| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375513 | A. Building<br>B. Wing | 02/18/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Golden Rule Home | 38801 Hardesty Road<br>Shawnee, OK 74801 |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 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** 29358<br><br>On 02/17/23 an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure residents #2 and #4 were free from abuse.<br><br>a. CNA #1 reported she witnessed, on 02/11/23, Res #6 with his arm and hand under the blanket of Res #2. The CNA reported Res #6's arm and hand were moving fast in an up and down motion causing the blanket to move and the bed to shake. CMA #1, CMA #3, CNA #2 and CNA #6 also reported they witnessed, on 02/11/23, Res #6 with his hand under the covers of Res #2. Multiple staff reported Res #6 had been going in Res #2's room numerous times everyday and reported they thought it was odd and some reported they were suspicious. Res #2 had diagnoses of aphasia and traumatic brain injury and was unable to be interviewed.<br><br>b. CNA #2 reported she witnessed, on 12/31/22, Res #5 lifted the shirt of Res #4 and touched her breast and was trying to put his hand in her pants. CNA #3 reported she witnessed, around the first of February 2023, Res #5 with one hand on the inner thigh of Res #4 and the other kneading the breast of Res #4. Res #4 had severely impaired cognition and was unable to be interviewed. In the days following the 12/31/23 incident, nurses notes documented Res #4 had been short tempered, difficult to redirect, had bit, hit, kicked, and pinched staff during care, had been argumentative with other residents, had attempted to access restricted areas of the facility, had attempted to get in bed with female residents, tearful at times, easily angered, easily agitated, was refusing to allow staff to put her to bed, and was sleeping in the lobby. On 01/04/23 the resident was started on a new order for Ativan 0.25 mg as needed for anxiety and agitation.<br><br>On 02/17/23 at 6:04 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation.<br><br>On 02/17/23 at 6:35 p.m., the administrator was notified of the IJ situation.<br><br>On 02/18/23 at 2:06 p.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The plan of removal documented:<br><br>The Administrator in conjunction with the entire department heads team members will ensure that adverse events that are ongoing, urgent or emergent are reported timely.<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 - Some | The Administrator has provided direction to all levels of leadership on how to appropriately report any adverse events that occur. In addition, the quality assurance team meets daily during morning meetings to review all reported events and ensure timeliness in reporting.<br><br>Immediate action taken to ensure resident safety:<br><br>1. Facility will immediately meet the federal and state health, safety, and quality regulations regarding the alleged.<br><br>2. Resident #6 discharged to [name of location deleted] under [name of person deleted] watch.<br><br>3. Resident #5 placed on an hourly watch in a private room per Doctors Orders until a bed available at the behavioral health hospital.<br><br>4. Resident #2 roommate swapped for a more cognitive resident to prevent any future incidents. On hourly staff watch<br><br>5. Resident #4 will be protected by hourly staff watch.<br><br>6. DON, Admin, Abuse Coordinator and other designated staff will immediately assess all residents for any behavioral signs of abuse. Assessment will include continued observation and monitoring for resident behaviors indicative of abuse.<br><br>7. Admin and DON will in-service MDS Coordinator for updates to affected residents care plan to include resident specific interventions to remove immediate jeopardy and ensure continued compliance and safety. A handwritten care plan will be completed immediately for affected residents and placed in chart. EMR will be updated by MDS Coordinator immediately upon return to work.<br><br>In-service and training to all staff will be completed on 2 levels:<br><br>1. Upper management to include Administrator, DON, and Abuse Coordinator will be in-serviced immediately via telephone by Owner/Operator. In-service training to include the following:<br><br>a. Facility Policy & Procedures, State and Federal guidelines reviewed regarding abuse identification, reporting and investigation requirements.<br><br>b. Reporting requirements for 2-hour reporting include allegation of abuse, neglect and misappropriation of funds; all other qualifying reportable incidents will be completed within 24 hours of notification per facility Policy.<br><br>c. Notification of required agencies, physician and family will be made immediately in conjunction with reporting guidelines.<br><br>d. Interventions put in place immediately to ensure resident safety.<br><br>e. Investigation process initiated immediately and must include resident assessment and interviews, staff interviews and interviews from any and all witnesses and reporting and involved individuals.<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 - Some | f. If allegation includes staff to resident abuse, staff member must be suspended immediately, pending investigation. If allegation includes resident to resident abuse, offending resident must be placed on watch and monitored (i.e. one to one, hourly, etc.) and resident victim must be kept safe and free from alleged offender. Remove the resident immediately!<br><br>g. Long-term interventions must be identified, care-planned and implemented. MDS must update care plan! If necessary, a hand-written update may be completed and MDS should include in the EHR as soon as possible (i.e., on a weekend).<br><br>2. In turn, training of all care staff will be conducted by Administrator, DON, Abuse Coordinator and other appointed Department Heads through immediate in-person and telephone in-servicing. In-service education will include the following:<br><br>a. Report immediately!!<br><br>b. Report to your direct supervisor and up the chain of command (i.e. CNA report to Charge Nurse; Charge Nurse report to DON; DON report to Administrator) (housekeeper report to Housekeeping Supervisor; Housekeeping Supervisor report to Administrator). Again, report immediately! Over report .you can not report enough to appropriate personnel. Ultimately, all reporting should be made to Administrator. A rule of thumb to implement is that all staff members should immediately report to their direct supervisor and/or at least two people in the Chain of Command!<br><br>c. Write down details while they are fresh! This will assist in our internal investigation. Include date, time, and details.<br><br>d. Immediately separate or remove a resident that may be harming another resident and report to your supervisor to ensure resident safety.<br><br>e. Watch for signs of abnormal behavior or atypical behavior of a resident as this may be a sign of abuse. Report any unusual resident behavior to your supervisor immediately.<br><br>All in-service training will be completed by February 18, 2023, approximately noon. In-service training will be conducted by phone for employees not currently in the building.<br><br>The IJ was lifted, effective 02/18/23 at 12:00 p.m., when all components of the plan of removal had been completed. The deficient practice remained at a pattern with potential for harm to the residents.<br><br>Based on record review, observation, and record review, the facility failed to ensure residents were free from abuse for two (#2 and #4) of five residents sampled for abuse.<br><br>The Resident Census and Conditions of Residents form documented 36 residents resided in the facility.<br><br>Findings:<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 - Some | A facility abuse policy, revised April 2022, documented in parts .The resident has the right to be free from verbal, sexual, physical, and mental abuse .The center ensures that all alleged violations involving mistreatment, neglect, or abuse .reported immediately to the Administrator of the center and to other officials in accordance with State law through established procedures (including to the state survey and certification agency) .Any and all allegations are reported to the DON and/or Administrator .Immediate response is taken to ensure the safety of the resident .Timelines and investigation begin immediately .An initial report will be completed and submitted to the Department of Health Immediately upon notification of the allegation .Within five (5) days (or per state regulations) of the incident-final report is submitted in writing to appropriate state agencies .Events are reviewed by the Quality Management Committee to determine what actions are necessary to prevent recurrence .The regulations do not give us any leeway to decide if an allegation is valid before we report it .You can never assume an event didn't happen .A system to follow up on altercations will place an emphasis on preventing further altercation .<br><br>1. Res #2 was admitted to the facility on [DATE] and had diagnoses which included aphasia, TBI, anxiety, contractures, and tracheostomy status.