| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115395 | A. Building<br>B. Wing | 05/16/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Winthrop Health and Rehabilitation | 12 Chateau Drive<br>Rome, GA 30161 |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38514<br><br>Based on observations, record review, interviews, and review of the facility policy titled, Abuse Prohibition, the facility failed to effectively address the sexually aggressive behavior of one of four residents (R#364). The facility failed to put effective interventions in place to protect three of four residents (R#17, R#55, R#42) from resident-to-resident sexual abuse. The deficient practice had the potential to affect all 61 residents residing in the facility<br><br>On 04/14/2022, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents.<br><br>The facility's Administrator was informed of the Immediate Jeopardy (IJ) on 04/14/2022 at 7:46 PM. The noncompliance related to the immediate jeopardy was identified to have existed on 05/23/2021. The immediate jeopardy was removed on 04/17/2022.<br><br>The IJ is outlined as follows:<br><br>The IJ began on 05/23/2021, when R#364 was found in the room of R#17, a resident with severe cognitive impairment, with his hands under the resident's shirt on the resident's breasts. On 5/23/2021, R#17, reported to staff that she had been molested. The facility failed to put interventions in place to prevent future incidents from taking place. R#17 was subsequently sexually abused a second time by R#364 on 07/11/2021 when R#364 was found with his hands under R#17's shirt. Additional residents were sexually abused by R#364. R#55, a bedbound resident with moderate cognitive impairment, was sexually abused by R#364 on 08/27/2021, when R#364 was observed in R#55's room, with his hand under R#55's cover. R#55's brief was observed to be un-taped and folded back. On 1/21/2022, R#364 was found with his hand on the chest of R#42 another resident with severe cognitive impairment. The facility failed to address the sexually aggressive behavior of R#364 and failed to put effective interventions in place and therefore failed to protect R#17, R#55, and R#42 from resident-to-resident sexual abuse.<br><br>The IJ was related to the facility's noncompliance with the program requirements, as follows:<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | F600: 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation (Scope/Severity [S/S]: J; F607: 42 CFR 483.12(b)(1)(4), Develop/Implement Abuse/Neglect, etc. Policies S/S: J; F608: 42 CFR 483.12(b)(5), Reporting of Reasonable Suspicion of a Crime, S/S: J; F610: 42 CFR 483.12(c)(2) (4), Alleged Violations-Investigate/Prevent/Correct S/S: J); F656: 42 CFR 483.21 - Comprehensive Resident Centered Care Plans, S/S: J; F835: 42 CFR 483.70 - Administration S/S: J.<br><br>Additionally, Substandard Quality of Care was identified with the requirements at F600: 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation (Scope/Severity [S/S]: J; F607: 42 CFR 483.12(b)(1)(4), Develop/Implement Abuse/Neglect, etc. Policies S/S: J; F608: 42 CFR 483.12(b)(5), Reporting of Reasonable Suspicion of a Crime, S/S: J; F610: 42 CFR 483.12(c)(2) (4), Alleged Violations-Investigate/Prevent/Correct S/S: J).<br><br>An Acceptable Removal Plan was received on 4/17/2022. The removal plan included placing R#364 and R#17 on one-to-one supervision, staff training, skin assessments on all residents including cognitively impaired residents and interviews with all cognitive residents regarding abuse, neglect, and sexual abuse. The survey team conducted observations, reviewed staff training records and monitoring logs, clinical record review of revised care plans, and interviews with staff and residents to verify all elements of the facility's Removal Plan were implemented. The immediacy of the Immediate Jeopardy was removed on 04/17/2022. The facility remained out of compliance at a lower scope and severity while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures governing the identification, reporting, investigation, and protection of residents from abuse, including sexual abuse<br><br>Findings include:<br><br>Review of the undated facility policy titled, Abuse Prohibition, revealed, Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm. Sexual abuse includes, but is not limited to sexual harassment, sexual coercion, or sexual assault.<br><br>1. A review of the facility's self-reported incidents revealed R#364 was the alleged perpetrator of sexual assaults upon R#17 on 05/23/2021 and 07/11/2021; R#55 on 08/27/2021; and R#42 on 01/21/2022.<br><br>A review of R#364's Face Sheet revealed the facility admitted the resident with diagnoses including cerebral infarction (stroke), vertebrobasilar artery syndrome (syndrome affecting blood supply to the brain), aphasia (comprehension and communication disorder) and chronic kidney disease.<br><br>Review of the Quarterly Minimum Data Set (MDS), dated [DATE] revealed R#364 was assessed to have a Brief Interview for Mental Status (BIMS) score of seven indicating the resident had severe cognitive impairment. This MDS documented R#364 required encouragement for transfers with setup help only needed. R#364 was assessed to be independent with locomotion off of the unit and used a wheelchair for locomotion. The resident was assessed to have no impairment to bilateral upper extremities with impairment to bilateral lower extremities.<br><br>Review of the Face Sheet for R#17 revealed the facility admitted the resident with diagnoses including Alzheimer's disease with early onset, dementia with behavioral disturbance, and delusional disorder.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of the annual Minimum Data Set (MDS), dated [DATE] revealed that R#17 was assessed to have a BIMS score of four indicating the resident had severe cognitive impairment. R#17 required extensive assistance of one person for transfers and supervision of one person with locomotion on the unit and that locomotion off the unit occurred only once or twice. R#17 used a wheelchair for mobility.<br><br>a. Review of a Facility Incident Report Form, dated 05/23/2021, revealed the facility initiated a report regarding abuse. The details of the incident indicated a nurse walked into R#17's room and found another resident (R#364) with his/her hands up R#17's shirt. The facility's investigation file contained the incident report, the one-page facility investigation, three witness statements, and one undated handwritten note from Social Worker (SW) FF. The statement of investigation, dated 05/27/2021, documented R#364 was found in R#17's room with his/her hands under R#17's shirt, fondling the resident's breasts. The report revealed a nurse (LPN TT) reported the incident and removed R#364 from the room. Registered Nurse (RN) CCC was then sent to interview R#17 regarding the incident. The report indicated that R#17 denied any male visitors in his/her room. The report revealed R#17 reported to Certified Nursing Assistant (CNA) AAA that a man had come to R#17's room and molested R#17. R#17 also spoke to a Licensed Practical Nurse (LPN) and stated that R#17 had told a man to get the hell out of the room, or R#17 would kick his ass. The report revealed R#364 was counseled regarding the incident and was instructed to not enter any other resident's room. The report indicated R#364 understood and that staff had been made aware if they witnessed R#364 and R#17 together, staff were to ask R#17 if the resident wanted to sit somewhere else. The report indicated the police were notified. There was a badge number on the report, but no incident number or tracking number for a police report.<br><br>Review of a typed statement, dated 05/23/2021 by RN CCC, revealed that R#364 was seen rubbing R#17's leg that morning and was told by a nurse (LPN TT) to stop touching R#17 and that this was not okay. R#364 proceeded to follow R#17 around, and R#17 went to the nurses' station with tears in his/her eyes and said he/she was scared. The statement documented when RN CCC returned from lunch, staff reported that R#364 was found in R#17's room grabbing R#17's breasts. RN CCC went to talk to R#17 alone, and R#17 did not remember anyone coming into his/her room. A few minutes later, RN CCC and CNA AAA went to talk to R#17, who then reported to CNA AAA that she was molested by a guy and R#17 told him to get the hell out. The statement indicated a full body assessment was conducted by an RN and LPN and there was no bruising or redness to the chest area or abdomen.<br><br>Review of a handwritten statement, dated 05/23/2021 and signed by CNA AAA, revealed the CNA went into R#17's room and asked if a man had come into the room. According to the statement, R#17 stated yes, and he molested me. CNA AAA asked the resident if the man tried to touch R#17. R#17 stated the man put his hands, down my pants and under my shirt. The resident also stated he/she told the man that he/she would kick his ass. During the survey, the surveyor attempted to contact CNA AAA via telephone; however, the CNA worked for an agency and the surveyor was unable to obtain a working number.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of a handwritten statement, dated 05/23/2021 by LPN TT, revealed the nurse had witnessed R#364 stroking R#17's left upper leg. LPN TT and two different CNAs told R#364 to stop touching R#17 and that this was not appropriate. The statement documented R#364 proceeded to follow R#17 around. LPN TT stated the staff were attempting to keep a close eye on both residents' whereabouts, as R#364 was trying to pursue and isolate R#17. The statement documented that at one point R#17 was retrieved from the hall and R#17 stated she was afraid and that someone had scared her. The statement documented that LPN TT had to provide care to another resident and when she returned to where R#17 was being monitored, R#17 and R#364 were both gone. LPN TT opened the door to R#17's room and found R#364 with both hands underneath R#17's blouse, fondling both of R#17's breasts. The statement documented that R#17 was not objecting but that R#17 was not mentally capable of giving consent. The statement revealed LPN TT removed R#364 from the room.<br><br>An interview on 04/17/2022 at 12:34 PM with LPN TT, when asked about the incident involving R#17 and R#364 that occurred on 05/23/2021, LPN TT stated she had directly reported the incident to the Administrator and demanded the police be notified because of how afraid R#17 was after the incident. LPN TT stated the previous Director of Nursing (DON) EEE, who was employed at the facility when this event and three other assaults by R#364 took place, did not recognize the seriousness of the incident. LPN TT stated the staff were never told if a report was filed with the state or if there were any new interventions in place for protection of R#17 and other residents, except to watch them closely.<br><br>Review of an undated, untimed statement from SW FF indicated the SW asked R#17 if the resident was afraid, and R#17 said no. There was no documentation in R#17's electronic health record (EHR) regarding the sexual assault.<br><br>An interview was conducted on 04/13/2022 at 1:38 PM with SW FF regarding the sexual assault of R#17 that occurred on 05/23/3021. SW FF stated the Administrator was the Abuse Coordinator, and everything was reported to her. When asked if she interviewed residents after allegations of abuse, SW FF stated she did, but that she did not document anything in the chart. SW FF stated she conducted a safety survey of other residents, and a list was provided to the Administrator. SW FF confirmed again that she did not document the information in the chart.<br><br>Record review of a Nurse's Note in R#17's EHR, dated 05/23/2021 at 2:02 PM and authored by RN CCC, revealed R#17's family member was notified of the incident between the resident and another resident in R#17's room. The note did not indicate whether the Abuse Coordinator were notified. The note indicated a full body assessment was completed and that the resident's skin integrity looked normal and there was no redness on the chest or abdomen.