STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675220	A. Building B. Wing	04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Place Kirbyville	700 N Herndon Kirbyville, TX 75956

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on observation, interview, and record review the facility failed to ensure the right to be free from abuse was provided for 4 of 11 residents reviewed for abuse. (Resident #s 1, 2, 4, and 5) 1. The facility did not provide required monitoring and supervision to prevent Resident #1 from sexually abusing Resident #2 on 04/11/22. Resident #2 wandered into Resident #1's room. Resident #2 was heard yelling. Resident #1 was found behind Resident #2, his hand on her shoulder, holding his partially erect penis while thrusting toward Resident #2. Residents #1 and #2's briefs were down. 2. The facility staff did not intervene and protect Resident #5 from Resident #4's verbal and physical abuse. On 4/9/22 Resident #4 was found hovering over Resident #5 yelling at him. The NA B opened the door to see what was occurring and then closed the door and called for the nurse. The nurse aide left Resident #5 in imminent harm. An Immediate Jeopardy (IJ) situation was identified on 04/14/22 at 3:00 p.m. While the IJ was removed on 04/15/22, the facility remained out of compliance at a potential for more than minimal harm with a scope identified as a pattern due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of abuse, physical harm, mental anguish, emotional distress, and death. Findings included: 1. Record review of face sheet dated 04/13/22, indicated Resident #1 was a [AGE] year-old male, admitted on [DATE] and his diagnoses included adjustment disorder (emotional or behavioral reaction to a stressful event or change in a person's life), Parkinson's (a brain disorder that leads to shaking, stiffness, and difficulty with walking, balance, and coordination), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), cognitive communication deficit (difficulty with thinking and how someone uses language), and schizophrenia (a serious mental disorder in which people interpret reality abnormally). Record review of MDS dated [DATE], indicated Resident #1's BIMS score was 7 (severe cognitive impairment), he wandered every 1-3 days, ambulated with a walker. There were no behaviors noted. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's care plan dated 04/11/22 indicated he displayed socially inappropriate behavior and inappropriate sexual gesture with a female resident. Interventions included 15-minute monitoring and sent out to behavioral hospital for evaluation and treatment. There was no previous care plan for sexually inappropriate behavior available for review. Record review of face sheet dated 04/13/22, indicated Resident #2 was a [AGE] year-old female, admitted on [DATE], and her diagnoses included Alzheimer's (a progressive neurologic disorder that causes the brain to shrink (atrophy) and brain cells to die) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of MDS dated [DATE] indicated Resident #2 had a BIMS score of 2 (severe cognitive impairment), wandered daily, and ambulated without assistance. Record review of care plan dated 12/30/21 indicated Resident #2 required placement on the secure unit due to wandering and significant safety awareness due to dementia. Interventions included assist with location of room with verbal cues, notify physician if behavior increases (1/18/22- in and out of other residents' rooms, at times will take things out of other residents' rooms, 2/6/22 altercation with another resident, 2/11/22 attempted to take another resident's walker, 4/11/22 victim of inappropriate sexual gesture). The care plan did not address supervision. Observation conducted on 04/14/22 with the Administrator, DON and ADON, who verified the identity of the staff and residents, of the facility's two separate camera recordings on 04/08/22 from 7:30 a.m. through 8:30 a.m. indicated: At 8:09 a.m. there were no aides on the hall, Resident #2 wandered on hall and then back into her room. Camera error exact time unknown-CNA F went into another resident's room while CNA C was in the shower room. At 8:13 a.m. Resident #2 wandered into the hall, then into a resident room next to the shower room. At 8:14 a.m., CNA C out of shower to get a wheelchair and then back into shower room. At 8:16 a.m., CNA C opened the shower door and took a resident in a wheelchair out of the shower. CNA C walked past the resident room next to the shower room. CNA C walked into Resident #1's room, escorted Resident #2 out of Resident #1's room and walks back toward Resident #2's room at the opposite end of the hall. At 8:19 a.m. CNA F comes out of other residents' room. Record review of nurse note dated 04/11/22 at 4:08 p.m., completed by LVN D, indicated CNA C heard Resident #2 scream no don't do that when she entered the room. The door was open and she witnessed Resident #1 standing behind Resident #2. Resident #1 was holding on to Resident #2 with one hand, his pants were down and he was exposed. Resident #2's pants were down and she was exposed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of nurse note dated 04/11/22 at 4:18 p.m., completed by the DON, indicated CNA C exited the shower room at approximately 8:15 a.m. and heard Resident #2's raised voice coming Resident #1's room. CNA C entered the room and noted Resident #2 had his pants down and was standing behind Resident #2. Resident #1 had his penis in his hand and was saying 'get it, get it'. Resident #2's incontinence protective wear and pants were down. CNA C separated Resident #1 and #2 and immediately removed Resident #2 from the room. DON and Treatment nurse examined Resident #2 in her room and did not notice any redness or drainage to rectal or perineal/vaginal area. Resident #2 was calm at the time of the examination. No injuries noted. The physician was notified and new orders to send Resident #1 to behavioral hospital for evaluation and treatment. The administrator was notified. Resident #2's daughter was notified. Psych services was notified. Record review of NP E's visit report dated 04/11/22 indicated Resident #1 denied any inappropriate behaviors occurred. Resident #1's BIMS was assessed and scored at 15. Record review of nurse note dated 04/11/22 at 7:48 p.m., completed by the DON, indicated new recommendations from NP and corporate nurse to inform police department of incident due to Resident #1's BIMS score of 15. Resident #1 already left facility and sent to behavioral hospital. Officer arrived at facility to obtain report. Resident #2's daughter advised of police notification. Resident #2's daughter requested the facility send Resident #2 to the hospital for evaluation. Record review of NP E's visit report dated 04/11/22 indicated Resident #1 denied any inappropriate behaviors occurred. Resident #1's BIMS was assessed and scored at 15. Record review of hospital records dated 04/11/22 a SANE exam was performed. There was genital injury noted. Crime lab and diagnostic specimens were collected. There were no results available for review. Record review of nurse note dated 04/12/22 at 6:27 p.m., completed by LVN A, indicated the hospital nurse reported no findings and waiting for labs. Record review of Resident #1's behaviors from 01/01/22 through 04/08/22 indicated no behaviors were documented. Record review of Resident #2 behaviors from 01/01/22 through 04/08/22 indicated there were 79 incidents of wandering into other residents' rooms and the nurse was notified. During an interview on 04/13/22 at 8:35 a.m. the Administrator said CNA C came out of the shower room and heard Resident #2 say 'stop'. She said the door was open and she saw Resident #1 standing behind Resident #2. She said both residents' pants and briefs were down. She said Resident #1 had his penis in his hand. She said Resident #2 was assessed and it was not determined she was penetrated. She said psych services was contacted and increased Resident #1's Zoloft (an antidepressant medication). She said Resident #1 denied the allegations. She said Resident #1's last BIMS score was a 7 but he was re-assessed and it was 15. She said police was notified and Resident #2 was sent to the hospital for evaluation/treatment. She said initially, resident #2's daughter did not want Resident #2 sent to the hospital for an evaluation, but she changed her mind. She said Resident #1 had previous sexually inappropriate behaviors and would masturbate on the porch. She said he was easily re-directed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 04/13/22 at 9:10 a.m., CNA C said she was previously trained on abuse and neglect prevention. She said approximately 2 or 3 weeks prior she had previously caught Resident #1 with another resident sitting on his bed. She said Resident #1 was standing between the other resident's legs as she was sitting on his bed. She said both residents were fully dressed. She said Resident #1 stepped back and said he was trying to help the other resident. She said she thought she told LVN G of the incident. She said the most recent incident occurred after breakfast at approximately 8:15 a.m She said she was in the shower room when heard Resident #2 scream No don't do that no no no. She said she brought the other resident out of the shower room and walked to Resident #1's room. She said both Resident #1 and Resident #2's pants were down. She said Resident #1 had his penis in his hand and was holding Resident #2's left shoulder as he was telling Resident #1 to get it, get it as he was thrusting. She said Resident #1 sat down on his bed when he walked into the room. She said Resident #2 was crying. She said she dressed Resident #2 and walked her out of the room. She said she and CNA F were working the secure unit together. She said they had cell phones to call the nurse if there as an emergency. During an interview on 04/13/22 at 9:47 a.m., the DON said she had heard of the incident of another resident being in Resident #1's room but she was not told the incident was sexual. During an interview on 04/13/22 at 11:35 a.m., LVN I said she had witnessed an incident approximately 2 - 3 months prior where another resident had taken off her clothes in her room and her roommate had opened the door as Resident #1 walked by. She said he stopped and stared, and when asked why he did that he said because he could. She said she had heard of the incident where he stood over the same resident while she sat on