<br><br>Res #6 was admitted to the facility on [DATE] and had diagnoses which included aftercare following joint replacement and post-polio syndrome.<br><br>Res #6's quarterly MDS assessment, dated 11/23/22, documented Res #6's cognition was intact, had no behaviors, was independent with most ADLs, and used a w/c and a walker for mobility.<br><br>Res #2's annual MDS assessment, dated 01/17/23, documented the resident's cognition was severely impaired, required total assistance with ADLs, had impairment in both upper and lower extremities, had an indwelling urinary catheter, and received nutrition by a feeding tube.<br><br>A facility Incident/Accident Report, signed by RN #1 and the DON on 02/13/23, documented an incident date of 02/11/23 at 10:20 a.m. The report documented the following: CNA #1 reported to RN on duty that she saw Res #6 with his hand under the covers of Res #2. CNA #1 did not see anything inappropriate. CNA #1 said she had a feeling. The RN reported to the DON who immediately reported to the abuse coordinator (SSD). The door was open and CMA #1 stated she asked Res #6 why his hand was under the covers. Res #6 said he was patting Res #2's hand. The steps taken to prevent recurrence was staff were informed to make frequent observations if residents were together and keep the door open.<br><br>A facility Resident Abuse Investigation Report Form, dated 02/15/23, documented an incident date of 02/11/23 and time unknown. The form documented CMA #1 reported an allegation of sexual abuse involving Res #6, the accused, and Res #2, the alleged victim. The form read in part, .Summary of witnesses .see attached (No other witnesses came forward) . CMA #1's statement dated 02/12/23 was attached. (The first staff to report was CNA #1 who reported to RN #1.) CNA #1's interview and/or statement was not provided. The form read in part, .Corrective action taken ., the line was blank. The form read in part, .Did the resident and/or the representative participate in determining the appropriate corrective action that was taken? . The form documented, No, Resident is non verbal. The form documented the administrator was notified on 02/11/23 at 2:23 p.m., the resident representative was notified on 02/15/23 at 12:40 p.m. and the law enforcement agency was notified on 02/15/23 at 11:00 a.m. The report form had a hand written signature by the SSD/abuse coordinator on the signature line for the Investigating Representative.<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 - Some | The abuse coordinator/SSD provided a document containing an interview with Res #6, dated 02/13/23. The interview documented Res #6 denied sexually touching Res #2. The interview documented Res #6 admitted he had put hand under Res #2's covers. The interview documented Res #6 admitted he had touched Res #2's hand, shoulders, and face.<br><br>The abuse coordinator/SSD provided statements from LPN #1; CMA #1 and #3; CNA #3, 4, and #5; and a cook. Interviews and/or statements were not provided to include RN #1 and CNA #1, 2, and #6 who had worked the shift the allegations were reported.<br><br>LPN #1's statement, dated 02/16/23 no time, documented CMA #1 reported to her about her concerns related to Res #6 and Res #2 on 02/11/23. LPN #1 documented she had, not witnessed any inappropriate touching or unwanted behaviors. This was the last statement/interview obtained, therefore ending the facility's investigation.<br><br>An initial 283 Incident Report Form, to OSDH, had a facsimile date of 02/16/23 at 10:47 a.m. The report documented an incident date of 02/11/23. The report documented an allegation of abuse and the resident involved was Res #2, no other resident was named. The report read in parts, .Part B Description of Incident: Please include injuries sustained as well as measures taken to protect the resident(s) during investigation . Med aide verbalized that another resident's hand was under his blanket but did not see anything suspicious . The report did not included the measures taken to protect the resident. The report documented the physician, family, and APS were notified. The report documented the local sheriff's office was notified at 02/15/23 at 11:30 a.m. and the case number was documented. The report had the DON's electronic signature.<br><br>An initial and final 283 Incident Report Form, to OSDH, had a facsimile date of 02/16/23 at 10:50 a.m. The report documented an incident date of 02/11/23. The report documented a CMA's allegation of another resident's hand under Res #2's blanket but did not see anything suspicious. The other resident, the alleged perpetrator, was not named on the report. Part C of the report documented after an investigation no form of abuse or mistreatment noted. The report had the DON's electronic signature.<br><br>On 02/16/23 at 11:28 a.m., Res #6 was observed in a wheelchair in the common area next to Res #2's wheelchair. Res #6 was observed facing Res #2's chair from the side with his back to the room.<br><br>On 02/16/23 at 1:03 p.m., CNA #3 was interviewed. CNA #3 stated she had seen Res #6 in Res #2's room multiple times but had not seen any inappropriate touching. She stated she had heard people say that they thought Res #6 was being inappropriate but no one had ever told me that they had seen any thing inappropriate. She stated she had heard Res #6 being called a chomo because he goes in the one room with the two young guys. She stated she didn't think any thing inappropriate because he was always getting Res #2 to laugh. She stated Res #6 treated Res #2 like a kid, like when you tried to make a baby laugh was how he treated him.<br><br>On 02/16/23 at 2:28 p.m., RN #3 was interviewed. She stated no one had reported to her any allegations of abuse related to Res #6 and Res #2. She stated she had never seen him do anything inappropriate, but it has always kinda bothered me how attentive he is to the boys. She stated the facility had not interviewed her related to the allegation.<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 - Some | On 02/16/23 at 2:58 p.m., CMA #3 was interviewed. CMA #3 stated he had not seen anything inappropriate, but RES #6 did spend a lot of time in Res #2's room. The CMA stated he had seen Res #6 put his hand under Res #2's blanket over the weekend, and maybe he was rubbing his arm as far as he could tell. The CMA said the administration already knew about it so there was nothing to report. The CMA stated over the weekend when it was an issue the nurses just said if he goes in there, we can't keep him out, but just keep an eye on him. The CMA stated some think Res #6 was doing something he shouldn't be doing, but if it was under the covers you couldn't tell. The CMA stated the way the bed sits and all you could see was that his arm is out but you couldn't see what was going on.<br><br>On 02/16/23 at 3:32 p.m., LPN #1 was interviewed. She stated she usually works weekends and last weekend CMA #1 had reported she saw Res #6 with his hand under the blanket of Res #2 making up and downward movements. She stated CMA #1 had reported it to the DON and the abuse coordinator. LPN #1 stated she kept a pretty good eye on Res #2 just in case because he is nonverbal. She stated Res #6 was in Res #2's room quite a bit. She stated around meal times or towards the ends of meals Res #6 would head in there and visit with Res #2. She stated it varied how long he stayed, some weekends a long time, like 30 minutes to an hour. LPN #1 stated Res #6 was pretty independent so it was hard to keep up with him sometimes but you start to pick up on his routine. She stated she had not witnessed any inappropriate behavior.<br><br>On 02/16/23 at 5:30 p.m., CNA #6 was interviewed. CNA #6 stated it was brought to her attention that CNA #1 caught Res #6 with his hand under Res #2's blanket in his private area. She stated the CNA had reported it to the nurse and the med aide. CNA #6 stated that on 02/11/23 she had also witnessed Res #6's hand under the covers of Res #2 as she walked by the room and had told her nurse. CNA #6 stated we have started to put the tab on Res #2's brief a certain way when we change him so to tell us if it had been moved. CNA #6 stated she had asked the nurse why we couldn't tell Res #6 that he can't go in there, but they have said we can't do that. The CNA was asked if the facility had interviewed her about the abuse allegation and stated she had not been interviewed until now.