<br><br>Record review of a Nurse's Note in R#17's EHR, dated 05/24/2021 at 12:27 PM as a late entry and authored by Resident Care Coordinator (RCC) OO, indicated R#17's family was notified of the incident that occurred on 05/23/2021. The family member was made aware that staff would attempt to keep the two residents apart.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of a COC [Change of Condition] - Behavior report for R#364 dated 05/23/2021, revealed the change of condition was physical aggression and that the resident was a danger to self or others. Resident has acted out sexual contact by touching and groping breast of resident after being careful to close the door to avoid exposure. The document also documented R#364 had been warned about going into female residents' rooms numerous times and had been removed several times. The report documented the resident (R#364), always slips around the other side to go into this resident's room. There were no further notes in R#364's record regarding the assault that occurred on 05/23/2022.<br><br>Review of the Summary Report for R#17 indicated there were no new physician's orders following the incident on 05/23/2021. Review of the Summary Report for R#364 revealed a physician's order, dated 05/27/2021, for Zoloft (an antidepressant) 50 milligrams (mg) at bedtime for a diagnosis of depression. This medication was discontinued on 08/27/2021 and no other medications were added at that time.<br><br>Record review of the EHR for R#364 revealed one Nurse's Note, dated 05/29/2021 at 2:44 PM, six days after the assault occurred. The note, which was documented by LPN TT, documented R#364 was continuing to go into a female resident's room and closing the door. On last Sunday, 5/23/2021, R#364 was found in R#17's room having inappropriate contact by having hands under the patients blouse and fondling her breast. Reported this incident and behavior, that has been observed prior, to the physical molestation to the Administrator. The note indicated LPN TT was surprised to see R#364 still having free range in the facility, considering the nature of the incident on 05/23/2021. LPN TT documented that at 2:10 PM that day (5/29/2021), the wound care nurse informed R#17's nurse that R#364 had entered R#17's room and closed the door. R#364 was removed from R#17's room, LPN TT told R#364 not to enter any rooms of female residents and close the door. R#364 cursed at LPN TT and stated he would call DON EEE.<br><br>b. Review of a Facility Incident Report Form, dated 07/11/2021, revealed the facility initiated a self-report regarding abuse. The file contained the incident report, the one-page facility investigation, one witness statement, a statement from another staff member who was not a witness to the incident, an electronic mail (e-mail) from the Administrator outlining why the incident was not reported to the police, and the confirmation e-mail from the state indicating a reference number for receipt of the report. The statement of investigation, dated 07/18/2021, revealed a CNA reported to LPN PP that the CNA walked into R#364's room and found R#364 massaging the breasts of R#17. The report indicated the CNA removed R#17 from the room. R#364 was counseled regarding touching other residents inappropriately and stated he understood. The report indicated staff were notified that if they saw R#364 and R#17 together, to ask R#17 if she wanted to be removed from being around R#364. The report stated a full assessment had been conducted and no injuries were noted.<br><br>Review of a typed statement, dated 07/11/2021 at 2:50 PM and signed by LPN GGG, revealed LPN GGG found R#17 in R#364's room. R#17's shirt was pulled up above the clavicles, exposing the resident's bare chest, and R#364 had both hands on R#17's breasts, massaging them. When R#364 was asked what he was doing, R#364 removed his hands, and very quickly pulled R#17's shirt down and stated, none of your business. LPN GGG removed R#17 from the room and told R#364 that he could not do that. R#364 stated, Oh yes I can. The statement documented R#17 was assisted to the other nurses' station near the resident's room, and LPN PP was informed of the incident.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of an email dated 7/12/2021, from the Administrator to Corporate contradicted the handwritten note written by LPN GGG (which documented that LPN GGG was the staff member that observed R#17 in R#364's room). The email indicted, in pertinent part, that a CNA found R#17 in R#364's room and that she was in no distress. The email indicated that R#17 (a severely cognitively impaired resident) probably thinks that R#364 is her husband and there is nothing that anyone can do, maybe try and keep them separated, but that would be too hard.<br><br>Review of the EHR for R#17 revealed there was no documentation indicating that the resident's family, or abuse coordinator were notified of the sexual assault on 07/11/2021. There was no nurse's note or assessment found in the chart related to the 07/11/2021 incident.<br><br>Review of the EHR for R#364 revealed there was no documentation regarding the sexual assault on 07/11/2021.<br><br>Review of the Summary Report revealed there were no new physician's orders for R#17 related to the 07/11/2021 incident. Review of the Summary Report for R#364 indicated Seroquel (antipsychotic used to treat schizophrenia, depression, and bipolar disorder) 50 mg at bedtime was added to the resident's medications on 07/29/2021 for a diagnosis of paranoia. There were no other medications added at this time. An order to consult psychiatric services was added on 07/15/2021; however, there was no documentation to indicate R#364 received the psychiatric evaluation until 09/10/2021 after the resident had sexually assaulted R#55 on 08/27/2021.<br><br>Observation on 04/12/2022 at 8:46 AM revealed R#17 sitting in his/her room, in a wheelchair. During an interview at this time, R#17 was asked what the month and year was and was unable to answer. When asked if any man had come to the residents room and touched R#17 in a way that made them uncomfortable, R#17 stated no and, I would kick their ass.<br><br>Observation on 04/12/2022 at 2:38 PM revealed R#17 self-propelling on the 400 Hall between the station I and station II nurses' stations. R#17 was not seen entering any rooms or opening any doors. R#17 went to the end of the hall near station II, tested the door to the outside, turned around, and propelled back down the hall to station I.<br><br>Observation on 04/12/2022 at 3:01 PM revealed R#17 self-propelling in a wheelchair on the 400 Hall between nurses' stations I and II. The surveyor observed R#17 self-propel back and forth on the hallway for 20 minutes. R#17 did not enter any rooms.<br><br>Observation on 04/13/2022 at 7:57 AM revealed R#17 self-propelling their wheelchair on the 400 Hall between nurses' stations I and II. The resident did not attempt to go into any rooms, but stopped long enough to talk to a female resident sitting in the hallway near the bird cages, and then continued back down the hallway to station I.<br><br>2. Review of the Quarterly MDS dated [DATE] revealed R#364 had a BIMS score of 12 indicating the resident had moderate cognitive impairment. This MDS documented R#364 required encouragement for transfers with setup help only needed. R#364 was assessed to require encouragement with two plus person assist for locomotion off of the unit. The resident was assessed to have no impairment to bilateral upper extremities with impairment to bilateral lower extremities.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of the quarterly Minimum Data Set (MDS), dated [DATE] revealed R#55 was assessed to have a BIMS score of nine indicating the resident had moderate cognitive impairment. The MDS documented R#55 required extensive assistance of two or more people for bed mobility and transfers, required limited assistance of one person for locomotion on the unit and locomotion off of the unit did not occur. R#55 used a wheelchair for mobility. R#55 was assessed to have no impairment to bilateral upper extremities but had impairment to bilateral lower extremities.<br><br>Review of R#55's Face Sheet revealed the facility admitted the resident with diagnoses including vascular dementia with behavioral disturbance, major depressive disorder, history of falling, and atherosclerosis of native arteries of bilateral legs.<br><br>Review of a Facility Incident Report Form, dated 08/27/2021, revealed the facility initiated a self-report regarding abuse. The file contained the incident report, a one-page facility investigation, three witness statements, one handwritten assessment, an e-mail report of the incident from DON EEE (former DON) to the Administrator, a handwritten note documenting an interview between R#55 and the Administrator, and a handwritten note documenting an interview between R#55 and Resident Care Coordinator (RCC) OO. There were no other documents provided. The statement of investigation, dated 09/02/2021, indicated that R#364 was found in R#55's room. After CNA JJJ notified LPN TT, R#55 was observed by LPN TT in bed, R#364 was in a wheelchair next to the bed with his hands under the covers. When LPN TT looked under the covers, she observed that R#55's brief had been untaped and the front of the brief folded back. LPN TT asked R#55 about the incident, and R#55 stated R#364 had not touched R#55 anywhere and better not. LPN TT stated that R#55 seemed confused. The report revealed the Administrator spoke to R#55 regarding the incident and when asked if R#364 was inappropriate, R#55 said, you mean touch me? R#55 then stated, I will let y'all know if he ever did. The investigation revealed that RCC OO spoke to R#55's family member. Former DON EEE and the Administrator counseled R#364 regarding going into another resident's room without permission and to not touch anyone inappropriately. The administrator explained to R#364 that a 30-day notice to leave the facility could be issued if there were any further occurrences. The investigation report revealed the physician and responsible party for R#364 were notified of the incident. The report revealed a conclusion that CNA JJJ's answers were inconsistent, and the facility felt there was no inappropriate behavior, that R#364 was just visiting R#55.<br><br>However, review of an e-mail, dated 08/27/2021 at 1:51 PM from former DON EEE to the Administrator, documented that LPN TT brought R#364 to the DON's office and stated that R#364 was found in R#55's room with his hands under the covers. The e-mail documented that DON EEE asked R#364 why he was in R#55's room and R#364 stated R#55 needed something. DON EEE reminded R#364 that he/she had previously discussed that R#364 was not going to be going in other residents' rooms. The e-mail revealed R#364 stated he did not do anything. Then, R#364 asked DON EEE if she didn't do it? When DON EEE asked R#364 what the resident meant, R#364 stated, sex. DON EEE documented that when she had sex with an individual it was consensual and that R#364 touching other residents was not consensual. DON EEE asked R#364 if he/she had urges and if that was what all this is about? R#364 admitted yes. DON EEE then informed the resident that the facility could get with the physician to see if he can give him something.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of a typed statement, dated 08/27/2021 by CNA JJJ, revealed CNA JJJ walked into R#55's room after opening the closed door. CNA JJJ saw R#364 sitting at the bedside of R#55. R#55 had her leg in the air and her brief was open. The statement indicated R#364 was touching R#55's private area. When R#364 noticed the staff member, he jumped and tried to exit the room. CNA JJJ notified LPN TT about the incident. A handwritten note was added (by the Administrator) to the bottom of the typed and signed note, that the Administrator spoke with CNA JJJ regarding the incident. The Administrator wrote that CNA JJJ was incorrect about the legs of R#55 being in the air, that the legs were under the covers, and that CNA JJJ did not see any of R#55's private areas.