 after an APS worker met with Resident #2 about another issue. The administrator stated no staff members reported any allegations or concerns about Resident #2 regarding CNA #4. The DON stated she interviewed Resident #2 and the resident reported inappropriate wiping in her peri-area and that the resident reported she had previously told CNA #1 and CNA #3 about the incident that occurred on the COVID unit. The DON stated when she talked with CNA #3 she stated she reported the allegations to LPN #2 and LPN #2 stated CNA #3 did not report the allegations directly to her. The DON stated she was not aware that Resident #2 had requested not to have CNA #4 provide her care or that RN #1 was not routinely assigning CNA #4 to Resident #2. The DON stated the reports of concern about CNA #4 made to RN#1 should have been reported to her or the administrator. The DON stated she was not aware Resident #2 expressed concerns about CNA #4 several months ago. The administrator stated RN #1 should have reported to her supervisor about the resident not wanting care by CNA #4. The DON stated it sounded like RN #1 and Resident #2 worked out a plan but the plan was not communicated. The DON stated CNA #3 and LPN #2 should have reported the allegations about the incident on the COVID unit immediately to her and that CNA #4 would have been suspended earlier if reported.

These findings were reviewed with the

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administrator, DON, regional director of clinical services on 11/10/22 at 10:35 a.m. and on 11/14/22 at 1:10 p.m.

2. Resident #15 had unwanting touching to upper thigh, but thwarted repeated attempts by a staff member to physically contact her perineal area. The facility identified the staff member as certified nurses' aide (CNA) #4. These allegations were not reported to the state agency or adult protective services.

Resident #15 was admitted to the facility with diagnoses that include end stage renal disease, diabetes, anemia and hypothyroidism. The minimum data set (MDS) dated 10/14/22 assessed Resident #15 as cognitively intact, always continent of bowel/bladder and as requiring limited assistance of one person for toileting.

The assistant director of nursing (registered nurse #2) documented an interview with Resident #15 dated 11/1/22 stating, "...I asked [Resident #15] if any staff member had touched her inappropriately. [Resident #15] stated, 'No but I am afraid of that man who works at night'... [Resident #15] stated, 'I don't know his name, but he is short, dark complexion, with an accent, he worked last night'...[Resident #15] stated, 'He came into my room and said he needed to change me, I told him I did not wear a brief, but he would not listen, he said he needed to make sure I was clean, I again told him no that I did not wear a brief...he then checked his paper and said oh, I need to check your roommate, and he left me alone..."

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F 609	Continued From page 42 Resident #15's clinical record documented a social worker (SW) note dated 11/2/22 documenting the resident stated she was "inappropriately touched and 'made to feel very uncomfortable'..." The social worker note documented he explained that the "perpetrator" was currently suspended from the facility. There was no facility reported incident form sent to the state survey agency and no notification to adult protective services regarding Resident #15's comments/allegations regarding the attempted brief change and inappropriate touching by a staff member identified by the facility as CNA #4. On 11/14/22 at 12:30 p.m., the administrator was interviewed about Resident #15. The administrator stated he did not initiate a facility reported incident form and make notification to protective agencies about Resident #15 because the resident reported that she was not physically touched. This finding was reviewed with the administrator, DON, regional director of clinical services on 11/10/22 at 10:35 a.m. and on 11/14/22 at 1:10 p.m. No further information was provided prior to exit.	F 609		
F 644 SS=E	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:	F 644		12/22/22

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F 644	Continued From page 43 §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to incorporate and follow Level II PASARR recommendations for one of 16 residents, Resident #3. Findings were: Resident #3 was admitted to the facility with the following diagnoses including but not limited to: Developmental Disorder of Scholastic Skills Unspecified, Morbid obesity, genetic related intellectual disability (ID), hypertension, and adult failure to thrive. An annual MDS (minimum data set) with an ARD (assessment reference date) of 09/27/2022 assessed Resident #3 as severely impaired with a cognitive summary score of "01". The clinical record was reviewed at approximately 11:30 a.m. on 11/09/2022. Two Level II PASARRs were observed. The first dated 02/01/2022, and the second dated 05/26/2022. The second Level II PASARR contained the following: " "This is his	F 644	F644 PASARR 1. Resident number 3 PASARR was sent to ASCEND for review during the survey for review and the CSB board was contacted regarding targeted case management and psych practitioner was contacted for implantation of a behavior care plan. during the survey. 2. Current residents with a Level II have the potential to be affected. An audit of current residents with a level 2 will be conducted for following the recommendations, any finding will be reported to the administrator. 3. The Regional Director of Clinical Services or designee with educate the Social Services department on implementation of items identified in the Level II by the ASCEND group and to notify the administrator if additional resources are needed to implement identified items. 4. The Administrator or designee will perform a weekly audit of new residents	

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F 644	Continued From page 44 second completed PASRR ...(Name) appears to meet PASRR criteria due to an Intellectual Disability, Moderate that emerged before the age of 18 which led to three or more lifelong limitations. IQ testing was conducted on 05/26/2022...(Name of Resident #3) was administered the Slosson Intelligence Test-Revised ...where he received the FSIQ score of <40 placing him in the moderate range of intellectual disability....limitations include self-care, self-direction, independent living, communication, functional academics, social/leisure skills, health and safety, and work...Per minimum data set...(Name of Resident #3) requires limited assistance with bed mobility, dressing, personal hygiene, supervision with transfers, and locomotion on the unit, and extensive assistance with toileting...utilizes a wheelchair for mobility ...is at increased risk of hitting himself and others...Per previous documentation...does not meet criteria for SMI (serious mental illness) population...SERVICE DETERMINATION Intense Specialized Services: Yes Rehabilitative Services: (services of lesser intensity): Yes...REHABILITATIVE SERVICES (SERVICES OF LESSER INTENSITY) RECOMMENDATION: Non-customized durable medical equipment, Restorative Nursing, Behavior Management, and Targeted Case Management...DETERMINATION SUMMARY Currently a nursing facility appears to provide (Name of Resident #10) with medical and nursing support including ADL care and supervision, and medication administration. Per this PASSR, specialized services that are recommended are self-help/personal care and mobility aids. Self-help/personal care is training in personal appearance and cleanliness, use of medication, and dental care. Mobility aid is equipment	F 644	with a Level II to ensure the PASARR recommendations are implemented and followed. 5) Results of the audit will be presented to the QAPI committee for review and recommendations. Once the QAPI committee determines the problem no longer exists, audits will be conducted 6) Date of Compliance 12/22/22	

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designed to increase, maintain, or improve one's capability to walk or maneuver in one's environment. Rehabilitative services of lesser intensity are recommended to include basic grooming, non-customized durable medical equipment, restorative nursing, behavioral management, and targeted case management...Behavioral Management is a lesser intensity application of behavior techniques in an attempt to systematically change maladaptive patterns of behavior. Targeted Case management is recommended to connect with supportive services and assess the potential for his needs to be met in a less restrictive environment if desired and medically able to be supported in a lower-level care setting. Collaboration with the Community Services Board (CSB) is encouraged to identify supports that may allow a transition to the community if discharge plan has been projected. Supports may include supportive housing that specializes in mental health care, adaptive medical equipment, environmental modifications, case management, outpatient psychiatric care, daily aid services, and home health services to monitor medical needs. A Targeted Resident Review is recommended for 180 days, if still admitted to a nursing facility at that time, to assess progress and identify additional supports as needed."