<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 - Some | On 02/16/23 at 7:15 p.m., CMA #1 was interviewed over the phone. She stated around 9:00 a.m., CNA #1 came to her while she was passing meds and asked her if she could go check on Res #2. CMA #1 stated CNA #1 said Res #6 was in Res #2's room with his arm under Res #2's blanket touching his private area. CMA #1 stated she moved her med cart outside of Res #2's door. She said she saw Res #6 with his arm under the blanket and appeared to be in his private area. She stated she then went in the room and stood by the bed, and at that time Res #6's slowly moved his arm back and began patting Res #2's hand at the edge of the bed. She stated Res #6's demeanor went from serious to laughing and loudly talking to Res #2. She stated she talked to Res #2, who was unable to speak, for a minute then went back to her cart. The CMA stated Res #6 continued playing and patting Res #2, rubbing his hands on Res #2's face, touching his lips, and using a stuffed animal to attack him playfully. She stated Res #6 kept looking to see if I was there and after about 10 minutes Res #6 left. She stated she then reported to her charge nurse, RN #1, immediately. The CMA stated she heard the RN contact the DON at approximately 9:30 a.m. After the phone call I was told to keep an eye on Res #6 but we can not say anything to Res #6. The CMA stated the RN told her the DON was going to notify the abuse coordinator (SSD). The CMA stated Res #6 went back to Res #2's room a couple of times before lunch that she knew. She stated she tried to watch him the best she could, but she had meds to give, and the CNAs were trying to watch also. She stated after lunch Res #6 returned to Res #2's room and his back was to the door and he wasn't aware she was there. She stated Res #6's arm and hand was again under the blanket and as she began to tell Res #6 that their hand was under the blanket, they moved their arm back and began patting Res #2's hand again and Res #6 stated, He likes that. She stated Res #6 then pulled his hand out from under the blanket and I went back to the hallway to observe. She stated Res #6 looked over their shoulder a few times and saw that she was there and then left the room. CMA #1 stated after that, at 2:12 p.m., she sent a text to the DON, because she felt something should be done. She said she then texted the abuse coordinator. She stated the abuse coordinator said there was nothing that could be done and that it was hearsay. The CMA stated the abuse coordinator told her without proof she couldn't say anything to Res #6. The CMA stated she shared her concern that they should protect the resident until it was investigated. The CMA stated she told the abuse coordinator other staff had made comments about how strange it was that Res #6 was in Res #2's room multiple times a day. The CMA stated the abuse coordinator became defensive towards her and told her it was hearsay. The CMA stated she asked the abuse coordinator if this was a state reportable and she stated it was. She stated the abuse coordinator stated it was just like another instance that often happens when Res #5 touches Res #4's breast and she can't consent, but nothing can be done because it's hearsay. The CMA stated she was not aware of occurrences involving Res #4 and #5. CMA #1 stated she asked the abuse coordinator if that also should be a state reportable that needed to be investigated and the abuse coordinator told her it had been and did not need CMA #1 telling her how to do her job.<br><br>On 02/17/23 at 9:45 a.m., Res #2's representative stated she was not notified of an allegation of abuse involving her loved one. The representative stated Res #2 was not able to consent and it was inappropriate for another resident to have their hands under his covers.<br><br>On 02/17/23 at 10:29 a.m., Res #6 was observed in the day area in a wheelchair next to Res #2's wheelchair. Res #6 noticed surveyor at the nurses station and began laughing and rocking Res #2's wheelchair from side to side by the handles on the back of the wheelchair briefly before leaving the day area.<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 - Some | On 02/17/23 at 11:38 a.m., the DON was interviewed. She stated on Saturday, the 11th, RN#1 called her around 10:00 a.m. and said there was an allegation of abuse against Res #6 involving Res #2. She said CNA #1 and CMA #1 had said Res #6 had his hand under Res #2's blanket. The DON stated she then called the abuse coordinator and told her. The DON stated CMA #1 called her later in the day because she was worried it wasn't being taken care of. The DON stated she was instructed to contact the abuse coordinator. The DON stated she suggested to not allow the resident to go back into Res #2's room, but was told by the abuse coordinator that he could go in there, he just had to be watched. The DON was asked if she had done an investigation. She stated the abuse coordinator was the one who did the investigations and had not directed her to do any interviews. The DON was asked if Res #2 was protected after the allegation was made? She stated they protected him by telling the staff to make frequent observations when Res #6 was in Res #2's room. She stated Res #2 should be protected while the investigation was on going. The DON stated she was directed by the abuse coordinator to allow Res #6 to go in the room but to ensure he is observed. She was asked if other residents should have been interviewed and she stated, Yes. The DON was asked if there should have been a more timely investigation started and she stated, Yes.<br><br>On 02/17/23 at 11:47 a.m., CNA #1 was interviewed over the phone. She stated on 02/11/23 around 8:30 to 8:45 a.m., she was passing ice to a room across the hall from Res #2's room. She said she heard a noise from Res #2's room and when she looked in the room, she witnessed Res #6 at Res #2's bedside with his arm under the covers. She said she could tell his hand was moving in the middle of the bed and the whole bed was shaking. She stated the blanket was moving. She stated Res #2 was unable to rotate, move, or even speak, and he had a weird look on his face. She stated Res #6's arm and hand were moving super fast under the blanket. She said you could tell what he was doing. There was nothing else he could have been doing. When Res #6 heard my cart he took his hand out from the blanket. She stated she was distraught and had a sick feeling. She stated she then went to tell RN #1 and she told me she didn't know how to go about asking him or doing anything about it. I had been assigned showers all day and then went to help one of my co-workers in the showers. She stated when she came back to check on Res #2, Res #6 was still in the room. She stated she felt like nothing was being done because Res #6 was still in there so she asked CMA #1 to check on Res #2 because she could not continue to watch him and CMA #1 did go. CNA #1 stated that later CMA #1 told her that Res #6 had finally left so finally left so she went in to check on Res #2 and checked his brief to see if he was soiled. She stated anyone who had changed Res #2 knew it was hard to loosen his diaper because of his contractures. She stated when she checked him the brief was super loose in the front main area where the peri-area was. She stated the resident was so contracted he was not able to put his hands down there and normally his brief was not moved like that. CNA #1 was asked if she had been interview by the administration. She said the DON had called her yesterday. (No documentation was provided related to an interview with CNA #1.) The CNA #1 stated the DON had explained to her that Res #6 had been there for a whole year and that was the first time that anything had been reported to her. The CNA stated she told her that just because that's the first time she had reported it doesn't mean it's the first time. The CNA stated there was an agency lady that had been there much longer and had told her and CMA #1 that she had reported it repeatedly. CNA #1 stated Res #2 was not the first one that it had happened to, it had also happened to Res #3, Res #2's roommate. (Res #3 unable to be interviewed related to severely impaired cognition.)<br><br>(continued on next page) |

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|---|---|---|---|
| | 375513 | A. Building<br>B. Wing | 02/18/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Golden Rule Home | 38801 Hardesty Road<br>Shawnee, OK 74801 |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 02/17/23 at 1:16 p.m., CNA #2 was interviewed over the phone. CNA #2 stated Res #6 was in Res #2's room multiple times a day and thought it was odd. She stated there were times she had walked by Res #2's room and it looked like Res #6's hand was under the cover but was hard to tell if you're just walking by. She stated sometimes when they would walk in Res #6 would get startled and then leave. CNA #2 stated she did see his hand under the covers for sure once last weekend but couldn't tell what he was doing. She stated Res #6 messes with Res #2's face and was actually kinda rough with him, touching him too hard on his face and on his chest. The CNA stated Res #6 pats Res #2 and sometimes he rubs his chest really hard, I guess he was trying to get him to laugh. She stated no one said to not let Res #6 go in there, they just told us to watch him, and see what Res #6 was doing. The CNA stated if we're busy we can't just stand there and watch him all the time and no one was assigned to watch him that she knew of. She stated anytime he would have been in there he would have been in there alone.