<br><br>Review of a second typed statement by CNA JJJ was dated 08/27/2021 documented that CNA JJJ knocked on the closed door of R#55's room, then found R#364 sitting at the bedside of R#55. The statement documented R#55's legs were raised, and R#364's hands were under the covers. CNA JJJ documented that R#364 looked startled and jumped, and CNA JJJ ran to get the nurse so she could witness R#364 coming out of the room.<br><br>The surveyor was unable to contact CNA JJJ for a telephone interview. The CNA worked for a staffing agency. The surveyor asked the Administrator for a contact number for CNA JJJ several times, but no phone number was provided.<br><br>Review of a handwritten statement, dated 08/27/2021 and signed by LPN TT, documented that LPN TT was notified of the encounter by CNA JJJ. LPN TT, and another staff member went to R#55's room and asked the resident why R#364 was at her bedside. LPN TT documented that when they lifted the cover they discovered that R#55's brief had been untaped on the right side and was folded back exposing the resident's privates. LPN TT documented that R#55 acted confused and said, he better not touch her and that she couldn't remember. Further review revealed a handwritten assessment written by LPN TT dated 8/27/2021 that documented: Minor redness to sacrum area, dry arms/elbows, no bruising noted. Slight redness to face-dry skin. No injuries noted. Toenails need attention- very thick and overgrown. The note did not indicate whether the family or abuse coordinator were notified.<br><br>An interview on 04/17/2022 at 12:34 PM with LPN TT, who stated the facility had a total disregard for the safety of the residents. She stated the staff were never told if a report was filed with the state and if there were any new interventions in place for protection of R#55 and other residents, except to watch them closely.<br><br>Record review of R#55's EHR revealed a Nurse's Note, dated 08/27/2021 at 4:12 PM and authored by LPN TT. The note indicated a complete head to toe assessment was completed, and no injury or bruising was noted. There was a Daily Skilled Note, dated 08/27/2021, that made no reference to the incident.<br><br>Review of the Summary Report for R#55 revealed there were no new physician's orders related to the 08/27/2021 incident. Review of the Summary Report for R#364 revealed a physician's order, dated 08/27/2021, for medroxyprogesterone (a female hormone sometimes used for treating male sexual hyperactivity by lowering testosterone levels). The directions were to administer a 150 mg per milliliter (150 mg/ml) intramuscular injection weekly on Mondays.<br><br>(continued on next page) |

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|---|---|---|---|
| | 115395 | A. Building<br>B. Wing | 05/16/2022 |

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| Winthrop Health and Rehabilitation | 12 Chateau Drive<br>Rome, GA 30161 |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of a Psychiatric Diagnostic Evaluation, dated 09/10/2021, revealed staff reported that R#364 was impulsive and inappropriately touching female staff (there was no mention of the resident inappropriately touching other residents). The current psychotropic medications in use included sertraline (an antidepressant), mirtazapine (an antidepressant), and quetiapine (an antipsychotic). The recommendations included:<br><br>- If inappropriate behaviors persist, continue medroxyprogesterone as ordered. Recommend monthly dose until stabilized.<br><br>- Continue current psychotropic medications and supportive care as ordered.<br><br>- Continue to monitor mood and behavior.<br><br>The surveyor attempted to contact the psychiatric nurse practitioner who documented the psychiatric evaluation but was unable to reach her.<br><br>An observation on 04/11/2022 at 8:08 AM revealed R#55 sitting in a wheelchair in front of nurses' station II. The resident was able to self-propel the wheelchair.<br><br>Observation on 04/12/2022 at 9:46 AM revealed R#55 sitting in a wheelchair in the hallway, across from nurses' station II.<br><br>An interview on 04/13/2022 at 2:10 PM with the Administrator confirmed there was no documentation of the counseling and warning of a 30-day notice for R#364 and stated, we should have documented it. When asked what medications changes were made, as indicated in the facility investigation, the Administrator stated she did not know. She also confirmed there was no documentation of the physician being notified, as stated in the facility's investigation.<br><br>Observation on 04/13/2022 at 10:07 AM revealed R#55 in bed. An interview was conducted with R#55 at this time. When asked if he/she knew any man by the name of (R#364), the resident stated no. R#55 also stated he/she did not remember anyone touching them inappropriately and would not be okay with that and would not like it. The resident was unable to state the current month or year.<br><br>3. Review of the Quarterly MDS for R#364 dated 12/15/2021 revealed the resident had a BIMS score of 11 indicating the resident was assessed to have moderate cognitive impairment. The MDS documented that R#364 was independent with transferring and with locomotion on and off the unit and used a wheelchair for locomotion. No behavioral symptoms were indicated on the MDS.<br><br>Review of a Quarterly Minimum Data Set (MDS), for R#42 dated 11/16/2021 revealed that a BIMS assessment was not conducted for R#42 as the resident was rarely or never understood and was severely impaired in cognitive skills for daily decision-making. The resident was totally dependent for bed mobility and locomotion on the unit and required extensive assistance of two or more people with transfers. Locomotion off the unit occurred only once or twice. The resident was assessed to have no impairment to bilateral upper extremity with impairment to bilateral lower extremities.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of R#42's Face Sheet revealed the facility admitted the resident with diagnoses including Alzheimer's disease with late onset, need for assistance with personal care, other signs and symptoms involving emotional state, and pseudobulbar affect (disorder of the nervous system that causes inappropriate laughing or crying).<br><br>Review of the Facility Incident Report Form, dated 01/21/2022, revealed the facility initiated a self-report regarding resident-to-resident abuse. The date of the incident was 01/20/2022. The file contained the incident report, the one-page facility investigation, and two witness statements. There were no other documents provided. The facility investigation, dated 01/28/2022, revealed that a nurse reported to former DON EEE that R#364 was seen with his hand on the outside of the shirt of R#42, near the breast area.<br><br>Review of a handwritten statement, dated 01/20/2022 and signed by LPN KKK, revealed R#364 was observed with his/her hand on R#42's chest. The report documented that R#364 was in his/her wheelchair beside R#42. There were no injuries.<br><br>The surveyor attempted to obtain a phone number for LPN KKK as well as the identity of the other witness, but LPN KKK was no longer employed by the facility, and the surveyor was unable to obtain contact information.<br><br>Review of a handwritten statement, dated 01/20/2021 at 7:35 PM, did not legibly identify the witness' title, and the Administrator did not recognize the name on the statement. The statement indicated LPN KKK separated R#364 and R#42. The statement also indicated that R#42 was not crying and was not in distress.<br><br>Record review of the Summary Report revealed there were no new physician's orders for Resident #42 related to the 01/21/2022 incident. Record review of the Summary Report for R#364 also revealed there were no new orders related to the 01/21/2022 incident. The only new orders for R#364 on 01/21/2022 were for a treatment to the left lower leg and an antibiotic to treat cellulitis to the left lower leg.<br><br>Observation on 04/11/2022 at 8:05 AM revealed R#42 was in the hallway at nurses' station II, in a recliner.<br><br>Observation on 04/12/2022 at 9:55 AM revealed R#42 was in the hallway, next to nurses' station II, in a recliner. The resident was nonverbal, other than moans and grunts.<br><br>Observation on 04/12/22 at 4:07 PM revealed R#364 was in their room, sitting in a wheelchair. The door to the room was closed.<br><br>Observation on 04/13/2022 at 8:04 AM revealed R#364 was in their room, sitting in his/her wheelchair.<br><br>Observation on 04/13/2022 at 10:02 AM revealed R#364 was in their |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38514<br><br>Based on interview, record review, document review, and review of facility policies titled, Reporting and Investigating Abuse, and Abuse Prohibition - Screening, Hiring and Training Practices, the facility failed to develop and/or implement the protection, reporting, training components of their abuse for three of four (R#17, R#42, R#55) residents reviewed for sexual abuse.<br><br>On 04/14/2022, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents.<br><br>The facility's Administrator was informed of the Immediate Jeopardy (IJ) on 04/14/2022 at 7:46 PM. The noncompliance related to the immediate jeopardy was identified to have existed on 05/23/2021. The immediate jeopardy was removed on 04/17/2022.<br><br>The IJ is outlined as follows:<br><br>The IJ began on 05/23/2021, when R#364 was found in the room of R#17, a resident with severe cognitive impairment, with his hands under the resident's shirt on the resident's breasts. On 5/23/2021, R#17, reported to staff that she had been molested. The facility failed to put interventions in place to prevent future incidents from taking place. R#17 was subsequently sexually abused a second time by R#364 on 07/11/2021 when R#364 was found with his hands under R#17's shirt. Additional residents were sexually abused by R#364. R#55, a bedbound resident with moderate cognitive impairment, was sexually abused by R#364 on 08/27/2021, when R#364 was observed in R#55's room, with his hand under R#55's cover. R#55's brief was observed to be un-taped and folded back. On 1/21/2022, R#364 was found with his hand on the chest of R#42 another resident with severe cognitive impairment. The facility failed to address the sexually aggressive behavior of R#364 and failed to put effective interventions in place and therefore failed to protect R#17, R#55, and R#42 from resident-to-resident sexual abuse.<br><br>The IJ was related to the facility's noncompliance with the program requirements, as follows:<br><br>F600: 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation (Scope/Severity [S/S]: J; F607: 42 CFR 483.12(b)(1)(4), Develop/Implement Abuse/Neglect, etc. Policies S/S: J; F608: 42 CFR 483.12(b)(5), Reporting of Reasonable Suspicion of a Crime, S/S: J; F610: 42 CFR 483.12(c)(2) (4), Alleged Violations-Investigate/Prevent/Correct S/S: J); F656: 42 CFR 483.21 - Comprehensive Resident Centered Care Plans, S/S: J; F835: 42 CFR 483.70 - Administration S/S: J.<br><br>Additionally, Substandard Quality of Care was identified with the requirements at F600: 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation (Scope/Severity [S/S]: J; F607: 42 CFR 483.12(b)(1)(4), Develop/Implement Abuse/Neglect, etc. Policies S/S: J; F608: 42 CFR 483.12(b)(5), Reporting of Reasonable Suspicion of a Crime, S/S: J; F610: 42 CFR 483.12(c)(2) (4), Alleged Violations-Investigate/Prevent/Correct S/S: J).