STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115585	A. Building B. Wing	07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Transitional Care & Rehabilitation	460 Auburn Avenue N.E. Atlanta, GA 30312

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20005 Based on observation, record review, review of facility policies titled Abuse Prevention Policy, Resident-to-Resident Altercations, and Behavioral Assessment, Intervention, and Monitoring, and interviews, the facility failed to provide adequate supervision for two identified vulnerable residents (R) (R#1 and R#6) from a sample of 20 residents, to protect from actual sexual abuse. This failure resulted in R#6 being raped by R#17 and R#1 was exposed to sexually inappropriate behavior by R#16. The facility failed to follow up with psychiatric services for R#16 and failed to put interventions in place to prevent other residents from potential sexually inappropriate behaviors. In addition, the facility failed to assess other residents who were at risk for sexual abuse. On [DATE] a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator and Director of Nursing (DON) were informed of the Immediate Jeopardy (IJ) for F600 and F609 on [DATE] at 2:50 p.m. The noncompliance related to the IJ was identified to have existed on [DATE]. The IJ is outlined as follows: 1. R#17, age 56, was admitted to the facility on [DATE], with a history of Schizophrenia and Human Immunodeficiency Virus (HIV). The resident was found by the Certified Nursing Assistant (CNA) in the room of R#6, a cognitively impaired resident, on [DATE] at 3:45 a.m., the same night he was admitted . R#17 was observed on top of R#6 having sexual intercourse. R#6 was noted to have blood in her brief which was taken as evidence by the police. R#6 was transported to the hospital, bloodwork, and a Sexual Assault Nurse Examiner (SANE) kit was collected. Per the facility, R#6 tested negative for HIV. R#17 was interviewed by the police and admitted that he had sexual intercourse with the resident, and that it had been a long time since he had sex. R#17 was arrested and removed from the facility. R#6 was transferred to another nursing home where she expired on [DATE] of cardiac arrest. The facility failed to assess the other residents who were also at risk for sexual abuse. (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. On [DATE], R#16 was found in the room of R#1, a cognitively impaired resident, with his hand in her brief. R#1 was sent to the hospital for evaluation and a SANE kit was collected. The police were called and during interview, R#1 told police that she asked R#16 to check if she was wearing a diaper. R#16, who was also cognitively impaired, was moved to another unit at the end of the hall. No other interventions were implemented, and R#1 remains in the facility. The facility failed to notify the State Survey Agency (SSA) within the two-hour timeframe of these two incidents. The IJ was related to the facility's noncompliance with the program requirements at 42 C.F.R. 483.12 (a)(a)(1), Freedom from Abuse, Neglect, and Exploitation (F600, Scope/Severity: J); and 42 CFR 483. 12(b)(1)(4) Reporting of Allege Violations (F609, Scope/Severity: J). Additionally, Substandard Quality of Care was identified at 42 CFR 483.12(a)(1) Abuse and Neglect, F600 Scope/Severity: J; and F609 Scope/Severity: J. At the time of the exit on [DATE], the IJ remained ongoing. Findings include: Review of the policy titled Abuse Prevention Policy with a review date of [DATE] revealed that residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. Continued review revealed that abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Sexual abuse includes but is not limited to sexual harassment, sexual coercion, or sexual assault. Further review revealed that it is the responsibility of all staff to provide a safe environment for the residents. Resident care and treatments shall be monitored by all staff, on an ongoing basis, so that residents are free from abuse, neglect, or mistreatment. Review of the policy titled Resident-to-Resident Altercations revised [DATE] revealed that the facility will take reasonable precautions including providing adequate supervision when the risk of resident-to-resident altercation is identified. Continued review revealed that the facility should identify the factors that increase the risks associated with individual residents, including those that could trigger an altercation. Interventions could include supervision and other actions that could address potential or actual negative interactions, can include: providing safe supervised areas for unrestricted movement; eliminating or reducing underlying causes of distressed behavior, such as boredom and pain; evaluating staffing levels to ensure adequate supervision; and ongoing staff training and supervision, including how to approach who may be agitated, combative, verbally or physically aggressive, or anxious, and how and when to obtain assistance in managing a resident with behavior symptoms. All direct care staff need to know which residents are at risk for behavior(s) and what interventions are needed to prevent an occurrence. Resident Kardex and care plan should include interventions and goals for managing the potential risk for resident-to-resident altercations. 