On 11/09/2022 at approximately 1:30 p.m., representatives from the local APS (adult protective services) came to the facility to speak with the survey team. OS (Other staff) #9 who was at one time listed as Resident #3's responsible party was in attendance. A discussion was held regarding Resident #3's behaviors and the recommendations on the most recent PASARR. OS #9 stated, "He is really just not

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appropriate for placement here. He needs to be somewhere else...His level two PASARR should get him services from the CSB. He also needs a legal guardian."

The social worker assistant/discharge planner (OS #3) was interviewed on 11/10/2022 at 8:10 a.m. Resident #3's PASARR recommendations from the most recent PASARR (05/26/2022) were discussed. She stated. "I took this over when the other social worker left, I've been trying to pick up the pieces...He is actually due for the next (PASARR) eval to be done...it's been about 180 days. We have contacted the CSB and I spoke with (Name of OS #6), he is the supervisor over ID (intellectual disability) services and told him what we need...He told me they couldn't provide services until we got a psychological evaluation...that's been done and we're waiting for the paperwork from (Name of University) to give to them...in the meantime he said they can't come in here and do case management because it would be double billing since he's in a nursing home.."

OS #6 was contacted at approximately 9:10 a.m. on 11/10/2022. He was asked about the CSB involvement with Resident #3. He stated, "They have contacted me about getting him a waiver slot...I explained what that would involve before we can get him on the waiting list." He was asked about Targeted Case Management services and behavior management. He stated, "We could provide Targeted Case Management through (Name) services but that does not cover a behavioral consultant or behavior management, that's part of a waiver slot....He could get case management, but COVID really eliminated a lot of our day support options....I was never told they

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wanted targeted case management, we just talked about a waiver....in my notes I have that I spoke with (Name of OS #3) in May and I told her then that he may be eligible for case management through (name of program) and she said she would let me know...that's all I have, I haven't heard anything else."

At 11:20 a.m. on 11/10/2022, the company completing PASARRs was contacted. OS #7, the quality control coordinator was interviewed. He was asked what the recommendations "targeted case management, and behavior management" actually entailed. He stated, "Case management comes from the local CSB. Behavior management is a physician involved plan that addresses the resident's needs and specific interventions for specific behaviors in order to change the behavior...it should be consistently followed." The following statement which was on the PASARR was discussed: "The Virginia Department of Behavioral Health and Developmental services makes referrals for Intense Specialized Services to the Community Service Board or the Department for Aging and Rehabilitative Services. The nursing facility makes arrangements to provide Rehabilitative Services..." He was asked what that statement actually meant and if the department had contacted the local community services board to ascertain needed services. He stated he would see what was being done.

Resident #3's care plan was reviewed and contained the following regarding behaviors: "The resident exhibits adverse behavioral symptoms (inconsolable crying, grabbing, hitting, throws hat, biting himself, slams bedroom door, closet doors removed for resident

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safety....Administer meds as ordered; Caregiver to provide opportunity for positive interactions, attention. Stop and talk with him as passing by; If reasonable discuss resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable...; praise indication of the resident's progress/improvement in behavior; redirect...during episodes of increased agitation/anxiety; send to ER for psych eval if...behaviors need further intervention."
Also:
"Resident has impaired cognitive function or impaired thought process r/t being developmentally delayed...Administer meds as ordered; Ask yes/no questions in order to determine needs; communicate with the resident/family/caregivers regarding residents capabilities and needs; COMMUNICATION: Use the resident preferred name...identify yourself...face the resident when speaking and make eye contact, close door, etc...resident understands consistent, simple, directive sentences. Provide the resident with necessary cues-stop and return if agitated; cue, reorient, and supervise as needed; present just one thought, idea, question or command at a time; Use task segmentation to support short term memory deficits. Break tasks into one step at a time."

An end of the day meeting was held with the DON (director of nursing), the administrator, and corporate staff on 11/10/2022 at approximately 1:20 p.m. The above information was discussed. They were asked if a behavior management plan had been developed for Resident #3. The administrator stated, "Just what's in the care plan." Concerns were voiced that the recommendations, specifically behavior

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management, on the PASARR had not been implemented. No specific interventions regarding Resident #3 grabbing/hitting other residents creating skin tears and bruises had been developed.

On 11/14/2022 at approximately 10:55 a.m., the psychiatric nurse practitioner (OS #5) for the facility was interviewed. PASARR recommendations regarding a behavior management plan was discussed. He was asked if anyone had asked him to help with such a plan. He stated, "No, no one here had discussed that, but it is easy enough. I can do that."

OS #3 was interviewed at 12:15 p.m. She stated the third PASARR for Resident #3 had been completed on Friday 11/11/2022. She stated, "What did you do?" She stated that she had spoken with OS #6 at the local CSB. His supervisor had been contacted by someone from the Department of Behavioral Health regarding targeted case management. "They want me to send them the psych eval when I get it, but they may not even need it...they are going to come in and evaluate him and see if he can get targeted case management and get him on the waiver list...I don't know who you called, but thank you."

The above information was discussed during a meeting with the DON, the administrator, and corporate staff on 11/14/2022 at approximately 1:10 p.m.

No further information was obtained prior to the exit conference on 11/14/2022.

This is a COMPLAINT DEFICIENCY.

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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		12/22/22

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F 656	Continued From page 51 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to develop a comprehensive care plan for two of sixteen residents in the survey sample. Residents #2 and #8 had no plan of care develop following incidents of inappropriate touching by a staff member. The findings include: 1. Resident #2 had no plan of care developed following an incident of inappropriate touching by certified nurses' aide (CNA) #4. Resident #2 was admitted to the facility with diagnoses that included anxiety, sleep apnea, major depressive disorder, heart failure, restless leg syndrome, overactive bladder, chronic respiratory failure, insomnia, hypertension and Parkinson's disease. The minimum data set (MDS) dated 10/7/22 assessed Resident #2 as cognitively intact, as always incontinent of bladder and as requiring the extensive assistance of one person for toileting. A facility reported incident form dated 10/24/22 documented Resident #2 reported to the facility	F 656	F656 1. Resident # 2□s care plan was updated during survey on 11/14/22. Resident # 8 is no longer a resident at the facility. 2. Current residents have the potential to be affected. 3. The DON/Designee will educate the current nursing management and the MDS department on timeliness of updating a care plan to reflect events/ changes in the resident□s health status or psychosocial well-being. 4. The DON/Designee will audit five times weekly to ensure changes to the resident health status or psychosocial status are updated timely in the resident□s care plan. 5) Results of the audit will be presented to the QAPI committee for review and recommendations. Once the QAPI committee determines the problem no longer exists, audits will be conducted 6) Date of Compliance 12/22/22	

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staff that a certified nurses' aide (CNA #4) had wiped her for an inappropriate length of time in her perineal area and made her uncomfortable. The resident reported CNA #4 made the comment while wiping her that he did not understand why she did not like it because "that's how his girlfriend likes it."