<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | An Acceptable Removal Plan was received on 4/17/2022. The removal plan included placing R#364 and R#17 on one-to-one supervision, staff training, skin assessments on all residents including cognitively impaired residents and interviews with all cognitive residents regarding abuse, neglect, and sexual abuse. The survey team conducted observations, reviewed staff training records and monitoring logs, clinical record review of revised care plans, and interviews with staff and residents to verify all elements of the facility's Removal Plan were implemented. The immediacy of the Immediate Jeopardy was removed on 04/17/2022. The facility remained out of compliance at a lower scope and severity while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures governing the identification, reporting, investigation, and protection of residents from abuse, including sexual abuse<br><br>Findings include:<br><br>Review of the undated facility policy titled, Reporting and Investigating Abuse revealed, Intent: It is the intent of this center to establish standards of practice for investigation and reporting abuse, neglect, mistreatment, exploitation, and misappropriation of property. Reporting: Once a complaint or situation is identified involving alleged mistreatment, neglect, or abuse, including injuries of unknown source and/or misappropriation of patient property and is reported to the Administrator, the incident will be immediately reported (within 2 hours) to the State. The Administrator or designee will take immediate action to prevent further potential violations while the alleged violation is being investigated. Within two hours, contact the local Police Department if there is reasonable cause to believe abuse or suspicion of a crime has occurred, to begin investigation. The section of the policy for protection of residents from further abuse only addressed measures to be taken if the alleged perpetrator was a staff member and indicated, The center will take all measures to provide emotional support and reassurance following reporting of suspected abuse and follow-up care as needed.<br><br>Review of the undated facility policy titled, Abuse Prohibition - Screening, Hiring and Training Practices revealed, New and existing associates will receive training that includes: Activities that constitute abuse, neglect, misappropriation of resident property, and exploitation; Procedures for reporting abuse, neglect, misappropriation of resident property, and exploitation; Preventing abuse, neglect, misappropriation of resident property, and exploitation, including injuries of unknown origin; and Dementia management.<br><br>A review of the facility's self-reported incidents revealed R#364 was the alleged perpetrator of sexual assaults upon R#17 on 05/23/2021 and 07/11/2021; R#55 on 08/27/2021; and R#42 on 01/21/2022.<br><br>1. A review of R#364's Face Sheet revealed the facility admitted the resident with diagnoses including cerebral infarction (stroke), vertebrobasilar artery syndrome (syndrome affecting blood supply to the brain), aphasia (comprehension and communication disorder) and chronic kidney disease.<br><br>Review of the Quarterly Minimum Data Set (MDS), dated [DATE] revealed R#364 was assessed to have a Brief Interview for Mental Status (BIMS) score of seven indicating the resident had severe cognitive impairment. Review of the Quarterly MDS dated [DATE] revealed R#364 had a BIMS score of 12 indicating the resident had moderate cognitive impairment. Quarterly MDS dated [DATE] revealed the resident had a BIMS score of 11 again indicating the resident was assessed to have moderate cognitive impairment.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of R#17's Face Sheet revealed the facility admitted the resident with diagnoses including Alzheimer's disease with early onset, dementia with behavioral disturbance, and delusional disorder.<br><br>Review of the annual Minimum Data Set (MDS), dated [DATE] revealed that R#17 was assessed to have a BIMS score of four indicating the resident had severe cognitive impairment.<br><br>1a. Review of a Facility Incident Report Form, dated 05/23/2021, revealed the facility initiated a report regarding abuse. The details of the incident indicated a nurse walked into R#17's room and found R#364 with his/her hands up R#17's shirt. The report indicated the police were notified. There was a badge number on the report, but no incident number or tracking number for a police report. There was no further indication of any measures taken by the facility to protect R#17 and other residents from further potential abuse by R#364.<br><br>Review of a typed statement, dated 05/23/2021 by RN CCC, and CNA AAA went to talk to R#17, who reported being molested to CNA AAA.<br><br>Record review of the EHR for R#364 revealed one Nurse's Note, dated 05/29/2021 at 2:44 PM, six days after the assault occurred. The note, which was documented by LPN TT, revealed R#364 was continuing to go into a resident's room and closing the door. The note indicated LPN TT was surprised to see R#364 still having free range in the facility, considering the nature of the incident on 05/23/2021.<br><br>An interview was conducted on 04/13/2022 at 2:10 PM with the Administrator when asked for the police report for the incident on 05/23/2021, and the Administrator stated no report number was provided, only a badge number.<br><br>1b. Review of a Facility Incident Report Form, dated 07/11/2021, revealed the facility initiated a self-report regarding abuse.<br><br>Review of a typed statement, dated 07/11/2021 at 2:50 PM and signed by LPN GGG, revealed the nurse found R#17 in R#364's room. The shirt of R#17 (a severely cognitively impaired resident) was pulled up above the clavicles, exposing the bare chest, and R#364 had both hands on R#17's breasts, massaging them.<br><br>Review of the Summary Report revealed an order dated 07/15/2021 to consult psychiatric services for R#364; however, there was no documentation to indicate R#364 received the psychiatric evaluation until 09/10/2021, after R#364 assaulted R#55 on 08/27/2021.<br><br>During an interview on 04/15/2022 at 11:40 AM, RCC OO confirmed there were no nurse's notes regarding the sexual assault on 07/11/2022 in R#17's chart. RCC OO confirmed a full body assessment for any injury related to the 07/11/2022 incident was not completed for R#17, and there was no documentation indicating whether the incident had been reported to the physician or the abuse coordinator.<br><br>2. Review of R#55's Face Sheet revealed the facility admitted the resident with diagnoses including vascular dementia with behavioral disturbance, major depressive disorder, history of falling, and atherosclerosis of native arteries of bilateral legs.<br><br>Review of the quarterly Minimum Data Set (MDS), dated [DATE] revealed R#55 was assessed to have a BIMS score of nine indicating the resident had moderate cognitive impairment.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of a Facility Incident Report Form, dated 08/27/2021, revealed the facility initiated a self-report regarding abuse. The statement of investigation, dated 09/02/2021, indicated that R#364 was found in R#55's room. There was no documentation regarding any further measures taken to protect R#55 or other residents from further potential abuse by R#364.<br><br>3. Review of the Face Sheet for R#42 revealed the facility admitted the resident with diagnoses including Alzheimer's disease with late onset, need for assistance with personal care, other signs and symptoms involving emotional state, and pseudobulbar affect (disorder of the nervous system that causes inappropriate laughing or crying).<br><br>Review of a Quarterly Minimum Data Set (MDS), dated [DATE] revealed that a BIMS assessment was not conducted for R#42 as the resident was rarely or never understood and was severely impaired in cognitive skills for daily decision-making.<br><br>Review of the Facility Incident Report Form, dated 01/21/2022, revealed the facility initiated a self-report regarding resident-to-resident abuse. The date of the incident was 01/20/2022. The facility investigation dated 01/28/2022 revealed that a nurse reported to former DON EEE that R#364 was seen with their hand on the outside of the shirt of R#42, near the breast area. There was no documentation of any further measures to protect R#42 and other facility residents from further potential abuse by R#364. There was no documentation any other residents were interviewed or assessed to determine if they may have experienced or witnessed sexual abuse by R#364. Review of the EHR for R#42 revealed there was no nurse's note regarding the incident on 01/21/2022.<br><br>An interview on 04/12/2022 at 4:08 PM with LPN MMM, who stated R#364 was spoiled by former DON EEE and was permitted to, basically get away with murder. LPN MMM confirmed R#364 had been sexually inappropriate with female staff members as well as female residents. LPN MMM, brought their concerns to DON EEE, the DON did not address the concerns and blew them off.<br><br>An interview on 04/12/2022 at 4:17 PM with RN NNN regarding the alleged sexual abuse perpetrated by R#364. When asked if the staff had been given any instruction on how to protect the female residents and staff from R#364's sexually inappropriate behaviors, RN NNN stated the only instruction staff had received was to redirect R#364.<br><br>An interview on 04/13/2022 at 8:07 AM with CNA RRR regarding R#364' sexual behaviors. CNA RRR confirmed the staff was not in-serviced regarding any interventions to protect other residents from sexual assault by R#364, but that staff tried to keep R#364 separated from R#17 and monitor them.<br><br>A telephone interview was conducted on 04/13/2022 at 4:15 PM with former DON EEE. DON EEE revealed when asked about her recollection of any incidents surrounding R#364 and sexual assault of any residents at the facility, DON EEE stated she was able to recall a few. When asked if any in-services were conducted after the two incidents involving R#17, DON EEE stated she felt there were, and the in-service would be in the paper documents. When asked if there were any in-services or training provided to the staff regarding that incident on interventions to prevent further sexual assault, DON EEE stated there may have been a paper in-service training but was not able to recall if any training was done.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | An interview was conducted on 04/14/2022 at 9:07 AM with Medical Director HHH, who was also the attending physician for R#364, R#17, R#55 and R#42. When asked what interventions could be helpful to protect vulnerable female residents from sexual abuse, Medical Director HHH stated to monitor R#364 closely and try to keep him/her away from female residents.<br><br>In each of the four documented incidents of sexual assault allegedly perpetrated by R#364, there was no documentation to indicate interviews were conducted with other residents to determine if they had been abused or had witnessed abuse by R#364. There was no documentation to indicate that staff were provided with education and clear instructions on how to protect the victims and other facility residents from further sexual abuse, nor on how to monitor and provide emotional support and follow-up care to the victims of sexual assault, as per the facility's abuse policy and procedures.<br><br>During the interview with Administrator on 04/13/2022 at 2:10 PM, the Administrator was asked for the facility's abuse prohibition policies. Administrator AA provided three separate policies. The first policy titled Abuse Prohibition, covered definitions of abuse, how to identify possible abuse, and prevention of abuse. The second policy titled Abuse Prohibition - Screening, Hiring and Training Practices, covered training and hiring practices at the facility. The third policy titled, Reporting and Investigating Abuse, covered reporting, investigation, protection, and confidentiality. The policy regarding protection did not include provision of an immediate response to protect the resident from physical and psychosocial harm during an investigation. The policy also did not include examination of the victim, including a physical and psychological examination of the resident. The facility policy did not include staffing or room changes or increased supervision of the resident. When asked what the facility policy was for investigating an allegation of abuse or neglect, the Administrator stated the facility would report the incident, complete the investigation, and send it to the state. When asked about the facility's policy for protecting residents from further potential abuse, the Administrator stated the facility would suspend an alleged staff perpetrator until the investigation was completed and would terminate the staff member if the complaint was substantiated by the state. The Administrator stated the facility would protect residents by not telling staff who made an accusation and by separating the residents if there was abuse between two residents. She stated the facility would have the physician intervene when needed. None of the policies addressed protection of residents from further potential abuse when the alleged perpetrator was another facility resident. Further interview revealed the Administrator confirmed no additional abuse/neglect in-services were provided to the staff after the incidents occurred and no new interventions were put in place for resident protection after the incidents involving R#364.