his bed. During an interview on 04/13/22 at 11:53 a.m., LVN G said she had not noticed Resident #1 having inappropriate sexual behaviors. She said Resident #1 did stare at the resident that was found sitting on his bed. During an interview on 04/14/22 at 10:15 a.m., the DON said staff are trained on abuse, neglect, and exploitation. She said the staff are trained through computer and as needed in the facility. She said she was not able to locate any staff training for sexually inappropriate behaviors or resident abuse. During an interview on 04/14/22 at 1:30 p.m., the Administrator said she was said she was not aware of any previous incidents related to inappropriate sexual behavior. She said no staff reported the behaviors to her during the morning meetings. She said the DON, ADON, and charge nurse were responsible for monitoring behaviors were documented. She said she became the new Administrator in January 2022 and was not aware staff was not trained. She said she and the DON or designee were responsible for ensuring staff was trained. During an interview on 04/14/22 at 1:54 p.m., the DON said both aides on the secure unit should not be providing resident care at the same time. She said one of the aides was supposed to monitor the other residents and the hall to ensure residents do not wander or to be able to intervene for resident safety. She said she could not locate the training records of the staff on the unit. She said she or designee were responsible for ensuring staff was trained. She could not say why the staff were not trained or she could not locate the training records. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 04/14/22 at 2:05 p.m., CNA F said a resident came out of his room and the resident required incontinent care. She said she went into the shower room to gather supplies. She said CNA C was almost finished showering a different resident so she left the shower room and assisted the other resident with his incontinent care. She said she did not see Resident #2 wandering in the hall. She said she had been working for 2 months and did not recall specific training related to monitoring the residents prior to the incident on 04/08/22. During an interview on 04/15/22 at 3:34 p.m. the administrator and DON said they had re-inserviced and educated three staff on 04/13/22 working on hall 300 to have one staff monitoring and the other staff providing care. They said staff were also trained to request help when they need to take care of residents and they were monitoring the hall. The DON said she was not able locate any staff training records that contained the names of the staff that worked during the incident. She said NA B was not a certified aide and there was no record she was trained regarding resident to resident During an interview on 04/15/22 at 4:14 p.m., Psych NP J said he received a call from the facility the morning of the incident with Residents #1 and #2. He said he had worked with Resident #1 for many years. He said Resident #1 had multiple hypersexual behaviors in the past that included exposing himself to others and masturbating. He said he had just recently started seeing Resident #2 as she was wandering and stealing items from other residents' rooms. He said staff have to monitor, intervene, and divert residents' behaviors. 2. Record review of face sheet dated 04/04/22 indicated Resident #4 was a [AGE] year-old male who was admitted on [DATE]. His diagnoses included schizophrenia (a serious mental disorder in which people interpret reality abnormally), dementia with behaviors, delusional disorders (serious mental illness - called a psychosis- in which a person cannot tell what is real from what is imagined), and anxiety (a feeling of fear, dread, and uneasiness). Record review of MDS dated [DATE] indicated Resident #4 had severe cognitive impairment and wandered every 1 to 3 days. There were no behaviors documented. Record review of care plan dated 10/08/21 indicated Resident #4 had a history of physical aggressive behavior. Interventions included social services to evaluate and visit, activities staff to visit and provide diversional activities, talk in a calm voice when behavior is disruptive, and remove from public area when behavior is disruptive and unacceptable. Record review of care plan dated 04/09/22 indicated Resident #4 exhibited aggressive behavior noted by staff standing over another resident and yelling, threatening and physical aggression directed at staff trying to diffuse the situation. Interventions included placing Resident #4 in an area for frequent observation social services to evaluate and visit, activities staff to visit and provide diversional activities, talk in a calm voice when behavior is disruptive, and remove from public area when behavior is disruptive and unacceptable, and sent to behavior hospital for evaluation/treatment. There was no care plan to address the verbal and physical aggression towards his roommate that occurred on 03/19/22. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #4's behavior monitoring from 01/01/22 through 04/09/22 indicated on 04/05/22 CNA C noted verbal behaviors directed at others included threatening others, screaming/yelling at others, and cursing at others-nurse notified. There were no additional dates completed. Record review of a face sheet dated 04/04/22 indicated Resident #5 was a [AGE] year-old male, admitted on [DATE], and his diagnoses included catatonic schizophrenia (rare severe mental disorder characterized by striking motor behavior, typically involving either significant reductions in voluntary movement or hyperactivity and agitation), vascular dementia with behavioral disturbances (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain), paranoid schizophrenia (characterized by predominantly positive symptoms of schizophrenia, including delusions and hallucinations), major depressive disorder (serious mood disorder), and anxiety. Record review of an MDS dated [DATE] indicated Resident #5 had severe cognitive impairment. Wandered every 1 to 3 days. There were no physical or verbal behaviors noted. Record review of Resident Incident Report dated 04/09/22 at 5:25 a.m. and completed by LVN A indicated NA B entered Resident #4 and Resident #5's room and found Resident #4 bent over Resident #5. Resident #4 was yelling at Resident #5. LVN A separated the residents. Resident #4 sat at the foot of his bed. LVN A sat on the floor by the foot of his bed. LVN A reached down to assist Resident #4 from the floor and Resident #4 swung his fist and struck LVN A's upper right arm. Resident #4 yelled he was going to kill LVN A. Resident #5 was moved to a different room. During an interview on 04/13/22 at 2:08 p.m., NA B said she heard voices and yelling and went to Residents #4 and #5's room. She said she opened the door and saw Resident #4 standing over Resident #5 while Resident #5 lay in his bed. She said she shut the door and told the other staff to get LVN A. She said she did not know why she did not intervene. She said she was not a certified aide and was not trained on behaviors. She said she was not trained on how to redirect residents. She said LVN A came to the room and directed Resident #4 to his bed. She said Resident #4 went toward his bed and said, I'll fucking kill you. She said CNA K was on shift with her. Record review of CNA K's undated statement included in the facility's investigation indicated CNA C told her she heard shouting and rumbling in the room and for her (CNA K) to go and get LVN A. LVN A opened the door and LVN A, CNA C and CNA K walked into Resident #4 and Resident #5's room. Resident #4 was standing over Resident #5 hitting him and cursing at him. LVN A was able to get Resident #4 off Resident #5. Resident #4 started to swing and curse at LVN A. Resident #4 fell on the floor as he swung. LVN A directed CNA K to get LVN I. LVN I tried to talk to Resident #4 and he started cursing at LVN A and picked up a shoe. LVN A moved Resident #5 to another room. All staff left Resident #4's room for their safety. During an interview on 04/13/22 at 4:27 p.m., LVN A said he was not trained on dementia for the secure unit. He said he was not aware of any specific care plans for Resident #4. He said there were other incidents of Resident #4 yelling at Resident #5 but he was able to redirect him. He said if resident #4 was not able to see' Resident #5 then he would calm down. He said he did not do a nurse note or an incident report. He could not say why he did not document the incident. He said the most recent incident, Resident #4 was screaming at the top of his lungs at Resident #5. He said Resident #4 continued to yell at Resident #5 when he (LVN A) got between the residents. He said Resident #5 said Resident #4 hit him in the back. He said Resident #5 did not have any marks on his back. He said Resident #4 was pretty traumatized for a day or two. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of nurse note dated 04/09/22 at 10:47 a.m., completed by LVN A, indicated LVN A was called to Resident #4 and Resident #5's room at 5:25 a.m. LVN A found Resident #4 standing over Resident #5, yelling. LVN A directed Resident #4 to sit on his bed but he sat on the floor. LVN A attempted to help him up but Resident #4 hit LVN A on the right upper arm and started to yell he was going to kill LVN A. LVN A moved Resident #5 to another room for safety. Resident #5 stated Resident #4 hit him in the back. There was no visible injury. Resident #5 was resting in a safe bed. Notified on-call ADON, and the ADON notified the DON. DON stated she was going to send Resident #4 to a behavioral hospital. During an interview on 04/13/22 at 8:35 a.m. the Administrator said she was not aware of any previous incidents between Residents #4 and #5. She said she was new to the facility as of January 2022 and no one reported anything during the morning meetings. She said they were roommates. She said Resident #4 was found standing over Resident #5. She said Resident #4 was recently put on Risperdal (antipsychotic medicine) for talking to inanimate objects. She said he was put on 1-1 staffing with 15-minute monitoring and sent to a behavior hospital for evaluation and treatment. During an interview on 04/14/22 at 1:54 p.m., The DON said she would have separated Residents #4 and #5 and they would not have continued as roommates if she was made aware of the previous incidents. She said no one told her of the previous incidents and nothing was reported during