1. Review of the clinical record for R#6 revealed she was admitted to the facility on [DATE] with a primary diagnosis of unspecified psychosis not due to substance or known physiological condition. R#6 also had diagnoses including but not limited to major depressive disorder, hypertension, and heart failure. R#6 resided on the second floor. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the BIMS (Brief Interview of Mental Status) Evaluation with effective date of [DATE] revealed that R#6 scored a one. BIMS scores between 0 and 7 indicate severe cognitive impact, scores between 8 and 12 indicate moderate cognitive impairment, and scores between 13 and 15 indicate little to no cognitive impairment. Review of the Social Services assessment dated [DATE] revealed that R#6 was alert and oriented to self and family with memory loss noted. Review of the Nurses' Note dated [DATE] revealed that at 4:15 a.m., the CNA in charge of assignments told the nurse that a male resident was found on top of R#6. The resident reported she was lying in her bed when male resident (R#17) entered her room and laid on top of her. Continued review revealed that the CNA separated the two residents, a thorough physical assessment was done on R#6, without any visible signs of injuries, and R#6 denied any pain. Further review revealed that the male resident (R#17) admitted to going into her room and getting on top of her. The family, DON, and Physician were notified of the incident, along with the Administrator. The facility contacted the police, and R#6 was sent out to the emergency room (ER) for evaluation and treatment. Review of the E-Interact Transfer Form dated [DATE] revealed that there was a sexual encounter with another resident (R#17), which R#6 was sent to the hospitalER on [DATE] at 7:25 a.m. Review of the Hospital Note dated [DATE] revealed that R#6 was brought in for alleged sexual abuse. Continued review revealed that R#6 was refusing any medications, she was alert and orientated to self only, and having visual hallucinations, stating that she sees a man outside trying to kill them and he had a gun, with actively pointing in the direction of the visual hallucination. Also, per review revealed that nursing home staff said that R#6 was alert and orientated x1 and was at baseline. Further review revealed that the night of [DATE] at 4:00 a.m., nursing home staff walked into R#6's room and found another resident (R#17) sexually assaulting R#6 with witnessed penetration and blood on bedsheets. The assailant (R#17) is HIV positive and has a history of syphilis which remains seropositive (positive result in blood test) despite treatment. Family member agreed to an exam for sexual assault victims along with agreeing for R#6 to receive all medical prophylactic treatment due to R#17's medical history. Laboratory testing was completed, including an HIV test, which came back negative, but recommended future testing; however, newly detected Hepatitis C was found, and family member unaware of any prior history. Review of the written statement by CNA LL on [DATE] revealed that around 3:45 a.m., she made rounds and all residents were in their beds. However, at 4:15 a.m., she went back into R#17's room to check on him, after having to redirect him several times prior, and found him missing. Continued review revealed that she went for assistance in locating the resident. Staff found R#17 in R#6's room. Further review revealed that when staff opened R#6's door, they noticed that R#17 was on top of R#6. She ran immediately and got the nurse. Review of a written statement by CNA MM on [DATE] revealed that she was in another room giving care when CNA LL asked for assistance in locating R#17 around 4:15 a.m. Continued review revealed that all night R#17 had to be redirected about staying in his room. She stated that R#17 was wearing a gown without a diaper, and he was observed on top of R#6. CNA MM questioned R#6 about penetration and R#6 said he (R#17) went as far as he could go and said that she (R#6) was [AGE] years old and had never been raped before. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a written statement by Registered Nurse (RN) TT on [DATE] revealed that she was the charge nurse that night on the 11:00 p.m. to 7:00 a.m. shift. Continued review revealed that around 4:15 a.m., CNA LL had informed her that R#17 had gone into R#6's room and laid on top of her without a diaper on. When questioned, R#17 admitted to going into R#6's room to have sex with her. However, when R#6 was interviewed, she could not recall much. The police were contacted, and R#17 was escorted out of the facility in handcuffs, while R#6 was taken to the hospital for further evaluation. Review of the Nurses' Note dated [DATE] revealed that R#17 was questioned by the police and admitted going into R#6's room and getting on top of her, stating he had not done it for a long time and that is why. Continued review revealed that R#17 was detained by the officer and escorted out of the facility. Review of the Police Department Incident Report dated [DATE] at 9:35 a.m., revealed that the event took place on [DATE] between 4:45 a.m. and 6:00 a.m., when the police were contacted by the facility and requested the investigative assistance for an alleged sexual assault. Continued review revealed that R#17 was just placed at the facility on [DATE]. However, R#6 had been a resident for some time. The two witnesses which are part of the CNA nursing