<br><br>Cross refer F600<br><br>17141 |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38514<br><br>Based on observations, record review, staff and family interviews, and review of facility policies titled, Reporting and Investigating Abuse, the facility failed to ensure allegations of sexual abuse were thoroughly investigated and failed to implement protective measures to prevent further incidences of sexual abuse for three of four (R#17, R#55, R#42) residents reviewed for sexual abuse.<br><br>On 04/14/2022, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents.<br><br>The facility's Administrator was informed of the Immediate Jeopardy (IJ) on 04/14/2022 at 7:46 PM. The noncompliance related to the immediate jeopardy was identified to have existed on 05/23/2021. The immediate jeopardy was removed on 04/17/2022.<br><br>The IJ is outlined as follows:<br><br>The IJ began on 05/23/2021, when R#364 was found in the room of R#17, a resident with severe cognitive impairment, with his hands under the resident's shirt on the resident's breasts. On 5/23/2021, R#17, reported to staff that she had been molested. The facility failed to put interventions in place to prevent future incidents from taking place. R#17 was subsequently sexually abused a second time by R#364 on 07/11/2021 when R#364 was found with his hands under R#17's shirt. Additional residents were sexually abused by R#364. R#55, a bedbound resident with moderate cognitive impairment, was sexually abused by R#364 on 08/27/2021, when R#364 was observed in R#55's room, with his hand under R#55's cover. R#55's brief was observed to be un-taped and folded back. On 1/21/2022, R#364 was found with his hand on the chest of R#42 another resident with severe cognitive impairment. The facility failed to address the sexually aggressive behavior of R#364 and failed to put effective interventions in place and therefore failed to protect R#17, R#55, and R#42 from resident-to-resident sexual abuse.<br><br>The IJ was related to the facility's noncompliance with the program requirements, as follows:<br><br>F600: 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation (Scope/Severity [S/S]: J; F607: 42 CFR 483.12(b)(1)(4), Develop/Implement Abuse/Neglect, etc. Policies S/S: J; F608: 42 CFR 483.12(b)(5), Reporting of Reasonable Suspicion of a Crime, S/S: J; F610: 42 CFR 483.12(c)(2) (4), Alleged Violations-Investigate/Prevent/Correct S/S: J); F656: 42 CFR 483.21 - Comprehensive Resident Centered Care Plans, S/S: J; F835: 42 CFR 483.70 - Administration S/S: J.<br><br>Additionally, Substandard Quality of Care was identified with the requirements at F600: 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation (Scope/Severity [S/S]: J; F607: 42 CFR 483.12(b)(1)(4), Develop/Implement Abuse/Neglect, etc. Policies S/S: J; F608: 42 CFR 483.12(b)(5), Reporting of Reasonable Suspicion of a Crime, S/S: J; F610: 42 CFR 483.12(c)(2) (4), Alleged Violations-Investigate/Prevent/Correct S/S: J).<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | An Acceptable Removal Plan was received on 4/17/2022. The removal plan included placing R#364 and R#17 on one-to-one supervision, staff training, skin assessments on all residents including cognitively impaired residents and interviews with all cognitive residents regarding abuse, neglect, and sexual abuse. The survey team conducted observations, reviewed staff training records and monitoring logs, clinical record review of revised care plans, and interviews with staff and residents to verify all elements of the facility's Removal Plan were implemented. The immediacy of the Immediate Jeopardy was removed on 04/17/2022. The facility remained out of compliance at a lower scope and severity while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures governing the identification, reporting, investigation, and protection of residents from abuse, including sexual abuse<br><br>Findings include:<br><br>Review of the undated facility policy titled, Reporting and Investigating Abuse revealed, Intent: It is the intent of this center to establish standards of practice for investigation and reporting abuse, neglect, mistreatment, exploitation, and misappropriation of property. The Administrator or designee will take immediate action to prevent further potential violations while the alleged violation is being investigated. The section of the policy for protection of residents from further abuse only addressed measures to be taken if the alleged perpetrator was a staff member. In addition, the investigative section of the policy did not address conducting an investigation of resident to resident abuse.<br><br>A review of R#364's Face Sheet revealed the facility admitted the resident with diagnoses including cerebral infarction (stroke), vertebrobasilar artery syndrome (syndrome affecting blood supply to the brain), aphasia (comprehension and communication disorder) and chronic kidney disease.<br><br>Review of the Quarterly Minimum Data Set (MDS), dated [DATE] revealed R#364 was assessed to have a Brief Interview for Mental Status (BIMS) score of seven indicating the resident had severe cognitive impairment. Review of the Quarterly MDS dated [DATE] revealed R#364 had a BIMS score of 12 indicating the resident had moderate cognitive impairment. Quarterly MDS dated [DATE] revealed the resident had a BIMS score of 11 again indicating the resident was assessed to have moderate cognitive impairment.<br><br>1. Review of R#17's Face Sheet revealed the facility admitted the resident with diagnoses including Alzheimer's disease with early onset, dementia with behavioral disturbance, and delusional disorder.<br><br>Review of the annual Minimum Data Set (MDS), dated [DATE] revealed that R#17 was assessed to have a BIMS score of four indicating the resident had severe cognitive impairment. R#17 required extensive assistance of one person for transfers and supervision of one person with locomotion on the unit and that locomotion off the unit occurred only once or twice. R#17 used a wheelchair for mobility.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 1.a. Review of a COC [Change of Condition] - Behavior report, dated 05/23/2021, for R#364 revealed the resident had sexual contact, which included touching and groping the breast of a female resident, after being careful to close the door to avoid exposure. The document also revealed R#364 had been warned about going into female residents' rooms numerous times and had been removed several times. The report indicated the resident, always slips around the other side to go into this resident's room.<br><br>Review of a Facility Incident Report Form, dated 05/23/2021, revealed the facility initiated a report regarding abuse. The details of the incident indicated a nurse walked into R#17's room and found another resident with his hands up R#17's shirt. The facility's investigation file contained the incident report, a one-page facility investigation, three witness statements, and one undated handwritten note from SW FF. The statement of investigation dated 05/27/21 indicated that R#364 was found in R#17's room with his hands under R#17's shirt, fondling the resident's breasts. The report revealed a nurse reported the incident and removed R#364 from the room. RN CCC interviewed R#17 regarding the incident and the resident denied any male visitors in her room. The report revealed R#17 reported to CNA AAA that a man had come to her room and molested her. R#17 also told an LPN that she had told a man to get the hell out of the room, or she would kick his ass. The report revealed that R#364 was counseled regarding the incident and was instructed not to enter any other resident's room. The report indicated R#364 understood and that staff had been made aware if they witnessed R#364 and R#17 together, they were to ask R#17 if she wanted to sit somewhere else. There was no documented evidence the facility interviewed R#364, or any other facility residents about their treatment at the facility and no documented evidence the facility assessed R#17's psychosocial well-being. In addition, there was no documented evidence any action was taken to protect Resident #17 or other facility residents from further potential abuse.<br><br>Review of a handwritten statement, dated 05/23/2021 by LPN TT, revealed the nurse had witnessed R#364 stroking R#17's left upper leg. LPN TT and two different CNAs told R#364 to stop touching R#17 and that this was not appropriate. The statement documented R#364 proceeded to follow R#17 around. LPN TT stated the staff were attempting to keep a close eye on both residents' whereabouts, as R#364 was trying to pursue and isolate R#17. The statement documented that at one point R#17 was retrieved from the hall and R#17 stated she was afraid and that someone had scared her. The statement documented that LPN TT had to provide care to another residents and when she returned to where R#17 was being monitored, R#17 and R#364 were both gone. LPN TT opened the door to R#17's room and found R#364 with both hands underneath R#17's blouse, fondling both of R#17's breasts. The statement documented that R#17 was not objecting but that R#17 was not mentally capable of giving consent. The statement revealed LPN TT removed R#364 from the room.<br><br>An interview conducted on 04/13/2022 at 1:38 PM with SW FF revealed she interviewed residents after allegations of abuse, but did not document anything in the chart. According to SW FF, she conducted a safety survey of other residents, and a list was provided to the Administrator. However, SW FF confirmed there was no documentation of the interviews.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 04/15/2022 at 11:40 AM, RCC OO confirmed that a nurse's note was in the EHR for R#17 regarding the sexual assault and that it addressed a skin assessment but nothing about the resident's emotional state. When asked what the procedure was after an allegation of sexual abuse, RCC OO stated a full head to toe assessment should be done. An incident report should be completed, and a nurse's note should be documented to include notification of the family, physician, and Administrator; and a description of the incident. When asked what time the incident occurred on 05/23/2021, RCC OO stated she did not know, because there was no documentation regarding when the incident occurred. RCC OO also confirmed a full body assessment was not completed for R#17, and there was no documentation indicating whether the incident was reported to the abuse coordinator. RCC OO also confirmed there was no documentation in R#364's chart referencing the sexual assault.<br><br>An interview was conducted on 04/13/2022 at 2:10 PM with the Administrator. The surveyor asked for the police report for the incident on 05/23/2021, and the Administrator stated no report number was provided, only a badge number. When asked where the assessment of R#17 was located, the Administrator stated it should be in the chart. The Administrator stated the facility conducted a skin assessment and that the skin assessment was possibly considered a full assessment. The Administrator stated he/she did not know the exact time the incident occurred or what was covered when R#364 was counseled, but the notes should be in the chart. The Administrator stated she was not sure when SW FF spoke to R#17 or where this was documented.