STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105935	A. Building B. Wing	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pensacola Nursing & Rehabilitation Center	235 West Airport Blvd Pensacola, FL 32505

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(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** 28603 Based on observation, record reviews, staff interviews, resident interviews, and facility policy review, the facility failed to honor resident rights to be free from or the likelihood of physical and sexual abuse for 6 of 20 sampled residents. (Resident #1, #8, #9, #10, #16, #17). This failure allowed Resident #2, with known sexual behavior and cognitive impairment, to expose his genitals to Resident #1, have a physical altercation with Resident #8, enter the room of Resident #9 and #10 and get into the occupied bed of Resident #9 while unclothed, and wander in the rooms of Resident #16 and Resident #17. The situation resulted in a finding of Immediate Jeopardy. The facility's Regional Administrator was notified of the findings of Immediate Jeopardy on 4/19/23 at approximately 1:30 PM. The Administrator was unavailable and did not return until 4/20/23. On 4/20/23, Immediate Jeopardy deficiencies was reduced from a K level to an E, pattern no actual harm with potential for no more than minimal harm level. Immediate Jeopardy was removed on 4/20/23 at approximately 3:15 PM when the facility provided evidence of the removal of immediacy actions which included placing Resident #2 on one to one constant staff supervision, immediate training of staff on abuse policies, auditing of resident records for abuse concerns, interviewing residents for abuse concerns, immediate federal reports were filed with the state agency, and developing a new system to audit and review notes daily for immediate response to any allegations or concerns. Cross reference F607, F609, F610, F835, and F867. The findings include: Resident #2 An observation and attempted interview was conducted with Resident #2 on 4/18/23 at 3:23 PM. The resident was in his bed covered with a sheet. The surveyor knocked on the door and asked to enter. The resident did not respond but only looked at the surveyor. The surveyor remained at the doorway. The resident was observed to be moving his hand under the sheet. The resident then pulled back the sheet and exposed his penis and began fondling himself. The observation was terminated. (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident #2's medical record revealed the resident was admitted to the facility on [DATE] and had diagnoses of Wernicke's encephalopathy (degenerative brain disorder caused by the lack of vitamin B-1), restlessness and agitation, psychosis, dementia, and generalized anxiety disorder. The quarterly minimum data set with an assessment reference date of 2/1/23 revealed Resident #2 was rarely or never understood, required supervision to ambulate, had moderately impaired cognitive skills, inattention and disorganized thinking was present, and no limitation was present in range of motion. Resident #2's current care plan was initiated 11/30/2020 for a behavior problem related to frequently masturbating, throwing himself on the floor, kicking staff, and refusing medications. The interventions included educating the resident on successful coping and interaction strategies; if reasonable, discuss the resident's behavior; explain/reinforce why certain behaviors are inappropriate; and provide a program of activities that is of interest. A review of the progress notes for Resident #2 revealed on 11/3/22 at 7:22 PM, the nurse was notified that the resident was displaying sexually inappropriate behavior towards the certified nursing assistant (CNA) by swinging his genitalia towards the CNA during check and change rounds. On 2/20/23 at 5:39 PM, the progress note read resident's behavior has changed today of being more aggressive, he went into another resident's room, threatened and pushed her, he went into a room and sat on the bed and demanded for that resident to get out of the room, he was redirected back to his room and the unit manager was notified. On 3/6/23 at 9:52 PM the progress note stated, he was eating food from roommate's side of the room, went across the hall and sat on another resident's bed and was eating her food and drink, then after having a bowel movement removed brief and chased another nurse with the brief in the halls. On 4/4/23 at 10:45 AM, the progress note read, CNA reported resident is self-pleasuring during bath time and brief changes, resident continued behavior even after being asked to stop, reported to nurse practitioner, social services, and psychiatry. On 4/14/23 at 10:55 PM, the progress noted read, resident wandered into another resident's room thinking it was his bedroom, he took his shirt and pants off and left brief intact, then climbed into bed, he was redirected to his room and clothing replaced, physician contacted for agitation and new order received for one time dose of Seroquel 50 mg. A review of the psychiatric progress note dated 11/21/22 indicated the provider's review of the progress notes over the past 30 days revealed 1 episode of sexually inappropriate behavior towards staff. The record included a room change notice dated 2/24/23 indicating the resident was moved to a different hall due to roommate incompatibility. The facility provided point of care task records indicating the resident was placed on every 15-minute safety checks from 4/5/23 through the survey date. Resident #1 A review of Resident #1's record revealed he was admitted to the facility on [DATE] with diagnoses to include encephalopathy and aphasia. The quarterly minimum data set, with an assessment reference date of 1/13/23, revealed the resident had a BIMS (Brief Interview of Mental Status) of 8, indicating moderate cognitive impairment, had hallucinations, and could ambulate with supervision. A medication administration note documented by Employee D (licensed practical nurse (LPN)) dated 2/16/23 at 10:45 PM stated the resident #1 was found by the CNA (Employee E) on the edge of their roommate's bed with his penis aroused sitting next to his roommate (Resident #2). The record revealed a room change notice dated 2/17/23 indicating Resident #1 was moved due to bed management. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted with Employee G (LPN) on 4/17/23 at 2:44 PM. She stated about 1- 1.5 months ago she heard a CNA walked in and Resident #2 had his penis out and Resident #1 was sitting on the foot of Resident #2's bed watching Resident #1 with an erect penis. An interview was conducted with Employee K (CNA) on 4/18/23 at 8:54 AM. She stated about 3 months ago she observed Resident #2 pulling on his penis and Resident #1 sitting on the foot of Resident #2's bed at the time. She reported the incident to Employee G (LPN) and had Resident #1 return to his side of the room. A telephone interview was conducted with Employee E (CNA) on 4/18/23 at 12:25 PM. Employee E stated she found Resident #1 sitting on Resident #2's bed with his penis aroused. It looked like Resident #1 had gone to the bathroom and took his brief off but he had on shorts. She did not recall if Resident #1's shorts were pulled down. She stated she did not recall which nurse she informed. An interview was conducted with the Regional Administrator on 4/18/23 at 12:48 PM. She stated she was the Administrator of record for the facility from 1/10/23 through 2/14/23 and she then oriented the new Administrator through 2/16/23. She had no knowledge of Resident #2 being found on his roommate's bed (Resident #1) with his penis aroused. She stated she would expect staff to report this to Administration. An interview was conducted with the Administrator on 4/18/23 at 3:48 PM. She stated she had no knowledge of the incident between Resident #1 and #2 and she was not aware of the incident on 2/20/23 when Resident #2 allegedly pushed a female resident. The staff would be expected to report those allegations to the Administrator and DON, complete a full investigation, and follow the facility policy and procedure for abuse. A telephone interview was conducted with Employee D (LPN) on 4/19/23 at 11:59 PM. She recalled the incident she documented on 2/16/23 regarding Resident #1 and #2 and she reported the incident to the nurse practitioner, director of social services, and the unit manager. An interview was conducted with the ADON on 4/19/23 at 2:04 PM. She stated she recalled hearing in a morning meeting about the incident involving Resident #1 and #2. She heard one of the residents was on the other resident's bed and the other resident had his own penis in his own hand. She was not aware of any investigation into the incident. Resident #2 was then moved to a different room. The ADON could not remember if the incident was discussed in a Quality Assurance meeting. Resident #8 An interview was conducted with Resident #8 on 4/19/23 at 10:28 AM. Resident #8 stated that Resident #2 came into her room toward the end of February in the afternoon. She asked him to get out of her room. She then grabbed his arm to try to get him to leave her room and he threw his arm at her throat. She stated she felt threatened by Resident #2 and did not always feel safe in the facility. Resident #8 revealed staff were aware because they came into her room and assisted removing Resident #2 from her room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted with Employee P (Registered Nurse (RN)) on 4/19/23 at 11:01 AM. She stated the incident involving Resident #2 going into Resident #8's room was discussed in the morning meeting the Tuesday following the 2/20/23 incident (2/21/23). The Director of Nursing (DON) and Assistant Director of Nursing (ADON) were present in the meeting. Resident #2 was subsequently moved to the other side of the facility. The incident on 4/14/23 regarding Resident #2 getting in bed with Resident #9 was discussed in the morning meeting on 4/17/23 and the DON and ADON were present. Employee P (RN) stated she has had no specific training regarding how to handle resident sexual behaviors. An interview was conducted with Employee Q (unit manager) on 4/19/23 at 11:29 AM. Employee Q stated she was notified of the incident between Resident #2 and #8 the following day on 2/21/23. The staff notified her Resident #2 had entered Resident #8's room. Resident #8 then pushed Resident #2 out of the room and Resident #2 swung his hands in the air at Resident #8 but did not make physical contact. Employee Q stated she reported the incident to administration during the stand down meeting. She was not aware of any specific training regarding resident sexual behaviors. Employee Q stated Resident #2 often masturbated in his room, and he was able to ambulate unassisted. An interview was conducted with Employee O (CNA) on 4/19/23 at 12:54 PM. Employee O stated, [Resident #2] plays with his genitals, he takes out his privates and wiggles it around. The last time she cared for Resident #2, he asked her to get in bed with him. An interview was conducted with the Social Services Director (SSD) on 4/19/23 at 2:15 PM. He stated he was made aware of Resident #2 attempting to go into Resident #8's room in February 2023. He believes the facility investigated the incident. He interviewed the unit manager (Employee Q) and Resident #8 regarding the incident. A further interview was conducted with the SSD on 4/19/23 at 2:36 PM. He provided documented interviews with Employee D regarding the incident between Resident #1 and #2 on 2/16/23 and Resident #2 and #8 on 2/20/23. He stated he did not interview the CNA that observed Resident #1 and #2 on 2/16/23. It did not occur to him that he needed to complete a full investigation because the nurse did not state the resident's penis was out. He stated, I am in crisis management in the facility, meaning I have residents that are always coming to the office, and I'm constantly putting out fires. Regarding the incident on 2/20/23, he stated he did not review the progress notes in the record. He reported his findings to the current Administrator. An interview was conducted with the DON on 4/19/23 at 2:26 PM. She stated there was a good possibility she had been notified of some of the allegations regarding Resident #2 during a meeting. An additional interview was conducted with the DON on 4/20/23 at 9:35 AM. She stated she did not feel the incidents on 2/16/23 and 2/20/23 were thoroughly investigated. The DON stated, she usually came in on Mondays and would go over anything that happened over the weekend and that did not occur for this incident. A follow-up interview was conducted with the Administrator on 4/20/23 at 9:35 AM. She stated the staff are expected to report allegations of abuse, neglect, and exploitation to the supervisor, Administrator, or DON. The facility reports the allegations of abuse to the regional staff, state agency, and Department of Children and Families. The SSD did complete an investigation for the incidents on 2/16/23 and 2/20/23. The Administrator was asked if she felt the investigations were thorough, she stated she could not answer the question. She stated it was hard to investigate when you do not know what is going on and, in her absence, the DON would be in charge of the facility. 