morning meeting. During an interview on 04/14/22 at 2:08 p.m., NA B said she realized after she shut the door of Residents #4 and #5 room that she had left Resident #5 in danger. She said she stood right outside of the door until LVN A arrived and intervened. During an interview on 04/15/22 at 3:34 p.m. the administrator and DON said NA B should have intervened and not shut the door. She said NA B was a new aide hired on and she needed more experience and training. They said staff were also trained to request help when they need to take care of residents. She said LVN A should have documented the prior incident and notified the administrator (the abuse coordinator and/or designee). The DON said she was not able locate staff training records that contained the names of the staff that worked during the incident. During an interview on 04/15/22 at 4:14 p.m., psych NP J said he was not made aware of previous incidents of aggression from Resident #4. He said he was in the facility every two weeks and more as needed. He said he received reports from staff if residents had behaviors. He said he would have addressed the aggressions and recommended Residents #4 and #5 be separated and not continued their status as roommates. Record review of nurse note dated 03/19/22 at 2:22 p.m., completed by LVN L, indicated LVN L heard shouting from Resident #4's room. LVN L observed Resident #4 shouting aggressively as he stood over Resident #5. Resident #4 was redirected to the dining room and offered snacks. Resident #4 refused snacks. LVN L notified CNAs to be on alert for any aggressive behavior towards other residents. Resident #5 had no apparent injuries and denied pain. Record review of In-Service Training Report dated 09/21/21 indicated the topic was safety monitoring-Hall-3: Hall-3 staff are to have safety monitoring of hall at all times. Staff may take turns, being safety monitor. Observe for potential abuse behaviors, wandering, and/or falls and attempt to prevent altercations and incidents. The in-service did not include the names of the LVN A, NA B, CNA C, or CNA K. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's Abuse Prohibition Guideline dated 2022 indicated : .will ensure a safe environment for residents by prohibiting physical and mental abuse including involuntary seclusion, neglect, exploitation and misappropriation of property. A. physical abuse includes but is not limited to hitting, slapping, and kicking, shoving, pinching, and corporal punishment. B. Verbal abuse includes but is not limited to the sue of oral, written or gestural language that willfully includes disparaging or derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Examples include cursing, yelling, name calling, threatening or saying things to frighten a resident. E. Sexual Abuse is defined as non-consensual contact of any type with a resident, includes but is not limited to any unnecessary touching or exposure of the resident's breast or any part of the genitals without voluntary, informed consent and with the intention to arouse or gratify the sexual desire of any person. This definition is to include sexual harassment, sexual coercion, or any sexual assault. Prevention: 3. Residents identified as exhibiting abusive behaviors will be assessed and appropriate interventions included in the plan of care. 4. staff will immediately report and protect the resident if an allegation or observation of abuse has occurred. Protection: 1. All residents will be immediately protected from harm. 3. Allegations involving residents will necessitate assessment and interventions appropriate to protect the victim which may include a. temporary one on one supervision. b. transfer to another level of care. c. discharge home or to a family member/responsible party. The facility was notified of the Immediate Jeopardy on 04/14/22 at 3:00 p.m. and the administrator was provided the Immediate Jeopardy template. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy. The Facility's Plan of Removal for Immediate Jeopardy was accepted on 04/15/22 at 1:55 p.m. and reflected the following: Facility failed to prevent Resident #1 from sexually abusing Resident #2. On 4/11/22 Resident #2 was heard yelling please don't no no no Resident #1 was found behind Resident #2 , his pants down and his hand on her shoulder . Resident #1 had a partially erect penis and was thrusting toward resident #2. Resident #2's brief was down. Approximately 2-3 weeks earlier Resident #3 was found sitting on Resident #1's bed. He was standing between her legs hovering over her. Both were fully clothed. There were no interventions put in place. Facility failed to prevent Resident #4 from verbally and physically abusing Resident #5. On 3/19/22 Resident #4 was seen standing over Resident #5, while Resident #5 was in bed, yelling aggressively at him. No interventions were put in place at the time. On 4/9/22 Resident #4 was found hovering over Resident #5 yelling at him. The nurse aide opened the door to see what was happening and then closed the door and called for the nurse. She did not intervene and separate the Residents. She had not been trained on dealing with behaviors. Please accept the following plan of removal: 1. Notify V.P. of Clinical Operations of immediate Jeopardy status - On site 4/14/22 @ 3 pm (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. Notify Regional Director of operations of Immediate Jeopardy status - Onsite 4/14/22@ 3 pm. 3. Notify facility Medical Director of Immediate Jeopardy status- Notified via phone by ADON -4/14/22@ 4pm. 4. Resident #1 was immediately placed on 1:1 monitoring beginning @ 8:30 am on 4/11/22. Attending MD /Designee and responsible party were notified. Medication orders were received. He remained on 1:1 monitoring until transferred to a Behavioral Hospital @3:30 pm on 4/11/22. He remains at the Behavioral Hospital at time of this report. 5. Resident #2 was assessed by facility licensed nursing staff on 4/11/22@ 8:21 am with no visible injuries noted. She was calm. Attending MD /Designee and responsible party were notified. Responsible party later called facility and requested she be sent out for exam .MD/Designee were notified of family's request and order received to send to ER for evaluation and examination. She was transferred to a hospital on 4/11/22 @ 8:30 pm. She returned to the facility on [DATE] @ 3 am. Verbal report was received from nurse at Hospital indicating no abrasions, tears or injuries on physical exam, specimens were collected during exam and are pending completion by forensics lab. She has been noted to be in pleasant mood and in no immediate distress or discomfort noted. 6. Resident #3 has been assessed on numerous occasions for the past 3 weeks with no noted skin issues or obvious discomfort observed. 7. Resident #4 was placed on 15-minute interval monitoring beginning 4/9/22 @ 6am. Attending MD/Designee were notified. Order received to transfer to behavioral hospital. Resident remained on 15-minute monitoring until transferred to Behavioral Hospital on 4/9/22 @4:45 pm. He remains at a Behavioral Hospital at the time of this report. 8. Resident #5 was assessed by licensed nursing staff on 4/9/22 with no injuries noted. He was placed on 15-minute monitoring beginning 4/9/22 @ 6 am and monitoring was discontinued on 4/12/22@ 7am with no further incidents noted. 9. Residents who reside on the secure unit have had skin assessments completed by licensed nursing staff treatment nurse for any unidentified concerns with none identified. Initiated 4/13/22 @t 11 am and Completed 4/13/22 @ 3:30 pm by Treatment Nurse. 10. Residents who reside on the secure unit were evaluated for any physical aggressive behaviors with none identified. Initiated 4/14/22@ approx. 4:30 pm and Completed 4/14/22@ 5:30 pm by ADON. Care plans for Residents #1, 2 , 4 & 5 were updated to reflect identified event and interventions were reviewed . 11. Facility staff were provided education by DON/Designee on: 11a) Inappropriate Resident to Resident touching. Reporting procedures discussed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Initiated 4/13/22@ 12:30 pm, Follow up sessions @2:30 pm and 6pm Completed @ 6:30pm on 4/13/22 Total attendees on 4/13/22-51 Subsequent sessions on 4/14 /22@beginning @ 10am, Completed @ 10:30 am on 4/14/22 -Total attendees 11. Follow up sessions conducted @ 4/15/22 beginning @ 6am completed by 9am. Total Attendees 29. 11b) Supervision and Monitoring of Hall 3/Secure Unit. Content discussed and procedures discussed to facilitate monitoring of unit. Staff were educated that one staff would be monitoring Residents and the hallway on Hall 3 while care is being delivered by the other staff member. Staff were instructed to take turns with these roles and to notify the nurse if additional monitoring assistance is needed. Initiated 4/13/22@ 11am, Follow up sessions @ 2:30 pm. and 6:00 pm. Completed @ 6:30 pm on 4/13/22. Total attendees 50 Subsequent sessions on 4/14/22@ 10 am, Completed@ 10 :30 am. 12 attendees Follow up sessions beginning 4/15/22 @ 6 am completed @ 945 am. Total attendees 29. 11c) Abuse -Content Abuse Coordinator - contact #s and the facility Abuse Prohibition Guideline. Initiated 4/13/22@10:30 am, Follow up sessions @2:30 pm and 6 pm. Completed @ 6:30 pm on 4/13/22. Total attendees 63 Subsequent sessions 4/14/22 beginning @10 am, Completed @ 10:30 am on 4/14/22- 17 attendees Follow up sessions on 4/15/22 beginning at 6am completed at 945 am. Total attendees 29. 12. Facility staff were provided education by DON/Designee on: 12a) Behavior Assessment, Intervention and Monitoring - content included facility policy. Initiated 4/14/22@ 5:30 pm, Completed @ 5:50 pm on 4/14/22 Attendees 32. Follow up session on 4/15/22 beginning at 6 am completed by 945 am. Total attendees 22. 12b) Unmanageable Residents - content included facility policy. Initiated 4/14/22@ 5:30 pm Completed @ 6:00 pm on 4/14/22 Attendees 35 Follow up sessions on 4/15/22 beginning at 6 am completed at 945 am. Total attendees 29. 13. Facility were provided education by DON/Designee on resident to resident-resident altercations, content including reporting procedures, interventions, and documentation procedures. Initiated 4/15/22 at 6am completed at 945 am. Total attendees 27. 14. Staff who were not on duty will be notified, to come to the facility for education by the DON/designee. No staff will be allowed to work on the floor until education has been completed for items #13, #14a, #14b, #14c, 15a, and 15b . Administrator, DON, and MDS Coordinator will monitor for employee completion of required edu [TRUNCATED]