On 11/9/22 at 11:30 a.m., Resident #2 was interviewed about her care in the facility and the allegations regarding CNA #4. Resident #2 stated approximately 3 to 4 months ago, CNA #4 came in her room around 2:00 a.m. and said he wanted to check her brief to see if she was wet. Resident #2 stated she told CNA #4 that she was "ok" and CNA #4 then stated he needed to check her anyway because that was his job. Resident #2 stated CNA #4 "wiped me for 10 minutes" using cleansing wipes. Resident #2 stated she watched the clock and he cleaned her for 10 minutes continually wiping her perineal area. Resident #2 stated CNA #4 "was down there a long time" and she was very uncomfortable with the continued wiping. Resident #2 stated she told her usual nurse (registered nurse #1) about the incident when she next worked and requested that CNA #4 not provide care for her anymore. Resident #2 stated registered nurse (RN) #1 agreed to not assign CNA #4 to her and she did not see CNA #4 again until she was moved to another unit after getting COVID-19. Resident #2 stated she was moved to the COVID unit in September (2022) for isolation and while on that unit, CNA #4 came in her room and again stated he wanted to check/change her brief. Resident #2 stated she told CNA #4 that he was not supposed to be in her room or provide care for her. Resident #2 stated CNA #4 stated he needed to check her and began wiping her

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buttock area. Resident #2 stated she told CNA #4 that he had done enough wiping and then he went to wiping her vaginal area. Resident #2 stated she told CNA #4 to "stop" and that's when CNA #4 told her he did not understand why she did not like it because his girlfriend liked it. Resident #2 stated, "I was scared of him." Resident #2 stated CNA #1 came in the room and she reported to her that CNA #4 was not supposed to be providing care for her and that he kept wiping her "pretty hard." Resident #2 stated CNA #1 said she reported the incident to the nurse but she was not aware of the nurse's name. Resident #2 stated, "I was fighting him off. Told him he'd done enough wiping." Resident #2 stated she did not remember the exact date of the incident but it was during the time she was on isolation for COVID. Resident #2 stated she was upset about the incident and was "shocked" that it happened because she had reported CNA #4 to RN #1 several months ago and thought the issue was taken care of. Resident #2 stated when she returned to her previous unit/room after COVID, she told her regular CNA (#3) about the incident on the COVID unit. Resident #2 stated she was tearful when talking with the police about the incident and still had questions about pressing charges. Resident #2 stated she had trouble sleeping for a few days after the last incident but felt better now that he no longer worked in the facility.

Resident #2's care plan (revised 10/31/22) documented no problems, goals and/or interventions regarding the resident's concerns and coping following the incidents involving CNA #4.

On 11/10/22 at 8:17 a.m., the licensed practical

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nurse unit manager (LPN #1) was interviewed about Resident #2. LPN #1 stated she was not made aware of the incident on the COVID unit until 10/24/22 and she had not added anything to the resident's plan of care regarding the incident with CNA #4. LPN #1 stated the interdisciplinary team was responsible for developing and updating care plans.

2. Resident #8 had a no care plan developed following a vaginal abrasion/bleeding resulting from inappropriate sexual contact by a staff member.

Resident #8 was admitted to the facility with diagnoses that included diabetes, anxiety, dementia with behaviors, major depressive disorder, schizoaffective disorder, insomnia, hypertension, mood disorder and dysphagia. The minimum data set (MDS) dated 10/16/22 assessed Resident #8 with moderately impaired cognitive skills, frequently incontinent of bladder and as requiring extensive assistance of one person for toileting.

A facility reported incident to the state agency dated 11/1/22 documented Resident #8 reported to the occupational therapist (OT) that she had been raped a few night ago by a short African-American CNA identified by the facility as CNA #4. The report listed the resident reported the CNA put his fingers in Resident #8's vagina when changing her brief and then left the room. The resident was assessed with blood in her brief and on her labia/vaginal area after the reported allegations and was sent to the emergency room for evaluation.

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Resident #8 was evaluated at the emergency department on 11/1/22 in response to the rape allegations. The emergency department report dated 11/1/22 documented, "...presents with alleged sexual assault. On 10/30/2022 a caregiver was helping to change her briefs...She states that the male staff member put his fingers in her vagina. Patient did not consent to this. There was no intercourse. No rectal penetration..." The physician assistant's examination documented, "Positive for vaginal bleeding. Negative for dysuria, urgency, frequency, hematuria and flank pain...does not bruise/bleed easily..." The report listed the resident's mental status as "alert" and that the resident "appeared anxious." The resident was diagnosed with "mild pyuria" and returned to the nursing facility on 11/1/22.

A family nurse practitioner (other staff #10) assessed Resident #8 on 11/2/22 and documented, "...Today, vaginal abrasion visualized and unchanged...continue to monitor daily..."

The psychiatric NP (other staff #5) assessed Resident #8 on 11/3/22. The psychiatric NP documented the resident stated when asked if she was getting along with the staff and other residents, "...I was raped by foreigner..." The psychiatric NP assess the resident as "not overly" agitated or emotional and with sleep problems that had initiated prior to the reported incident.

Resident #8's plan of care (revised 11/7/22) documented no problems, goals and/or interventions regarding the vaginal abrasion, bleeding following the incident of inappropriate touching by a staff member.

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F 656	Continued From page 56 On 11/10/22 at 10:35 a.m., the director of nursing (DON) was interviewed about a plan of care for Resident #8. The DON stated the interdisciplinary team was responsible for care plan development. The DON stated nothing had yet been added to Resident #8's plan of care about the vaginal trauma and abuse incident. On 11/14/22 at 11:00 a.m. the assistant director of nursing (registered nurse #2) was interviewed about a plan of care for Resident #8. Registered nurse (RN) #2 stated she had been filling-in as unit manager on Resident #8's unit when the abuse allegations were made. RN #2 stated there was nothing on the care plan about the vaginal trauma incident and that changes in condition were discussed with the interdisciplinary team during morning meetings. RN #2 stated she did not know why Resident #8 had no plan of care about the incident. These findings were reviewed with the administrator, DON, regional director of clinical services on 11/14/22 at 1:10 p.m.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		12/22/22

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F 684	Continued From page 57 by: Based on clinical record review and staff interview during a complaint investigation, the facility staff failed to follow physician orders for one of 15 residents in the survey sample. The facility staff failed to remove Resident #1's surgical staples timely as instructed by the physician's orders. The findings include: Resident #1 was admitted to the facility with diagnoses that included aftercare for hip fracture, hyperlipidemia, osteoporosis, depression, anxiety, hypertensive heart, congestive heart failure, type 2 diabetes, muscle weakness, and dementia with behavioral disturbance. The most recent minimum data set (MDS) dated 10/05/2022 was a quarterly assessment and assessed Resident #1 as severely impaired for daily decision making with a score of 2 out of 15. On 11/09/2022 during the initial tour, Resident #1 was observed laying in her bed. An attempt to interview the resident was unsuccessful as the resident only spoke non-sequential comments. Resident #1's clinical record was reviewed on 11/09/2022. Observed on the order summary report for the period of 07/01/2022 - 07/31/2022 were the following orders: "L (left) hip: dry dressing q day every day shift. Order date: 07/08/2022." "L (left) hip: remove staples and place dry dressing every day shift for 1 day. Order Date: 07/08/2022. Start Date: 07/19/2022. End Date: 07/20/2022." Resident #1's treatment administration record	F 684	F 684 1. Residents #1□s staples were removed at her surgeon□s office on 8/2/22. 2. Current residents have the potential to be affected. 3. The DON or designee will educate the current licensed nursing staff on following physician orders to include removing of staples and correctly documenting in the medical record. 4. The DON/designee will audit physician orders to ensure they are correctly followed as stated on the TAR 5 times per week. 5) Results of the audit will be presented to the QAPI committee for review and recommendations. Once the QAPI committee determines the problem no longer exists, audits will be conducted 6) Date of Compliance 12/22/22	

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(TAR) for the period of 07/01/2022 - 07/31/2022 was reviewed and documented the resident received the daily dry dressing changes as ordered. Continued review of the TAR documented on 07/19/2022 the treatment order to remove the staples was signed off as completed by a licensed practical nurse identified (LPN #3).