46833 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #9 & Resident #10 A record review was conducted on 04/18/2023 at approximately 8:30 AM for Resident #9. Resident #9 has diagnoses to include: chronic obstructive pulmonary disease with acute exacerbation, asthma, acute respiratory failure with hypoxia, pneumonia, mobility, assistance with personal care, difficulty walking, repeated falls, muscle weakness, systolic and diastolic heart failure, chronic atrial fibrillation, malignant neoplasm of temporal lobe, anemia, and abdominal aortic aneurysm. The record revealed no documentation in Resident #9's chart regarding the incident with Resident #2 entering her room and getting into bed with her. An interview was conducted on 04/17/2023 at approximately 12:00 PM with Resident #9. Resident #9 stated, About four or five days ago, a man came into my room, took his clothes off and got into bed with me. I was in my bed, and he got into bed with me. That poor guy didn't have a chance. I started beating his back and telling him to get out. I'm not sure where he touched me at because I was hitting him so much. The staff finally came and got him out of my bed. It took a bunch of them to get him out of here. An interview was conducted on 04/17/2023 at approximately 12:15 PM with Resident # 10. Resident #10 stated, We have some people who wander around and come into our room. But they have dementia. This was a completely different situation. It was very scary. He had his hands on her. I don't know what part of her body exactly. But I did see him touching her. I went to the door and screamed so loudly. I have a pretty big mouth. I was screaming for help. He was going to do something to her. It took a few of them to get him out of here. (Resident #10's account of the incident in which Resident #2 got into the bed with Resident #9) An interview was conducted on 04/17/2023 at approximately 2:00 PM with the Director of Nursing (DON). The DON stated she did get a message regarding Resident #2 going into Resident #9's room on Friday, 04/14/2023. The DON stated that Resident #2 does get confused and does wander around the facility. The DON stated, We did call the Administrator and our Corporate team to report it to them. The DON stated, We haven't had any other reports of similar situations with Resident #2. He was moved from one side of the building to the other side because of complaints from other residents of snoring from this resident. So, we moved him. The DON stated the facility corporate team consisted of the [NAME] President of Clinical Operations, Clinical Regional Administrator, and [NAME] President of Operations. An interview was conducted on 04/18/2023 at approximately 9:30 AM with Staff A (LPN). Staff A stated, I was at the nurses' station, and we heard [Resident # 9's] roommate, [Resident # 10] at her door yelling down the hallway. We all ran down there, and we saw his shirt, pants, and shoes on the floor beside Resident #9's bed. [Resident #2] had gotten in bed with her and woke her up. Then the roommate yelled out for help. We had to redirect [Resident #2] out of the room. We called and got medication ordered for him to calm him down. He didn't touch her that we know of. [Resident #2] does have behavioral issues. He does walk in and out of people's rooms. He must be constantly redirected. He has been pacing and fidgeting. He throws his feces around. He has had increased agitation lately. And he does get aggressive. Staff A reported recently having an abuse in-service and additional in-services in the future. Staff A stated, But I am not sure of the whole process to report anything or what I am supposed to report. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted on 04/18/2023 at approximately 12:45 PM with the DON. The DON stated, If I know of an issue with any type of abuse, I will report it to my corporate team and start an investigation. I did not start an investigation this past Friday because I didn't think it was really anything. But I would start my investigation within an hour or two of finding out and then report it. An interview was conducted on 04/18/2023 at approximately 2:50 PM with Staff B (CNA). Staff B stated, [Resident #2] wanders sometimes. He went into [Resident #9's] room and got in bed with her while she was sleeping. We escorted him out and took him back to his room. [Resident #2] didn't do anything sexual with her. He took off his clothes with his brief on and got onto the bed with her. Staff B reported that Resident #2 has wandered in other rooms before. But we keep an eye on him and try and redirect him. An interview was conducted on 04/19/2023 at approximately 10:45 AM with the Administrator. The Administrator stated, I am not aware of any instances of abuse being reported to me. I was in orientation that first week (this Administrator started at the facility on 02/14/2023). I was not in all the morning meetings. The first four days were me acclimating to the facility and being oriented. I do know that both residents (Residents #1 and #2) have had behaviors since I have been there. I don't remember the behaviors that were being talked about. But I do know they have had some behaviors. Additional Incidents of Wandering Into Residents Rooms Unsupervised An interview was conducted on 04/19/2023 at approximately 9:30 AM with Resident #16. Resident #16 stated, [Resident #2] used to come into my room. But I don't think he meant any harm. I would just tell him to get out. Resident #16 stated Resident # 2 never tried anything with me or sat on my bed or anything. An interview was conducted on 04/19/2023 at approximately 9:45 AM with Resident #17. Resident #17 stated, Yes. [Resident #2] has been in our room twice. It was a couple of months ago. [Resident #2] was naked when he came into our room. They moved him to another area of the building. [Resident #2] has never sat on my bed or done anything in front of me. Review of the facility policy for Prevention of Resident Abuse, Neglect, Mistreatment, or Misappropriation of Property (8/22/22) revealed, It is the policy of this Center that each resident has the right to be free from verbal, sexual, physical and mental abuse; corporal punishment; involuntary seclusion; mistreatment of any kind, exploitation, and misappropriation of property. In addition, each resident will be protected from those practices and omissions, which if left unchecked, could lead to abuse. Further, each resident will be treated with respect and dignity at all times. The Center will foster an environment that recognizes the worth and uniqueness of all individuals with regards to person-centered care and to promote respect and set standards of care. Residents will not be subjected to abuse by anyone, including but not limited to, Center staff, other residents, consultants, volunteer staff, contract staff, family members, friends, or others. On 4/19/2023, the facility submitted a removal plan for F600 with immediate corrective actions to further prevent residents from further sexual abuse. The facility's removal plan included: 1. Resident #2 placed on one-on-one supervision 4/19/2023. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. All current residents in the facility audited for concerns of abuse in the resident records completed 4/19/2023. 3. Administrator and Director of Nursing (DON) and department heads educated by Director of Clinical Services on facility policy and procedures of sexual abuse, investigations, and reporting into allegations of abuse with consultation with Regional Administrator on 4/19/2023. 4. Residents #8, #9, #10 to be evaluated 4/20/2023 and followed by psych APRN to provide psychosocial support from exposure to sexual abuse. 5. 100% of interviewable residents were interviewed for concerns with care or abuse 4/19/23. 6. In-services and competencies completed on abuse policy and procedure, inservices completed on the following dates: a. 4/19/2023 - 90% of all staff complete. b. 4/20/2023 - 100% of all staff complete. c. No staff members were permitted to work until all topic education and post in-service competency test for abuse policy and procedure, investigation and report was completed. 7. Upon hire and annually, all staff will complete abuse in servicing by staff developer or designee. 8. Immediate federal reporting for abuse completed for resident #2 on 4/17/2023 for 4/14/2023. 9. Immediate federal reporting for abuse completed for resident #2 on 4/18/2023 for 2/16/2023 and 2/20/2023. 10. DON or designee to audit progress notes and EMAR notes for any note with areas of concern to be investigated starting 4/20/2023. 11. This issue was resolved on 4/20/23 as evidenced by resident #2 was placed on one-on-one supervision, APS notification 4/17/2023 and 4/18/2023, federal immediate reporting completed for all occurrences, staff education completed for all areas, system developed and implemented for auditing the residents' records daily to be aware of concerns not reported. 12. This issue was taken to Quality Assurance Performance Improvement (QAPI) at an ad-hoc meeting on 4/18/2023 with Medical Director, Administrator, Director of Nursing, Social Services Director, MDS Director, and Unit Managers for both Units to discuss the concerns with sexual abuse, investigations, reporting and adequate follow up with PIP with new system to audit and review notes daily for immediate response in any allegations or concerns. On 4/20/23 at approximately 3:15PM, Immediate Jeopardy deficiencies was reduced from a K level to an E, pattern no actual harm with potential for no more than minimal harm level. As evidenced by the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/20/23 at 11:04PM, Resident #2 was observed to in bed while his 1:1 supervision staff was seated at the resident's open bedroom door. This started on 4/19/23 according to documentation reviewed. Evidence of the resident record audits was provided to surveyors and dated 4/20/23. Upon review all residents were audited and no additional concerns were identified. Staff education in-services for the Administrator, DON, and other Department Heads, related to sexual abuse reporting, sexual abuse, investigative processes, and investigations was reviewed. Training dated for 4/19/23. The facility provided a sign-in sheet with 18 staff signatures. Interviews with Administrator, DON, and at least 3 other Department Heads validating reeducation. One Hundred percent of staff received staff education on abuse policy and procedures, inservices verified to have been completed on 4/19-4/20/23. Staff interviews conducted with at least 10 staff(non-administrative) from various shifts and departments which indicated training was received. Staff were able to verbally recite abuse policies and procedures they recently received in re-education related to abuse. Review of staff files for verification of abuse training upon hire. Education provided included but not limited to an explanation of abuse, signs and symptoms of abuse, and reporting. 3 recently hired staff records reviewed verifying training had been completed. Review of records for Residents #8, #9, and #10 revealed orders dated 4/20/23 for Psych eval and treat for psychosocial support status post resident interaction in her room. Observed Psychiatric Provider seeing Resident #10 on 4/20/23 at approximately 11:47AM. The Facility developed and conducted a Questionnaire for interviewable residents on 4/18-4/19/23. Interviewed a total of 6 residents and all confirmed that facility staff had interviewed them about abuse and staff concerns. No additional concerns identified. Review of the facility's federal reporting for abuse was completed for resident #2 for all incidents that were discovered. Documentation provided confirm all three incidents had been reported to the abuse hotline. Review of audits completed of progress notes and EMAR (Electronic Medication Administration Records). No additional concerns noted. Review of Meeting Notes and Interview with the Administrator verified adhoc QAPI meeting on 4/18/223 to discuss supervision for Resident #2 and concerns with sexual abuse, investigations, reporting and an update to the facility's action plan started on 4/17/23.