staff, advised that R#17 was missing from his room around 3:45 a.m., where CNA LL began walking the floor looking for R#17. CNA LL stated that she observed the door to the room of R#6 closed, and reports that the door normally is left partially open in case R#6 needs assistance. CNA LL stated that she opened R#6's door and found R#17 physically on top of R#6, engaging in what she believed to be sexual intercourse based on his humping movements. Both R#17 and R#6 were wearing hospital gowns and R#6 had on a diaper. CNA LL left the room and went to get assistance from staff. CNA MM accompanied CNA LL back to R#6's room at which time they observed R#17 in the same position and CNA MM told R#17 to remove himself. CNA MM stated that she observed R#6's diaper moved to the side. When CNA MM asked R#6 if R#17 penetrated her, R#6 stated that he got all of what he could in her and stated that she had never been raped before. The primary officer arrived on the scene and questioned R#17, at which time R#17 admitted to having sex with R#6 because it has been a long time since I had sex. R#6 was placed under arrest and was transported to police headquarters, where R#17 was interviewed by a detective from the Special Victims Unit (SVU). However, R#17 told the officer no thanks. R#17 was charged accordingly and transported to jail. R#6 was attempted to be interviewed, which R#6 appeared disoriented and later was informed R#6 was blind. R#6 was transported to hospital to be treated and a sexual assault kit administered. The crime scene was processed along with collecting R#6's gown, bedding, and diaper, which nursing staff observed blood stains in R#6's diaper. Review of the Police Arrest Report dated [DATE] revealed that on [DATE] between 6:00 a.m. and 7:07 a.m., R#17 was arrested on a general felony arrest (when the police take a person into custody, on suspicion that they have committed a crime) with a charge of rape. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During phone interview with CNA LL on [DATE] at 4:42 p.m. she revealed that R#17 was wandering up and down the halls, behind the nursing station and in an out of resident rooms throughout the night and that evening and she had to redirect him. She stated that R#17 had on a hospital gown and could not recall if he was wearing a diaper. She stated that she had this feeling about him, which required her to check on him frequently that evening, including around 3:45 a.m., when she made her rounds and R#17 was in his room. However, after returning from downstairs getting ice, she went to check on R#17 and he was not there. She enlisted another CNA's assistance, CNA MM, in locating R#17. When they opened R#6's bedroom door, she found R#17 on top of R#6 making movements as if he was having sex with her. She screamed and ran to get the nurse while CNA MM stayed at the doorway. She said that it could not have been more than 20 minutes between the time that she went to get ice to when she found R#17 on top of R#6. When she returned with the nurse, the two residents were separated. The police were notified and came to the facility along with the crime scene people, which collected R#6's sheets, diaper and gown. She and CNA MM cleaned up R#6 prior to her going out to the hospital, which included changing her brief, that was dry but had spots of blood inside and one side undone (unsure of the side that was undone). They also changed her linen and placed a fresh gown on R#6. CNA LL could not recall if there were any spots of blood on the linen. She said that at first the resident was refusing care, but when the two CNAs obtained the help from the treatment nurse, R#6 began to cooperate. She confirmed that R#6 was alert and stated that R#6 said that the man got up in her as far as he could. During phone interview with Police Lieutenant NN from the SVU on [DATE] at 5:14 p.m., she revealed that she was unsure of the timeframe for the rape kit to return. The other evidence will be processed at the same time as the rape kit. Police Lieutenant NN confirmed that the alleged perpetrator (R#17) was currently in jail. During phone interview with family of R#17 on [DATE] at 8:40 p.m. she revealed she had been trying to get help for the resident for years. She stated that R#17 had been off his medication for over one year and was having behaviors. During phone interview with CNA MM on [DATE] at 9:19 p.m. she revealed she currently works as a night shift CNA and had for the past four years. Continued interview revealed that she was working with another CNA that night, CNA LL. She said that she was in another resident's room working with that resident when CNA LL came to get her and asked for her assistance in locating R#17. R#17 had been having wandering behavior throughout the night, such as walking towards the nursing station and he had to be redirected back into his room. She stated that when they entered R#6's room, R#17 was observed lying flat on R#6, hunching R#6. R#17 had only his gown on with no diaper. At first, she screamed and stated to R#17 that he was going to jail for this behavior, when R#17 turned his head and calmly got off R#6 and returned to his room. The police were contacted and came to the facility along with the crime scene investigators. She assisted other staff in getting R#6 ready for transport to the hospital, when R#6 said that he went as far as he could go, and R#6 said that she had never been raped before. She confirmed that R#6's brief had some red little stuff inside, which was packed with R#6's gown and linen by the crime scene staff. During an interview with the DON on [DATE] at 10:47 a.m., she revealed that R#17 was a new admission to the unit when it was reported to her that R#17 had been wandering since admission up and down the hallways, but denies any wandering into other resident rooms. However, she stated that the facility did not know of any inappropriate sexual behavior prior to admission. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview with the DON and Administrator on [DATE] at 3:54 p.m., the DON said that the third floor is the memory care/behavioral unit where most of the dementia and Alzheimer's residents will be located. This is due to having to ensure that these residents receive special attention with line-of-sight observation. If the rooms are full on the third floor then the residents can be placed on the other floors (second and fourth) with alternatives put into place such as line of sight observation, and increased communication with direct care staff. The DON also said that staff can redirect any wandering behavior by using Velcro stop signs that can be placed at a resident's door. Review of the clinical record for R#17 revealed that he was admitted to the facility on [DATE], the day before the sexual assault occurred involving R#6. Review of the clinical record revealed R#17 had diagnoses including but not limited to HIV, unspecified dementia with behavioral disturbance, and schizophrenia. R#6 resided on the second floor. Review of the hospital paperwork revealed that R#17 had been on psychiatric medications in the past but currently had not been taking for over a month. Review of the Hospital Discharge Summary dated [DATE] revealed that R#17 was brought into the ER by police after a call from his family related to behavioral disturbances. Continued review revealed that per family member, R#17 had been living at another nursing home for one year where he escaped from and was found roaming the streets, and tormenting family members. R#17 has a history of breaking items at home and at a nearby church. He had not been taking his medications for over a month and was having positive A/V/H (Auditory and Visual Hallucinations) while seeing gentiles but was unclear of what they are telling him. Review revealed that R#17 was admitted to the hospital for further treatment. R#17 demonstrated improvement in behavior after re-start of medications. Review of the Clinical Admission Evaluation dated [DATE] revealed that resident was admitted on a stretcher after he was living at another facility. Even though the resident was observed to be wandering since admission, continued review revealed that R#17 was assessed as mildly impaired for cognition, follows commands with mood being pleasant without any wandering behavior at night. Review of the facility's investigation revealed no evidence that other vulnerable residents were assessed for signs of sexual abuse. 2. Review of the clinical record revealed that R#1 was admitted to the facility on [DATE] with diagnosis including cerebrovascular disease, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, and major depressive disorder. The Physician's Orders for R#1, dated [DATE], revealed, Psychiatry and Psychology to evaluate and treat as needed. Review of a Quarterly MDS, dated [DATE], coded R#1 with a BIMS of 2, indicating severe cognitive impairment. The resident was coded as not having any behaviors or moods. The MDS coded R#1 as needing extensive assistance with bed mobility and dressing and also was totally dependent on staff for hygiene, toilet use, locomotion off unit and transfers. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Facility Incident Report Form, dated [DATE], documented, that the CNA reported to the charge nurse that upon entering R#1's room she noted R#16 in the room. Upon approaching the bed, she noticed R#16's hand under R#1's gown. When asked what he was doing he removed his hand. R#16 was removed from the room and assessment was done for R#1. The assessment revealed no injuries. Steps taken by the facility to prevent further incidents: R#1 was transferred out to the emergency room for further evaluation and treatment. The police were called with no action taken. Investigative findings to follow. On [DATE], R#16 was spoken to regarding the incident with the female peer. R#16 denied any wrongdoing by avoiding questions being asked and not making eye contact. R#16 has been referred to behavioral health for follow up on next visit. Social Services will continue to monitor and intervene as needed. R#16 adjusting with room change and roommate. On [DATE], after readmission R#1 was interviewed by writer who does not recall incident of abuse with peer and appears to be adjusting with no adverse reactions on readmission. Family is aware. Social Worker will continue to monitor and intervene as needed. Review of the police report, dated [DATE], documented, a call was placed from (the facility) in reference to a male and female in dispute. (The hospital) was called to the scene and transported R#1 to (the hospital). R#1 was asked what took place and they advised nothing. R#1 stated she called R#16 to her room to check and see if she had a diaper on because she didn't believe the staff