Observed in the miscellaneous section of the clinical record was the hospital discharge (DC) summary dated 07/08/22. The DC summary was signed by the facility's nurse practitioner. The DC summary included additional instructions to "REMOVE post-op staples 7/19/2022" and to follow-up with the orthopedic specialist on 8/2/2022 at 11:30 a.m. The clinical record also included a copy of the orthopedic physician's progress note dated 8/2/22. The note documented "...staples removed in office today. XR (x-ray) shows good early healing..."

On 11/09/2022 at 3:30 p.m., LPN #3 who was identified as signing the TAR on 07/19/2022 as removing the staples was interviewed. LPN #3 stated she did not remove the staples as signed off. LPN #3 stated she mistakenly signed off the wrong order. LPN #3 stated the two orders were worded very similarly and she thought she was signing off on the daily dressing change order. LPN #3 stated "it was a mistake. I got the two orders mixed up and signed the wrong one."

Resident #1's clinical record documented nursing staff continued to perform daily dressing changes as ordered and did not observe any concerns with the surgical hip wound.

On 11/09/2022 at 3:45 p.m., the above findings

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F 684	Continued From page 59 were reviewed during a meeting with the administrator, DON, ADON, and corporate consultant. The facility's DON was asked if a LPN could remove the staples as ordered. The DON stated, "Yes." The DON was asked who verified that signed TAR orders were completed. The DON stated if the TAR documented the order as signed/completed then the staff would presume the orders were completed unless otherwise documented or if there were other concerns. No other information was received by the survey team prior to exit on 11/14/2022. This is a complaint deficiency.	F 684		
F 689 SS=E	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, resident interview, and clinical record review, the facility staff failed to implement interventions and adequate supervision to prevent resident to resident altercations instigated by one of 16 residents, Resident #3. Findings were: Resident #3 was admitted to the facility with the	F 689	F689 1. Resident number 3 was placed on 1:1 during the survey on 11/11/22. 2. Current residents have the potential to be affected. 3. The DON/designee will educate current facility staff on dealing with difficult behaviors and how to assist in deescalating a resident□s behavior to prevent resident to resident altercations.	12/22/22

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F 689	Continued From page 60 following diagnoses including but not limited to: Developmental Disorder of Scholastic Skills Unspecified, Morbid obesity, genetic related intellectual disability (ID), hypertension, and adult failure to thrive. An annual MDS (minimum data set) with an ARD (assessment reference date) of 09/27/2022 assessed Resident #3 as severely impaired with a cognitive summary score of "01". The clinical record was reviewed at approximately 11:30 a.m. on 11/09/2022. Two Level II PASARRs were observed. The first dated 02/01/2022, and the second dated 05/26/2022. The second Level II PASARR contained the following: " "This is his second completed PASRR ...(Name) appears to meet PASRR criteria due to an Intellectual Disability, Moderate that emerged before the age of 18 which led to three or more lifelong limitations. IQ testing was conducted on 05/26/2022...(Name of Resident #3) was administered the Slosson Intelligence Test-Revised ...where he received the FSIQ score of <40 placing him in the moderate range of intellectual disability....limitations include self-care ,self-direction, independent living, communication, functional academics, social/leisure skills, health and safety, and work...Per minimum data set...(Name of Resident #3) requires limited assistance with bed mobility, dressing, personal hygiene, supervision with transfers, and locomotion on the unit, and extensive assistance with toileting...utilizes a wheelchair for mobility ...is at increased risk of hitting himself and others...Per previous documentation...does not meet criteria for SMI (serious mental illness) population...SERVICE DETERMINATION Intense Specialized Services:	F 689	4. The DON/designee will perform audits weekly on those residents with behaviors to ensure intervention implemented are being followed and are effective to keep the behavior from escalation. 5) Results of the audit will be presented to the QAPI committee for review and recommendations. Once the QAPI committee determines the problem no longer exists, audits will be conducted 6) Date of Compliance 12/22/22	

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Yes Rehabilitative Services: (services of lesser intensity): Yes...REHABILITATIVE SERVICES (SERVICES OF LESSER INTENSITY) RECOMMENDATION: Non-customized durable medical equipment, Restorative Nursing, Behavior Management, and Targeted Case Management...DETERMINATION SUMMARY Currently a nursing facility appears to provide (Name of Resident #10) with medical and nursing support including ADL care and supervision, and medication administration. Per this PASSR, specialized services that are recommended are self-help/personal care and mobility aids. Self-help/personal care is training in personal appearance and cleanliness, use of medication, and dental care. Mobility aid is equipment designed to increase, maintain, or improve one's capability to walk or maneuver in one's environment. Rehabilitative services of lesser intensity are recommended to include basic grooming, non-customized durable medical equipment, restorative nursing, behavioral management, and targeted case management...Behavioral Management is a lesser intensity application of behavior techniques in an attempt to systematically change maladaptive patterns of behavior. Targeted Case management is recommended to connect with supportive services and assess the potential for his needs to be met in a less restrictive environment if desired and medically able to be supported in a lower-level care setting. Collaboration with the Community Services Board (CSB) is encouraged to identify supports that may allow a transition to the community if discharge plan has been projected. Supports may include supportive housing that specializes in mental health care, adaptive medical equipment, environmental modifications, case management,

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outpatient psychiatric care, daily aid services, and home health services to monitor medical needs. A Targeted Resident Review is recommended for 180 days, if still admitted to a nursing facility at that time, to assess progress and identify additional supports as needed."

Progress notes from 07/01/2022 to 11/09/2022 were reviewed in the clinical record. Behaviors documented throughout the time period included, slamming and kicking doors, throwing clothing items into the hallway, loud crying, physical aggression towards other residents, striking another resident repeatedly on the arm and grabbing his wheelchair, and beating on walls. Resident #3 was redirected by staff on these occasions, taken to his room for a nap, given an activity, given a snack, or medicated. A total of 16 progress notes documented these types of behavior.

Five facility reported resident to resident altercations involving Resident #3 from 08/01/2022 through 09/23/2022 were reviewed. They were:
08/01/2022 Grabbed Resident #6's wheelchair and struck him repeatedly on the arm
08/09/2022 Grabbed Resident #5 by his right arm causing a skin tear
08/16/2022 Grabbed Resident #7 by the left arm, bruising noted
09/14/2022 Grabbed Resident #11 by the arm
09/23/2022 Smacked Resident #4 on the hand

Clinical records for the above residents were reviewed.

Resident #7 was admitted to the facility with the following diagnoses, including, but not limited to:

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dementia, atrial fib, congestive heart failure and anxiety. An annual MDS with an ARD of 09/07/2022 assessed Resident #7 as impaired with both long and short term memory and severely impaired with daily decision making skills. The clinical record was reviewed on 11/09/2022 at approximately 11:55 a.m. The following note regarding the resident to resident altercation with Resident #3 contained the following: "08/17/2022 14:21 (2:21 p.m.) Receptionist reported to nurse another resident (Resident #3) grabbed resident left arm aggressively. Resident has discolored area to LT (left) forearm after (Resident #3) grabbed her. Residents separated by staff." On 11/09/2022 at approximately 12:00 p.m., Resident # 7 was observed in her room sitting in a chair. Her speech was nonsensical, she was not interviewable regarding the incident.