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28603 Based on observation, record reviews, staff interviews, resident interviews, and facility policy review, the facility failed to implement their policies regarding sexual and physical abuse for 4 of 4 sampled residents. (Resident #1, #2, #8, and #9) This failure allowed Resident #2, with known sexual behavior and cognitive impairment, to expose his genitals to Resident #1, have a physical altercation with Resident #8, and enter the occupied bed of Resident #9 unclothed. The allegations of physical and sexual abuse were not reported to the State Survey Agency or abuse hotline, or thoroughly investigated. The facility failed to implement effective interventions to protect vulnerable residents. The situation resulted in a finding of Immediate Jeopardy. The facility's Regional Administrator was notified of the findings of Immediate Jeopardy on 4/19/23 at approximately 1:30 PM. The Administrator was unavailable and did not return until 4/20/23. Immediate Jeopardy was removed on 4/20/23 at approximately 3:15 PM when the facility provided evidence of the removal of immediacy actions which included placing Resident #2 on one to one constant staff supervision, immediate training of staff on abuse policies, auditing of resident records for abuse concerns, interviewing residents for abuse concerns, immediate federal reports were filed with the state agency, and developing a new system to audit and review notes daily for immediate response to any allegations or concerns. Cross reference F600, F609, F610, F835, and F867. The findings include: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pensacola Nursing & Rehabilitation Center	235 West Airport Blvd Pensacola, FL 32505

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility policy for Prevention of Resident Abuse, Neglect, Mistreatment, or Misappropriation of Property (dated 8/22/22) revealed, It is the policy of this Center that each resident has the right to be free from verbal, sexual, physical and mental abuse; corporal punishment; involuntary seclusion; mistreatment of any kind, exploitation, and misappropriation of property. In addition, each resident will be protected from those practices and omissions, which if left unchecked, could lead to abuse. Further, each resident will be treated with respect and dignity at all times. The Center will foster an environment that recognizes the worth and uniqueness of all individuals with regards to person-centered care and to promote respect and set standards of care. Residents will not be subjected to abuse by anyone, including but not limited to, Center staff, other residents, consultants, volunteer staff, contract staff, family members, friends, or others. Prevention of abuse will be accomplished by the timely reporting of the suspected abuse and a thorough investigation of these instances. Those reporting abuse should not be subjected to any disciplinary action for the correct reporting of abuse or suspected abuse. The Center will post steps on abuse and abuse reporting for staff, residents, and family members in designated areas of the Center. The material will advise the parties on how to report and to whom to report. The Center will ensure that the call will be confidential. Resident Behavior- our residents have the right to be free from resident-to-resident abuse. All altercations, including those that may represent resident to resident abuse shall be investigated and reported in accordance with established reporting procedures. If two residents are involved in an altercation, staff will separate the residents, identify what happened, assess both residents for any clinical, psychological and/or psychosocial changes that may have led to the incident, and notify the attending physician, each resident's respective representative and the appropriate State agency as required by State law. Investigation- all suspected cases of abuse or misappropriation of resident's property will be fully investigated by the Administrator, Abuse Coordinator, or designee. The findings should be reported to the appropriate governing agencies. Reporting/Documentation Requirements- ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported to the administrator of the center and to other officials (including to the State Survey Agency and adult protective services where state law provides jurisdiction in long-term care Centers) in accordance with State law through established procedures in these timeframes: * If the events that cause the allegation involve abuse or result in serious bodily injury, the event must be reported immediately, but not later than 2 hours after the allegation is made. * If the events that cause the allegation do not involve abuse and do not result in serious bodily injury, the event must be reported no later than 24 hours after the allegation is made. Resident #2's Behavioral History A review of Resident #2's medical record revealed the resident was admitted to the facility on [DATE] and had diagnoses of Wernicke's encephalopathy (degenerative brain disorder caused by the lack of vitamin B-1), restlessness and agitation, psychosis, dementia, and generalized anxiety disorder. The quarterly minimum data set with an assessment reference date of 2/1/23 revealed Resident #2 was rarely or never understood, required supervision to ambulate, had moderately impaired cognitive skills, inattention and disorganized thinking was present, and no limitation was present in range of motion. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #2's current care plan was initiated 11/30/2020 for a behavior problem related to frequently masturbating, throwing himself on the floor, kicking staff, and refusing medications. The interventions included educating the resident on successful coping and interaction strategies; if reasonable, discuss the resident's behavior; explain/reinforce why certain behaviors are inappropriate; and provide a program of activities that is of interest. A review of the progress notes for Resident #2 revealed on 11/3/22 at 7:22 PM, the nurse was notified that the resident was displaying sexually inappropriate behavior towards the certified nursing assistant (CNA) by swinging his genitalia towards the CNA during check and change rounds. On 2/20/23 at 5:39 PM, the progress note read resident's behavior has changed today of being more aggressive, he went into another resident's room, threatened and pushed her, he went into a room and sat on the bed and demanded for that resident to get out of the room, he was redirected back to his room and the unit manager was notified. On 3/6/23 at 9:52 PM the progress note stated, he was eating food from roommate's side of the room, went across the hall and sat on another resident's bed and was eating her food and drink, then after having a bowel movement removed brief and chased another nurse with the brief in the halls. On 4/4/23 at 10:45 AM, the progress note read, CNA reported resident is self-pleasuring during bath time and brief changes, resident continued behavior even after being asked to stop, reported to nurse practitioner, social services, and psychiatry. On 4/14/23 at 10:55 PM, the progress noted read, resident wandered into another resident's room thinking it was his bedroom, he took his shirt and pants off and left brief intact, then climbed into bed, he was redirected to his room and clothing replaced, physician contacted for agitation and new order received for one time dose of Seroquel 50 mg. A review of the psychiatric progress note dated 11/21/22 indicated the provider's review of the progress notes over the past 30 days revealed 1 episode of sexually inappropriate behavior towards staff. The record included a room change notice dated 2/24/23 indicating the resident was moved to a different hallway due to roommate incompatibility. The facility provided point of care task records indicating the resident was placed on every 15-minute safety checks from 4/5/23 through the survey date. During the survey, an attempt was made by this surveyor to interview resident #2. On 4/18/23 at 3:23 PM, Resident #2 was observed to be in bed covered with a sheet. The surveyor knocked on the door and asked to enter. The resident did not respond but only looked at the surveyor. The surveyor remained at the doorway. The resident was observed to be moving his hand under the sheet. Then the resident pulled back the sheet and exposed his penis and began fondling himself. The surveyor terminated the observation. Incident #1 (between Resident #1 and Resident #2 on 2/16/23) According to record reviews and staff interviews for Resident #2, this resident was observed with his penis out and erected while Resident #1 was sitting on Resident #2's bed with an erection on 2/16/23. The quarterly minimum data set, with an assessment reference date of 1/13/23, revealed resident #1 had a BIMS (Brief Interview of Mental Status) of 8, which indicated resident #1 to have moderately impaired Cognition (A person's decisions are consistently poor or unsafe; the person requires reminders, cues, or supervision at all times to plan, organize, and conduct daily routines). An interview was conducted with the Regional Administrator on 4/18/23 at 12:48 PM. She stated she was the Administrator of record for the facility from 1/10/23 through 2/14/23 and she then oriented the new Administrator through 2/16/23. She had no knowledge of Resident #1 being found on his roommate's bed with his penis aroused. She stated she would expect staff to report this to Administration. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted with the Administrator on 4/18/23 at 3:48 PM. She stated she had no knowledge of the incident between Resident #1 and #2. She stated the staff would be expected to report such allegations to the Administrator and Director of Nursing (DON), complete a full investigation, and follow the facility policy and procedure for abuse. An interview was conducted with the ADON on 4/19/23 at 2:04 PM. She stated she recalled hearing in a morning meeting about the incident involving Resident #1 and #2. She heard one of the residents was on the other resident's bed and the other resident had his own penis in his own hand. She was not aware of any investigation into the incident. She stated Resident #2 was then moved to a different room. She stated the incident was not discussed in a Quality Assurance meeting. Incident #2 (between Resident #2 and Resident #8 on 2/20/23) An interview was conducted with the Administrator on 4/18/23 at 3:48 PM. She was not aware of the incident on 2/20/23 when Resident #2 allegedly pushed a female resident. She stated the staff would be expected to report those allegations to the Administrator and DON, complete a full investigation, and follow the facility policy and procedure for abuse. An interview was conducted with Resident #8 on 4/19/23 at 10:28 AM. Resident #8 stated that Resident #2 came into her room toward the end of February in the afternoon. She asked him to get out of her room. She then grabbed his arm to try to get him to leave her room and he threw his arm at her throat. She stated she felt threatened by Resident #2 and did not always feel safe in the facility. Resident #8 revealed staff were aware because they came into her room and assisted removing Resident #2 from her room. An interview was conducted with Employee P (Registered Nurse (RN)) on 4/19/23 at 11:01 AM. She stated the incident involving Resident #2 going into Resident #8's room was discussed in the morning meeting the Tuesday following the 2/20/23 incident (2/21/23). The DON and Assistant Director of Nursing (ADON) were present in the meeting. Resident #2 was subsequently moved to the other side of the facility. An interview was conducted with Employee Q (unit manager) on 4/19/23 at 11:29 AM. Employee Q stated she was notified of the incident between Resident #2 and #8 the following day on 2/21/23. The staff notified her Resident #2 had entered Resident #8's room. Resident #8 then pushed Resident #2 out of the room and Resident #2 swung his hands in the air at Resident #8 but did not make physical contact. Employee Q stated she reported the incident to administration during the stand down meeting. She was not aware of any specific training regarding resident sexual behaviors. Incident #3 (between Resident #2 and Resident #9 on 4/14/23) An interview was conducted on 04/17/2023 at approximately 12:00 PM with Resident #9. Resident #9 stated, About four or five days ago, a man came into my room, took his clothes off and got into bed with me. I was in my bed, and he got into bed with me. That poor guy didn't have a chance. I started beating his back and telling him to get out. I'm not sure where he touched me at because I was hitting him so much. The staff finally came and got him out of my bed. It took a bunch of them to get him out of here. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The record revealed no documentation in Resident #9's chart regarding the incident with Resident #2 entering her room and getting into bed with her. Additional Interview with the Administrator on 4/18/23 at 3:48 PM, revealed she was not aware of the incident on 2/20/23 when Resident #2 allegedly pushed a female resident. She stated the staff would be expected to report those allegations to the Administrator and DON, complete a full investigation, and follow the facility policy and procedure for abuse. An interview was conducted on 04/17/2023 at approximately 12:15 PM with Resident # 10. Resident #10 stated, We have some people who wander around and come into our room. But they have dementia. This was a completely different situation. It was very scary. He had his hands on her. I don't know what part of her body exactly. But I did see him touching her. I went to the door and screamed so loudly. I have a pretty big mouth. I was screaming for help. He was going to do something to her. It took a few of them to get him out of here. (Resident #10's account of the incident in which Resident #2 got into the bed with Resident #9) An interview was conducted with Employee P (Registered Nurse (RN)) on 4/19/23 at 11:01 AM. The incident on 4/14/23 regarding Resident #2 getting in bed with Resident #9 was discussed in the morning meeting on 4/17/23 and the DON and ADON were present. Employee P (RN) stated she has had no specific training regarding how to handle resident sexual behaviors. An additional interview was conducted with the Regional Administrator on 4/19/23 at 9:55 AM. She stated none of the allegations had been reported to the abuse hotline prior to the state survey. An interview was conducted with the Social Services Director (SSD) on 4/19/23 at 2:15 PM. He stated he was made aware of Resident #2 attempting to go into Resident #8's room in February 2023. He believes the facility investigated the incident. He stated he interviewed the unit manager and Resident #8. Further interview was conducted with the SSD on 4/19/23 at 2:36 PM when he provided documented interviews regarding the incident between Resident #1 and #2 on 2/16/23 and Resident #2 and #8 on 2/20/23. He stated he did not interview the CNA that observed Resident #1 and #2 on 2/16/23. He stated he did not realize a full investigation was necessary. Regarding the incident on 2/20/23, he stated he did not review the progress notes in the record. He stated he reported his findings to the current Administrator. An interview was conducted with the DON on 4/19/23 at 2:26 PM. She stated there was a good possibility she had been notified of some of the allegations regarding Resident #2 during a meeting. An additional interview was conducted with the DON on 4/20/23 at 9:35 AM. She stated she did not feel the incidents on 2/16/23 and 2/20/23 were thoroughly investigated. She stated she did not believe a thorough review of the incident on 4/14/23 occurred. An interview was conducted with the Administrator on 4/20/23 at 9:35 AM. She stated the staff are expected to report allegations of abuse, neglect, and exploitation to the supervisor, Administrator, or DON. The facility reports the allegations of abuse to the regional staff, state agency, and Department of Children and Families. She stated SSD did complete some investigation. The Administrator was asked if she felt the investigations were thorough, she stated she could not answer the question. She stated it was hard to investigate when you do not know what is going on and in her absence the DON would be in charge of the facility. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/19/2023, the facility submitted a removal plan for F607 with immediate corrective actions to further prevent residents from further sexual abuse. The facility's removal plan included: 1. Resident #2 placed on one-on-one supervision 4/19/2023. 2. All current residents in the facility audited for concerns of abuse in the resident records completed 4/19/2023. Any identified instances were investigated with no new concerns noted. 3. Administrator and Director of Nursing (DON) and department heads educated by Director of Clinical Services on facility policy and procedures of sexual abuse, investigations, and reporting into allegations of abuse with consultation with Regional Administrator on 4/19/2023. 4. Residents #8, #9, #10 to be evaluated 4/20/2023 and followed by psych APRN to provide psychosocial support from exposure to sexual abuse. 5. 100% of interviewable residents were interviewed for concerns with care or abuse 4/19/2023. 6. In-services and competencies completed on abuse policy and procedure, inservices completed on the following dates: a. 4/19/2023 - 90% of all staff complete. b. 4/20/2023 - 100% of all staff complete. c. No staff members were permitted to work until all topic education and post in-service competency test for abuse policy and procedure, investigation and report was completed. 7. Upon hire and annually, all staff will complete abuse in servicing by staff developer or designee. 8. Immediate federal reporting for abuse completed for resident #2 on 4/17/2023 for 4/14/2023. 9. Immediate federal reporting for abuse completed for resident #2 on 4/18/2023 for 2/16/2023 and 2/20/2023. 10. DON or designee to audit progress notes and EMAR notes for any note with areas of concern to be investigated starting 4/20/2023. 11. The immediate jeopardy was removed on 4/20/23 as evidenced by resident #2 was placed on one-on-one supervision, Adult Protective Services state abuse agency notification 4/17/2023 and 4/18/2023, federal immediate reporting completed for all occurrences dates, staff education completed for all areas, system developed and implemented for auditing the residents' records daily to be aware of concerns not reported. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	12. This issue was taken to Quality Assurance Performance Improvement at an ad-hoc meeting on 4/18/2023 with Medical Director, Administrator, Director of Nursing, Social Services Director, MDS Director, and Unit Managers for both Units to discuss the concerns with sexual abuse, investigations, reporting and adequate follow up with PIP with new system to audit and review notes daily for immediate response in any allegations or concerns. Abuse Policy reviewed for meeting requirements of regulation. No changes indicated. On 4/20/23 at approximately 3:15PM, Immediate Jeopardy deficiencies was reduced from a K level to an E, pattern no actual harm with potential for no more than minimal harm level. As evidenced by the following: On 4/20/23 at 11:04PM, Resident #2 was observed to in bed while his 1:1 supervision staff was seated at the resident's open bedroom door. This started on 4/19/23 according to documentation reviewed. Evidence of the resident record audits was provided to surveyors and dated 4/20/23. Upon review all residents were audited and no additional concerns were identified. Staff education in-services for the Administrator, DON, and other Department Heads, related to sexual abuse reporting, sexual abuse, investigative processes, and investigations was reviewed. Training dated for 4/19/23. The facility provided a sign-in sheet with 18 staff signatures. Interviews with Administrator, DON, and at least 3 other Department Heads validating reeducation. One Hundred percent of staff received staff education on abuse policy and procedures, inservices verified to have been completed on 4/19-4/20/23. Staff interviews conducted with at least 10 staff(non-administrative) from various shifts and departments which indicated training was received. Staff were able to verbally recite abuse policies and procedures they recently received in re-education related to abuse. Review of staff files for verification of abuse training upon hire. Education provided included but not limited to an explanation of abuse, signs and symptoms of abuse, and reporting. 3 recently hired staff records reviewed verifying training had been completed. Review of records for Residents #8, #9, and #10 revealed orders dated 4/20/23 for Psych eval and treat for psychosocial support status post resident interaction in her room. Observed Psychiatric Provider seeing Resident #10 on 4/20/23 at approximately 11:47AM. The Facility developed and conducted a Questionnaire for interviewable residents on 4/18-4/19/23. Interviewed a total of 6 residents and all confirmed that facility staff had interviewed them about abuse and staff concerns. No additional concerns identified. Review of the facility's federal reporting for abuse was completed for resident #2 for all incidents that were discovered. Documentation provided confirm all three incidents had been reported to the abuse hotline. Review of audits completed of progress notes and EMAR (Electronic Medication Administration Records). No additional concerns noted. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Meeting Notes and Interview with the Administrator verified adhoc QAPI meeting on 4/18/223 to discuss supervision for Resident #2 and concerns with sexual abuse, investigations, reporting and an update to the facility's action plan started on 4/17/23.

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 28603 Based on observation, record reviews, staff interviews, resident interviews, and facility policy review, the facility failed to report immediately all allegations of abuse to the State Survey Agency and adult protective services in accordance with facility policy, involving 4 of 4 sampled residents. (Resident #1, #2, #8, and #9). Failure to report allegations of abuse to the appropriate authorities placed residents at risk for further abuse. The situation resulted in a finding of Immediate Jeopardy. The facility's Regional Administrator was notified of the findings of Immediate Jeopardy on 4/19/23 at approximately 1:30 PM. The Administrator was unavailable and did not return until 4/20/23. Immediate Jeopardy was removed on 4/20/23 at approximately 3:15 PM, when the facility provided evidence of immediate corrective actions which included placing Resident #2 on one to one constant staff supervision, immediate training of staff on abuse policies, auditing of resident records for abuse concerns, interviewing residents for abuse concerns, immediate federal reports were filed with the state agency, and the facility developed a new system to audit and review notes daily for immediate response to any allegations or concerns. Cross reference F600, F607, F610, F835, and F867. The findings include: Resident #2 had a history of behaviors that included but not limited to frequently masturbating, throwing himself on the floor, kicking staff, and refusing medications. There were multiple documented incidents in Resident #2's medical record that revealed incidents of the resident displaying sexually inappropriate and/or physical behaviors toward staff and residents dating back to 11/30/20 (date of behavior problems initiated on resident's care plan). According to record reviews, staff interviews, and resident interviews, Resident # 2 was observed with his penis out and erected while Resident #1 was sitting on Resident #2's bed with an erection on 2/16/23. The quarterly minimum data set, with an assessment reference date of 1/13/23, revealed resident #1 had a BIMS (Brief Interview of Mental Status) of 8, which indicated resident #1 to have moderately impaired Cognition (A person's decisions are consistently poor or unsafe; the person requires reminders, cues, or supervision at all times to plan, organize, and conduct daily routines). On 4/19/23 at 10:28 AM, Resident #8 reported that on 2/20/23, Resident #2 entered her room and would not leave. Resident #8 stated that in her attempt to guide the resident from her room by grabbing his arm and walking toward the door, Resident #2 swung his arm at her throat. Resident #8 reports that staff had to come into her room to assist in removing resident #2 from her room. Resident #8 reports she felt threatened by resident #2 and did not always feel safe in the facility. Staff interviews and record reviewed collaborated these allegations. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/14/23, staff documented in resident #2's chart that [Resident #2] wandered into another resident's room thinking it was his bedroom, he took his shirt and pants off and left brief intact, then climbed into bed, he was redirected to his room and clothing replaced, physician contacted for agitation and new order received for one time dose of Seroquel 50 mg. Interview with Resident #9 and her roommate (#10) collaborated the documented incident on 4/14/23. An interview was conducted on 04/17/2023 at approximately 12:00 PM with Resident #9. Resident #9 stated, About four or five days ago, a man came into my room, took his clothes off and got into bed with me. I was in my bed, and he got into bed with me. That poor guy didn't have a chance. I started beating his back and telling him to get out. I'm not sure where he touched me at because I was hitting him so much. The staff finally came and got him out of my bed. It took a bunch of them to get him out of here. On 4/17/23 at approximately 12:15PM, Resident #10 reported to this surveyor, We have some people who wander around and come into our room. But they have dementia. This was a completely different situation. It was very scary. He (referring to Resident #2) had his hands on her. I don't know what part of her body exactly. But I did see him touching her. I went to the door and screamed so loudly. I have a pretty big mouth. I was screaming for help. He was going to do something to her. It took a few of them to get him out of here. (Resident #10's account of the incident in which Resident #2 got into the bed with Resident #9) The medical record revealed no documentation in Resident #9's chart regarding the incident with Resident #2 entering her room and getting into bed with her. However, staff interviews during the survey collaborated Resident #9's allegations toward Resident #2. An interview was conducted with Employee P (Registered Nurse (RN)) on 4/19/23 at 11:01 AM. She stated the incident involving Resident #2 going into Resident #8's room was discussed in the morning meeting the Tuesday following the 2/20/23 incident (2/21/23). The Director of Nursing (DON) and Assistant Director of Nursing (ADON) were present in the meeting. Resident #2 was subsequently moved to the other side of the facility. The incident on 4/14/23 regarding Resident #2 getting in bed with Resident #9 was discussed in the morning meeting on 4/17/23 and the DON and ADON were present. Employee P (RN) stated she has had no specific training regarding how to handle resident sexual behaviors. An interview was conducted with Employee Q (unit manager) on 4/19/23 at 11:29 AM. Employee Q stated she was notified of the incident between Resident #2 and #9 the following day on 2/21/23. The staff notified her Resident #2 had entered Resident #8's room. Resident #8 then pushed Resident #2 out of the room and Resident #2 swung his hands in the air at Resident #8 but did not make physical contact. Employee Q stated she reported the incident to administration during the stand down meeting. She was not aware of any specific training regarding resident sexual behaviors. An interview was conducted with the Regional Administrator on 4/18/23 at 12:48 PM. She stated she was the Administrator of record for the facility from 1/10/23 through 2/14/23 and she then oriented the new Administrator through 2/16/23. She had no knowledge of Resident #1 being found on his roommate's bed with his penis aroused. She stated she would expect staff to report this to Administration. An interview was conducted with the Administrator on 4/18/23 at 3:48 PM. She stated she had no knowledge of the incident between Resident #1 and #2 and she was not aware of the incident on 2/20/23 when Resident #2 allegedly pushed a female resident. She stated the staff would be expected to report those allegations to the Administrator and DON, complete a full investigation, and follow the facility policy and procedure for abuse. An additional interview was conducted with the Regional Administrator on 4/19/23 at 9:55 AM. She stated none of the allegations had been reported to the abuse hotline prior to the state survey. (continued on next page)