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on observation, interview, and record review the facility failed to ensure residents received adequate supervision to prevent abuse for 4 of 11 residents (Resident #s 1, 2, 4, and 5) reviewed for supervision. 1. The facility staff did not provide supervision to prevent Resident #1 from sexually abusing Resident #2 on 04/11/22. Resident #2 wandered into Resident #1's room. Resident #2 was heard yelling. Resident #1 was found behind Resident #2, his hand on her shoulder, holding his partially erect penis while thrusting toward Resident #2. Residents #1 and #2's briefs were down. 2. The facility staff did not separate and supervise Resident #5 to prevent his continued verbal and physical abuse of Resident #4. On 04/9/22 Resident #4 was found hovering over Resident #5 yelling at him. The NA B opened the door to see what was happening and then closed the door and called for the nurse. NA B left Resident #5 in imminent harm. An Immediate Jeopardy (IJ) situation was identified on 04/14/22 at 3:00 p.m. While the IJ was removed on 04/15/22, the facility remained out of compliance at a potential for more than minimal harm with a scope identified as a pattern due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of abuse, physical harm, mental anguish, emotional distress, and death. Findings included: 1. Record review of face sheet dated 04/13/22, indicated Resident #1 was a [AGE] year-old male, admitted on [DATE] and his diagnoses included adjustment disorder (emotional or behavioral reaction to a stressful event or change in a person's life), Parkinson's (a brain disorder that leads to shaking, stiffness, and difficulty with walking, balance, and coordination), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), cognitive communication deficit (difficulty with thinking and how someone uses language), and schizophrenia (a serious mental disorder in which people interpret reality abnormally). Record review of MDS dated [DATE], indicated Resident #1's BIMS score was 7 (severe cognitive impairment), he wandered every 1-3 days, ambulated with a walker. There were no behaviors noted. Record review of Resident #1's care plan dated 04/11/22 indicated he displayed socially inappropriate behavior and inappropriate sexual gesture with a female resident. Interventions included 15-minute monitoring and sent out to behavioral hospital for evaluation and treatment. There was no previous care plan for sexually inappropriate behavior available for review. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of face sheet dated 04/13/22, indicated Resident #2 was a [AGE] year-old female, admitted on [DATE], and her diagnoses included Alzheimer's (a progressive neurologic disorder that causes the brain to shrink (atrophy) and brain cells to die) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of MDS dated [DATE] indicated Resident #2 had a BIMS score of 2 (severe cognitive impairment), wandered daily, and ambulated without assistance. Record review of care plan dated 12/30/21 indicated Resident #2 required placement on the secure unit due to wandering and significant safety awareness due to dementia. Interventions included assist with location of room with verbal cures, notify physician if behavior increases (1/18/22- in and out of other residents' rooms, at times will take things out of other residents' rooms, 2/6/22 altercation with another resident, 2/11/22 attempted to take another residents walker, 4/11/22 victim of inappropriate sexual gesture). The care plan did not address supervision. Observation conducted on 04/14/22 with the Administrator, DON and ADON, who verified the identity of the staff and residents, of the facility's two separate camera recordings on 04/08/22 from 7:30 a.m. through 8:30 a.m. indicated: At 8:09 a.m. there were no aides on the hall, Resident #2 wandered on hall and then back into her room. Camera error exact time unknown-CNA F went into another resident's room while CNA C was in the shower room. At 8:13 a.m. Resident #2 wandered into the hall, then into a resident room next to the shower room. At 8:14 a.m., CNA C out of shower to get a wheelchair and then back into shower room. At 8:16 a.m., CNA C opened the shower door and took a resident in a wheelchair out of the shower. CNA C walked past the resident room next to the shower room. CNA C walked into Resident #1's room, escorted Resident #2 out of Resident #1's room and walks back toward Resident #2's room at the opposite end of the hall. At 8:19 a.m. CNA F comes out of other residents' room. Record review of nurse note dated 04/11/22 at 4:08 p.m., completed by LVN D, indicated CNA C heard Resident #2 scream no don't do that when she entered the room. The door was open and she witnessed Resident #1 standing behind Resident #2. Resident #1 was holding on to Resident #2 with one hand, his pants were down and he was exposed. Resident #2's pants were down and she was exposed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of nurse note dated 04/11/22 at 4:18 p.m., completed by the DON, indicated CNA C exited the shower room at approximately 8:15 a.m. and heard Resident #2's raised voice coming Resident #1's room. CNA C entered the room and noted Resident #2 had his pants down and was standing behind Resident #2. Resident #1 had his penis in his hand and was saying 'get it, get it'. Resident #2's incontinence protective wear and pants were down. CNA C separated Resident #1 and #2 and immediately removed Resident #2 from the room. DON and Treatment nurse examined Resident #2 in her room and did not notice any redness or drainage to rectal or perineal/vaginal area. Resident #2 was calm at the time of the examination. No injuries noted. The physician was notified and new orders to send Resident #1 to behavioral hospital for evaluation and treatment. The administrator was notified. Resident #2's daughter was notified. Psych services was notified. Record review of NP E's visit report dated 04/11/22 indicated Resident #1 denied any inappropriate behaviors occurred. Resident #1's BIMS was assessed and scored at 15. Record review of Resident #1's behavior monitoring from 01/01/22 through 04/08/22 indicated no behaviors were documented. Record review of Resident #2 behavior monitoring from 01/01/22 through 04/08/22 indicated there were 79 incidents of wandering into other residents' rooms and the nurse was notified. During an interview on 04/13/22 at 8:35 a.m. the Administrator said CNA C came out of the shower room and heard Resident #2 say 'stop'. She said the door was open and she saw Resident #1 standing behind Resident #2. She said both residents' pants and briefs were down. She said Resident #1 had his penis in his hand. She said Resident #2 was assessed and it was not determined she was penetrated. She said psych services was contacted and increased Resident #1's Zoloft (an antidepressant medication). She said Resident #1 denied the allegations. She said Resident #1's last BIMS score was a 7 but he was re-assessed and it was 15. She said Resident #1 had previous sexually inappropriate behaviors and would masturbate on the porch. She said he was easily re-directed. During an interview on 04/13/22 at 9:10 a.m., CNA C said she was previously trained on abuse and neglect prevention. She said approximately 2 or 3 weeks prior she had previously caught Resident #1 with another resident sitting on his bed. She said Resident #1 was standing between the other resident's legs as she was sitting on his bed. She said both residents were fully dressed. She said Resident #1 stepped back and said he was trying to help the other resident. She said she thought she told LVN G of the incident. She said the most recent incident occurred after breakfast at approximately 8:15 a.m. She said was in the shower room when heard Resident #2 scream No don't do that no no no. She said she brought the other resident out of the shower room and walked to Resident #1's room. She said both Resident #1 and Resident #2's pants were down. She said Resident #1 had his penis in his hand and was holding Resident #2's left shoulder as he was telling Resident #1 to get it, get it as he was thrusting. She said Resident #1 sat down on his bed when he walked into the room. She said Resident #2 was crying. She said she dressed Resident #2 and walked her out of the room. She said she and CNA F were working the secure unit together. She said they had cell phones to call the nurse if there as an emergency. During an interview on 04/13/22 at 9:47 a.m., the DON said she had heard of the incident of another resident being in Resident #1's room but she was not told the incident was sexual. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 04/13/22 at 11:35 a.m., LVN I said she had witnessed an incident approximately 2 - 3 months prior where another resident had taken off her clothes in her room and her roommate had opened the door as Resident #1 walked by. She said he stopped and stared, and when asked why he did that he said because he could. She said she had heard of the incident where he stood over the same resident while she sat on his bed. During an interview on 04/13/22 at 11:53 a.m., LVN G said she had not noticed Resident #1 having inappropriate sexual behaviors. She said Resident #1 did stare at the resident that was found sitting on his bed. During an interview on 04/14/22 at 10:15 a.m., the DON said she was not able to locate LVN A, NA B, or CNA C's training for sexually inappropriate behaviors or resident abuse. During an interview on 04/14/22 at 1:30 p.m., the Administrator said she was not aware of any previous incidents related to inappropriate sexual behavior. She said she was not aware LVN A, NA B, or CNA C were not trained. She said she became the new Administrator in January 2022 and was not aware staff was not trained. She said she and the DON or designee were responsible for ensuring staff was trained. During an interview on 04/14/22 at 1:54 p.m., the DON said both aides on the secure unit should not be providing resident care at the same time. She said one of the aides was supposed to monitor and supervise the other residents and the hall to ensure residents do not wander or to be able to intervene for resident safety. She said she was not able to locate training records to indicate the staff had been trained. She said she or designee were responsible