Resident #5 was admitted to the facility with the following diagnoses including but not limited to: COPD (chronic obstructive pulmonary disease), diabetes mellitus, Gum malignancy, tracheostomy, PEG tube, and heart failure. A quarterly MDS with an ARD of 09/28/2022, assessed Resident #5 as cognitively intact with a summary score of "15". Resident #5's clinical record was reviewed at approximately 12:00 p.m. A note from the date of the resident to resident altercation on 08/09/2022 contained the following: "At 1045 (a.m.,) resident out in hallway and (Resident #3) began yelling and propelled w/c (wheelchair) toward resident, grabbing his R (right) arm and pulling on it. Staff nearby and separated residents immediately....observed with approx 3 cm linear scratch over R bicep with scant bleeding." Resident #5 was interviewed on 11/10/2022 at approximately 12:30 p.m. Resident

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#5 was nonverbal and used a dry erase board to communicate. He was asked about Resident #3 and if he remembered the incident on 08/01/2022. Resident #5 nodded his head and wrote, "He grabs me when he gets a chance. He throws things, slams doors, yells...cries...they give him candy to calm him down, just what he needs more sugar." He was asked if he was fearful of Resident #3's behaviors, He nodded his head "Yes." and wrote, "It has been suggested to me to stay in my room when he is in the hallway."

Resident #4 was admitted to the facility with the diagnosis of schizoaffective disorder, diabetes mellitus, bipolar disorder, and unspecified intellectual disabilities. A quarterly MDS with an ARD of 10/07/2022, assessed Resident #4 as moderately impaired with a cognitive summary score of "09". A note dated 09/23/2022 included the following regarding the resident to resident altercation with Resident #3. "09/23/2022 06:38 (a.m.) Patient was the recipient of physical aggression received. Patient from (Resident #3's room number) wheeling down short hall this patient was sitting outside of shower room awaiting shower and patient from (Resident #3's room number) smacked her right hand. No injury noted upon assessment....Pt from (Resident #3's room number) was moved away...and taken to his room..." Resident #4 was interviewed at approximately 2:30 p.m. and asked if she remembered being hit on her hand by another resident. She stated, "You mean (Name of Resident #3), I remember. He was mad because they made him go to his room...he can't come out...he throws his hat down...he didn't hurt me...my sister knows."

Resident #6 was admitted to the facility with the

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following diagnoses including but not limited to: Heart failure, hypertension, dementia, major depressive disorder, and epilepsy. A quarterly MDS with an ARD of 08/29/2022 assessed Resident #6 as moderately impaired in his cognitive status. Resident #6's clinical record was reviewed on 11/09/2022 at approximately 2:50 p.m. The following note was observed on the date of the resident to resident altercation with Resident #3. "08/01/2022 15:57 (3:57 p.m.) Housekeeper states she was in the hall near the dining room entrance. She witnessed (Resident #3) grabbed resident RT (right) forearm and began hitting. No advance notice. Residents separated and return to their units..." Resident #6 was interviewed at approximately 3:00 p.m. He was asked if he remembered being hit on the arm by another resident. He stated, "No, I don't remember anything about anybody hitting me."

Resident #11 was a closed record. He was admitted to the facility with the following diagnoses, Atrial fib, chronic kidney disease. Per the facility reported incident, Resident #11 was in the lobby and was grabbed on his arm by Resident #3. Resident #11 was not available for interview.

Resident #3's care plan was reviewed and contained the following regarding behaviors: "The resident exhibits adverse behavioral symptoms (inconsolable crying, grabbing, hitting, throws hat, biting himself, slams bedroom door, closet doors removed for resident safety....Administer meds as ordered; Caregiver to provide opportunity for positive interactions, attention. Stop and talk with him as passing by; If reasonable discuss resident's behavior. Explain/reinforce why behavior is inappropriate

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and/or unacceptable...; praise indication of the resident's progress/improvement in behavior; redirect...during episodes of increased agitation/anxiety; send to ER for psych eval if...behaviors need further intervention."
Also:
"Resident has impaired cognitive function or impaired thought process r/t being developmentally delayed...Administer meds as ordered; Ask yes/no questions in order to determine needs; communicate with the resident/family/caregivers regarding residents capabilities and needs; COMMUNICATION: Use the resident preferred name...identify yourself...face the resident when speaking and make eye contact, close door, etc...resident understands consistent, simple, directive sentences. Provide the resident with necessary cues-stop and return if agitated; cue, reorient, and supervise as needed; present just one thought, idea, question or command at a time; Use task segmentation to support short term memory deficits. Break tasks into one step at a time."

On 11/10/2022, an end of the day meeting was held with the DON (director of nursing), the administrator, and corporate staff. The above information was discussed. They were asked if a behavior management plan had been developed for Resident #3. The administrator stated, "Just what's in the care plan." Concerns were voiced that the recommendations, specifically behavior management, on the PASARR had not been implemented. No specific interventions regarding Resident #3 grabbing/hitting other residents creating skin tears and bruises had been developed. Concerns were voiced regarding the safety of other residents due to Resident #3's

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behaviors.

On 11/14/2022 at approximately 10:30 a.m., Resident #3 was observed lying on his bed. A staff member was sitting in his room. CNA #5 was interviewed and asked why she was sitting with Resident #3. She stated, "I'm not sure what happened, it's my understanding that he got physical with another resident over the weekend...I don't know the situation, I was just told to sit with him."

On 11/14/2022 at approximately 10:55 a.m., the psychiatric nurse practitioner (OS #5) for the facility was interviewed. He stated, "I believe you and I talked about (Name of Resident #3) when you were here last...He really needs to be in a group home or some other smaller setting where he can get what he needs....He needs consistency, seeing the same faces every day, less stimulation...he can't get that here....he has grabbed or hit other residents. So far, no one has been seriously hurt, but the potential is definitely there." The PASARR recommendation regarding a behavior management plan was discussed. He was asked if anyone had asked him to help with such a plan. He stated, "No, no one here has discussed that, but it is easy enough. I can do that."

At approximately 11:00 a.m., Resident #5 was interviewed. He was asked if anything had occurred over the weekend between him and Resident #3. He nodded his head "Yes" and wrote, "He grabbed my arm...that's at least 20 times now that he has grabbed me ...they can't do anything with him...he doesn't need to be here." He was asked if he felt safe at the facility. He shook his head "No". Asked if he was afraid. He

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nodded his head "Yes" and wrote, "I am afraid that he is going to come up from behind and grab me and I will instinctively turn around and punch him...I can't yell for help." He was asked what would make him feel safe. He wrote, "Get him out of here."

OS #3 was interviewed at 12:15 p.m. She stated the third PASARR for Resident #3 had been completed on Friday 11/11/2022. She was asked if she was aware of the incident between Resident #3 and two other residents over the weekend and if so had she spoken with any of them. She stated, "No, I didn't know anything about that."

At approximately 11:30 a.m., the administrator presented the facility reported incident that occurred on 11/11/2022 between Resident #3, Resident #16, and Resident #5 that resulted in Resident #3 being placed on 1:1 supervision. The FRI contained the following:

11/11/2022 (Name of Resident #16) entered the lobby and during this time (Resident #3) became upset and began to yell and cry. When the receptionist went to console him he reached out and grabbed (Resident #16) by the arm. The receptionist told (Resident #3) to let go of his arm and he did. As (Resident #3) was being escorted to his room, they passed (Resident #5) and (Resident #3) grabbed him by the arm. He immediately let go and went to lay down in his room. Residents assessed and no injuries noted...(Resident #3) placed on 1:1". The administrator was asked how long Resident #3 would be on 1:1. He stated, "Indefinitely".