put one on her. R#1 advised that R#16 pulled the covers back and that's when the nurse walked in and called the police. R#1 said R#16 did not do anything to her. Writer advised the nurse of what R#1 stated. Nothing further. Review of documentation from the Hospital Emergency Department for R#1, dated [DATE], revealed that R#1 was brought to the ER for an allegation of Sexual Assault of Adult, Initial Encounter, and Nauseous. Lab tests were completed including HIV-,d+[DATE] AB Screen, Metabolic profile, Imaging tests CAT Scan of Abdomen and pelvis with IV contrast only, x-ray abdomen KUB (kidney, urinary and bladder), and XR chest x-ray 1 view. Review of the (name) Behavioral psychology reviews for R#1 revealed the resident was seen in April and May of 2021. The report dated [DATE] (prior to the incident) documented R#1 was assessed for depressed mood. The staff reported the resident had attention seeking behaviors. The report dated [DATE] documented the resident's mood was mildly depressed with associated symptom of feeling down. Per staff, [DATE]: On readmission resident was interviewed by writer who does not recall incident of abuse with peer and appears to be adjusting with no adverse reactions upon readmission. Family is aware. Social worker will intervene as needed. Discontinue Zoloft and start Cymbalta. Review of the clinical record revealed R#16 was admitted to the facility on [DATE] with diagnoses including vascular dementia without behaviors, cerebral vascular disease, hemiplegia and hemiparesis following non traumatic intracerebral hemorrhage affecting right dominant side, and major depressive disorder recurrent, mild. Review of the Physician's Orders revealed an order, dated [DATE], Consult Psychiatrist to evaluate and treat as needed. Review of the Annual MDS Assessment, dated [DATE], for R#16 documented a BIMS score of 6, indicating severe cognitive impairment. The resident was coded as needing supervision of one for bed mobility and transfer, limited assistance with walking in room, on unit and in corridor. The resident used a wheelchair and didn't walk off the unit. The resident was coded as not having any behaviors or moods for the time frame and behavioral symptoms did not trigger for further review utilizing the Care Area Assessment (CAA) summary process. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R#16's care plan, initiated [DATE], and revised on [DATE], listed under Focus, R#16 has a history of demonstrated physical behaviors related to anger, history of observed throwing bowl of dessert, resident has difficulty in expressing and/or finding words to say during conversing and seems to upset him. R#16's care plan was updated on [DATE] to include the problem deficit of the resident having a history of touching other residents sexually. The care planned problem deficit was reviewed on [DATE] with documentation stating there had been no behaviors noted. Interventions included to obtain a psychiatric/psychogeriatric consult, as indicated. Continued review of the care plan revealed another focus area, which was checked as resolved, listed Problematic manner in which resident has a history of acts characterized by inappropriate sexual behavior (masturbation) related to need for affection. The goal listed was that the resident will carry out sexual behavior with self only in privacy of own room. Interventions listed were to avoid type of conversation that could encourage or initiate inappropriate behavior, determine cause and previous sexual history and document it, display an accepting, nonjudgmental manner to encourage resident to discuss concerns about sexuality, explain and explore with resident effects of his behavior on other residents and staff, and move to another floor. After specifying the resident was moved to another floor the care plan focus area was indicated to be resolved. The care plan did not include interventions to address the resident's history of sexually inappropriate behaviors. Review of (name) Behavioral psychology reviews for R#16 revealed the resident was seen by the Physician's Assistant in February and March of 2021. The [DATE] Behavioral Report documented the resident was seen as a result of the staff thought the resident's confusion was getting worse. A review of the [DATE] report revealed documentation: Patient is forgetful and confused related to dementia. Mood is pleasant today. Patient is seen again today due to worsened confusion since last visit. Improving symptoms now. The [DATE] report documented, Mood has been improving. Staff does not report worsening depressed mood. There were no other reports for 2021. Review of R#16's medical record revealed that the resident was not seen by Psychological services following the incident. Review of R#16's Documentation Survey Report for [DATE], revealed R#16's behaviors were being monitored and documented. Review of documentation for [DATE] revealed R#16 had no documented behaviors for that date. All three shifts documented no evidence of behavior. However, review of a Facility Incident Report Form revealed on [DATE] staff discovered R#16 touching R#1 in a sexually inappropriate manner. Further review of the documentation revealed for the month of [DATE], there were 27 out of 31 days where nursing staff did not consistently document behaviors for all three shifts. For the month of [DATE], there were 27 out of 30 days that were left blank for all three shifts and no behaviors were documented for R#16. For the month of [DATE], there were 21 out of 23 days where R#16's behaviors were not consistently documented. An observation of R#16 on [DATE] at 11:30 a.m. revealed the resident used a wheelchair to propel himself throughout the unit. R#16 had some difficulty using their right arm but was still able to maneuver throughout the unit. The resident's room was located near the end of the hall away from the nursing station. (continued on next page)