<br><br>An interview with LPN TT on 04/17/2022 at 12:34 PM revealed the facility had total disregard for the safety of the residents, especially R#17. LPN TT stated former Director of Nursing (DON) EEE, who was employed at the facility when this event occurred did not recognize the seriousness of the incident.<br><br>1.b. Review of a Facility Incident Report Form, dated 07/11/2021, revealed a CNA walked into R#364's room and found R#364 massaging the breasts of R#17. The report indicated the CNA removed R#17 from the room. R#364 was counseled regarding touching other residents inappropriately and the resident stated understanding. The report indicated staff were notified that if they saw R#364 and R#17 together, to ask R#17 if the resident wanted to be removed from being around R#364. The report stated a full assessment had been conducted and no injuries were noted.<br><br>Review of a typed statement, dated 07/11/2021 at 2:50 PM and signed by LPN GGG, revealed the nurse found R#17 in R#364's room. R#17's shirt was pulled up above the resident's clavicles, exposing the bare chest, and R#364 had both hands on R#17's breasts, massaging them. When R#364 was asked what he was doing, R#364 removed his/her hands, pulled R#17's shirt down and stated, None of your business. LPN GGG removed R#17 from the room and told R#364 that he could not do that. R#364 replied, Oh yes I can. The statement indicated R#17 was assisted to the other nurses' station near his room, and the nurse informed LPN PP of the incident.<br><br>Further review of the Facility Incident Report Form, dated 07/11/2021 revealed no documented evidence the facility obtained a witness statement from any CNA, specifically the CNA who initially found R#17 in R#364's room. Further review revealed no evidence the facility interviewed R#364 regarding the incident, nor any other facility residents about their treatment at the facility. According to the investigation, a full skin assessment of R#17 was conducted, and no injuries were noted; however, a review of the resident's electronic health record revealed no documented evidence the facility assessed R#17's physical or psychosocial status. In addition, there was no documented evidence any action was taken to protect Resident #17 or other facility residents from further potential abuse.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of a handwritten statement, dated 07/11/2021 at 2:50 PM and signed by LPN PP, revealed LPN PP was not a witness to the actual incident, but that LPN GGG brought R#17 back to the side of the building where R#17's room was located.<br><br>Review of an email dated 7/12/2021, from the Administrator to Corporate contradicted the handwritten note written by LPN GGG (which documented that LPN GGG was the staff member that observed R#17 in R#364's room). The email indicted, in pertinent part, that a CNA found R#17 in R#364's room and that she was in no distress. The email indicated that R#17 (a severely cognitively impaired resident) probably thinks that R#364 is her husband and there is nothing that anyone can do, maybe try and keep them separated, but that would be too hard. The email also documented that the incident was reported (to the State) however, it was not reported to the police since there was no crime committed.<br><br>The surveyor attempted to contact LPN PP for a telephone interview; however, LPN PP was an agency nurse, and the surveyor was unable to obtain a working phone number.<br><br>There was no witness statement from any CNA attached to the investigation.<br><br>An interview was conducted on 04/13/2022 at 2:10 PM with Administrator. When asked why the sexual abuse on 07/11/2021 was not reported to the police, the Administrator stated he/she did not report all incidents and that it depended on the circumstances of each incident. The Administrator stated he/she reported the incident on 05/23/2021 because R#17 had used the word molested.<br><br>During an interview on 04/15/2022 at 11:40 AM, RCC OO confirmed there were no nurse's notes regarding the sexual assault on 07/11/2022 in R#17's chart. When asked what time this incident occurred, RCC OO stated he/she did not know, because there was no documentation regarding what time the incident occurred. RCC OO confirmed a full body assessment was not completed for R#17, and there was no documentation indicating whether the incident had been reported to the physician or the abuse coordinator. RCC OO also confirmed there was no documentation in R#364's chart regarding the sexual assault.<br><br>2. Review of a Facility Incident Report Form, dated 08/27/2021, revealed the facility initiated a self-report regarding abuse. According to the statement of investigation, dated 09/02/2021, R#364 was found in R#55's room. Certified Nursing Assistant (CNA) JJJ alerted Licensed Practical Nurse (LPN) TT and LPN TT observed R#55 in bed with the resident's legs elevated. R#364 was in a wheelchair next to the bed with his hands under the covers. When LPN TT looked under the covers, the tape strips on R#55's brief were undone and the front of the brief was folded back.<br><br>Review of R#55's Face Sheet revealed the facility admitted the resident on 11/21/2019 with diagnoses including vascular dementia with behavioral disturbance, major depressive disorder, history of falling, and atherosclerosis of native arteries of bilateral legs.<br><br>Review of the quarterly Minimum Data Set (MDS), dated [DATE] revealed R#55 was assessed to have a BIMS score of nine indicating the resident had moderate cognitive impairment.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of an e-mail, dated 08/27/2021 at 1:51 PM from former Director of Nursing (DON) EEE to Administrator, revealed that LPN TT brought R#364 to the DON's office and stated that R#364 was found in R#55's room with his hands under the covers. The e-mail indicated the DON asked R#364 why he was in R#55's room and R#364 stated R#55 needed something. The DON reminded R#364 that they had previously discussed that R#364 was not going to be going in other residents' rooms. The e-mail revealed R#364 stated he did not do anything, then asked the DON if she didn't do it. When the DON asked R#364 what he meant, R#364 stated, sex. DON EEE indicated she asked R#364 if he had urges and if that was what all this is about. R#364 admitted yes. DON EEE then informed the resident she would consult the physician to see if something could be ordered.<br><br>Review of a handwritten statement, dated 08/27/2021 and signed by LPN TT, documented that LPN TT was notified of the encounter by CNA JJJ. LPN TT, and another staff member went to R#55's room and asked the resident why R#364 was at her bedside. LPN TT documented that when they lifted the cover they discovered that R#55's brief had been untaped on the right side and was folded back exposing the resident's privates. LPN TT documented that R#44 acted confused and said, he better not touch her and that she couldn't remember.<br><br>Review of a Facility Incident Report Form, dated 08/27/2021, and the statement of investigation, dated 09/02/2021, revealed the Former DON EEE and the Administrator counseled R#364 regarding going into another resident's room without permission and to not touch anyone inappropriately. The Administrator explained to R#364 that a 30-day notice to leave the facility could be issued if there were any further occurrences. There was no documented evidence when considering whether the allegation was substantiated that the facility considered what LPN TT observed when she went into R#55's nor the conversation the resident had with DON EEE. In addition, there was no documented evidence the facility implemented interventions to monitor R#364's behavior to prevent further potential abuse.<br><br>An interview was conducted on 04/13/2022 at 2:10 PM with the Administrator when asked about the assessments that the investigation stated were completed, the Administrator stated assessments should be in the chart. The Administrator confirmed there was no documentation regarding counseling or the possible 30-day notice, stated we should have documented it.<br><br>During an interview on 04/15/2022 at 11:40 AM, RCC OO confirmed that there was one nurse's note in the EHR for R#55 regarding the sexual assault. The note did not include the time this incident occurred, who had been notified, nor the description of the incident. RCC OO stated there should have been notes with this information. RCC OO also confirmed there was no documentation in R#364's chart describing the sexual assault that occurred on 08/27/2021.<br><br>3. Review of the Facility Incident Report Form, dated 01/21/2022, revealed the facility initiated a self-report regarding resident-to-resident abuse. The date of the incident was 01/20/2022. The facility investigation, dated 01/28/2022, revealed that a nurse reported to former Director of Nursing (DON) EEE that R#364 was seen with his hand on the outside of the shirt of R#42, near the breast area.<br><br>Review of R#42's Face Sheet revealed the facility admitted the resident with diagnoses including Alzheimer's disease with late onset, need for assistance with personal care, other signs and symptoms involving emotional state, and pseudobulbar affect (disorder of the nervous system that causes inappropriate laughing or crying).<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of a Quarterly Minimum Data Set (MDS), dated [DATE] revealed that a BIMS assessment was not conducted for R#42 as the resident was rarely or never understood and was severely impaired in cognitive skills for daily decision-making.<br><br>Review of a handwritten statement dated 01/20/2022 and signed by Licensed Practical Nurse (LPN) KKK revealed R#364 was observed with his hand on R#42's chest. The report indicated R#364 was in his wheelchair beside R#42. There were no injuries.<br><br>The surveyor attempted to obtain a phone number for LPN KKK as well as the identity of the other witness, but LPN KKK was no longer employed by the facility, and the surveyor was unable to obtain contact information.<br><br>Review of a handwritten statement, dated 01/20/2021 at 7:35 PM, did not legibly identify the witness' title, and the Administrator did not recognize the name on the statement. The statement indicated LPN KKK separated R#364 and R#42. The statement also indicated R#42 was not crying and was not in distress.<br><br>Review of the Electronic Health Record (her) for R#42 revealed there was no nurse's note regarding the incident on 01/20/2022. The record did indicate a skin assessment was completed on 01/21/2022. There was no documentation in the chart indicating what time the incident occurred, or details of the incident.<br><br>Record review of a Summary Report for R#42 and R#364 revealed there were no new physician's orders related to the incident.<br><br>During an interview on 04/15/2022 at 11:40 AM, Resident Care Coordinator (RCC) OO confirmed there was no nurse's note in the EHR for R#42 or R#364 regarding the incident.<br><br>An interview was conducted with the Family of R#42 on 04/13/2022 at 10:17 AM. The Family indicated the facility did not explain any processes or interventions that would be put into place to protect R#42.<br><br>Continued review of the Facility Incident Report Form, dated 01/21/2022, the report indicated a full head to toe assessment had been completed and that R#364 was counseled that he could not touch other residents inappropriately. R#364 stated he understood. The nurse practitioner was informed of the incident and added a medication for R#364's behavior. The investigation indicated staff was made aware of the situation and staff were to report if they saw R#364 being inappropriate with another resident. There was no documented evidence the facility implemented any action to monitor R# 364's behavior to prevent further potential abuse.