Resident #16 was added to the survey sample due to the above resident to resident altercation.

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F 689	Continued From page 69 Resident #16's diagnoses included Alzheimer's disease. His most recent MDS was a quarterly review with an ARD of 10/26/2022. Resident #16 was assessed as severely impaired with a cognitive summary score of "03". Resident #16 was not in his room and when an interview was attempted at approximately 11:45 a.m. The above information was discussed during a meeting with the DON, the administrator, and corporate staff on 11/14/2022 at approximately 1:10 p.m. Concerns were voiced that Resident #3's behaviors were not being effectively managed and other residents were fearful of him or subject to injury due to those behaviors. . The administrator stated, "He's on 1:1, we are doing what we can to get him out of here...he was here when I got here, we can't dump him on the street, he has a right to be here...we're doing all we can." No further information was obtained prior to the exit conference on 11/14/2022. This is a COMPLAINT DEFICIENCY.	F 689		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide care to a PICC	F 694	F694 1. Resident # 10 is no longer a resident at this facility.	12/22/22

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F 694	Continued From page 70 (peripherally inserted central catheter) line per physician orders for one of 16 residents, Resident #10. Findings were: Resident #10 was admitted to the facility with the following diagnoses including but not limited to: Incomplete paraplegia, hypertension, pressure ulcers, urinary tract infection (ESBL-extended spectrum beta-lactamase), and acute kidney failure. An admission MDS (minimum data set) with an ARD (assessment reference date) of 07/31/2022, assessed Resident #10 as cognitively intact with a summary score of "15". The clinical record was reviewed on 11/09/2022 at approximately 12:00 p.m. Observed in the physician orders were the following: "PICC line-Measure external portion of PICC line catheter weekly with dressing changes...every Mon (Monday)... PICC line dressing change on admission, then Q (every) week and PRN (as needed)...every Mon..." The MARs (Medication administration records) for July, August, and September 2022 were then reviewed. The PICC line dressing was documented as changed per order every week except for Monday, August 29, 2022. Other medications and treatments for that day had been signed off as completed by LPN (licensed practical nurse) #4. On 11/09/2022 at approximately 1:30 p.m., representatives from the local APS (adult protective services) came to the facility to speak with the survey team. OS (Other staff) #8 who had reported to the state agency that PICC line	F 694	2. Current residents with PICC lines have the potential to be affected. An audit of current residents with PICC lines will be performed to ensure dressing is changed per MD order. Results will be communicated with the DON and Administrator. 3. The DON/Designee will educate the current licensed nursing staff on the policy and procedure for PICC line dressing changes to include documentation of completion on the TAR. 4. DON/Designee will audit 3 times weekly to ensure PICC line dressing are being changed per MD orders. 5) Results of the audit will be presented to the QAPI committee for review and recommendations. Once the QAPI committee determines the problem no longer exists, audits will be conducted 6) Date of Compliance 12/22/22	

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(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
F 694	Continued From page 71 dressing changes had not been done for Resident #10 due to lack of supplies was present and interviewed. She stated that a friend of Resident #10 had reported to her that the dressing changes had not been completed. She stated that she had asked the DON (director of nursing) why they had not been done and had been told there were no supplies in the facility to complete the dressing changes. At approximately 3:45 p.m., the DON was interviewed regarding supplies in the facility. She stated that there were supplies in the facility and there had not been a shortage. She was asked if she knew why the dressing change had not been done as ordered on 08/29/2022. She stated she didn't know what had happened. On 11/10/2022 at approximately 7:15 a.m., LPN # 4 was interviewed. She reviewed the MARs as well as her progress notes from 08/29/2022. She stated, "It doesn't look like I did it...if I had done it I would have signed it off on the MAR." She was asked if supplies were available to do the PICC line dressing changes. She stated, "Yes, we have supplies...I must have gotten busy and not gotten to it, it's my fault." The above information was discussed with the DON and the administrator during an end of the day meeting on 11/10/2022. No further information was obtained prior to the exit conference on 11/14/2022. This is a COMPLAINT DEFICIENCY.	F 694		
F 740 SS=E	Behavioral Health Services CFR(s): 483.40	F 740		12/22/22

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F 740	Continued From page 72 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and clinical record review, the facility staff failed to ensure behavioral health services were provided to one of 16 residents to maintain his highest practicable level of well-being, Resident #3. Findings were: Resident #3 was admitted to the facility with the following diagnoses including but not limited to: Developmental Disorder of Scholastic Skills Unspecified, Morbid obesity, genetic related intellectual disability (ID), hypertension, and adult failure to thrive. An annual MDS (minimum data set) with an ARD (assessment reference date) of 09/27/2022 assessed Resident #3 as severely impaired with a cognitive summary score of "01". The clinical record was reviewed at approximately 11:30 a.m. on 11/09/2022. Two Level II PASARRs were observed. The first dated 02/01/2022, and the second dated 05/26/2022. The second Level	F 740	F740 1. For resident # 3 the CSB board was contacted regarding targeted case management and psych practitioner was contacted for implementation of a behavior care plan during the survey. Social Services continues to get the results of outstanding IQ test. 2. Current residents with behavioral health needs have the potential to be affected. 3. The Administrator or designee with educate the Social Services department on implementation of items identified in the Level II by the ASCEND group and to notify the administrator if additional resources are needed to implement identified items. The Administrator or designee will educate Nursing management on implementation of nursing services and support to maintain residents current level of function and implementation of a behavior care plan. 4. The Administrator or designee will perform weekly audits intervention identified in the behavior care plan to	

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F 740	Continued From page 73 II PASARR contained the following: " "This is his second completed PASRR ...(Name) appears to meet PASRR criteria due to an Intellectual Disability, Moderate that emerged before the age of 18 which led to three or more lifelong limitations. IQ testing was conducted on 05/26/2022...(Name of Resident #3) was administered the Slosson Intelligence Test-Revised ...where he received the FSIQ score of <40 placing him in the moderate range of intellectual disability....limitations include self-care ,self-direction, independent living, communication, functional academics, social/leisure skills, health and safety, and work...Per minimum data set...(Name of Resident #3) requires limited assistance with bed mobility, dressing, personal hygiene, supervision with transfers, and locomotion on the unit, and extensive assistance with toileting...utilizes a wheelchair for mobility ...is at increased risk of hitting himself and others...Per previous documentation...does not meet criteria for SMI (serious mental illness) population...SERVICE DETERMINATION Intense Specialized Services: Yes Rehabilitative Services: (services of lesser intensity): Yes...REHABILITATIVE SERVICES (SERVICES OF LESSER INTENSITY) RECOMMENDATION: Non-customized durable medical equipment, Restorative Nursing, Behavior Management, and Targeted Case Management...DETERMINATION SUMMARY Currently a nursing facility appears to provide (Name of Resident #10) with medical and nursing support including ADL care and supervision, and medication administration. Per this PASSR, specialized services that are recommended are self-help/personal care and mobility aids. Self-help/personal care is training in personal appearance and cleanliness, use of medication,	F 740	ensure they are being followed and ensure items in the PASARR are completed per recommendations. 5) Results of the audit will be presented to the QAPI committee for review and recommendations. Once the QAPI committee determines the problem no longer exists, audits will be conducted 6) Date of Compliance 12/22/22	

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F 740	Continued From page 74	F 740		

and dental care. Mobility aid is equipment designed to increase, maintain, or improve one's capability to walk or maneuver in one's environment. Rehabilitative services of lesser intensity are recommended to include basic grooming, non-customized durable medical equipment, restorative nursing, behavioral management, and targeted case management...Behavioral Management is a lesser intensity application of behavior techniques in an attempt to systematically change maladaptive patterns of behavior. Targeted Case management is recommended to connect with supportive services and assess the potential for his needs to be met in a less restrictive environment if desired and medically able to be supported in a lower-level care setting. Collaboration with the Community Services Board (CSB) is encouraged to identify supports that may allow a transition to the community if discharge plan has been projected. Supports may include supportive housing that specializes in mental health care, adaptive medical equipment, environmental modifications, case management, outpatient psychiatric care, daily aid services, and home health services to monitor medical needs. A Targeted Resident Review is recommended for 180 days, if still admitted to a nursing facility at that time, to assess progress and identify additional supports as needed."