for ensuring staff was trained. She could not say why the staff were not trained or she could not locate the training records. During an interview on 04/14/22 at 2:05 p.m., CNA F said a resident came out of his room and the resident required incontinent care. She said she went into the shower room to gather supplies. She said CNA C was almost finished showering a different resident so she left the shower room and assisted the other resident with his incontinent care. She said she did not see Resident #2 wandering in the hall. She said had been working for 2 months and did not recall specific training related to monitoring the residents prior to the incident on 04/08/22. During an interview on 04/15/22 at 3:34 p.m. the administrator and DON said they had re-inserviced and educated three staff on 04/13/22 working on hall 300 to have one staff monitoring and the other staff providing care. They said staff were also trained to request help when they need to take care of residents and they were monitoring the hall. The DON said she was not able locate any staff training records that contained the names of the staff that worked during the incident. She said NA B was not a certified aide and there was no record she was trained regarding resident to resident aggression. During an interview on 04/15/22 at 4:14 p.m., Psych NP J said he received a call from the facility the morning of the incident with Residents #1 and #2. He said he had worked with Resident #1 for many years. He said Resident #1 had multiple hypersexual behaviors in the past that included exposing himself to others and masturbating. He said he had just recently started seeing Resident #2 as she was wandering and stealing items from other residents' rooms. He said staff have to monitor, intervene, and divert residents' behaviors. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. Record review of face sheet dated 04/04/22 indicated Resident #4 was a [AGE] year-old male who was admitted on [DATE]. His diagnoses included schizophrenia (a serious mental disorder in which people interpret reality abnormally), dementia with behaviors, delusional disorders (serious mental illness - called a psychosis- in which a person cannot tell what is real from what is imagined), and anxiety (a feeling of fear, dread, and uneasiness). Record review of MDS dated [DATE] indicated Resident #4 had severe cognitive impairment and wandered every 1 to 3 days. There were no behaviors documented. Record review of care plan dated 10/08/21 indicated Resident #4 had a history of physical aggressive behavior. Interventions included social services to evaluate and visit, activities staff to visit and provide diversional activities, talk in a calm voice when behavior is disruptive, and remove from public area when behavior is disruptive and unacceptable. Record review of care plan dated 04/09/22 indicated Resident #4 exhibited aggressive behavior noted by staff standing over another resident and yelling, threatening and physical aggression directed at staff trying to diffuse the situation. Interventions included placing Resident #4 in an area for frequent observation social services to evaluate and visit, activities staff to visit and provide diversional activities, talk in a calm voice when behavior is disruptive, and remove from public area when behavior is disruptive and unacceptable, and sent to behavior hospital for evaluation/treatment. There was no care plan to address verbal and physical aggression towards his roommate that occurred on 03/19/22. Record review of Resident #4's behavior monitoring from 01/01/22 through 04/09/22 indicated on 04/05/22 CNA C noted verbal behaviors directed at others included threatening others, screaming/yelling at others, and cursing at others-nurse notified. There were no additional dates completed. Record review of nurse note dated 03/19/22 at 2:22 p.m., completed by LVN L, indicated LVN L heard shouting from Resident #4's room. LVN L observed Resident #4 shouting aggressively as he stood over Resident #5. Resident #4 was redirected to the dining room and offered snacks. Resident #4 refused snacks. LVN L notified CNAs to be on alert for any aggressive behavior towards other residents. Resident #5 had no apparent injuries and denied pain. Record review of a face sheet dated 04/04/22 indicated Resident #5 was a [AGE] year-old male, admitted on [DATE], and his diagnoses included catatonic schizophrenia (rare severe mental disorder characterized by striking motor behavior, typically involving either significant reductions in voluntary movement or hyperactivity and agitation), vascular dementia with behavioral disturbances (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain), paranoid schizophrenia (characterized by predominantly positive symptoms of schizophrenia, including delusions and hallucinations), major depressive disorder (serious mood disorder), and anxiety. Record review of an MDS dated [DATE] indicated Resident #5 had severe cognitive impairment. Wandered every 1 to 3 days. There were no physical or verbal behaviors noted. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident Incident Report dated 04/09/22 at 5:25 a.m. and completed by LVN A indicated NA B entered Resident #4 and Resident #5's room and found Resident #4 bent over Resident #5. Resident #4 was yelling at Resident #5. LVN A separated the residents. Resident #4 sat at the foot of his bed. LVN A sat on the floor by the foot of his bed. LVN A reached down to assist Resident #4 from the floor and Resident #4 swung his fist and struck LVN A's upper right arm. Resident #4 yelled he was going to kill LVN A. Resident #5 was moved to a different room. During an interview on 04/13/22 at 2:08 p.m., NA B said she heard voices and yelling and went to Residents #4 and #5's room. She said she opened the door and saw Resident #4 standing over Resident #5 while Resident #5 lay in his bed. She said she shut the door and told the other staff to get LVN A. She said she did not know why she did not intervene. She said she was not a certified aide and was not trained on behaviors. She said she was not trained on how to redirect residents. She said LVN A came to the room and directed Resident #4 to his bed. She said Resident #4 went toward his bed and said, I'll fucking kill you. She said CNA K was on shift with her. Record review of CNA K's undated statement included in the ongoing facility's investigation indicated CNA C told her she heard shouting and rumbling in the room and for her (CNA K) to go and get LVN A. LVN A opened the door and LVN A, CNA C and CNA K walked into Resident #4 and Resident #5's room. Resident #4 was standing over Resident #5 hitting him and cursing at him. LVN A was able to get Resident #4 off Resident #5. Resident #4 started to swing and curse at LVN A. Resident #4 fell on the floor as he swung. LVN A directed CNA K to get LVN I. LVN I tried to talk to Resident #4 and he started cursing at LVN A and picked up a shoe. LVN A moved Resident #5 to another room. All staff left Resident #4's room for their safety. During an interview on 04/13/22 at 4:27 p.m., LVN A said he was not trained on dementia for the secure unit. He said he was not aware of any specific care plans for Resident #4. He said there were other incidents of Resident #4 yelling at Resident #5 but he was able to redirect him. He said if resident #4 was not able to see' Resident #5 then he would calm down. He said he did not do a nurse note or an incident report. He could not say why he did not document the incident. He said the most recent incident, Resident #4 was screaming at the top of his lungs at Resident #5. He said Resident #4 continued to yell at Resident #5 when he (LVN A) got between the residents. He said Resident #5 said Resident #4 hit him in the back. He said Resident #5 did not have any marks on his back. He said Resident #4 was pretty traumatized for the next day or two. Record review of nurse note dated 04/09/22 at 10:47 a.m., completed by LVN A, indicated LVN A was called to Resident #4 and Resident #5's room at 5:25 a.m. LVN A found Resident #4 standing over Resident #5, yelling. LVN A directed Resident #4 to sit on his bed but he sat on the floor. LVN A attempted to help him up but Resident #4 hit LVN A on the right upper arm and started to yell he was going to kill LVN A. LVN A moved Resident #5 to another room for safety. Resident #5 stated Resident #4 hit him in the back. There was no visible injury. Resident #5 was resting in a safe bed. Notified on-call ADON, and the ADON notified the DON. DON stated she was going to send Resident #4 to a behavioral hospital. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 04/13/22 at 8:35 a.m. the Administrator said she was not aware of any previous incidents between Residents #4 and #5. She said she was new to the facility as of January 2022 and no one reported anything during the morning meetings. She said they were roommates. She said Resident #4 was found standing over Resident #5. She said Resident #4 was recently put on Risperdal (antipsychotic medicine) for talking to inanimate objects. She said he was put on 1-1 staffing with 15-minute monitoring and sent to a behavior hospital for evaluation and treatment. During an interview on 04/14/22 at 1:54 p.m., The DON said she would have separated Residents #4 and #5 and they would not have continued as roommates if she was made aware of the previous incidents. She said no one told her of the previous incidents and nothing was reported during morning meeting. During an interview on 04/14/22 at 2:08 p.m., NA B said she realized after she shut the door of Residents #4 and #5 room that she had left Resident #5 in danger. She said she stood right outside of the door until LVN A arrived and intervened. During an interview on 04/15/22 at 3:34 p.m. the administrator and DON said NA B should have intervened and not shut the door. The DON said NA B was a new aide and she needed more experience and training. They said staff were also trained to request help when they need to take care of residents. The DON said LVN A should have documented the prior incident and notified the administrator (the abuse coordinator and/or designee). The DON said she was not able locate staff training records that contained the names of the staff that worked during the incident. During an interview on 04/15/22 at 4:14 p.m., psych NP J said he was not made aware of previous incidents of aggression from Resident #4. He said he would have addressed the aggressions and recommended Residents #4 and #5 be separated and not continued their status as roommates. Record review of In-Service Training Report dated 09/21/21 indicated the topic was safety monitoring-Hall-3: Hall-3 staff are to have safety monitoring of hall at all times. Staff may take turns, being safety monitor. Observe for potential abuse behaviors, wandering, and/or falls and attempt to prevent altercations and incidents. The in-service did not include the names of the LVN A, NA B, CNA C, or CNA K. Record review of the facility's Safety and Supervision of Residents policy dated 2001 indicated Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. 