<br><br>On 02/17/23 at 2:03 p.m., the SSD/abuse coordinator was interviewed. The abuse coordinator stated she was aware of the allegation of abuse involving Res #6 and Res #2. She stated the DON notified her Saturday the 11th. She stated she was told that "some staff" had seen Res #6 in Res #2's room with his hand under the cover. The abuse coordinator stated she told the DON to tell the staff that the door remains open and when Res #6 visits Res #2 the staff were to go in there. The abuse coordinator was asked if she had the staff remove Res #6 from Res #2's room. She stated, No mam, because because it was an allegation, did they ask [Res name deleted] where was his hand was, did they witness him in the groin area, they said no, I said ok. The abuse coordinator was asked if she interviewed all the staff working the shift when the allegation was reported. She said she asked for statements, but nobody came forward, just CMA #1. She stated she called CNA #1 but she did not return the call. She stated she received statements from CMA #1, Res #6, CNA #4, CMA #3, and LPN #1. She was asked if she documented her attempt and she said she did not. She was asked if she came to the facility on Saturday the 11th or Sunday the 12th to start the investigation. She stated she came in on Monday to begin the investigation. She stated the DON came into the facility at 6:00 on Sunday. The abuse coordinator was informed that the DON stated that she was not directed to do any of the investigations. The abuse coordinator was asked if two days after the allegation was a timely start of the investigation of sexual abuse. The Abuse coordinator stated, My opinion I was protecting [Res #2 name deleted] by telling them to stay in the room and I notified my proper people, the administrator. The abuse coordinator was asked if she interviewed any residents and she responded, Res #6. She was asked if she considered it a thorough investigation if you interview the alleged only? She stated she interviewed Res #6 because he was the one the allegation was against. She stated she didn't interview other residents. She stated Res #2 and Res #3 are nonverbal. The abuse coordinator was asked how the staff were to know to watch Res #6. She stated she trusted her DON to relay that information. The abuse coordinator was then informed that multiple staff did not know to watch Res #6 if he went into Res #2's room.<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 - Some | On 02/17/23 at 3:55 p.m., the administrator was interviewed. The administrator stated she was aware of the allegation of abuse involving Res #6 and Res #2. She stated the DON reported it to her Saturday, the 11th, in the afternoon. She stated the DON was the one who completed the reportable's most of the time. She stated the DON at least does the initial report and she would do the final when the investigation was complete. The administrator was asked why the allegation of abuse was not reported within the two hour time frame. She stated she thought the DON had taken care of it on Sunday, the 12th. She sated it should have been done on Saturday. The administrator was asked if the resident was protected while the investigation was pending. The administrator stated CMA #1 was not for certain what she actually witnessed, that's why we told her to stay in there and not allow Res #6 into the room by himself. The administrator stated when they called her on the weekend she tried to make sure they protected the resident and it was not happening again. The administrator was asked whose responsibility was it to watch the resident? She stated the abuse coordinator told them to make sure there was a staff in the room at all times. She stated usually we have only certain number who are supposed to work and we had too many so she told CMA #1 to make sure that someone watched him. The administrator was asked if the investigation was timely and thorough. She stated the abuse coordinator started the investigation and told them what to do and then the DON came in on Sunday the 12th which made her feel better. The administrator stated when she came in on Monday she called CMA #1 and put her on speaker with the abuse coordinator. The administrator stated that what got her alarmed was that Res #6 kept coming back. She stated she didn't get to talk to CNA #1 because she was agency. The administrator was asked what the tasks were for the abuse coordinator. She stated For years, this is now going to change, she did the investigation and we did the reportable, the abuse coordinator had never completed the reportable. The people report to [abuse coordinator name deleted] and she does the investigation and I help. The administrator was asked if she thought the investigation should have started on Saturday the 11th? She stated she told the DON to get a hold of CNA #1 and we didn't get anything from her timely. She stated the investigation should have started on Saturday. She stated when the DON came in on Sunday she intentionally came in to make sure that nothing would repeat from Saturday and eventually she told me she talked to RN #1. The administrator was asked about resident interviews. The administrator stated the DON told her she didn't do any resident interviews because the residents in the room were non-verbal. She stated she told the DON to conduct interviews with at least three random residents in the hallway.<br><br>46387<br><br>2. Res #4 had diagnoses which included cerebral infarction, major depressive disorder, dementia, and bipolar disorder.<br><br>A quarterly MDS, dated [DATE], documented Res #4 was severely cognitively impaired, required limited to extensive assistance of one staff with ADLs, had no behaviors, and utilized a walker and wheelchair for mobility.<br><br>A nurse progress note, dated 12/28/22 at 1:00 p.m., documented Res #5 was incontinent of bowel and bladder by choice. The note documented Res #5 was [TRUNCATED] |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29358<br><br>Based on record review and interview, the facility facility failed to ensure allegations of abuse were reported to OSDH, the residents' representatives, and law enforcement. The facility failed to report:<br><br>a. allegations of abuse to OSDH within two hours for residents #2, 4, 5, and #6.<br><br>b. results of investigations of alleged violations within five working days to OSDH for residents #4 and #5.<br><br>c. allegations of abuse to law enforcement not later than 24 hours for residents #2, 4, 5, and #6.<br><br>d. allegations of abuse to the residents' representatives for residents #2 and #4.<br><br>The Resident Census and Conditions of Residents form documented 36 residents resided in the facility.<br><br>Findings:<br><br>A facility abuse policy, revised April 2022, documented in parts . The center ensures that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property is reported immediately to the Administrator of the center and to other officials in accordance with State law through established procedures (including to the state survey and certification agency) .Any and all allegations are reported to the DON and/or Administrator .Immediate response is taken to ensure the safety of the resident .Timelines and investigation begin immediately .An initial report will be completed and submitted to the Department of Health Immediately upon notification of the allegation .Within five (5) days (or per state regulations) of the incident-final report is submitted in writing to appropriate state agencies .Events are reviewed by the Quality Management Committee to determine what actions are necessary to prevent recurrence .The regulations do not give us any leeway to decide if an allegation is valid before we report it .You can never assume an event didn't happen .A system to follow up on altercations will place an emphasis on preventing further altercation .<br><br>1. Res #2 was admitted to the facility on [DATE] and had diagnoses which included aphasia, TBI, anxiety, contractures, and tracheostomy status.<br><br>Res #6 was admitted to the facility on [DATE] and had diagnoses which included aftercare following joint replacement and post-polio syndrome.<br><br>Res #6's quarterly MDS assessment, dated 11/23/22, documented Res #6's cognition was intact, had no behaviors, was independent with most ADLs, and used a w/c and a walker for mobility.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Res #2's annual MDS assessment, dated 01/17/23, documented the resident's cognition was severely impaired, required total assistance with ADLs, had impairment in both upper and lower extremities, had an indwelling urinary catheter, and received nutrition by a feeding tube.<br><br>A facility Incident/Accident Report, signed by RN #1 and the DON on 02/13/23, documented an incident date of 02/11/23 at 10:20 a.m. The report documented the following: CNA #1 reported to RN on duty that she saw Res #6 with his hand under the covers of Res #2. CNA #1 did not see anything inappropriate. CNA #1 said she had a feeling. The RN reported to the DON who immediately reported to the abuse coordinator (SSD). The door was open and CMA #1 stated she asked Res #6 why his hand was under the covers. Res #6 said he was patting Res #2's hand. The steps taken to prevent recurrence was staff were informed to make frequent observations if residents were together and keep the door open.<br><br>A facility Resident Abuse Investigation Report Form, dated 02/15/23, documented the administrator was notified on 02/11/23 at 2:23 p.m., the resident representative was notified on 02/15/23 at 12:40 p.m. and the law enforcement agency was notified on 02/15/23 at 11:00 a.m. The report form had a hand written signature by the SSD/abuse coordinator.