Progress notes from 07/01/2022 to 11/09/2022 were reviewed in the clinical record. Behaviors documented throughout the time period included, slamming and kicking doors, throwing clothing items into the hallway, loud crying, physical aggression towards other residents, striking another resident repeatedly on the arm and grabbing his wheelchair, and beating on walls.

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Resident #3 was redirected by staff on these occasions, taken to his room for a nap, given an activity, medicated, and after one incident was placed on 1:1 supervision.. A total of 16 progress notes documented these types of behavior.

Five facility reported resident to resident altercations involving Resident #3 from 08/01/2022 through 09/23/2022 were reviewed. They were:
08/01/2022 Grabbed Resident #5's wheelchair and struck him repeatedly on the arm.
08/09/2022 Grabbed Resident #5 by his right arm causing a skin tear.
08/16/2022 Grabbed Resident #7 by the left arm, bruising noted
09/14/2022 Grabbed Resident #11 by the arm
09/23/2022 Smacked Resident #4 on the hand

Resident #5, whose cognitive summary score was assessed as a "15" on a quarterly MDS (ARD 09/28/2022) was interviewed on 11/10/2022 at approximately 12:30 p.m. Resident #5 was nonverbal and used a dry erase board to communicate. He was asked about Resident #3 and if he remembered the incident listed above on 08/01/2022. Resident #5 nodded his head and wrote, "He grabs me when he gets a chance. He throws things, slams doors, yells...cries...they give him candy to calm him down, just what he needs more sugar." He was asked if he was fearful of Resident #3's behaviors, He nodded his head "Yes." and wrote, "It has been suggested to me to stay in my room when he is in the hallway."

The social worker assistant/discharge planner (OS #3) was interviewed on 11/10/2022 at 8:10 a.m. Resident #3's PASARR recommendations from the most recent PASARR (05/26/2022) were

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discuss. She stated. "I took this over when the other social worker left, I've been trying to pick up the pieces...He is actually due for the next (PASARR) eval to be done...it's been about 180 days. We have contacted the CSB and I spoke with (Name of OS #6), he is the supervisor over ID (intellectual disability) services and told him what we need...He told me they couldn't provide services until we got a psychological evaluation...that's been done and we're waiting for the paperwork from (Name of University) to give to them...in the meantime he said they can't come in here and do case management because it would be double billing since he's in a nursing home.."

Resident #3's care plan was reviewed and contained the following regarding behaviors:
"The resident exhibits adverse behavioral symptoms (inconsolable crying, grabbing, hitting, throws hat, biting himself, slams bedroom door, closet doors removed for resident safety....Administer meds as ordered; Caregiver to provide opportunity for positive interactions, attention. Stop and talk with him as passing by; If reasonable discuss resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable...; praise indication of the resident's progress/improvement in behavior; redirect...during episodes of increased agitation/anxiety; send to ER for psych eval if...behaviors need further intervention."
Also:
"Resident has impaired cognitive function or impaired thought process r/t being developmentally delayed...Administer meds as ordered; Ask yes/no questions in order to determine needs; communicate with the resident/family/caregivers regarding residents

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capabilities and needs; COMMUNICATION: Use the resident preferred name...identify yourself...face the resident when speaking and make eye contact, close door, etc...resident understands consistent, simple, directive sentences. Provide the resident with necessary cues-stop and return if agitated; cue, reorient, and supervise as needed; present just one thought, idea, question or command at a time; Use task segmentation to support short term memory deficits. Break tasks into one step at a time."

On 11/10/2022 at approximately 1:00 p.m., Resident #3 was observed in the hallway. One of the fire doors between his hallway and the next was closed. Resident #3 was sitting, facing the closed door. He wheeled back from the door then up to the door. He used his right fist to bang on the door making growling noises. He then backed his wheelchair up and propelled back up to the door, banging it harder with his right fist and growling louder. He did not attempt to go through the side of the door that was propped open. Multiple staff members were observed walking by him through the open door, none stopped to assist him. He continued to back his wheelchair up and propel forward, each time banging on the closed door with his fist and growling. At approximately 1:05 p.m. a resident was wheeled through the open door on a stretcher. When the staff member that was accompanying that resident returned to go back to her unit, she stopped and spoke to Resident #3. She propped the closed fire door open. Resident #3 then came back up the hallway to his room and grabbed the handle of the closed door to his room and jiggled it up and down. The staff member then came and opened his room door for him. Resident #3

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became upset, began smacking himself in the head, yelling out, and crying, as he propelled himself to the lobby.

An end of the day meeting was held with the DON (director of nursing), the administrator, and corporate staff on 11/10/2022 at approximately 1:20 p.m. The above information was discussed. They were asked if a behavior management plan had been developed for Resident #3. The administrator stated, "Just what's in the care plan." Concerns were voiced that the recommendations, specifically behavior management, on the PASARR had not been implemented. No specific interventions regarding Resident #3 grabbing/hitting other residents creating skin tears and bruises had been developed.

On 11/14/2022 at approximately 10:30 a.m., Resident #3 was observed lying on his bed. A staff member was sitting in his room. CNA #5 was interviewed and asked why she was sitting with Resident #3. She stated, "I'm not sure what happened, it's my understanding that he got physical with another resident over the weekend...I don't know the situation, I was just told to sit with him."

On 11/14/2022 at approximately 10:55 a.m., the psychiatric nurse practitioner (OS #5) for the facility was interviewed. He stated, "I believe you and I talked about (Name of Resident #3) when you were here last...He really needs to be in a group home or some other smaller setting where he can get what he needs....He needs consistency, seeing the same faces every day, less stimulation...he can't get that here." The PASARR recommendations regarding a behavior

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management plan was discussed. He was asked if anyone had asked him to help with such a plan. He stated, "No, no one here has discussed that, but it is easy enough. I can do that."

At approximately 11:00 a.m., Resident #5 was interviewed. He was asked if anything had occurred over the weekend between him and Resident #3. He nodded his head "Yes" and wrote, "He grabbed my arm...that's at least 20 times now that he has grabbed me ...they can't do anything with him...he doesn't need to be here." He was asked if he felt safe at the facility. He shook his head "No". Asked if he was afraid. He nodded his head "Yes" and wrote, "I am afraid that he is going to come up from behind and grab me and I will instinctively turn around and punch him...I can't yell for help." He was asked what would make him feel safe. He wrote, "Get him out of here."