3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision .5. Monitoring the effectiveness of interventions shall include the following: a. Ensuring that interventions are implemented correctly and consistently; .Systems Approach to Safety .2. Resident supervision is a core component of the systems approach to safety. The type and frequency of the resident supervision is determined by the individual resident's assessed needs .Resident Risks and Environment Hazards .risk factors and environmental hazards include: .d. unsafe wandering; . Record review of the facility's Behavioral Assessment, Intervention and Monitoring policy dated 2001 indicated .8. Interventions and approaches will be based on detailed assessment of physical, psychological and behavioral symptoms and their underlying causes.interventions will be adjusted based on the impact on behavior and other symptoms . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility was notified of the Immediate Jeopardy on 04/14/22 at 3:00 p.m. and the administrator was provided the Immediate Jeopardy template. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy. The Facility's Plan of Removal for Immediate Jeopardy was accepted on 04/15/22 at 1:55 p.m. and reflected the following: Facility failed to prevent Resident #1 from sexually abusing Resident #2. On 4/11/22 Resident #2 was heard yelling please don't no no no Resident #1 was found behind Resident #2 , his pants down and his hand on her shoulder . Resident #1 had a partially erect penis and was thrusting toward resident #2. Resident #2's brief was down. Approximately 2-3 weeks earlier Resident #3 was found sitting on Resident #1's bed. He was standing between her legs hovering over her. Both were fully clothed. There were no interventions put in place. Facility failed to prevent Resident #4 from verbally and physically abusing Resident #5. On 3/19/22 Resident #4 was seen standing over Resident #5, while Resident #5 was in bed, yelling aggressively at him. No interventions were put in place at the time. On 4/9/22 Resident #4 was found hovering over Resident #5 yelling at him. The nurse aide opened the door to see what was happening and then closed the door and called for the nurse. She did not intervene and separate the Residents. She had not been trained on dealing with behaviors. Please accept the following plan of removal: 1. Notify V.P. of Clinical Operations of immediate Jeopardy status - On site 4/14/22 @ 3 pm 2. Notify Regional Director of operations of Immediate Jeopardy status - Onsite 4/14/22@ 3 pm. 3. Notify facility Medical Director of Immediate Jeopardy status- Notified via phone by ADON -4/14/22@ 4pm. 4. Resident #1 was immediately placed on 1:1 monitoring beginning @ 8:30 am on 4/11/22. Attending MD /Designee and responsible party were notified. Medication orders were received. He remained on 1:1 monitoring until transferred to a Behavioral Hospital @3:30 pm on 4/11/22. He remains at the Behavioral Hospital at time of this report. 5. Resident #2 was assessed by facility licensed nursing staff on 4/11/22@ 8:21 am with no visible injuries noted. She was calm. Attending MD /Designee and responsible party were notified. Responsible party later called facility and requested she be sent out for exam .MD/Designee were notified of family's request and order received to send to ER for evaluation and examination. She was transferred to a hospital on 4/11/22 @ 8:30 pm. She returned to the facility on [DATE] @ 3 am. Verbal report was received from nurse at Hospital indicating no abrasions, tears or injuries on physical exam, specimens were collected during exam and are pending completion by forensics lab. She has been noted to be in pleasant mood and in no immediate distress or discomfort noted. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	12a) Behavior Assessment, Intervention and Monitoring - content included facility policy. Initiated 4/14/22@ 5:30 pm, Completed @ 5:50 pm on 4/14/22 Attendees 32. Follow up session on 4/15/22 beginning at 6 am completed by 945 am. Total attendees 22. 12b) Unmanageable Residents - content included facility policy. Initiated 4/14/22@ 5:30 pm Completed @ 6:00 pm on 4/14/22 Attendees 35 Follow up sessions on 4/15/22 beginning at 6 am completed at 945 am. Total attendees 29. 13. Facility were provided education by DON/Designee on resident to resident-resident altercations, content including reporting procedures, interventions and documentation procedures. Initiated 4/15/22 at 6am completed at 945 am. Total attendees 27. 14. Staff who were not on duty will be notified, to come to the facility for education by the DON/designee. No staff will be allowed to work on the floor until education has been completed for items #13, #14a, #14b, #14c, 15a, and 15b . Administrator ,DON, and MDS Coordinator will monitor for employee completion of required education topics . Administrator, DON, MDS Coordinator and HR Director will conduct audits of current facility employees and indicate completion dates for required education . Staff are being notified to report to facility for education completion via phone and texts. Notifications started on 4/14/22 @ 3:30 pm and are continuing on 4/15/22. Administrator, DON and MDS Coordinator will continue to audit , notify, and provide education items until all employees have completed the requirement . 15. Safe surveys were conducted for Residents on the secure unit and reside in the facility general population area with no safety or abuse concerns identified. Initiated 4/13/22 @ 4:00 per Social Worker and Completed 4/14/22@8:20 pm per facility Administrator . 10 Residents interviewed. 16. Compliance will be monitored through: 16a) Review of 24-Hour Reports, A/I Reports and Medical record review by Nursing Management and Administrator during Clinical meetings with corrective actions taken for identified concerns. The DON and administrator will conduct clinical meetings 3 x weekly and this will be an ongoing process. 16b) Findings will submitted to the facility QAPI Committee for review and additional Audits and corrective actions if indicated. 17. Facility Administrator and the DON were provided education on compliance and (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on observation, interview and record review, the facility failed to ensure nursing staff demonstrated competencies and skill sets necessary to care for resident needs for 4 of 11 residents (Resident #s 1, 2, 4, and 5) reviewed for competent nursing staff. The facility did not ensure LVN A, NA B and CNA F were trained to supervise and intervene for residents with behaviors. The facility did not provide required monitoring and supervision to prevent Resident #1 from sexually abusing Resident #2 on 04/11/22. Resident #2 wandered into Resident #1's room. Resident #2 was heard yelling. Resident #1 was found behind Resident #2, his hand on her shoulder, holding his partially erect penis while thrusting toward Resident #2. Residents #1 and #2's briefs were down. The facility staff did not intervene and protect Resident #5 from Resident #4's verbal and physical abuse. On 4/9/22 Resident #4 was found hovering over Resident #5 yelling at him. The NA B opened the door to see what was occurring and then closed the door and called for the nurse. NA B left Resident #5 in imminent harm. An Immediate Jeopardy (IJ) situation was identified on 04/14/22 at 3:00 p.m. While the IJ was removed on 04/15/22, the facility remained out of compliance at a potential for more than minimal harm with a scope identified as a pattern due to the facility's need to evaluate the effectiveness of the corrective systems. These failures placed residents at risk of receiving supervision and interventions from staff without the needed skills and competencies. Findings included: Record review of face sheet dated 04/13/22, indicated Resident #1 was a [AGE] year-old male, admitted on [DATE] and his diagnoses included adjustment disorder (emotional or behavioral reaction to a stressful event or change in a person's life), Parkinson's (a brain disorder that leads to shaking, stiffness, and difficulty with walking, balance, and coordination), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), cognitive communication deficit (difficulty with thinking and how someone uses language), and schizophrenia (a serious mental disorder in which people interpret reality abnormally). Record review of MDS dated [DATE], indicated Resident #1's BIM score was 7 (severe cognitive impairment), he wandered every 1-3 days, ambulated with a walker. There were no behaviors noted. Record review of Resident #1's care plan dated 04/11/22 indicated he displayed socially inappropriate behavior and inappropriate sexual gesture with a female resident. Interventions included 15-minute monitoring and sent out to behavioral hospital for evaluation and treatment. There was no previous care plan for sexually inappropriate behavior available for review. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of face sheet dated 04/13/22, indicated Resident #2 was a [AGE] year-old female, admitted on [DATE], and her diagnoses included Alzheimer's (a progressive neurologic disorder that causes the brain to shrink (atrophy) and brain cells to die) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of MDS dated [DATE] indicated Resident #2 had a BIMS score of 2 (severe cognitive impairment), wandered daily, and ambulated without assistance. Record review of care plan dated 12/30/21 indicated Resident #2 required placement on the secure unit due to wandering and significant safety awareness due to dementia. Interventions included assist with location of room with verbal cues, notify physician if behavior increases (1/18/22- in and out of other residents' rooms, at times will take things out of other residents' rooms, 2/6/22 altercation with another resident, 2/11/22 attempted to take another residents walker, 4/11/22 victim of inappropriate sexual gesture). The care plan did not address supervision. Observation conducted on 04/14/22 with the Administrator, DON and ADON, who verified the identity of the staff and residents, of the facility's two separate camera recordings on 04/08/22 from 7:30 a.m. through 8:30 a.m. indicated: At 8:09 a.m. there were no aides on the hall, Resident #2 wandered on hall and then back into her room. Camera error exact time unknown-CNA F went into another resident's room while CNA C was in the shower room. At 8:13 a.m. Resident #2 wandered into the hall, then into a resident room next to the shower room. At 8:14 a.m., CNA C out of shower to get a wheelchair and then back into shower room. At 8:16 a.m., CNA C opened the shower door and took a resident in a wheelchair out of the shower. CNA C walked past the resident room next to the shower room. CNA C walked into Resident #1's room, escorted Resident #2 out of Resident #1's room and walks back toward Resident #2's room at the opposite end of the hall. At 8:19 a.m. CNA F comes out of other residents' room. Record review of nurse note dated 04/11/22 at 4:08 p.m., completed by LVN D, indicated CNA C heard Resident #2 scream no don't do that when she entered the room. The door was open and she witnessed Resident #1 standing behind Resident #2. Resident #1 was holding on to Resident #2 with one hand, his pants were down and he was exposed. Resident #2's pants were down and she was exposed. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of nurse note dated 04/11/22 at 4:18 p.m., completed by the DON, indicated CNA C exited the shower room at approximately 8:15 a.m. and heard Resident #2's raised voice coming Resident #1's room. CNA C entered the room and noted Resident #2 had his pants down and was standing behind Resident #2. Resident #1 had his penis in his hand and was saying 'get it, get it'. Resident #2's incontinence protective wear and pants were down. CNA C separated Resident #1 and #2 and immediately removed Resident #2 from the room. DON and Treatment nurse examined Resident #2 in her room and did not notice any redness or drainage to rectal or perineal/vaginal area. Resident #2 was calm at the time of the examination. No injuries noted. The physician was notified and new orders to send Resident #1 to behavioral hospital for evaluation and treatment. The administrator was notified. Resident #2's daughter was notified. Psych services was notified. Record review of NP E's visit report dated 04/11/22 indicated Resident #1 denied any inappropriate behaviors occurred. Resident #1's BIMS was assessed and scored at 15. Record review of Resident #1's behavior monitoring from 01/01/22 through 04/08/22 indicated no behaviors were documented. Record review of Resident #2 behavior monitoring from 01/01/22 through 04/08/22 indicated there were 79 incidents of wandering into other residents' rooms and the nurse was notified. During an interview on 04/13/22 at 8:35 a.m. the Administrator said CNA C came out of the shower room and heard Resident #2 say 'stop'. She said the door was open and she saw Resident #1 standing behind Resident #2. She said both residents' pants and briefs were down. She said Resident #1 had his penis in his hand. She said Resident #2 was assessed and it was not determined she was penetrated. She said psych services was contacted and increased Resident #1's Zoloft (an antidepressant medication). She said Resident #1 denied the allegations. She said Resident #1's last BIMS score was a 7 but he was re-assessed and it was 15. She said Resident #1 had previous sexually inappropriate behaviors and would masturbate on the porch. She said he was easily re-directed. During an interview on 04/13/22 at 9:10 a.m., CNA C said she was previously trained on abuse and neglect prevention. She said approximately 2 or 3 weeks prior she had previously caught Resident #1 with another resident sitting on his bed. She said Resident #1 was standing between the other resident's legs as she was sitting on his bed. She said both residents were fully dressed. She said Resident #1 stepped back and said he was trying to help the other resident. She said she thought she told LVN G of the incident. She said the most recent incident occurred after breakfast at approximately 8:15 a.m. She said she was in the shower room when heard Resident #2 scream No don't do that no no no. She said she brought the other resident out of the shower room and walked to Resident #1's room. She said both Resident #1 and Resident #2's pants were down. She said Resident #1 had his penis in his hand and was holding Resident #2's left shoulder as he was telling Resident #2 to get it, get it as he was thrusting. She said Resident #1 sat down on his bed when he walked into the room. She said Resident #2 was crying. She said she dressed Resident #2 and walked her out of the room. She said she and CNA F were working the secure unit together. She said they had cell phones to call the nurse if there as an emergency. During an interview on 04/14/22 at 10:15 a.m., the DON said she was not able to locate LVN A, NA B, or CNA C's training for sexually inappropriate behaviors or resident abuse. She said the staff are trained through computer and as needed in the facility. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 04/14/22 at 1:30 p.m., the Administrator said she was not aware LVN A, NA B, or CNA C were not trained. She said she became the new Administrator in January 2022 and was not aware staff was not trained. She said she and the DON or designee were responsible for ensuring staff was trained. During an interview on 04/14/22 at 1:54 p.m., the DON said both aides on the secure unit should not be providing resident care at the same time. She said one of the aides was supposed to monitor and supervise the other residents and the hall to ensure residents do not wander or to be able to intervene for resident safety. She said she could not locate the training records of the staff on the unit. She said she or designee were responsible for ensuring staff was trained. She could not say why the staff were not trained or she could not locate the training records. During an interview on 04/14/22 at 2:05 p.m., CNA F said a resident came out of his room and the resident required incontinent care. She said she went into the shower room to gather supplies. She said CNA C was almost finished showering a different resident so she left the shower room and assisted the other resident with his incontinent care. She said she did not see Resident #2 wandering in the hall. She said she had been working for 2 months and did not recall specific training related to monitoring the residents prior to the incident on 04/08/22. During an interview on 04/15/22 at 3:34 p.m. the administrator and DON said they had re-inserviced staff and educated staff working on hall 300 to have one staff monitoring and the other staff providing care. They said staff were also trained to request help when they need to take care of residents and they were monitoring the hall. The DON said she was not able locate any staff training records that contained the names of the staff that worked during the incident. She said NA B was not a certified aide and there was no record she was trained regarding resident-to-resident aggression prior to the incident between Resident #4 and Resident #5. During an interview on 04/15/22 at 4:14 p.m., Psych NP J said staff have to monitor, intervene, and divert residents' behaviors. 2. Record review of face sheet dated 04/04/22 indicated Resident #4 was a [AGE] year-old male who was admitted on [DATE]. His diagnoses included schizophrenia (a serious mental disorder in which people interpret reality abnormally), dementia with behaviors, delusional disorders (serious mental illness - called a psychosis- in which a person cannot tell what is real from what is imagined), and anxiety (a feeling of fear, dread, and uneasiness). Record review of MDS dated [DATE] indicated Resident #4 had severe cognitive impairment and wandered every 1 to 3 days. There were no behaviors documented. Record review of care plan dated 10/08/21 indicated Resident #4 had a history of physical aggressive behavior. Interventions included social services to evaluate and visit, activities staff to visit and provide diversional activities, talk in a calm voice when behavior is disruptive, and remove from public area when behavior is disruptive and unacceptable. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of care plan dated 04/09/22 indicated Resident #4 exhibited aggressive behavior noted by staff standing over another resident and yelling, threatening and physical aggression directed at staff trying to diffuse the situation. Interventions included placing Resident #4 in an area for frequent observation social services to evaluate and visit, activities staff to visit and provide diversional activities, talk in a calm voice when behavior is disruptive, and remove from public area when behavior is disruptive and unacceptable, and sent to behavior hospital for evaluation/treatment. There was no care plan to address the verbal and physical aggression towards his roommate that occurred on 03/19/22. Record review of Resident #4's behavior monitoring from 01/01/22 through 04/09/22 indicated on 04/05/22 CNA C noted verbal behaviors directed at others included threatening others, screaming/yelling at others, and cursing at others-nurse notified. There were no additional dates completed. Record review of nurse note dated 03/19/22 at 2:22 p.m., completed by LVN L, indicated LVN L heard shouting from Resident #4's room. LVN L observed Resident #4 shouting aggressively as he stood over Resident #5. Resident #4 was redirected to the dining room and offered snacks. Resident #4 refused snacks. LVN L notified CNAs to be on alert for any aggressive behavior towards other residents. Resident #5 had no apparent injuries and denied pain. Record review of a face sheet dated 04/04/22 indicated Resident #5 was a [AGE] year-old male, admitted on [DATE], and his diagnoses included catatonic schizophrenia (rare severe mental disorder characterized by striking motor behavior, typically involving either significant reductions in voluntary movement or hyperactivity and agitation), vascular dementia with behavioral disturbances (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain), paranoid schizophrenia (characterized by predominantly positive symptoms of schizophrenia, including delusions and hallucinations), major depressive disorder (serious mood disorder), and anxiety. Record review of an MDS dated [DATE] indicated Resident #5 had severe cognitive impairment. Wandered every 1 to 3 days. There were no physical or verbal behaviors noted. Record review of Resident Incident Report dated 04/09/22 at 5:25 a.m. and completed by LVN A indicated NA B entered Resident #4 and Resident #5's room and found Resident #4 bent over Resident #5. Resident #4 was yelling at Resident #5. LVN A separated the residents. Resident #4 sat at the foot of his bed. LVN A sat on the floor by the foot of his bed. LVN A reached down to assist Resident #4 from the floor and Resident #4 swung his fist and struck LVN A's upper right arm. Resident #4 yelled he was going to kill LVN A. Resident #5 was moved to a different room. During an interview on 04/13/22 at 2:08 p.m., NA B said she heard voices and yelling and went to Residents #4 and #5's room. She said she opened the door and saw Resident #4 standing over Resident #5 while Resident #5 lay in his bed. She said she shut the door and told the other staff to get LVN A. She said she did not know why she did not intervene. She said she was not a certified aide and was not trained on behaviors. She said she was not trained on how to redirect residents. She said LVN A came to the room and directed Resident #4 to his bed. She said Resident #4 went toward his bed and said, I'll fucking kill you. She said CNA K was on shift with her. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CNA K's undated statement included in the ongoing facility's investigation indicated CNA C told her she heard shouting and rumbling in the room and for her (CNA K) to go and get LVN A. LVN A opened the door and LVN A, CNA C and CNA K walked into Resident #4 and Resident #5's room. Resident #4 was standing over Resident #5 hitting him and cursing at him. LVN A was able to get Resident #4 off Resident #5. Resident #4 started to swing and curse at LVN A. Resident #4 fell on the floor as he swung. LVN A directed CNA K to get LVN I. LVN I tried to talk to Resident #4 and he started cursing at LVN A and picked up a shoe. LVN A moved Resident #5 to another room. All staff left Resident #4's room for their safety. During an interview on 04/13/22 at 4:27 p.m., LVN A said he was not trained on dementia for the secure unit. He said he was not aware of any specific care plans for Resident #4. He said there were other incidents of Resident #4 yelling at Resident #5 but he was able to redirect him. He said if resident #4 was not able to see' Resident #5 then he would calm down. He said he did not do a nurse note or an incident report. He could not say why he did not document the incident. He said the most recent incident, Resident #4 was screaming at the top of his lungs at Resident #5. He said Resident #4 continued to yell at Resident #5 when he (LVN A) got between the residents. He said Resident #5 said Resident #4 hit him in the back. He said Resident #5 did not have any marks on his back. He said Resident #4 was pretty traumatized for a day or two. Record review of nurse note dated 04/09/22 at 10:47 a.m., completed by LVN A, indicated LVN A was called to Resident #4 and Resident #5's room at 5:25 a.m. LVN A found Resident #4 standing over Resident #5, yelling. LVN A directed Resident #4 to sit on his bed but he sat on the floor. LVN A attempted to help him up but Resident #4 hit LVN A on the right upper arm and started to yell he was going to kill LVN A. LVN A moved Resident #5 to another room for safety. Resident #5 stated Resident #4 hit him in the back. There was no visible injury. Resident #5 was resting in a safe bed. Notified on-call ADON, and the ADON notified the DON. DON stated she was going to send Resident #4 to a behavioral hospital. During an interview on 04/14/22 at 2:08 p.m., NA B said she realized after she shut the door of Residents #4 and #5 room that she had left Resident #5 in danger. She said she stood right outside of the door until LVN A arrived and intervened. During an interview on 04/15/22 at 3:34 p.m. the administrator and DON said NA B should have intervened and not shut the door. The DON said NA B was a new aide and she needed more experience and training. The DON said staff were also trained to request help when they need to take care of residents. The DON said she was not able locate staff training records for LVN A, NA B and CNA F. During an interview on 04/15/22 at 4:14 p.m., psych NP J said he was not made aware of previous incidents of aggression from Resident #4. He said he would have addressed the aggressions and recommended Residents #4 and #5 be separated and not continued their status as roommates. Record Review of LVN A (DOH 09/09/21), NA B (DOH 04/01/22) and CNA F (DOH 02/01/22)'s personnel files indicated there was no records of training or competency checks for interventions and supervision of residents with behaviors. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's Nurse Aide Qualifications and Requirements dated 2001 indicated . 4. Our facility will not use any individual as a nurse aide for more than (4) months full-time, temporary, per diem, or other basis unless: a. That individual is competent to provide nursing and nursing related services; and b. That person has completed a training program and competency evaluation program, or a competency evaluation program approved by the state; or c. That individual has been deemed competent as provided in S483.150) and (b) of the Requirements of Participation. 5. Our facility will not sue any induvial as a nurse aide who has worked less than 4 months unless the individual: a. Is a full-time employee and participating in a state-approved training and competency evaluation program; or b. Has demonstrated competence through satisfactory participation in a state-approved nurse aide training and competency evaluation program; or c. Has been deemed competent as provided in S483.150) and (b) of the Requirements of Participation. Record review of In-Service Training Report dated 09/21/21 indicated the topic was safety monitoring-Hall-3: Hall-3 staff are to have safety monitoring of hall at all times. Staff may take turns, being safety monitor. Observe for potential abuse behaviors, wandering, and/or falls and attempt to prevent altercations and incidents. The in-service did not include the names of the LVN A, NA B or CNA F. The facility was notified of the Immediate Jeopardy on 04/14/22 at 3:00 p.m. and the administrator was provided the Immediate Jeopardy template. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy. The Facility's Plan of Removal for Immediate Jeopardy was accepted on 04/15/22 at 1:55 p.m. and reflected the following: Facility failed to prevent Resident #1 from sexually abusing Resident #2. On 4/11/22 Resident #2 was heard yelling please don't no no no Resident #1 was found behind Resident #2 , his pants down and his hand on her shoulder . Resident #1 had a partially erect penis and was thrusting toward resident #2. Resident #2's brief was down. Approximately 2-3 weeks earlier Resident #3 was found sitting on Resident #1's bed. He was standing between her legs hovering over her. Both were fully clothed. There were no interventions put in place. Facility failed to prevent Resident #4 from verbally and physically abusing Resident #5. On 3/19/22 Resident #4 was seen standing over Resident #5, while Resident #5 was in bed, yelling aggressively at him. No interventions were put in place at the time. On 4/9/22 Resident #4 was found hovering over Resident #5 yelling at him. The nurse aide opened the door to see what was happening and then closed the door and called for the nurse. She did not intervene and separate the Residents. She had not been trained on dealing with behaviors. Please accept the following plan of removal: 1. Notify V.P. of Clinical Operations of immediate Jeopardy status - On site 4/14/22 @ 3 pm 2. Notify Regional Director of operations of Immediate Jeopardy status - Onsite 4/14/22@ 3 pm. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	16. Compliance will be monitored through: 16a) Review of 24-Hour Reports, A/I Reports and Medical record review by Nursing Management and Administrator during Clinical meetings with corrective actions taken for identified concerns. The DON and administrator will conduct clinical meetings 3 x weekly and this will be an ongoing process. 16b) Findings will submitted to the facility QAPI Committee for review and additional Audits and corrective actions if indicated. 17. Facility Administrator and the DON were provided education on compliance and monitoring procedures by V.P. Of Clinical Operations. Monitoring of the facility's plan or removal occurred on 04/15/22 and included the following: Observations, interviews, and record reviews were conducted on 04/15/22 from 12:00 p.m. through 4:35 p.m. and included 9 residents, 6 nurses including charge nurses, treatment nurse, MDS nurse, 6 certified nurse aides, activity director, activity coordinator, BOM, housekeeping, dietary staff, and the ADON and DON that were on duty during this time. Staff were able to identify inappropriate resident to resident touching and reporting procedures. Staff provided appropriate resident supervision and redirection. There were no observed concerns. Staff were able to discuss the required supervision and monitoring of Hall 3/Secure Unit. Staff were able to identify the Abuse Coordinator, indicated reporting was immediate to the charge nurse or administrator and were able to give example of physical, verbal, sexual abuse and immediate intervention procedures. Staff were able to give examples of behavior monitoring and documentation, appropriate notification, and facility assessment procedures. Staff were able to identify Unmanageable Residents and indicated appropriate facility policy. Staff were able to give examples of resident to resident-resident altercations, reporting procedures, interventions, and documentation procedures. Resident #1 remained at the behavioral hospital. Resident #2 did not appear in distress and did not recall the incident. Resident #3 continued wandering around the secure unit and did not appear anxious or distressed. Resident #4 remained at a behavioral hospital. Resident #5 did not recall the incident and displayed no signs of anxiety. (continued on next page)

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