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Legacy Transitional Care & Rehabilitation	460 Auburn Avenue N.E. Atlanta, GA 30312

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the fourth floor Unit Manager on [DATE] at 10:50 a.m., she confirmed that R#16 currently resides on the fourth floor. She stated the resident has not had any behaviors since he has been on the unit, which was [DATE]. When asked how behaviors are monitored, the LPN stated they document in the progress notes and behavior monitoring is listed on the CNA Kardex. She stated they will also list behaviors on the communication form they use for report at the end of shift. However, review of R#16 Visual/Bedside Kardex Report revealed behaviors were not listed as a concern to be monitored on the Kardex as of [DATE]. During an interview with the Administrator on [DATE] at 11:56 a.m., he stated that he did not think R#16 had been seen by behavioral health after the incident. He stated the psychologist went out on maternity leave the day after the evaluation was ordered. During an interview with R#16, with the Activity Director present, on [DATE] at 10:50 a.m., the resident stated he didn't remember R#1 and didn't remember having any female friends on the second floor. He stated he didn't know of any incident between himself and another resident. An observation of R#1 on [DATE] at 11:00 a.m., revealed the resident used a Geri-chair when out of her room. The resident stated that she was comfortable and didn't know who R#16 was. She stated she didn't have any male friends on the unit. During an interview with CNA WW on [DATE] at 11:25 a.m., she stated she found R#16 in R#1 room on [DATE] with his hand in R#1 brief. CNA WW said R#1 reported she had asked R#16 to change her tampon. When R#16 was removed from the room he said, My bad, my bad, I'm sorry, I'm sorry. She stated that R#16 told the police he did something very bad. The police said R#1 gave him permission. CNA WW stated R#16 could be a little inappropriate with the staff when they were changing him. He would sometimes try to grab at staff who were trying to change him or start to masturbate. During an interview with LPN VV on [DATE] at 11:35 p.m., she confirmed that she was the Unit Manager on the second floor when the incident occurred. She stated R#16 normally stayed in the dining room and normally did not go into other resident's rooms. She stated that R#16 has had to be redirected around the staff, but not residents. LPN VV stated no one had reported anything to her about R#16 before or since the incident. During an interview with the DON and Administrator on [DATE] at 3:54 p.m., the Administrator stated it was a very broad category to keep the residents safe. He said they educate, have private rooms, and try to match up residents with appropriate roommates. The Administrator stated the third floor is for dementia care and is a locked unit where behaviors are closely monitored. The second and fourth floor are general floors. He stated for the third-floor dementia care, they keep residents in the line-of -sight and have increased communication with the unit manager and direct care staff to determine behavior management. He stated that R#16 had been at the facility since 2017 and the staff know him. He stated there must have been some trigger between the two residents that triggered R#16 to do what he did. The Administrator also explained they had a weekly Behavioral Meeting in which Social Services, Unit Managers, MDS and Care Plan, and Psychotherapist attend. He confirmed that the first Behavioral Meeting where R#16's behaviors had been discussed was on [DATE], two months after the resident had exhibited sexually inappropriate behaviors. The only intervention in place was to move R#16 to a different floor. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the DON on [DATE] at 9:27 a.m., she stated R#16's behavior did not trigger for the CNA Visual/Bedside Kardex Report because the behavior was a one-time thing. She confirmed that nothing else was done, other than move the R#16 to another floor, to closely monitor him and prevent additional behaviors. She confirmed that R#16's care planned intervention of obtaining a psychiatric/psychogeriatric consult, as indicated had not been implemented. Review of the facility policy, Behavioral Assessment, Intervention, and Monitoring, undated, documented, New onset or changes in behavior will be documented regardless of the degree of risk to the resident or others. To conclude, R#16 sexually abused R#1 on [DATE]. R#16 was moved to the fourth floor with the same vulnerable population as on the second floor where the assault occurred. R#16 continued to reside among vulnerable residents with no mechanism, including lack of behavior monitoring, in place to prevent further incidents of sexual abuse of vulnerable residents.