<br><br>An interview was conducted on 04/13/2022 at 2:10 PM with Administrator revealed the Administrator could not speak to how staff were made aware of the incident and should report inappropriate behavior and stated he/she did not know if there was any documentation that it occurred.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A telephone interview was conducted on 04/13/2022 at 4:15 PM with former DON EEE. DON EEE stated when asked if she felt R#17 was afraid and crying, as indicated by the witnesses after the encounter on 05/23/2021, DON EEE stated, I don't think [R#17] was fearful. DON EEE stated regarding R#42, she felt R#364 was just comforting R#42 and did not put his hands under her shirt. Further interview with DON EEE revealed she felt the witness was incorrect regarding R#55 and R#364. She stated she did not feel R#55 would be able to lift her legs in the air. DON EEE stated to prevent further potential abuse staff would keep R#364 in eyesight, place him at the nurse's station, and monitor.<br><br>Cross refer F600<br><br>17141 |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>38514<br><br>Based on observations, interviews, record review, document review, and review of the facility policy titled, Patient's Plan of Care, the facility failed to ensure person-centered, comprehensive care plans were developed to meet the safety and psychological needs of four of 16 (R#364, R#17, R#42 and R#55) whose care plans were reviewed. Specifically, the facility failed to ensure the comprehensive care plan for R#364 addressed the resident's sexually abusive behaviors to prevent further sexual abuse of other facility residents; and the comprehensive care plans for R#17, R#42, and R#55 failed to address protective measures and the necessary care, assessments and monitoring related to having been sexually assaulted by R#364.<br><br>On 04/14/2022, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents.<br><br>The facility's Administrator was informed of the Immediate Jeopardy (IJ) on 04/14/2022 at 7:46 PM. The noncompliance related to the immediate jeopardy was identified to have existed on 05/23/2021. The immediate jeopardy was removed on 04/17/2022.<br><br>The IJ is outlined as follows:<br><br>The IJ began on 05/23/2021, when R#364 was found in the room of R#17, a resident with severe cognitive impairment, with his hands under the resident's shirt on the resident's breasts. On 5/23/2021, R#17, reported to staff that she had been molested. The facility failed to put interventions in place to prevent future incidents from taking place. R#17 was subsequently sexually abused a second time by R#364 on 07/11/2021 when R#364 was found with his hands under R#17's shirt. Additional residents were sexually abused by R#364. R#55, a bedbound resident with moderate cognitive impairment, was sexually abused by R#364 on 08/27/2021, when R#364 was observed in R#55's room, with his hand under R#55's cover. R#55's brief was observed to be un-taped and folded back. On 1/21/2022, R#364 was found with his hand on the chest of R#42 another resident with severe cognitive impairment. The facility failed to address the sexually aggressive behavior of R#364 and failed to put effective interventions in place and therefore failed to protect R#17, R#55, and R#42 from resident-to-resident sexual abuse.<br><br>The IJ was related to the facility's noncompliance with the program requirements, as follows:<br><br>F600: 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation (Scope/Severity [S/S]: J; F607: 42 CFR 483.12(b)(1)(4), Develop/Implement Abuse/Neglect, etc. Policies S/S: J; F608: 42 CFR 483.12(b)(5), Reporting of Reasonable Suspicion of a Crime, S/S: J; F610: 42 CFR 483.12(c)(2) (4), Alleged Violations-Investigate/Prevent/Correct S/S: J); F656: 42 CFR 483.21 - Comprehensive Resident Centered Care Plans, S/S: J; F835: 42 CFR 483.70 - Administration S/S: J.<br><br>(continued on next page) |

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|---|---|---|---|
| | 115395 | A. Building<br>B. Wing | 05/16/2022 |

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| Winthrop Health and Rehabilitation | 12 Chateau Drive<br>Rome, GA 30161 |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Additionally, Substandard Quality of Care was identified with the requirements at F600: 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation (Scope/Severity [S/S]: J; F607: 42 CFR 483.12(b)(1)(4), Develop/Implement Abuse/Neglect, etc. Policies S/S: J; F608: 42 CFR 483.12(b)(5), Reporting of Reasonable Suspicion of a Crime, S/S: J; F610: 42 CFR 483.12(c)(2) (4), Alleged Violations-Investigate/Prevent/Correct S/S: J).<br><br>An Acceptable Removal Plan was received on 4/17/2022. The removal plan included placing R#364 and R#17 on one-to-one supervision, staff training, skin assessments on all residents including cognitively impaired residents and interviews with all cognitive residents regarding abuse, neglect, and sexual abuse. The survey team conducted observations, reviewed staff training records and monitoring logs, clinical record review of revised care plans, and interviews with staff and residents to verify all elements of the facility's Removal Plan were implemented. The immediacy of the Immediate Jeopardy was removed on 04/17/2022. The facility remained out of compliance at a lower scope and severity while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures governing the identification, reporting, investigation, and protection of residents from abuse, including sexual abuse<br><br>Findings include:<br><br>Review of the undated facility policy, titled, Patient's Plan of Care, indicated, Intent: Each patient will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the patient's medical, physical, mental, and psychosocial needs. Guideline: A comprehensive care plan should be developed within 7 days after completion of the comprehensive MDS [Minimum Data Set] assessment. When developing the comprehensive care plan, facility staff should use the MDS to assess the patient's clinical condition, cognitive and functional status, and use of services. The patient's care plan should be reviewed after each MDS assessment and revised based on changing goals, preferences and needs of the patient and in response to current interventions. The comprehensive care plan should also be updated as ongoing clinical assessments identify changes.<br><br>A review of the facility's self-reported incidents revealed R#364 was the alleged perpetrator of sexual assaults upon R#17 on 05/23/2021 and 07/11/2021; R#55 on 08/27/2021; and R#42 on 01/21/2022.<br><br>1. A review of R#364's Face Sheet revealed the facility admitted the resident with diagnoses including cerebral infarction (stroke), vertebrobasilar artery syndrome (syndrome affecting blood supply to the brain), aphasia (comprehension and communication disorder) and chronic kidney disease.<br><br>Review of R#17's Face Sheet revealed the facility admitted the resident with diagnoses including Alzheimer's disease with early onset, dementia with behavioral disturbance, and delusional disorder.<br><br>a. Review of a handwritten statement, dated 05/23/2021 by LPN TT, revealed in pertinent part, LPN TT opened the door to R#17's room and found R#364 with both hands underneath R#17's blouse, fondling both of R#17's breasts. The statement documented that R#17 was not objecting but that R#17 was not mentally capable of giving consent.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | b. Review of a typed statement, dated 07/11/2021 at 2:50 PM and signed by LPN GGG, revealed the nurse found R#17 in R#364's room. R#17's shirt was pulled up above the clavicles, exposing the bare chest, and R#364 had both hands on R#17's breasts, massaging them.<br><br>Review of the Care Plan, updated 01/27/2022, revealed R#364 had behaviors as evidenced by pacing, wandering, verbal aggression and inappropriate sexual behaviors. Interventions included:<br><br>- Assess patterns of behavior with behavior monitoring.<br><br>- Be an active listener.<br><br>- Allow for expression of feelings without censure.<br><br>- Communicate face to face.<br><br>- Involve in activities based on the resident's preferences and cognitive functioning.<br><br>- Redirect patient as needed.<br><br>- Use medication for short periods in the lowest possible dosage.<br><br>Review of the Care Plan, updated 01/13/2022, revealed R#17 was at risk for behaviors related to psychosocial factors and Alzheimer's disease, as evidenced by wandering and restlessness. Interventions included:<br><br>- Conduct behavior assessment as needed.<br><br>- Provide activities of choice to reduce frustration and dependence on others.<br><br>- Remove patient from stressful situations.<br><br>- Be an active listener, allow for expression of feelings without censure.<br><br>Review of the care plans for R#364 revealed there was no care plan developed regarding his sexual behaviors which contributed to the sexual assault against R#17. No prevention interventions were implemented to prevent future sexual assaults.<br><br>Review of the care plans for R#17 revealed there was no care plan developed following the sexual assault to address protection from further assaults or monitoring of psychological harm.<br><br>2. Review of R#55's Face Sheet revealed the facility admitted the resident with diagnoses including vascular dementia with behavioral disturbance, major depressive disorder, history of falling, and atherosclerosis of native arteries of bilateral legs.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of a Facility Incident Report Form, dated 08/27/2021, revealed the statement of investigation, dated 09/02/2021, indicated that R#364 was found in R#55's room. After CNA JJJ notified LPN TT, R#55 was observed by LPN TT in bed, with legs elevated. R#364 was in a wheelchair next to the bed with his hands under the covers. When LPN TT looked under the covers, R#55's brief had the tape strips undone and the front of the brief folded back. LPN TT asked R#55 about the incident, and R#55 stated R#364 had not touched R#55 anywhere and better not.<br><br>Review of the Care Plan, updated 03/24/2022, revealed R#55 had a cognitive deficit related to a diagnosis of vascular dementia, as evidenced by poor decision-making, a short-term memory problem, and impulsive behavior. Interventions included:<br><br>- Explain all procedures and treatments.<br><br>- Monitor labs.<br><br>- Assess for pain.<br><br>- Observe for any changes or decline in cognitive status.<br><br>Review of the Care Plan, updated 04/22/2021, revealed R#55 had behaviors, as evidenced by impulsiveness, verbal aggression, disrobing, hitting at staff during attempts to provide care, agitation, delusions, and a history of cussing at others. The interventions included:<br><br>- Conduct behavior assessment as needed.<br><br>- Provide activities of choice.<br><br>- Redirect as needed, enjoys talking about past, children, and work life.<br><br>- Remove from stressful situations.<br><br>Review of the care plans for R#364 revealed there was no care plan developed regarding his sexual behaviors which contributed to the sexual assault against R#55. No prevention interventions were implemented to prevent future sexual assaults.<br><br>Review of the care plans for R#55 revealed there was no care plan developed following the sexual assault to address protection from further assaults or monitoring of psychological harm.<br><br>3. Review of R#42's Face Sheet revealed the facility admitted the resident with diagnoses including Alzheimer's disease with late onset, need for assistance with personal care, other signs and symptoms involving emotional state, and pseudobulbar affect (disorder of the nervous system that causes inappropriate laughing or crying).<br><br>Review of the Facility Incident Report Form, dated 01/21/2022, revealed the facility initiated a self-report regarding resident-to-resident abuse. The date of the incident was 01/20/2022. revealed that a nurse reported to former DON EEE that R#364 was seen with his hand on the outside of the shirt of R#42, near the breast area.