<br><br>An initial 283 Incident Report Form, to OSDH, had a facsimile date of 02/16/23 at 10:47 a.m. The report documented an incident date of 02/11/23. The report documented an allegation of abuse and the resident involved was Res #2, no other resident was named. The report read in parts, .Part B Description of Incident: Please include injuries sustained as well as measures taken to protect the resident(s) during investigation . Med aide verbalized that another resident's hand was under his blanket but did not see anything suspicious . The report did not included the measures taken to protect the resident. The report documented the physician, family, and APS were notified. The report documented the local sheriff's office was notified at 02/15/23 at 11:30 a.m. and the case number was documented. The report had the DON's electronic signature.<br><br>An initial and final 283 Incident Report Form, to OSDH, had a facsimile date of 02/16/23 at 10:50 a.m. The report documented an incident date of 02/11/23. The report documented a CMA's allegation of another resident's hand under Res #2's blanket but did not see anything suspicious. The other resident, the alleged perpetrator, was not named on the report. Part C of the report documented after an investigation no form of abuse or mistreatment noted. The report had the DON's electronic signature.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 02/16/23 at 7:15 p.m., CMA #1 was interviewed over the phone. She stated around 9:00 a.m., CNA #1 came to her while she was passing meds and asked her if she could go check on Res #2. CMA #1 stated CNA #1 said Res #6 was in Res #2's room with his arm under Res #2's blanket touching his private area. CMA #1 stated she moved her med cart outside of Res #2's door. She said she saw Res #6 with his arm under the blanket and appeared to be in his private area. She stated she then went in the room and stood by the bed, and at that time Res #6's slowly moved his arm back and began patting Res #2's hand at the edge of the bed. She stated Res #6's demeanor went from serious to laughing and loudly talking to Res #2. She stated she talked to Res #2, who was unable to speak, for a minute then went back to her cart. The CMA stated Res #6 continued playing and patting Res #2, rubbing his hands on Res #2's face, touching his lips, and using a stuffed animal to attack him playfully. She stated Res #6 kept looking to see if she was there and after about 10 minutes Res #6 left the room. She stated she then reported to her charge nurse, RN #1, immediately. The CMA stated she heard the RN contact the DON at approximately 9:30 a.m. After the phone call I was told to keep an eye on Res #6 but we can not say anything to Res #6. The CMA stated the RN told her the DON was going to notify the abuse coordinator (SSD). The CMA stated Res #6 went back to Res #2's room a couple of times before lunch that she knew. She stated she tried to watch him the best she could, but she had meds to give, and the CNAs were trying to watch also. She stated after lunch Res #6 returned to Res #2's room and his back was to the door and he wasn't aware she was there. She stated Res #6's arm and hand was again under the blanket and as she began to tell Res #6 that his hand was under the blanket, he moved his arm back and began patting Res #2's hand again and Res #6 stated, He likes that. She stated Res #6 then pulled his hand out from under the blanket and I went back to the hallway to observe. She stated Res #6 looked over his shoulder a few times and saw that she was there and then left the room. CMA #1 stated after that, at 2:12 p.m., she sent a text to the DON, because she felt something should be done. She said she then texted the abuse coordinator. She stated the abuse coordinator said there was nothing that could be done and that it was hearsay. The CMA stated the abuse coordinator told her without proof she couldn't say anything to Res #6. The CMA stated she shared her concern that they should protect the resident until it was investigated. The CMA stated she told the abuse coordinator other staff had made comments about how strange it was that Res #6 was in Res #2's room multiple times a day. The CMA stated the abuse coordinator became defensive towards her and told her it was hearsay. The CMA stated she asked the abuse coordinator if this was a state reportable and she stated it was. She stated the abuse coordinator stated it was just like another instance that often happens when Res #5 touches Res #4's breast and she can't consent, but nothing can be done because it's hearsay. The CMA stated she was not aware of occurrences involving Res #4 and #5. CMA #1 stated she asked the abuse coordinator if that also should be a state reportable that needed to be investigated and the abuse coordinator told her it had been and did not need CMA #1 telling her how to do her job.<br><br>On 02/17/23 at 9:45 a.m., Res #2's representative stated she was not notified of an allegation of abuse involving her loved one. The representative stated Res #2 was not able to consent and it was inappropriate for another resident to have their hands under his covers.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 2/17/23 at 11:38 a.m., the DON was interviewed. She stated on Saturday, the 11th, RN#1 called her around 10:00 a.m. and said there was an allegation of abuse against Res #6 involving Res #2. She said CNA #1 and CMA #1 had said Res #6 had his hand under Res #2's blanket. The DON stated she then called the abuse coordinator and told her. The DON stated she suggested to not allow the resident to go back into Res #2's room, but was told by the abuse coordinator that he could go in there, he just had to be watched. The DON stated the SSD/abuse coordinator had never completed a state reportable, those were completed by the administrator. She stated she started the report, but she did not finish the report or send it. The DON stated she was instructed by the administration to contact the abuse coordinator related to allegations of abuse. The DON stated the allegation was not reported to OSDH within two hours. She stated she did not notify the family and the family should have been notified of the allegation.<br><br>On 2/17/23 at 11:47 a.m., CNA #1 was interviewed over the phone. She stated on 02/11/23 around 8:30 to 8:45 a.m., she was passing ice to a room across the hall from Res #2's room. She said she heard a noise from Res #2's room and when she looked in the room, she witnessed Res #6 at Res #2's bedside with his arm under the covers. She said she could tell his hand was moving in the middle of the bed and the whole bed was shaking. She stated the blanket was moving and Res #2 had a weird look on his face. She stated Res #6's arm and hand were moving super fast under the blanket. She said you could tell what he was doing. There was nothing else he could have been doing. When Res #6 heard my cart he took his hand out from the blanket. She stated she had a sick feeling. She stated she then went to go tell RN #1 and she told me she didn't know how to go about asking him or doing anything about it. I had been assigned showers all day and then went to help one of my co-workers in the showers. She stated when she came back to check on Res #2, Res #6 was still in the room. She stated she then went and told CMA #1 to check on Res #2 because she could not continue to watch him and she did.<br><br>On 2/17/23 at 2:03 p.m., the SSD/abuse coordinator was interviewed. The abuse coordinator stated she was aware of the allegation of abuse involving Res #6 and Res #2. She stated the DON notified her Saturday the 11th. She stated she was told that some staff had seen Res #6 in Res #2's room with his hand under the cover. The abuse coordinator stated she told the DON to tell the staff that the door remains open and when Res #6 visits Res #2 the staff were to go in there. She stated she did not do the state reportable's. She was asked if she filled out the state reportable for this allegation. She stated she did not fill it out. She stated she did write the law enforcement case number down. She stated the sheriff's office was called on the 15th and showed up on the 15th. She stated the administrator and the DON fill out the reportable's. She stated she had never completed one in the [AGE] years she had worked there. She stated the DON told her on Wednesday the 15th, she was notifying the family.<br><br>On 2/17/23 at 3:55 p.m., the administrator was interviewed. The administrator stated she was aware of the allegation of abuse involving Res #6 and Res #2. She stated the DON reported it to her Saturday, the 11th, in the afternoon. She stated the DON was the one who completed the reportable's most of the time. She stated the DON at least does the initial report and she would do the final when the investigation was complete. The administrator was asked why the allegation of abuse was not reported within the two hour time frame. She stated she thought the DON had taken care of it on Sunday, the 12th. She sated it should have been done on Saturday.<br><br>46387<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. Res #4 had diagnoses which included cerebral infarction, major depressive disorder, dementia, and bipolar disorder.<br><br>A quarterly MDS, dated [DATE], documented Res #4 was severely cognitively impaired, required limited to extensive assistance of one staff with ADLs, and utilized a walker and wheelchair for mobility.