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	105935	A. Building B. Wing	04/20/2023

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted with the Social Services Director (SSD) on 4/19/23 at 2:15 PM. He stated he was made aware of Resident #2 attempting to go into Resident #8's room in February 2023. He believes the facility investigated the incident. He stated he interviewed the unit manager and Resident #8. Further interview was conducted with the SSD on 4/19/23 at 2:36 PM when he provided documented interviews regarding the incident between Resident #1 and #2 on 2/16/23 and Resident #2 and #8 on 2/20/23. He stated he did not interview the CNA that observed Resident #1 and #2 on 2/16/23. He stated he did not realize a full investigation was necessary. Regarding the incident on 2/20/23, he stated he did not review the progress notes in the record. He stated he reported his findings to the current Administrator. An interview was conducted with the DON on 4/19/23 at 2:26 PM. She stated there was a good possibility she had been notified of some of the allegations regarding Resident #2 during a meeting. An interview was conducted with the Administrator on 4/20/23 at 9:35 AM. She stated the staff are expected to report allegations of abuse, neglect, and exploitation to the supervisor, Administrator, or DON. The facility reports the allegations of abuse to the regional staff, state agency, and Department of Children and Families. She stated SSD did complete some investigation. The Administrator was asked if she felt the investigations were thorough, she stated she could not answer the question. She stated it was hard to investigate when you do not know what is going on and in her absence the DON would be in charge of the facility. Despite the facility staff and management having knowledge of the reported allegations of abuse by Resident #2 toward resident #1, #8, and #9, there was no evidence that either of the above-mentioned incidents were reported to the State Survey Agency nor adult protective services. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility policy for Prevention of Resident Abuse, Neglect, Mistreatment, or Misappropriation of Property (dated 8/22/22) revealed, It is the policy of this Center that each resident has the right to be free from verbal, sexual, physical and mental abuse; corporal punishment; involuntary seclusion; mistreatment of any kind, exploitation, and misappropriation of property. In addition, each resident will be protected from those practices and omissions, which if left unchecked, could lead to abuse. Further, each resident will be treated with respect and dignity at all times. The Center will foster an environment that recognizes the worth and uniqueness of all individuals with regards to person-centered care and to promote respect and set standards of care. Residents will not be subjected to abuse by anyone, including but not limited to, Center staff, other residents, consultants, volunteer staff, contract staff, family members, friends, or others. Prevention of abuse will be accomplished by the timely reporting of the suspected abuse and a thorough investigation of these instances. Those reporting abuse should not be subjected to any disciplinary action for the correct reporting of abuse or suspected abuse. The Center will post steps on abuse and abuse reporting for staff, residents, and family members in designated areas of the Center. The material will advise the parties on how to report and to whom to report. The Center will ensure that the call will be confidential. Resident Behavior- our residents have the right to be free from resident-to-resident abuse. All altercations, including those that may represent resident to resident abuse shall be investigated and reported in accordance with established reporting procedures. If two residents are involved in an altercation, staff will separate the residents, identify what happened, assess both residents for any clinical, psychological and/or psychosocial changes that may have led to the incident, and notify the attending physician, each resident's respective representative and the appropriate State agency as required by State law. Investigation- all suspected cases of abuse or misappropriation of resident's property will be fully investigated by the Administrator, Abuse Coordinator, or designee. The findings should be reported to the appropriate governing agencies. Reporting/Documentation Requirements- ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported to the administrator of the center and to other officials (including to the State Survey Agency and adult protective services where state law provides jurisdiction in long-term care Centers) in accordance with State law through established procedures in these timeframes: * If the events that cause the allegation involve abuse or result in serious bodily injury, the event must be reported immediately, but not later than 2 hours after the allegation is made. * If the events that cause the allegation do not involve abuse and do not result in serious bodily injury, the event must be reported no later than 24 hours after the allegation is made. A review of the facility's policy titled Reporting Reasonable Suspicion of Crime dated 08/22/2022 revealed it is the center's policy to comply with the Elder Justice Act (EJA) about reporting reasonable suspicion of a crime to the State Survey Agency (SSA) and local law enforcement. Associates must report the suspicion of an incident to the Administrator or Director of Nursing. When an associate suspects a crime has occurred against a resident at the center, they must report the incident to SSA and local law enforcement. If the reportable event does not result in serious bodily injury, the associate shall report the suspicion not later than 24 hours after forming the suspicion. On 4/19/2023, the facility submitted a removal plan for F600 with immediate corrective actions to further prevent residents from further sexual abuse. The facility's removal plan included:1. All current residents in the facility audited for concerns of abuse in the resident records completed 4/19/2023. No additional concerns which required abuse reporting found. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/20/23 at 11:04PM, Resident #2 was observed to in bed while his 1:1 supervision staff was seated at the resident's open bedroom door. This started on 4/19/23 according to documentation reviewed. Evidence of the resident record audits was provided to surveyors and dated 4/20/23. Responsible parties were notified. Upon review all residents were audited and no additional concerns were identified. Staff education in-services for the Administrator, DON, and other Department Heads, related to sexual abuse reporting, sexual abuse, investigative processes, and investigations was reviewed. Training dated for 4/19/23. The facility provided a sign-in sheet with 18 staff signatures. Interviews with Administrator, DON, and at least 3 other Department Heads validating reeducation. One Hundred percent of staff received staff education on abuse policy and procedures, inservices verified to have been completed on 4/19-4/20/23. Staff interviews conducted with at least 10 staff(non-administrative) from various shifts and departments which indicated training was received. Staff were able to verbally recite abuse policies and procedures they recently received in re-education related to abuse. Review of staff files for verification of abuse training upon hire. Education provided included but not limited to an explanation of abuse, signs and symptoms of abuse, and reporting. 3 recently hired staff records reviewed verifying training had been completed. Review of records for Residents #8, #9, and #10 revealed orders dated 4/20/23 for Psych eval and treat for psychosocial support status post resident interaction in her room. Observed Psychiatric Provider seeing Resident #10 on 4/20/23 at approximately 11:47AM. The Facility developed and conducted a Questionnaire for interviewable residents on 4/18-4/19/23. Interviewed a total of 6 residents and all confirmed that facility staff had interviewed them about abuse and staff concerns. No additional concerns identified. Review of the facility's federal reporting for abuse was completed for resident #2 for all incidents that were discovered. Documentation provided confirm all three incidents had been reported to the abuse hotline. Evidence of additional designees being granted access to the federal reporting system. Review of audits completed of progress notes and EMAR (Electronic Medication Administration Records). No additional concerns noted. Review of Meeting Notes and Interview with the Administrator verified adhoc QAPI meeting on 4/18/223 to discuss supervision for Resident #2 and concerns with sexual abuse, investigations, reporting and an update to the facility's action plan started on 4/17/23.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. 28603 Based on observation, record reviews, staff interviews, resident interviews, and facility policy review, the facility failed to thoroughly investigate and report the results of investigations of all sexual and physical abuse allegations to the state survey agency within 5 working days of the alleged violations involving 4 of 4 sampled residents (Resident #1, #2, #8, and #9). The failure to thoroughly investigate, report allegations of abuse to the authorities, and implement effective interventions placed residents in the facility at risk for physical and/or sexual abuse. The situation resulted in a finding of Immediate Jeopardy. The facility's Regional Administrator was notified of the findings of Immediate Jeopardy on 4/19/23 at approximately 1:30 PM. The Administrator was unavailable and did not return until 4/20/23. Immediate Jeopardy was removed on 4/20/23 at approximately 3:15 PM when the facility provided evidence of immediate corrective actions which included placing resident number 2 on one to one constant staff supervision, immediate training of staff on abuse policies, resident records were audited for abuse concerns, residents were interviewed for abuse concerns, immediate federal reports were filed with the state agency, and the facility developed a new system to audit and review notes daily for immediate response to any allegations or concerns. The scope and severity of the Immediate Jeopardy deficiencies was reduced from a K level to a E level. Cross reference F600, F607, F609, F835, and F867. The findings include: Incident #1 (between Resident #1 and Resident #2 on 2/16/23) According to record reviews and staff interviews for Resident #2, this resident was observed with his penis out and erected while Resident #1 was sitting on Resident #2's bed with an erection on 2/16/23. The quarterly minimum data set, with an assessment reference date of 1/13/23, revealed resident #1 had a BIMS (Brief Interview of Mental Status) of 8, which indicated resident #1 to have moderately impaired Cognition (A person's decisions are consistently poor or unsafe; the person requires reminders, cues, or supervision at all times to plan, organize, and conduct daily routines). An interview was conducted with Employee K (CNA) on 4/18/23 at 8:54 AM. She stated about 3 months ago she observed Resident #2 pulling on his penis and Resident #1 sitting on the foot of Resident #2's bed at the time. She reported the incident to Employee G (LPN) and had Resident #1 return to his side of the room. A telephone interview was conducted with Employee E (CNA) on 4/18/23 at 12:25 PM. Employee E stated she found Resident #1 sitting on Resident #2's bed with his penis aroused. It looked like Resident #1 had gone to the bathroom and took his brief off, but he had on shorts. She did not recall if Resident #1's shorts were pulled down. She stated she did not recall which nurse she informed. Incident #2 (between Resident #2 and Resident #8 on 2/20/23) (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted with Resident #8 on 4/19/23 at 10:28 AM. Resident #8 stated that Resident #2 came into her room toward the end of February in the afternoon. She asked him to get out of her room. She then grabbed his arm to try to get him to leave her room and he threw his arm at her throat. She stated she felt threatened by Resident #2 and did not always feel safe in the facility. Resident #8 revealed staff were aware because they came into her room and assisted removing Resident #2 from her room. An interview was conducted with Employee P (Registered Nurse (RN)) on 4/19/23 at 11:01 AM. She stated the incident involving Resident #2 going into Resident #8's room was discussed in the morning meeting the Tuesday following the 2/20/23 incident (2/21/23). The DON and Assistant Director of Nursing (ADON) were present in the meeting. Resident #2 was subsequently moved to the other side of the facility. An interview was conducted with Employee Q (unit manager) on 4/19/23 at 11:29 AM. Employee Q stated she was notified of the incident between Resident #2 and #8 the following day on 2/21/23. The staff notified her Resident #2 had entered Resident #8's room. Resident #8 then pushed Resident #2 out of the room and Resident #2 swung his hands in the air at Resident #8 but did not make physical contact. Employee Q stated she reported the incident to administration during the stand down meeting. She was not aware of any specific training regarding resident sexual behaviors. Incident #3 (between Resident #2 and Resident #9 on 4/14/23) An interview was conducted on 04/17/2023 at approximately 12:00 PM with Resident #9. Resident #9 stated, About four or five days ago, a man came into my room, took his clothes off and got into bed with me. I was in my bed, and he got into bed with me. That poor guy didn't have a chance. I started beating his back and telling him to get out. I'm not sure where he touched me at because I was hitting him so much. The staff finally came and got him out of my bed. It took a bunch of them to get him out of here. The record revealed no documentation in Resident #9's chart regarding the incident with Resident #2 entering her room and getting into bed with her. An interview was conducted on 04/17/2023 at approximately 12:15 PM with Resident # 10. Resident #10 stated, We have some people who wander around and come into our room. But they have dementia. This was a completely different situation. It was very scary. He had his hands on her. I don't know what part of her body exactly. But I did see him touching her. I went to the door and screamed so loudly. I have a pretty big mouth. I was screaming for help. He was going to do something to her. It took a few of them to get him out of here. (Resident #10's account of the incident in which Resident #2 got into the bed with Resident #9) An interview was conducted with the Administrator on 4/18/23 at 3:48 PM. She stated she had no knowledge of the incident between Resident #1 and #2 and she was not aware of the incident on 2/20/23 when Resident #2 allegedly pushed a female resident. She stated the staff would be expected to report those allegations to the Administrator and DON, complete a full investigation, and follow the facility policy and procedure for abuse. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted with the ADON on 4/19/23 at 2:04 PM. She stated she recalled hearing in a morning meeting about the incident involving Resident #1 and #2. She heard one of the residents was on the other resident's bed and the other resident had his own penis in his own hand. She was not aware of any investigation into the incident. She stated Resident #2 was then moved to a different room. She stated the incident was not discussed in a Quality Assurance meeting. An interview was conducted with the Social Services Director (SSD) on 4/19/23 at 2:15 PM. He stated he was made aware of Resident #2 attempting to go into Resident #8's room in February 2023. He believes the facility investigated the incident. He stated he interviewed the unit manager and Resident #8. Further interview was conducted with the SSD on 4/19/23 at 2:36 PM when he provided documented interviews regarding the incident between Resident #1 and #2 on 2/16/23 and Resident #2 and #8 on 2/20/23. He stated he did not interview the CNA that observed Resident #1 and #2 on 2/16/23. He stated he did not realize a full investigation was necessary. Regarding the incident on 2/20/23, he stated he did not review the progress notes in the record. He stated he reported his findings to the current Administrator. An additional interview was conducted with the DON on 4/20/23 at 9:35 AM. She stated she did not feel the incidents on 2/16/23 and 2/20/23 were thoroughly investigated. She stated she did not believe a thorough review of the incident on 4/14/23 occurred. An interview was conducted with the Administrator on 4/20/23 at 9:35 AM. She stated the staff are expected to report allegations of abuse, neglect, and exploitation to the supervisor, Administrator, or DON. The facility reports the allegations of abuse to the regional staff, state agency, and Department of Children and Families. She stated SSD did complete some investigation. The Administrator was asked if she felt the investigations were thorough, she stated she could not answer the question. She stated it was hard to investigate when you do not know what is going on and in her absence the DON would be in charge of the facility. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. 100% of interviewable residents were interviewed for concerns with care or abuse 4/19/2023. No further investigations required. 4. Investigation for abuse completed for resident #2 on 4/17/2023 for 4/14/2023. 5. Investigation for abuse completed for resident #2 on 4/18/2023 for 2/16/2023 and 2/20/2023. 6. In-services and competencies completed on abuse policy and procedure with investigations with focus on the charge nurses interviewing staff involved, any resident witnesses, assessing the scene, documentation of findings to give to the Administrator and DON, inservices completed on the following dates: a. 4/19/2023 - 90% of all staff complete. b. 4/20/2023 - 100% of all staff complete. c. No staff members were permitted to work until all topic education and post in-service competency test for abuse policy and procedure, investigation and report was completed. 7. DON or designee to audit progress notes and EMAR notes for any note with areas of concern to be investigated starting 4/20/2023. 8. The immediate jeopardy was removed on 4/20/23 as evidenced by resident #2 was placed on one-on-one supervision, Adult Protective Services state abuse agency notification 4/17/2023 and 4/18/2023, federal immediate reporting completed for all occurrences dates with full investigations, staff education completed for all areas, system developed and implemented for auditing the residents' records daily to be aware of concerns not reported. 9. This issue was taken to Quality Assurance Performance Improvement at an ad-hoc meeting on 4/18/2023 with Medical Director, Administrator, Director of Nursing, Social Services Director, MDS Director, and Unit Managers for both Units to discuss the concerns with sexual abuse, investigations, reporting and adequate follow up with PIP with new system to audit and review notes daily for immediate response in any allegations or concerns. Risk Policy reviewed for meeting requirements of regulation. No changes indicated. Investigation process review with focus on the interviewing staff involved any resident witnesses, assessing the scene, record review, mitigating factors and root cause analysis. On 4/20/23 at approximately 3:15PM, Immediate Jeopardy deficiencies was reduced from a K level to an E, pattern no actual harm with potential for no more than minimal harm level. As evidenced by the following: On 4/20/23 at 11:04PM, Resident #2 was observed to in bed while his 1:1 supervision staff was seated at the resident's open bedroom door. This started on 4/19/23 according to documentation reviewed. Evidence of the resident record audits was provided to surveyors and dated 4/20/23. Responsible parties were notified. Upon review all residents were audited and no additional concerns were identified. (continued on next page)

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	105935	A. Building B. Wing	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pensacola Nursing & Rehabilitation Center	235 West Airport Blvd Pensacola, FL 32505

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Staff education in-services for the Administrator, DON, and other Department Heads, related to sexual abuse reporting, sexual abuse, investigative processes, and investigations was reviewed. Training dated for 4/19/23. The facility provided a sign-in sheet with 18 staff signatures. Interviews with Administrator, DON, and at least 3 other Department Heads validating reeducation. One Hundred percent of staff received staff education on abuse policy and procedures, inservices verified to have been completed on 4/19-4/20/23. Staff interviews conducted with at least 10 staff(non-administrative) from various shifts and departments which indicated training was received. Staff were able to verbally recite abuse policies and procedures they recently received in re-education related to abuse. Review of staff files for verification of abuse training upon hire. Education provided included but not limited to an explanation of abuse, signs and symptoms of abuse, and reporting. 3 recently hired staff records reviewed verifying training had been completed. Review of records for Residents #8, #9, and #10 revealed orders dated 4/20/23 for Psych eval and treat for psychosocial support status post resident interaction in her room. Observed Psychiatric Provider seeing Resident #10 on 4/20/23 at approximately 11:47AM. The Facility developed and conducted a Questionnaire for interviewable residents on 4/18-4/19/23. Interviewed a total of 6 residents and all confirmed that facility staff had interviewed them about abuse and staff concerns. No additional concerns identified. Review of the facility's federal reporting for abuse was completed for resident #2 for all incidents that were discovered. Documentation provided verified all three incidents had been reported to the abuse hotline. Evidence of additional designees being granted access to the federal reporting system. Review of audits completed of progress notes and EMAR (Electronic Medication Administration Records). No additional concerns noted. Review of Meeting Notes and Interview with the Administrator verified adhoc QAPI meeting on 4/18/223 to discuss supervision for Resident #2 and concerns with sexual abuse, investigations, reporting and an update to the facility's action plan started on 4/17/23.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 28603 Based on observations, record review, staff interviews, Administrator job description review, and policy review, the facility failed to utilize its resources effectively, provide adequate training, report findings to state and federal agencies as required by law and implement facility policies to ensure residents within the facility are properly assessed and treated when exhibiting signs and symptoms of sexual tendencies. The facility further failed to ensure other residents in the facility were free from any form of physical or sexual abuse from Resident #2 and to ensure that staff are aware of the resident's behaviors and followed facility policy for reporting. This has the potential to affect all residents in the facility who encounter the resident. The situation resulted in a finding of Immediate Jeopardy. The facility's Regional Administrator was notified of the findings of Immediate Jeopardy on 4/19/23 at approximately 1:30 PM. The Administrator was unavailable and did not return until 4/20/23. Immediate Jeopardy was removed on 4/20/23 at approximately 3:15 PM when the facility provided evidence of immediate corrective actions which included placing resident #2 on one to one constant staff supervision, immediate training of staff on abuse policies, resident records were audited for abuse concerns, residents were interviewed for abuse concerns, immediate federal reports were filed, and the facility developed a new system to audit and review notes daily for immediate response in any allegations or concerns. The scope and severity of the Immediate Jeopardy deficiencies was reduced from a K level to a E level. Cross reference F607, F609, F610, F835, and F867. The findings include: According to record reviews, staff interviews, and resident interviews during the survey conducted on 4/17/23 through 4/20/23, it was revealed that Resident #2 had inappropriate sexual incidents with at least 3 residents within the facility. Resident #2 was observed by staff to be sitting on his roommate's bed (#1) with his penis out and erected while Resident #1 was sitting on Resident #2's bed with an erection on 2/16/23. Resident #8 reported that on 2/20/23, Resident #2 came into her room toward the end of February in the afternoon. She asked him to get out of her room. She then grabbed his arm to try to get him to leave her room and he threw his arm at her throat. She stated she felt threatened by Resident #2 and did not always feel safe in the facility. Resident #8 revealed staff were aware because they came into her room and assisted removing Resident #2 from her room. Resident #9 reported that approximately 4/14/23, a man(#2) came into her room took clothes off and got into bed with me. I was in bed, and he got into bed with me. Staff failed to immediately report the allegations to facility administration. The allegations of physical and sexual abuse were not reported to the State Survey Agency or abuse hotline, thoroughly investigated, nor were additional effective interventions implemented to protect vulnerable residents. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted with the Regional Administrator on 4/18/23 at 12:48 PM. She stated she was the Administrator of record for the facility from 1/10/23 through 2/14/23 and she then oriented the new Administrator through 2/16/23. She had no knowledge of resident #1 being found on his roommate's bed with his penis aroused. She stated she would expect staff to report this to Administration. An interview was conducted with the Administrator on 4/18/23 at 3:48 PM. She stated she had no knowledge of the incident between resident # 1 and 2 and she was not aware of the incident on 2/20/23 when resident # 2 allegedly pushed a female resident. The staff would be expected to report those allegations to the Administrator and DON, complete a full investigation, and follow the facility policy and procedure for abuse. An interview was conducted with the ADON on 4/19/23 at 2:04 PM. She stated she recalled hearing in a morning meeting about the incident involving resident #s 1 and 2. She heard one of the residents was on the other resident's bed and the other resident had his own penis in his own hand. She was not aware of any investigation into the incident. Resident # 2 was then moved to a different room. The incident was not discussed in a Quality Assurance meeting. An interview was conducted with the Social Services Director (SSD) on 4/19/23 at 2:15 PM. He stated he was made aware of resident # 2 attempting to go into resident # 8's room in February 2023. He believes the facility investigated the incident. He interviewed the unit manager and resident # 8. Further interview was conducted with the SSD on 4/19/23 at 2:36 PM when he provided documented interviews with employee D regarding the incident between resident # 1 and 2 on 2/16/23 and resident # 2 and 8 on 2/20/23. He stated he did not interview the CNA that observed resident #s 1 and #2 on 2/16/23. It did not hit him that he needed to complete a full investigation because the nurse did not state the resident's penis was out. He stated he was in crisis management in the facility meaning he has residents that are always coming to the office, and he was putting out fires. Regarding the incident on 2/20/23 he stated he did not review the progress notes in the record. He reported his findings to the current Administrator. An interview was conducted with the DON on 4/19/23 at 2:26 PM. She stated there was a good possibility she had been notified of some of the allegations regarding resident # 2 during a meeting. An additional interview was conducted with the DON on 4/20/23 at 9:35 AM. She stated she did not feel the incidents on 2/16/23 and 2/20/23 were thoroughly investigated. She would come in on Monday and go over anything that happened over the weekend to review the incident on 4/14/23 and that did not occur. An interview was conducted with the Administrator on 4/20/23 at 9:35 AM. She stated the staff are expected to report allegations of abuse, neglect, and exploitation to the supervisor, Administrator, or DON. The facility reports the allegations of abuse to the regional staff, state agency, and Department of Children and Families. SSD did complete some investigation. The Administrator was asked if she felt the investigations were thorough, she stated she could not answer the question. She stated it was hard to investigate when you do not know what is going on and in her absence the DON would be in charge of the facility. 46833 (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted by this writer on 04/17/2023 at approximately 2:00 PM with the DON. The DON stated she had not had any abuse allegations reported to her regarding Resident #2 or #9. The DON stated she did get a message regarding Resident #2 going into Resident # 9's room on Friday, 04/14/2023. The DON stated, We did call the Administrator and our Corporate team to report it to them. The DON stated, We haven't had any other reports of similar situations with Resident # 2. He was moved from one side of the building to the other because of arguments of snoring. So, we moved him. The DON stated the facility corporate team consisted of the [NAME] President of Clinical Operations, Clinical Regional Administrator, and [NAME] President of Operations Another interview was conducted on 04/18/2023 at approximately 12:45 PM with the DON. The DON stated, If I know of an issue with any type of abuse, I will report it to my corporate team and start an investigation. I did not start an investigation this past Friday because I didn't think it was really anything. But I would start my investigation within an hour or two of finding out and then report it. An interview was conducted on 04/19/2023 at approximately 10:45 AM with the Administrator. The Administrator stated, I am not aware of any instances of abuse being reported to me. I was in orientation that first week (started at facility on 02/14/2023). I was not in all the morning meetings. The first four days were me acclimating to the facility and being orientated. I do know that both residents (Resident's 1 and 2) have had behaviors since I have been there. I don't remember the behaviors that were being talked about. But I do know they have had some behaviors. An interview was conducted on 04/20/2023 at approximately 10:00 AM with the DON. The DON stated she does call the Administrator with any problems. The DON stated if the Administrator is not available, she would call her corporate team for director and provide them with the situation needing guidance. The DON stated she has educated the staff regularly to place an incident report if something happens. The DON stated she does not currently have access to the reporting system for mandated state reporting problems. The DON reported the Administrator did not have access to the system either. The DON stated any reports of abuse goes to the Regional Administrator or to the [NAME] President of Clinical Operations. The DON stated the only current leadership member that has access to the state reporting system is the ADON of the facility. The DON stated she began as the Interim DON at the end of February. She stated she accepted the formal position as DON approximately a week after these two incidents happened. The DON stated, I'm just frustrated. We had a corporate nurse every week. She would come in and she was on the phone with us. Corporate did a realignment. They got rid of her. We walk in and we are off just putting out fires every day. We are constantly just trying to play catch up. We're just trying to put the immediate fires out. I'm going to say I don't feel like I've had any formal training. The Administrator has tried to help me. I still talk to the corporate nurse that we had even though she's no longer with them for guidance. We have the corporate Administrator. She has been great. But the corporate Administrator is not a nurse and not sure of the clinical side. The [NAME] President of Clinical Services checks in and all that. But there's so many little things that we're just trying to keep our head above water in the building. I can't always stop and reach out to her. I don't how she can help me from South Carolina. The DON stated she has not had formal training for her position. The DON stated, It's trying to take everything on and figure out what's the most important. And, keeping the people safe. That is my most important. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the Administrator job description dated 04/2022 revealed the Administrator is to lead and direct the overall operation of the facility in accordance with resident needs, government regulations, and company policies as to maintain excellent care for the resident s while achieving the facility's business objectives. The job description further states the Administrator will work with the facility management staff and consultants in planning all aspects of facility operations. The administrator will maintain a working knowledge of and ensure compliance with all governmental regulations. The Administrator will supervise, conduct, and participate in departmental and facility education activities and staff meetings. The Administrator will understand, comply with, and promote rules regarding residents' rights. A review of the Director of Nursing (DON) job description (no date) revealed the DON executes the goals and objectives of the nursing department regarding patient/resident rights, patient/resident care and reflects the mission statement of the facility. The DON provides leadership and direction for the nursing staff while being responsible for the overall management of the Nursing Department. Ensures nursing staff's compliance with all facility and nursing policies and procedures as well as compliance with regulatory requirements. The DON will review all incident and accident reports before submitting to the Administration and the Medical Director Plan and maintain a Master Staffing Plan. The DON will actively participate in committees such as Quality Assurance Performance Improvement (QAPI), Infection Control, Safety, Ethics, Leadership, and others. The DON will investigate reports of resident abuse and report their findings to the Administrator. The DON will participate in mandatory in-service and job training programs. A review of the Assistant Director of Nursing (ADON) job description (no date) revealed the ADON supports the Director of Nursing in executing the goals and objectives of the nursing department in regard to patient/resident rights, patient/resident care and reflects the mission statement of the facility. The ADON provides leadership and direction for the nursing staff while being responsible for the overall management of the Nursing Department. Ensures nursing staff's compliance with all facility and nursing policies and procedures as well as compliance with regulatory requirements. The ADON will review all incident and accident reports before submitting to the DON. The ADON will actively participate in committees such as Quality Assurance Performance Improvement (QAPI), Infection Control, Safety, Ethics, Leadership, and others. The ADON will investigate reports of resident abuse and report their findings to the Administrator. The ADON will participate in mandatory in-service and job training programs. The ADON is responsible for New Hire Training of required mandatory training; Works directly with Department Heads to assure that department specific requirements are conducted for new hires and ensures that annual mandatory training are conducted for all staff. A review of the Social Worker (SSD)job description (no date) revealed the social worker will work with the residents in the nursing home by identifying their psychosocial, mental, and emotional needs. The nursing home social worker is responsible for fostering a climate, policies, and routines the enable residents to maximize their individuality, independence, and dignity. The social worker will review facility policies and procedures to assure compliance in state and federal regulations. The social worker will participate in QAPI meetings. The social worker will understand and meet the government requirements for social services documentation. The social worker will work with the interdisciplinary team and administration to promote and protect resident rights and the psychological well -being of each resident. Prevent and address resident abuse as mandated by law and professional licensure. Educate staff regarding residents' rights and how to recognize and prevent abuse, neglect, and mistreatment. The social services director must always review any documents given to governmental bodies or third parties with the Administrator prior to submittal to said agencies. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/19/2023, the facility submitted a removal plan for F600 with immediate corrective actions to further prevent residents from further sexual abuse. The facility's removal plan included: 1. Administrator and Director of Nursing (DON) and department heads educated by Director of Clinical Services on facility policy and procedures of sexual abuse, investigations, and reporting into allegations of abuse with consultation with Regional Administrator on 4/19/2023. 2. In-services and competencies completed on abuse policy and procedure, inservices completed on the following dates by DON, Unit Managers, Housekeeping Director, Dietary Manager, Admission Director after being Trained by Director of Clinical Services: a. 4/19/2023 - 90% of all staff complete. b. 4/20/2023 - 100% of all staff complete. c. No staff members were permitted to work until all topic education and post in-service competency test for abuse policy and procedure, investigation and report was completed. 3. Immediate federal reporting for abuse completed for resident #2 on 4/17/2023 for 4/14/2023. 4. Immediate federal reporting for abuse completed for resident #2 on 4/18/2023 for 2/16/2023 and 2/20/2023. 5. DON or designee to audit progress notes and EMAR notes for any note with areas of concern to be investigated starting 4/20/2023. 6. The immediate jeopardy was removed on 4/20/23 as evidenced by resident #2 was placed on one-on-one supervision, Adult Protective Services state abuse agency notification 4/17/2023 and 4/18/2023, federal immediate reporting completed for all occurrences dates, staff education completed for all areas, system developed and implemented for auditing the residents' records daily to be aware of concerns not reported. 7. This issue was taken to Quality Assurance Performance Improvement at an ad-hoc meeting on 4/18/2023 with Medical Director, Administrator, Director of Nursing, Social Services Director, MDS Director, and Unit Managers for both Units to discuss the concerns with sexual abuse, investigations, reporting and adequate follow up with PIP with new system to audit and review notes daily for immediate response in any allegations or concerns. Abuse Policy reviewed for meeting requirements of regulation. No changes indicated. Corporate Compliance program reviewed for inclusion of Elder Justice Act reporting, Federal and State abuse reporting requirements, resident safety intervention guidelines and mandatory reporting requirements. No changes required. 8. Administrator and Director of Nursing have submitted for access to federal reporting system access. Regional Administrator has current access to assist until access granted. On 4/20/23 at approximately 3:15PM, Immediate Jeopardy deficiencies was reduced from a K level to an E, pattern no actual harm with potential for no more than minimal harm level. As evidenced by the following: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/20/23 at 11:04PM, Resident #2 was observed to in bed while his 1:1 supervision staff was seated at the resident's open bedroom door. This started on 4/19/23 according to documentation reviewed. Evidence of the resident record audits was provided to surveyors and dated 4/20/23. Upon review all residents were audited and no additional concerns were identified. Staff education in-services for the Administrator, DON, and other Department Heads, related to sexual abuse reporting, sexual abuse, investigative processes, and investigations was reviewed. Training dated for 4/19/23. The facility provided a sign-in sheet with 18 staff signatures. Interviews with Administrator, DON, and at least 3 other Department Heads validating reeducation. One Hundred percent of staff received staff education on abuse policy and procedures, inservices verified to have been completed on 4/19-4/20/23. Staff interviews conducted with at least 10 staff(non-administrative) from various shifts and departments which indicated training was received. Staff were able to verbally recite abuse policies and procedures they recently received in re-education related to abuse. Review of staff files for verification of abuse training upon hire. Education provided included but not limited to an explanation of abuse, signs and symptoms of abuse, and reporting. 