OS #3 was interviewed at 12:15 p.m. She stated the third PASARR for Resident #3 had been completed on Friday 11/11/2022. She was asked if she was aware of the incident between Resident #3 and two other residents over the weekend and if so had she spoken with any of them. She stated, "No, I didn't know anything about that."

At approximately 11:30 a.m., the administrator presented the facility reported incident that occurred on 11/11/2022 between Resident #3, Resident #16, and Resident #5 that resulted in Resident #3 being placed on 1:1 supervision. The FRI contained the following:

11/11/2022 (Name of Resident #16) entered the lobby and during this time (Resident #3) became upset and began to yell and cry. When the

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F 740	Continued From page 80 receptionist went to console him he reached out and grabbed (Resident #16) by the arm. The receptionist told (Resident #3) to let go of his arm and he did. As (Resident #3) was being escorted to his room, they passed (Resident #5) and (Resident #3) grabbed him by the arm. He immediately let go and went to lay down in his room. Residents assessed and no injuries noted...(Resident #3) placed on 1:1". The administrator was asked how long Resident #3 would be on 1:1. He stated, "Indefinitely". The above information was discussed during a meeting with the DON, the administrator, and corporate staff on 11/14/2022 at approximately 1:10 p.m. Concerns were voiced that Resident #3 was not receiving services to promote his behavioral health. The administrator stated, "He's on 1:1, we are doing what we can to get him out of here...he was here when I got here, we can't dump him on the street, he has a right to be here...we identified that when housekeeping goes in his room it upsets him and we make sure he isn't in the when they clean...it's my F*** up that we didn't put that on the care plan...I came in here last night and sat with him. We are doing all we can." No further information was obtained prior to the exit conference on 11/14/2022. This is a COMPLAINT DEFICIENCY.	F 740		
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	F 745		12/22/22

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F 745	Continued From page 81 and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to provide medically-related social services for one of sixteen residents in the survey sample. Social services were not offered or provided to Resident #2 following an incident of inappropriate touching by a staff member. The findings include: Resident #2 was admitted to the facility with diagnoses that included anxiety, sleep apnea, major depressive disorder, heart failure, restless leg syndrome, overactive bladder, chronic respiratory failure, insomnia, hypertension and Parkinson's disease. The minimum data set (MDS) dated 10/7/22 assessed Resident #2 as cognitively intact, as always incontinent of bladder and as requiring the extensive assistance of one person for toileting. Resident #2 was provided incontinence care with inappropriate touching of her perineal area and was subjected to a sexually suggestive verbal comment by certified nurses' aide (CNA) #4. A facility reported incident form dated 10/24/22 documented Resident #2 reported to the facility staff that a certified nurses' aide (CNA #4) had wiped her for an inappropriate length of time in her perineal area and made her uncomfortable. The resident reported CNA #4 made the comment while wiping her that he did not understand why she did not like it because "that's how his girlfriend likes it."	F 745	F 745 1. Resident #2 was seen by facility Discharge Planner/Social Services on 11/15/22. 2.Current residents have the potential to be affected. An audit of current facility incidents over the last 30 will be conducted to ensure Social Services followed up if deemed necessary. Results will be communicated to the Administrator. 3. The Administrator/designee will educate the Social Services department on situations that need follow up visitation and documentation concerning resident psychosocial well being following events. 4. The Administrator/designee will audit incidents 3 times per week to review incidents and ensure Social Services had visited the resident to evaluate their psychosocial well-being. 5) Results of the audit will be presented to the QAPI committee for review and recommendations. Once the QAPI committee determines the problem no longer exists, audits will be conducted 6) Date of Compliance 12/22/22	

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On 11/9/22 at 11:30 a.m., Resident #2 was interviewed about her care in the facility and the allegations regarding CNA #4. Resident #2 stated approximately 3 to 4 months ago, CNA #4 came in her room around 2:00 a.m. and said he wanted to check her brief to see if she was wet. Resident #2 stated she told CNA #4 that she was "ok" and CNA #4 then stated he needed to check her anyway because that was his job. Resident #2 stated CNA #4 "wiped me for 10 minutes" using cleansing wipes. Resident #2 stated she watched the clock and he cleaned her for 10 minutes continually wiping her perineal area. Resident #2 stated CNA #4 "was down there a long time" and she was very uncomfortable with the continued wiping. Resident #2 stated she told her usual nurse (registered nurse #1) about the incident when she next worked and requested that CNA #4 not provide care for her anymore. Resident #2 stated registered nurse (RN) #1 agreed to not assign CNA #4 to her and she did not see CNA #4 again until she was moved to another unit after getting COVID-19. Resident #2 stated she was moved to the COVID unit in September (2022) for isolation and while on that unit, CNA #4 came in her room and again stated he wanted to check/change her brief. Resident #2 stated she told CNA #4 that he was not supposed to be in her room or provide care for her. Resident #2 stated CNA #4 stated he needed to check her and began wiping her buttock area. Resident #2 stated she told CNA #4 that he had done enough wiping and then he went to wiping her vaginal area. Resident #2 stated she told CNA #4 to "stop" and that's when CNA #4 told her he did not understand why she did not like it because his girlfriend liked it. Resident #2 stated, "I was scared of him."

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(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
F 745	Continued From page 83	F 745		

Resident #2 stated CNA #1 came in the room and she reported to her that CNA #4 was not supposed to be providing care for her and that he kept wiping her "pretty hard." Resident #2 stated CNA #1 said she reported the incident to the nurse but she was not aware of the nurse's name. Resident #2 stated, "I was fighting him off. Told him he'd done enough wiping." Resident #2 stated she did not remember the exact date of the incident but it was during the time she was on isolation for COVID. Resident #2 stated she did not think CNA #4 harmed her because she stopped him and stated she had no vaginal/perineal bleeding or trauma from the rubbing. Resident #2 stated she was upset about the incident and was "shocked" that it happened because she had reported CNA #4 to RN #1 several months ago and thought the issue was taken care of. Resident #2 stated when she returned to her previous unit/room after COVID, she told her regular CNA (#3) about the incident on the COVID unit. Resident #2 stated she had trouble sleeping for a few days after the last incident but felt better now that he no longer worked in the facility. Resident #2 stated she was tearful when talking with the police about the incident and still had questions about pressing charges. When asked if the social worker had visited and/or talked with her about the incident or offered any services to help her cope with the incident, the resident stated, "No." Resident #2 stated she did not know the social worker.

Resident #2's clinical record reviewed from 9/22/22 through 11/8/22 documented no assessment or notes from social services about the inappropriate touching incident with CNA #4.

On 11/10/22 at 9:40 a.m., the facility's social

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495093	A. BUILDING _____ B. WING _____	C 11/14/2022

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F 745	Continued From page 84 worker (other staff #2) was interviewed about Resident #2. The social worker stated he had not assessed or offered any assistance for Resident #2 because he had not been made aware of the abuse allegations. The social worker stated he was asked to speak with Residents #8, #13 and #15 but not Resident #2. The social worker was interviewed again on 11/14/22 at 12:30 p.m. about Resident #2. The social worker stated he had not worked in the facility very long and he waited to be told about residents needing services. The social worker stated again he had not evaluated or provided any follow-up services to Resident #2 regarding the inappropriate touching incident with CNA #4. This finding was reviewed with the administrator, director of nursing and regional director of clinical services during a meeting on 11/14/22 at 1:10 p.m.	F 745		