<br><br>A nurse progress note dated 12/28/22 at 1:00 p.m., documented Res #5 was incontinent of bowel and bladder by choice. The note documented Res #5 was able to toilet self but refused and enjoyed being changed by staff. The note documented Res #5 made inappropriate comments to staff during care.<br><br>A nurse progress note, dated 12/29/22 at 1:00 p.m., documented Res #5 made inappropriate comments to staff during incontinent care.<br><br>A nurse progress note, dated 12/30/22 at 1:40 p.m., documented Res #5 was able to toilet self but chose to have incontinent care by female staff. The note documented Res #5 made inappropriate comments to staff at times and would remove brief and soak bed with urine and laugh when staff were required to clean it up. The note documented the social services director was notified of Res #5's behavior.<br><br>A nurse progress note, dated 12/31/22, documented a CNA reported Res #5 had inappropriate behavior towards another resident. The note documented staff notified the primary care provider and administrator. The note documented staff placed resident on one-to-one monitoring while awake and hourly checks while sleeping.<br><br>A facility Incident/Accident Report, dated 12/31/22 at 7:30 p.m., documented in parts, .Resi to front lobby via w/c, another resi rolled [up] next to her inappropriately attempted to put his hands in this resi's pants also lifted her shirt [up] attempting to touch breast . The incident report documented the physician and family were notified. The incident report documented in the additional comments/steps to prevent recurrence section, the other resident was moved away from Res #4. The incident report was documented as prepared by LPN #1 and signed by the DON, medical director, and administrator.<br><br>A facility Incident/Accident Report dated 12/31/22 at 7:30 p.m., documented Res #5 was witnessed touching Res #4. The report documented the resident was removed from Res #4 and 15 minute checks started then every hour, then discontinue after no further behavior. The incident report was documented as prepared by LPN #1 and signed by the DON, medical director, and administrator.<br><br>Res #4's health record did not document the incident on 12/31/22.<br><br>A nurse progress note, dated 01/02/23 at 12:30 a.m., documented Res #4 was on day two of monitoring related to an incident with another resident.<br><br>A nurse progress note, dated 01/02/23 at 2:00 p.m., documented Res #4 had been short tempered most of the shift, had been difficult to redirect, had bit, hit, kicked, and pinched staff during care, had been argumentative with other residents, had attempted to access restricted areas of the facility, and had attempted to get in bed with female residents.<br><br>(continued on next page) |

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| | 375513 | A. Building<br>B. Wing | 02/18/2023 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A nurse progress note, dated 01/03/23, documented Res #4 was on day three of monitoring related to an incident with another resident. The note documented Res #4 was tearful at times, easily angered, easily agitated, and unable to make needs known. The note documented Res #4 was refusing to allow staff to put them to bed and was sleeping in the lobby.<br><br>A nurse progress note, dated 01/04/23, documented Res #4 was seen by the physician and received a new order for Ativan 0.25 mg by mouth every 8 hours as needed for anxiety and agitation.<br><br>A care plan, dated 01/17/23, documented Res #5 was at risk for behaviors. The care plan documented to document behaviors as they occur, and monitor for changes in behavior and follow up with physician as needed.<br><br>A quarterly MDS, dated [DATE], documented Res #5 was moderately cognitively impaired, required limited to extensive assistance with ADLs, had no behaviors, and utilized a walker and wheelchair for mobility.<br><br>On 02/16/23 at 1:31 p.m., CNA #4 stated there was a rumor regarding an incident that occurred within the last month regarding Res #5, but she was not given any instruction specific to the incident. She stated she thought it had been reported to the abuse coordinator.<br><br>On 02/16/23 at 2:28 p.m., the MDS Coordinator stated she was made aware of the incident between Res #4 and #5 days after the incident as gossip. She stated she had heard it had already been reported. She stated the DON told her the situation had been taken care of.<br><br>On 02/16/23 at 2:49 p.m., RN #1 stated she did not believe Res #5 had touched anyone inappropriately. She stated she was told to keep an eye on the resident and ensure they were not in any female resident's room. She stated she believed the rumor regarding Res #5 had already been reported and did not remember where she heard the information.<br><br>On 02/16/23 at 3:32 p.m., LPN #1 stated she had not witnessed any inappropriate contact from Res #5 since the end of December. She stated it was reported to her that Res #5 had attempted to raise the shirt of Res #4 at that time. She stated the staff watch Res #5 because he has a history of inappropriate comments towards staff. She stated she believed Res #4 was targeted because of their cognitive status. She stated she would separate Res #4 and Res #5 in the dining room and ensured there are only same sex residents seated at the table with Res #5. She stated she spoke with her staff when the incident occurred but there have been no formal training or in-services regarding Res #5.<br><br>On 02/17/23 at 10:00 a.m., CNA #3 stated she witnessed an incident about two weeks ago of inappropriate touching of Res #4 by Res #5. She stated she was walking through the lobby and another resident pointed to get her attention. She stated she witnessed Res #5 with one hand on the inner thigh of Res #4 and the other kneading the breast of Res #4. She stated she removed Res #5 and told him not to do that as it was inappropriate. She stated she reported to the abuse coordinator who took a statement.<br><br>On 02/17/23 at 10:52 a.m., Res #4's daughter stated she was not informed of any allegation of abuse involving the resident. She stated Res #4 would be unlikely to report any abuse because of her cognition and a history of abuse.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 02/17/23 at 11:29 a.m., the DON stated there was no report to OSDH after the incident on 12/31/22 because it was alleged as an attempted inappropriate touching, and not actual touching. The DON stated the incident on 12/31/22 was the first incident but a second had occurred approximately two weeks ago in which Res #4 had again been touched inappropriately by Res #5. The DON stated neither event was reported to OSDH. She stated as far as she was aware an investigation of the second incident was not completed. She stated there was no long-term intervention placed to prevent further incidents. She stated after the second incident Res #4 and Res #5 were separated and there was no monitoring or intervention placed. She stated the facility did not follow its abuse policy.<br><br>There was no documentation law enforcement was contacted for either incident.<br><br>On 02/17/23 at 1:16 p.m., CNA #2 stated she had witnessed the event on 12/31/22. She stated Res #5 lifted the shirt of Res #4 and was touching their breast. She stated Res #5 was attempting to put their hand in Res #4's pants. She stated she reported the incident to the nurse on duty and wrote a statement.<br><br>On 02/17/23 at 2:03 p.m., the abuse coordinator was interviewed and stated she did not fill out the incident report from 12/31/22. She stated she did not speak with the staff following the incident as she trusted the DON to take care of it. She stated she did not do any state reportable incident reports for the facility. She stated she was told by the DON that the family was notified. She stated the incident from 12/31/22 was not brought to her attention as the DON did it all on her own. She stated the DON resolved the situation by herself and the abuse coordinator was not involved. She stated she was not aware of any incident from two weeks ago. She stated CNA #3 did not report to her.<br><br>On 02/17/23 at 3:55 p.m., the administrator stated the incident on 12/31/22 was reported to her as an attempt at inappropriate touching. She stated she instructed the staff to start one-to-one observation on Res #5 and ensure residents were separated. She stated she told the staff the rest of the investigation would be completed later. She stated when she arrived in the facility the following Monday, the DON told her that it was taken care of. She stated she did not report the incident from 12/31/22 to OSDH because the DON told her it was completed. She stated she did not report the incident from two weeks ago to OSDH because she was not aware of it until notified by surveyors. She stated information like this should be communicated to staff during report. She stated this behavior by Res #5 should not be ongoing and had she known of the second incident she would have contacted the resident's physician for further intervention.