3 recently hired staff records reviewed verifying training had been completed. Review of records for Residents #8, #9, and #10 revealed orders dated 4/20/23 for Psych eval and treat for psychosocial support status post resident interaction in her room. Observed Psychiatric Provider seeing Resident #10 on 4/20/23 at approximately 11:47AM. The Facility developed and conducted a Questionnaire for interviewable residents on 4/18-4/19/23. Interviewed a total of 6 residents and all confirmed that facility staff had interviewed them about abuse and staff concerns. No additional concerns identified. Review of the facility's federal reporting for abuse was completed for resident #2 for all incidents that were discovered. Documentation provided confirm all three incidents had been reported to the abuse hotline. Review of audits completed of progress notes and EMAR (Electronic Medication Administration Records). No additional concerns noted. Review of Meeting Notes and Interview with the Administrator verified adhoc QAPI meeting on 4/18/223 to discuss supervision for Resident #2 and concerns with sexual abuse, investigations, reporting and an update to the facility's action plan started on 4/17/23.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 46833 Based on record review, staff interviews, quality assurance performance improvement plan review, and policy review the facility failed to develop and implement appropriate plans of action to correctly identify quality deficiencies related to the supervision of a resident (Resident #2) who was exhibiting sexual tendencies including wandering into other resident rooms and to report findings to state and federal agencies as required by law. The facility further failed to develop a Performance Improvement Plan to ensure other residents in the facility were free from any form of physical or sexual abuse and that Resident #2 had appropriate interventions in place. The situation resulted in a finding of Immediate Jeopardy. The facility's Regional Administrator was notified of the findings of Immediate Jeopardy on 4/19/23 at approximately 1:30 PM. The Administrator was unavailable and did not return until 4/20/23. Immediate Jeopardy was removed on 4/20/23 at approximately 3:15 PM when the facility provided evidence of immediate corrective actions which included placing resident number 2 on one to one constant staff supervision, immediate training of staff on abuse policies, resident records were audited for abuse concerns, residents were interviewed for abuse concerns, immediate federal reports were filed, and the facility developed a new system to audit and review notes daily for immediate response in any allegations or concerns. The scope and severity of the Immediate Jeopardy deficiencies was reduced from a K level to a E level. Cross reference F607, F609, F610, and F835. The findings include: According to record reviews, staff interviews, and resident interviews during this survey, it was revealed that Resident #2 had inappropriate sexual incidents with at least 3 residents within the facility. Resident #2 was observed by staff to be sitting on his roommate's bed (#1) with his penis out and erected while Resident #1 was sitting on Resident #2's bed with an erection on 2/16/23. Resident #8 reported that on 2/20/23, Resident #2 came into her room toward the end of February in the afternoon. She asked him to get out of her room. She then grabbed his arm to try to get him to leave her room and he threw his arm at her throat. She stated she felt threatened by Resident #2 and did not always feel safe in the facility. Resident #8 revealed staff were aware because they came into her room and assisted removing Resident #2 from her room. Resident #9 reported that approximately 4/14/23, a man(#2) came into her room took clothes off and got into bed with me. I was in bed, and he got into bed with me. Reference F600, F607, F609, and F610. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted on 04/20/2023 at approximately 10:10 AM with the Administrator. The Administrator stated a Quality Assurance Performance Improvement (QAPI) was done in February 2023 and in March 2023. The Administrator stated she did not have any previous notes regarding Resident #2 and any type of behaviors. The Administrator stated she has no recollection of these behaviors or abuse reports being reported in the QAPI meeting. The Administrator stated that any type of abuse reporting should be completed at the daily stand-up meetings. The Administrator stated that during the facility QAPI meetings the QAPI committee would, Normally, we focus on each area where there might be a Performance Improvement Plan (PIP) or where we might have a deficiency or something that needs corrected. The Administrator stated that a stand-down meeting is held every evening at the facility. The Administrator stated, We discuss what happened for the day or what is happening today and from the morning meeting. That's how we gather the information as to what we need to be focusing on and concentrating on. A review of the facility morning meeting notes dated 02/20/2023 did not reveal any report of Resident #2's behaviors. The meeting notes were signed by the Administrator, Director of Nursing, Assistant Director of Nursing, and the Director of Social Services. A review of the facility morning meeting notes dated 04/14/2023 did not reveal any report of Resident #2's behaviors. The meeting notes were signed by the Director of Nursing. A Performance Improvement Plan (PIP) was created on 04/17/2023: Reporting allegations of abuse, neglect, and misappropriation. The team facilitators for the PIP were the Administrator and the DON. The team members included members of the interdisciplinary team. The PIP included obtaining full and completed statements from any resident or staff member who has an allegation. The DON or designee will provide an in-service to all staff on abuse and unwanted touching. A second staff member will conduct a secondary interview for clarification or need for additional information. An audit will be completed for 90 days for any reportable to ensure compliance and reported to the monthly QAPI meeting for three months or until compliance is met. The PIP on 04/17/2023 was updated on 04/18/2023. The PIP was updated to include: Ensuring the staff were notifying the Administrator or DON of possible allegations and ensuring staff fully understand what to report as abuse. The Nurse Manager will read progress notes daily. Interviews were conducted with all residents to ensure no complaints of abuse were needed. An abuse competency was completed with all staff on abuse and reporting. A review of the facility QAPI plan dated 12/07/2022 revealed the need for guidance for the overall quality improvement program which coincides with our Vision and Mission Statements. Decisions will be made to promote excellence in quality of care, quality of life, resident choice, person-directed care, and resident transitions. The administrator will be Quality Assurance (QAA) committee. Further review of the QAPI plan revealed the principles of QAPI will be taught to all staff, volunteers, and board members on an ongoing basis. QAPI activities will aim for the highest levels of safety, excellence in clinical interventions, resident and family satisfaction and management practices. When the need is identified, we will implement corrective action plans or performance improvement projects to improve processes, systems, outcomes, and satisfaction. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105935	A. Building B. Wing	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pensacola Nursing & Rehabilitation Center	235 West Airport Blvd Pensacola, FL 32505

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The administrator has responsibility and is accountable to the Internal Risk Management and Quality Assessment and Assurance Committee and for ensuring that QAPI is implemented throughout our Center. QAPI activities and discussion will be a standing item on our meeting agenda. The administrator is responsible for assuring that all QAPI activities and required documentation is provided to our corporation. The QAA committee will respond in a timely manner to ensure momentum is maintained. The team will develop an action plan. Interventions that will make change will be implemented by the team. The team will use root cause analysis (RCA) to ensure that the root cause and contributing factors are identified. When determining and implementing interventions, Plan-Do-Study-Act (PDSA) cycles will be used. The team will select and/or create measurement tools to ensure that the changes they are implementing are having the desired effect. A review of the facility Quality Assurance and Performance Improvement policy revealed that the facility develops a plan that describes the process for conducting QAPI/QAA activities, including to identify and correct quality deficiencies and opportunities for improvement. The facility policy stated the purpose of the policy was to develop, implement, and maintain an effective comprehensive, data-driven QAPI program that focuses on outcomes of care and quality of life. On 4/19/2023, the facility submitted a removal plan for F600 with immediate corrective actions to further prevent residents from further sexual abuse. The facility's removal plan included: 1. All current residents in the facility audited for concerns of abuse in the resident records completed 4/19/2023. 2. The Administrator and Director of Nursing (DON) and department heads/ QAPI team educated by Director of Clinical Services on facility policy and procedures of sexual abuse, investigations, and reporting into allegations of abuse with consultation with Regional Administrator and the QAPI process with PIP development, system review, data collection and review, root cause analysis including fish bone and five why drill down on 4/19/2023. 3. DON or designee to audit progress notes and EMAR notes for any note with areas of concern to be investigated starting 4/20/2023. 4. The immediate jeopardy was removed on 4/20/23 as evidenced by resident #2 was placed on one-on-one supervision, Adult Protective Services state abuse agency notification 4/17/2023 and 4/18/2023, federal immediate reporting completed for all occurrences dates, staff education completed for all areas, system developed and implemented for auditing the residents' records daily to be aware of concerns not reported. 5. This issue was taken to Quality Assurance Performance Improvement at an ad-hoc meeting on 4/18/2023 with Medical Director, Administrator, Director of Nursing, Social Services Director, MDS Director, and Unit Managers for both Units to discuss the concerns with sexual abuse, investigations, reporting and adequate follow up with PIP with new system to audit and review notes daily for immediate response in any allegations or concerns. Abuse Policy reviewed for meeting requirements of regulation. No changes indicated. Corporate Compliance program reviewed for inclusion of Elder Justice Act reporting, Federal and State abuse reporting requirements, resident safety intervention guidelines and mandatory reporting requirements. No changes required. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105935	A. Building B. Wing	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pensacola Nursing & Rehabilitation Center	235 West Airport Blvd Pensacola, FL 32505

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	6. Administrator and Director of Nursing have submitted for access to federal reporting system access. Regional Administrator has current access to assist until access granted. On 4/20/23 at approximately 3:15PM, Immediate Jeopardy deficiencies were reduced from a K level to an E, pattern no actual harm with potential for no more than minimal harm level. As evidenced by the following: On 4/20/23 at 11:04PM, Resident #2 was observed to be in bed while his 1:1 supervision staff was seated at the resident's open bedroom door. This started on 4/19/23 according to documentation reviewed. Evidence of the resident record audits was provided to surveyors and dated 4/20/23. Upon review all residents were audited and no additional concerns were identified. Staff education in-services for the Administrator, DON, and other Department Heads, related to sexual abuse reporting, sexual abuse, investigative processes, and investigations was reviewed. Training dated for 4/19/23. The facility provided a sign-in sheet with 18 staff signatures. Interviews with Administrator, DON, and at least 3 other Department Heads validating reeducation. One Hundred percent of staff received staff education on abuse policy and procedures, in-services verified to have been completed on 4/19-4/20/23. Staff interviews conducted with at least 10 staff(non-administrative) from various shifts and departments which indicated training was received. Staff were able to verbally recite abuse policies and procedures they recently received in re-education related to abuse. Review of staff files for verification of abuse training upon hire. Education provided included but not limited to an explanation of abuse, signs and symptoms of abuse, and reporting. 3 recently hired staff records reviewed verifying training had been completed. Review of records for Residents #8, #9, and #10 revealed orders dated 4/20/23 for Psych eval and treat for psychosocial support status post resident interaction in her room. Observed Psychiatric Provider seeing Resident #10 on 4/20/23 at approximately 11:47AM. The Facility developed and conducted a Questionnaire for interviewable residents on 4/18-4/19/23. Interviewed a total of 6 residents and all confirmed that facility staff had interviewed them about abuse and staff concerns. No additional concerns identified.