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of the Care Plan, dated 03/10/2022 revealed R#42 had cognitive impairment related to dementia and delirium, as evidenced by short and long-term memory problems and severely impaired decision-making. Interventions included explaining all procedures and treatments, allowing ample time to absorb and respond to information, and providing a consistent routine.<br><br>Review of the care plans for R#364 revealed there was no care plan developed regarding his sexual behaviors which contributed to the sexual assault against R#42. No prevention interventions were implemented to prevent future sexual assaults.<br><br>Review of the care plans for R#364 revealed there was no care plan developed following the sexual assault to address protection from further assaults or monitoring of psychological harm.<br><br>An interview was conducted on 04/12/2022 at 4:08 PM with LPN MMM, LPN MMM confirmed R#364 had been sexually inappropriate with female staff members as well as female residents.<br><br>During an interview on 04/13/2022 at 2:10 PM, Administrator stated R#364's inappropriate behavior should be addressed in the care plan and updated.<br><br>As of 04/14/2022 at 11:00 AM, the care plan for R#364 did not address the history of sexual assaults against other facility residents. R364's care plan did not contain interventions to prevent R#364 from sexually assaulting other residents. The care plans for R#17, R#42 and R#55 did not address protection from further assaults or monitoring for psychological harm related to the assaults.<br><br>An interview was conducted with RN LLL on 04/14/2022 at 11:08 AM. RN LLL stated all nurses played a part in care planning. RN LLL confirmed there were no care plans developed for R#364's sexual assaults or for protection for R#17, R#42, and R#55. RN LLL stated the care plans did not have the proper interventions.<br><br>An interview was conducted with the Administrator on 04/14/2022 at 1:19 PM revealed the care plans should be updated annually, quarterly and with significant changes. She indicated care plans should tell the story of the resident. The Administrator agreed the care plans for R#364, R#17, R#42 and R#55 should have been updated.<br><br>On 04/14/2022 at 1:50 PM, an interview was conducted with the current DON (DON CC) regarding care plans. DON CC stated care plans were to be developed on admission and should be person-centered. DON CC indicated care plans should be reviewed after events and updated.<br><br>On 04/15/2022 at 11:40 AM, Resident Care Coordinator (RCC) OO was interviewed regarding the care plans of R#364, R#17, R#42, and R#55. RCC OO stated the care plans should be updated or a new care plan should be developed and that she would expect there to be interventions in place to protect residents.<br><br>Cross refer F600<br><br>17141<br><br>46194 |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>38514<br><br>Based on observations, record review, review of the Facility's Job Title: Administrator and the Facility's Job Title: Director of Nursing Services Administration failed to ensure residents were free from resident-to-resident sexual abuse, failed to develop and implement policies and procedures to prohibit abuse, failed to develop policies and procedures to ensure reasonable suspicion of a crime against any resident was reported to local law enforcement, failed<br><br>to ensure all alleged incidents of sexual abuse were thoroughly investigated and immediate protective measures were put into place, failed to ensure person-centered, comprehensive care plans were developed to meet the safety and psychological needs. The failed practice had the potential to affect all 61 residents residing in the facility.<br><br>On 04/14/2022, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents.<br><br>The facility's Administrator was informed of the Immediate Jeopardy (IJ) on 04/14/2022 at 7:46 PM. The noncompliance related to the immediate jeopardy was identified to have existed on 05/23/2021. The immediate jeopardy was removed on 04/17/2022.<br><br>The IJ is outlined as follows:<br><br>The IJ began on 05/23/2021, when R#364 was found in the room of R#17, a resident with severe cognitive impairment, with his hands under the resident's shirt on the resident's breasts. On 5/23/2021, R#17, reported to staff that she had been molested. The facility failed to put interventions in place to prevent future incidents from taking place. R#17 was subsequently sexually abused a second time by R#364 on 07/11/2021 when R#364 was found with his hands under R#17's shirt. Additional residents were sexually abused by R#364. R#55, a bedbound resident with moderate cognitive impairment, was sexually abused by R#364 on 08/27/2021, when R#364 was observed in R#55's room, with his hand under R#55's cover. R#55's brief was observed to be un-taped and folded back. On 1/21/2022, R#364 was found with his hand on the chest of R#42 another resident with severe cognitive impairment. The facility failed to address the sexually aggressive behavior of R#364 and failed to put effective interventions in place and therefore failed to protect R#17, R#55, and R#42 from resident-to-resident sexual abuse.<br><br>The IJ was related to the facility's noncompliance with the program requirements, as follows:<br><br>F600: 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation (Scope/Severity [S/S]: J; F607: 42 CFR 483.12(b)(1)(4), Develop/Implement Abuse/Neglect, etc. Policies S/S: J; F608: 42 CFR 483.12(b)(5), Reporting of Reasonable Suspicion of a Crime, S/S: J; F610: 42 CFR 483.12(c)(2) (4), Alleged Violations-Investigate/Prevent/Correct S/S: J); F656: 42 CFR 483.21 - Comprehensive Resident Centered Care Plans, S/S: J; F835: 42 CFR 483.70 - Administration S/S: J.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Additionally, Substandard Quality of Care was identified with the requirements at F600: 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation (Scope/Severity [S/S]: J; F607: 42 CFR 483.12(b)(1)(4), Develop/Implement Abuse/Neglect, etc. Policies S/S: J; F608: 42 CFR 483.12(b)(5), Reporting of Reasonable Suspicion of a Crime, S/S: J; F610: 42 CFR 483.12(c)(2) (4), Alleged Violations-Investigate/Prevent/Correct S/S: J).<br><br>An Acceptable Removal Plan was received on 4/17/2022. The removal plan included placing R#364 and R#17 on one-to-one supervision, staff training, skin assessments on all residents including cognitively impaired residents and interviews with all cognitive residents regarding abuse, neglect, and sexual abuse. The survey team conducted observations, reviewed staff training records and monitoring logs, clinical record review of revised care plans, and interviews with staff and residents to verify all elements of the facility's Removal Plan were implemented. The immediacy of the Immediate Jeopardy was removed on 04/17/2022. The facility remained out of compliance at a lower scope and severity while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures governing the identification, reporting, investigation, and protection of residents from abuse, including sexual abuse<br><br>Findings include:<br><br>A review of the facility's, Job Title: Administrator, revealed the Administrator was to direct the day-to-day functions of the nursing center in accordance with current federal, state, and local regulations that govern long-term care centers. The essential regulatory included that the Administrator was responsible for procedural guidelines relative to the prevention and reporting of patient abuse.<br><br>A review of the facility's, Job Title: Director of Nursing Services, revealed the Director of Nursing (DON) was to plan, organize, develop, and direct the overall operation of the nursing service department in accordance with current federal, state, and local regulations. The essential clinical services functions included that the DON was responsible for directing, evaluating and supervising patient care and initiating corrective action as necessary; honoring patient's rights to fair and equitable treatment, self-determination, and privacy; and assuming responsibility for procedural guidelines relative to the prevention and reporting of patient abuse.<br><br>A review of the facility's self-reported incidents revealed R#364 was the alleged perpetrator of sexual assaults upon R#17 on 05/23/2021 and 07/11/2021; R#55 on 08/27/2021; and R#42 on 01/21/2022.<br><br>1. Administration failed to put effective interventions in place to protect three of four residents (R#17, R#55, R#42) from resident-to-resident sexual abuse.<br><br>Cross refer F600<br><br>2. Administration failed to develop and/or implement the protection, reporting, training components of their abuse for three of four (R#17, R#42, R#55) residents reviewed for sexual abuse.<br><br>Cross refer F607<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 3. Administration failed to ensure allegations of sexual abuse were reported to the police for three of four (R#17, R#55 R#42) reviewed for sexual abuse.<br><br>Cross refer F608<br><br>4. Administration failed to ensure allegations of sexual abuse were thoroughly investigated and failed to implement protective measures to prevent further incidences of sexual abuse for three of four (R#17, R#55, R#42) residents.<br><br>Cross refer F610<br><br>5. Administration failed to ensure person-centered, comprehensive care plans were developed to meet the safety and psychological needs of four of 16 (R#364, R#17, R#42 and R#55) whose care plans were reviewed.<br><br>Cross refer F656<br><br>An interview on 4/13/2022 at 7:46 AM with RN LLL when asked what education staff had received regarding protecting other residents from sexual assault/abuse from R#364, RN LLL stated she was told to separate R#364 from the female residents and monitor R#364.<br><br>An interview on 04/13/2022 at 7:52 AM with Housekeeper QQQ revealed that she had not ever been in-serviced on what to do regarding sexual abuse.<br><br>An interview on 04/13/2022 at 2:10 PM with the Administrator when asked why the allegations of sexual abuse for R#17 that occurred on 7/11/2021, for R#55, which occurred on 08/27/2021, and for R#42 which occurred on 1/21/2022 were not reported to the police, the Administrator stated she did not report all incidents, that it depended on each incident. When asked how staff were made aware of the sexual assaults, in the facility's investigation, the Administrator stated she did not know and did not know if there was any documentation of that.<br><br>A telephone interview on 04/13/2022 at 4:15 PM with former DON EEE revealed she had worked at the facility for approximately two years and left the job about two months ago. When asked about her recollection of any incidents surrounding R#364 and sexual assault with any female residents at the facility, DON EEE stated she was able to recall a few. When asked if there were any in-services or training provided to the staff regarding that incident on interventions to prevent further sexual assault, DON EEE stated there may have been a paper in-service training but was not able to recall if any training was done. When asked about the sexual assault on R#55 by R#364, When asked what interventions or controls had been put into place to protect other female residents from sexual abuse from R#364, DON EEE stated staff would keep R#364 in eyesight, place them at the nurse's station and monitor. DON EEE was asked what procedure was to be followed, after an allegation of sexual abuse. DON EEE stated the physician would be notified either by her or a member of the management team, and this would be documented in the resident's record. DON EEE stated the SW would speak to other residents regarding safety, and those forms would be kept in the Administrator's office. DON EEE did not indicate the incidents should be reported to local law enforcement.<br><br>An interview on 04/17/2022 at 12:34 PM with LPN TT stated the facility had previously had a total disregard for the safety of the residents.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 17141 |