<br><br>3. A facility Resident Abuse Investigation Report Form, dated 01/03/23, documented Res #5 had been cussed at by CNA #4. A statement from RN #2 documented Res #5 reported to her that he had been cursed at by a staff member because he was having loose stools. The statement documented Res #5 pointed to CNA #4 and said there she is. The report documented the findings indicated no abuse had occurred because the resident denied anyone cursed at him when questioned. The report documented the corrective action taken was an in-service over abuse and neglect on 01/09/23.<br><br>A quarterly MDS, dated [DATE], documented Res #5 was moderately cognitively impaired, required limited to extensive assistance with ADLs, had no behaviors, and utilized a walker and wheelchair for mobility.<br><br>On 02/17/23 at 12:26 p.m., the DON stated she knew the incident was not reported to OSDH. She stated the abuse policy was not followed. |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29358<br><br>On 02/17/23 an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure residents #2 and #4 were protected from further sexual abuse and investigations were timely and thorough.<br><br>a. CNA #1 reported an allegation of sexual abuse to the charge nurse on 02/11/23 at approximately 8:45 a. m. CNA #1 reported she observed Res #6<br><br>with his arm and hand under the blanket of Res #2. The CNA reported Res #6's arm and hand were moving fast in an up and down motion causing the blanket to move and the bed to shake. The alleged perpetrator was not removed from Res #2's room and was allowed to re-enter the room multiple times and was not separated from the resident in the common areas for the entire length of the investigation. The investigation was not started until two days after the allegation and ended on 02/16/23. The investigation did not include CNA #1, other CNAs who worked the shift, RN #1, and resident interviews, except for the alleged perpetrator.<br><br>b. CNA #2 reported she witnessed, on 12/31/22, Res #5 lift the shirt of Res #4 and touch her breast and was trying to put his hand in her pants. The resident was protected for a couple of days but no long term interventions were communicated and put in place. CNA #3 reported she witnessed, around the first of February 2023, Res #5 with one hand on the inner thigh of Res #4 and the other kneading the breast of Res #4. CNA #3 reported to the abuse coordinator and DON. The allegation was not investigated and there were no interventions or corrective measures to protect Res #4.<br><br>On 02/17/23 at 6:04 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation.<br><br>On 02/17/23 at 6:35 p.m., the administrator was notified of the IJ situation.<br><br>On 02/18/23 at 2:06 p.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The plan of removal documented:<br><br>The Administrator in conjunction with the entire department heads team members will ensure that adverse events that are ongoing, urgent or emergent are reported timely.<br><br>The Administrator has provided direction to all levels of leadership on how to appropriately report any adverse events that occur. In addition, the quality assurance team meets daily during morning meetings to review all reported events and ensure timeliness in reporting.<br><br>Immediate action taken to ensure resident safety:<br><br>1. Facility will immediately meet the federal and state health, safety, and quality regulations regarding the alleged.<br><br>2. Resident #6 discharged to [name of location deleted] under [name of person deleted] watch.<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 - Some | 3. Resident #5 placed on an hourly watch in a private room per Doctors Orders until a bed available at the behavioral health hospital.<br><br>4. Resident #2 roommate swapped for a more cognitive resident to prevent any future incidents. On hourly staff watch<br><br>5. Resident #4 will be protected by hourly staff watch.<br><br>6. DON, Admin, Abuse Coordinator and other designated staff will immediately assess all residents for any behavioral signs of abuse. Assessment will include continued observation and monitoring for resident behaviors indicative of abuse.<br><br>7. Admin and DON will in-service MDS Coordinator for updates to affected residents care plan to include resident specific interventions to remove immediate jeopardy and ensure continued compliance and safety. A handwritten care plan will be completed immediately for affected residents and placed in chart. EMR will be updated by MDS Coordinator immediately upon return to work.<br><br>In-service and training to all staff will be completed on 2 levels:<br><br>1. Upper management to include Administrator, DON, and Abuse Coordinator will be in-serviced immediately via telephone by Owner/Operator. In-service training to include the following:<br><br>a. Facility Policy & Procedures, State and Federal guidelines reviewed regarding abuse identification, reporting and investigation requirements.<br><br>b. Reporting requirements for 2-hour reporting include allegation of abuse, neglect and misappropriation of funds; all other qualifying reportable incidents will be completed within 24 hours of notification per facility Policy.<br><br>c. Notification of required agencies, physician and family will be made immediately in conjunction with reporting guidelines.<br><br>d. Interventions put in place immediately to ensure resident safety.<br><br>e. Investigation process initiated immediately and must include resident assessment and interviews, staff interviews and interviews from any and all witnesses and reporting and involved individuals.<br><br>f. If allegation includes staff to resident abuse, staff member must be suspended immediately, pending investigation. If allegation includes resident to resident abuse, offending resident must be placed on watch and monitored (i.e. one to one, hourly, etc.) and resident victim must be kept safe and free from alleged offender. Remove the resident immediately!<br><br>g. Long-term interventions must be identified, care-planned and implemented. MDS must update care plan! If necessary, a hand-written update may be completed and MDS should include in the EHR as soon as possible (i.e., on a weekend).<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 - Some | 2. In turn, training of all care staff will be conducted by Administrator, DON, Abuse Coordinator and other appointed Department Heads through immediate in-person and telephone in-servicing. In-service education will include the following:<br><br>a. Report immediately!!<br><br>b. Report to your direct supervisor and up the chain of command (i.e. CNA report to Charge Nurse; Charge Nurse report to DON; DON report to Administrator) (housekeeper report to Housekeeping Supervisor; Housekeeping Supervisor report to Administrator). Again, report immediately! Over report .you can not report enough to appropriate personnel. Ultimately, all reporting should be made to Administrator. A rule of thumb to implement is that all staff members should immediately report to their direct supervisor and/or at least two people in the Chain of Command!<br><br>c. Write down details while they are fresh! This will assist in our internal investigation. Include date, time, and details.<br><br>d. Immediately separate or remove a resident that may be harming another resident and report to your supervisor to ensure resident safety.<br><br>e. Watch for signs of abnormal behavior or atypical behavior of a resident as this may be a sign of abuse. Report any unusual resident behavior to your supervisor immediately.<br><br>All in-service training will be completed by February 18, 2023, approximately noon. In-service training will be conducted by phone for employees not currently in the building.<br><br>The IJ was lifted, effective 02/18/23 at 12:00 p.m., when all components of the plan of removal had been completed. The deficient practice remained at a pattern with potential for harm to the residents.<br><br>Based on record review, observation, and record review, the facility failed to ensure residents were protected from further sexual abuse and investigations were timely and thorough for two (#2 and #4) of five residents sampled for abuse.<br><br>The Resident Census and Conditions of Residents form documented 36 residents resided in the facility.<br><br>Findings:<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 - Some | A facility abuse policy, revised April 2022, read in parts .The center ensures that all alleged violations involving mistreatment, neglect, or abuse .is reported immediately to the Administrator of the center and to other officials in accordance with State law through established procedures (including to the state survey and certification agency) .Any and all allegations are reported to the DON and/or Administrator .Immediate response is taken to ensure the safety of the resident .Timelines and investigation begin immediately .An initial report will be completed and submitted to the Department of Health Immediately upon notification of the allegation .Within five (5) days (or per state regulations) of the incident-final report is submitted in writing to appropriate state agencies .Events are reviewed by the Quality Management Committee to determine what actions are necessary to prevent recurrence .The regulations do not give us any leeway to decide if an allegation is valid before we report it .You can never assume an event didn't happen .A system to follow up on altercations will place an emphasis on preventing further altercation .