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20005 Based on interview, record review, and review of facility policy titled Abuse Prevention Policy, the facility failed to ensure that alleged sexual abuse was reported to the State Survey Agency (SSA) within a two-hour timeframe for two identified vulnerable residents (R) (R#1 and R#6) of 20 sampled residents. On [DATE] a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator and Director of Nursing (DON) were informed of the Immediate Jeopardy (IJ) for F600 and F609 on [DATE] at 2:50 p.m. The noncompliance related to the IJ was identified to have existed on [DATE]. The IJ is outlined as follows: 1. R#17, age 56, was admitted to the facility on [DATE], with a history of Schizophrenia and Human Immunodeficiency Virus (HIV). The resident was found by the Certified Nursing Assistant (CNA) in the room of R#6, a cognitively impaired resident, on [DATE] at 3:45 a.m., the same night he was admitted . R#17 was observed on top of R#6 having sexual intercourse. R#6 was noted to have blood in her brief which was taken as evidence by the police. R#6 was transported to the hospital, bloodwork, and a Sexual Assault Nurse Examiner (SANE) kit was collected. Per the facility, R#6 tested negative for HIV. R#17 was interviewed by the police and admitted that he had sexual intercourse with the resident, and that it had been a long time since he had sex. R#17 was arrested and removed from the facility. R#6 was transferred to another nursing home where she expired on [DATE] of cardiac arrest. The facility failed to assess the other residents who were also at risk for sexual abuse. 2. On [DATE], R#16 was found in the room of R#1, a cognitively impaired resident, with his hand in her brief. R#1 was sent to the hospital for evaluation and a SANE kit was collected. The police were called and during interview, R#1 told police that she asked R#16 to check if she was wearing a diaper. R#16, who was also cognitively impaired, was moved to another unit at the end of the hall. No other interventions were implemented, and R#1 remains in the facility. The facility failed to notify the SSA within the two-hour timeframe of these two incidents. The IJ was related to the facility's noncompliance with the program requirements at 42 C.F.R. 483.12 (a)(a)(1), Freedom from Abuse, Neglect, and Exploitation (F600, Scope/Severity: J); and 42 CFR 483. 12(b)(1)(4) Reporting of Alleged Violations (F609, Scope/Severity: J). Additionally, Substandard Quality of Care was identified at 42 CFR 483.12(a)(1) Abuse and Neglect, F600 Scope/Severity: J; and F609 Scope/Severity: J. At the time of the exit on [DATE], the IJ remained ongoing. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Findings include: Review of the policy titled Abuse Prevention Policy with a review date of [DATE] revealed that all alleged violation involving abuse, neglect, exploitation or mistreatment . are reported immediately, but no later than two hours after the allegation is made if the events that cause the allegation involve abuse or result in seriously bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the SSA) and adult protective services where state law provides for jurisdiction in long term care facilities in accordance with state law. Continued review revealed that the results of all investigations will be reported to the facility Administrator and the SSA within five working days of incident, and if the alleged violation is verified, appropriate corrective action must be taken. 1. Review of the clinical record for R#6 revealed that she was admitted to the facility on [DATE] with a primary diagnosis of unspecified psychosis not due to substance or known physiological condition. R#6 also had diagnoses including but not limited to major depressive disorder, hypertension, and heart failure. Review of the clinical record revealed R#17 was admitted on [DATE] and had diagnoses including but not limited to HIV, unspecified dementia with behavioral disturbance, and schizophrenia. Review of the Nurses' Note dated [DATE] revealed that at 4:15 a.m., the CNA in charge of assignments told the nurse that a male resident (R#17) was found on top of R#6. R#6 admitted she was lying in her bed when R#17 entered her room and laid on top of her. Continued review revealed that the CNA separated the two residents and a thorough physical assessment was done on R#6 without any visible signs of injuries. Further review revealed that R#17 admitted to going into R#6's room and getting on top of R#6. R#6 was sent out to the hospital for an evaluation. R#17 was arrested by the police. Review of a written statement by Registered Nurse (RN) TT on [DATE] revealed that she was the charge nurse that night on the 11:00 p.m. to 7:00 a.m. shift. Around 4:15 a.m., CNA LL informed her that R#17 had gone into R#6's room and laid on top of her without a diaper on. When questioned, R#17 admitted to going into R#6's room to have sex with her. The police were contacted, and R#17 was escorted out of the facility in handcuffs, while R#6 was taken to the hospital for further evaluation. Review of the report to the SSA dated [DATE], revealed that the type of incident reported to the SSA was a resident-to-resident encounter. Continued review revealed that R#17 was observed in R#6's room on top of her with his pants down. Further review revealed that R#17 was removed and placed back into his room with the police being called. Review of the email confirmation that the facility received back from the SSA on [DATE] at 11:11 a.m. revealed the initial report was sent via computer. During an interview on [DATE] at 10:47 a.m., the DON revealed that R#17 was a new admission to the unit when it was reported to her that R#17 had been wandering since admission up and down the hallways. Continued interview revealed that on [DATE] at 4:00 a.m. facility staff found R#17 in R#6's room on top of R#6. The DON confirmed that the initial report was sent to the SSA on [DATE] at 11:11 a.m. with an email confirmation sent back with a due date for follow up report as of [DATE]. The DON said that she was unaware of the two-hour reporting requirement for abuse. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a follow up interview with the DON on [DATE] at 2:38 p.m., she revealed that at the time of the alleged incident, the facility felt it was a resident-to-resident encounter, but she was unable to explain the meaning of a resident-to-resident. 2. Review of the clinical record for R#1 revealed that she was admitted to the facility on [DATE] with diagnoses including cerebrovascular disease, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, major depressive disorder, and cerebral infarction, unspecified. Review of the clinical record for R#16 revealed that he was admitted to the facility on [DATE] with diagnoses including vascular dementia without behaviors, cerebral vascular disease, hemiplegia and hemiparesis following non traumatic intracerebral hemorrhage affecting right dominant side, and major depressive disorder recurrent, mild. Review of the Facility Incident Report Form, dated [DATE], documented, that the CNA reported to the charge nurse that upon entering R#1's room she noted R#16 in the room. Upon approaching the bed, she noticed R#16's hand under R#1's gown. When asked what he was doing he removed his hand. R#16 was removed from the room and assessment was done for R#1. The assessment revealed no injuries. Steps taken by the facility to prevent further incidents: R#1 was transferred out to the emergency room for further evaluation and treatment. The police were called with no action taken. The report to the SSA was dated [DATE] without a time. Review of facility documentation revealed the facility failed to report the allegation of sexual abuse by R#16 toward R#1 within a two-hour timeframe. A review of the facility's email confirmation, on [DATE] at 6:04 p.m., revealed the initial report was sent via computer to the SSA. During an interview with the Social Services Director on [DATE] at 1:30 p.m., she stated the actual incident between R#1 and R#16 occurred mid-morning on [DATE]. However, the facility failed to document the exact time of the alleged sexual abuse. During an interview with the Administrator on [DATE] at 1:21 p.m., he revealed that all allegations of abuse or anything with bodily injury is reported to the SSA within a two-hour timeframe. Continued interview revealed that he confirmed that the initial report for R#6 and R#1 were not submitted to the SSA within this two-hour timeframe. Cross refer to F600.