<br><br>1. Res #2 was admitted to the facility on [DATE] and had diagnoses which included aphasia, TBI, anxiety, contractures, and tracheostomy status.<br><br>Res #6 was admitted to the facility on [DATE] and had diagnoses which included aftercare following joint replacement and post-polio syndrome.<br><br>Res #6's quarterly MDS assessment, dated 11/23/22, documented Res #6's cognition was intact, had no behaviors, was independent with most ADLs, and used a w/c and a walker for mobility.<br><br>Res #2's annual MDS assessment, dated 01/17/23, documented the resident's cognition was severely impaired, required total assistance with ADLs, had impairment in both upper and lower extremities, had an indwelling urinary catheter, and received nutrition by a feeding tube.<br><br>A facility Incident/Accident Report, signed by RN #1 and the DON on 02/13/23, documented an incident date of 02/11/23 at 10:20 a.m. The report documented the following: CNA #1 reported to RN on duty that she saw Res #6 with his hand under the covers of Res #2. CNA #1 did not see anything inappropriate. CNA #1 said she had a feeling. The RN reported to the DON who immediately reported to the abuse coordinator (SSD). The door was open and CMA #1 stated she asked Res #6 why his hand was under the covers. Res #6 said he was patting Res #2's hand. The steps taken to prevent recurrence was staff were informed to make frequent observations if residents were together and keep the door open.<br><br>A facility Resident Abuse Investigation Report Form, dated 02/15/23, documented an incident date of 02/11/23 and time unknown. The form documented CMA #1 reported an allegation of sexual abuse involving Res #6, the accused, and Res #2, the alleged victim. The form read in part, .Summary of witnesses .see attached (No other witnesses came forward) . CMA #1's statement dated 02/12/23 was attached. (The first staff to report was CNA #1 who reported to RN #1.) CNA #1's interview and/or statement was not provided. The form read in part, .Corrective action taken ., the line was blank. The form read in part, .Did the resident and/or the representative participate in determining the appropriate corrective action that was taken? . The form documented, No, Resident is non verbal. The form documented the administrator was notified on 02/11/23 at 2:23 p.m., the resident representative was notified on 02/15/23 at 12:40 p.m. and the law enforcement agency was notified on 02/15/23 at 11:00 a.m. The report form had a hand written signature by the SSD/abuse coordinator on the signature line for the Investigating Representative.<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 - Some | The abuse coordinator/SSD provided a document containing an interview with Res #6, dated 02/13/23. The interview documented Res #6 denied sexually touching Res #2. The interview documented Res #6 admitted he had put hand under Res #2's covers. The interview documented Res #6 admitted he had touched Res #2's hand, shoulders, and face.<br><br>The abuse coordinator/SSD provided statements from LPN #1; CMA #1 and #3; CNA #3, 4, and #5; and a cook. Interviews and/or statements were not provided to include RN #1 and CNA #1, 2, and #6 who had worked the shift the allegations were reported.<br><br>LPN #1's statement, dated 02/16/23 no time, documented CMA #1 reported to her about her concerns related to Res #6 and Res #2 on 02/11/23. LPN #1 documented she had, not witnessed any inappropriate touching or unwanted behaviors. This was the last statement/interview obtained, therefore ending the facility's investigation.<br><br>An initial 283 Incident Report Form, to OSDH, had a facsimile date of 02/16/23 at 10:47 a.m. The report documented an incident date of 02/11/23. The report documented an allegation of abuse and the resident involved was Res #2, no other resident was named. The report read in parts, .Part B Description of Incident: Please include injuries sustained as well as measures taken to protect the resident(s) during investigation . Med aide verbalized that another resident's hand was under his blanket but did not see anything suspicious . The report did not included the measures taken to protect the resident. The report documented the physician, family, and APS were notified. The report documented the local sheriff's office was notified at 02/15/23 at 11:30 a.m. and the case number was documented. The report had the DON's electronic signature.<br><br>An initial and final 283 Incident Report Form, to OSDH, had a facsimile date of 02/16/23 at 10:50 a.m. The report documented an incident date of 02/11/23. The report documented a CMA's allegation of another resident's hand under Res #2's blanket but did not see anything suspicious. The other resident, the alleged perpetrator, was not named on the report. Part C of the report documented after an investigation no form of abuse or mistreatment noted. The report had the DON's electronic signature.<br><br>On 02/16/23 at 11:28 a.m., Res #6 was observed in a wheelchair in the common area next to Res #2's wheelchair. Res #6 was observed facing Res #2's chair from the side with his back to the room.<br><br>On 02/16/23 at 1:03 p.m., CNA #3 was interviewed. CNA #3 stated she had seen Res #6 in Res #2's room multiple times but had not seen any inappropriate touching. She stated she had heard people say that they thought Res #6 was being inappropriate but no one had ever told me that they had seen any thing inappropriate. She stated she had heard Res #6 being called a chomo because he goes in the one room with the two young guys. She stated she didn't think any thing inappropriate because he was always getting Res #2 to laugh. She stated Res #6 treated Res #2 like a kid, like when you tried to make a baby laugh was how he treated him.<br><br>On 02/16/23 at 2:28 p.m., RN #3 was interviewed. She stated no one had reported to her any allegations of abuse related to Res #6 and Res #2. She stated she had never seen him do anything inappropriate, but it has always kinda bothered me how attentive he is to the boys. She stated the facility had not interviewed her related to the allegation.<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 - Some | On 02/16/23 at 2:58 p.m., CMA #3 was interviewed. CMA #3 stated he had not seen anything inappropriate, but RES #6 did spend a lot of time in Res #2's room. The CMA stated he had seen Res #6 put his hand under Res #2's blanket over the weekend, and maybe he was rubbing his arm as far as he could tell. The CMA said the administration already knew about it so there was nothing to report. The CMA stated over the weekend when it was an issue the nurses just said if he goes in there, we can't keep him out, but just keep an eye on him. The CMA stated some think Res #6 was doing something he shouldn't be doing, but if it was under the covers you couldn't tell. The CMA stated the way the bed sits and all you could see was that his arm is out but you couldn't see what was going on.<br><br>On 02/16/23 at 3:32 p.m., LPN #1 was interviewed. She stated she usually works weekends and last weekend CMA #1 had reported she saw Res #6 with his hand under the blanket of Res #2 making up and downward movements. She stated CMA #1 had reported it to the DON and the abuse coordinator. LPN #1 stated she kept a pretty good eye on Res #2 just in case because he is nonverbal. She stated Res #6 was in Res #2's room quite a bit. She stated around meal times or towards the ends of meals Res #6 would head in there and visit with Res #2. She stated it varied how long he stayed, some weekends a long time, like 30 minutes to an hour. LPN #1 stated Res #6 was pretty independent so it was hard to keep up with him sometimes but you start to pick up on his routine. She stated she had not witnessed any inappropriate behavior.<br><br>On 02/16/23 at 5:30 p.m., CNA #6 was interviewed. CNA #6 stated it was brought to her attention that CNA #1 caught Res #6 with his hand under Res #2's blanket in his private area. She stated the CNA had reported it to the nurse and the med aide. CNA #6 stated that on 02/11/23 she had also witnessed Res #6's hand under the covers of Res #2 as she walked by the room and had told her nurse. CNA #6 stated we have started to put the tab on Res #2's brief a certain way when we change him so to tell us if it had been moved. CNA #6 stated she had asked the nurse why we couldn't tell Res #6 that he can't go in there, but they have said we can't do that. The CNA was asked if the facility had interviewed her about the abuse allegation and stated she had not been interviewed until now.<br><br>(continued on next page) |

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|---|---|---|---|
| | 375513 | A. Building<br>B. Wing | 02/18/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Golden Rule Home | 38801 Hardesty Road<br>Shawnee, OK 74801 |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 02/16/23 at 7:15 p.m., CMA #1 was interviewed over the phone. She stated around 9:00 a.m., CNA #1 came to her while she was passing meds and asked her if she could go check on Res #2. CMA #1 stated CNA #1 said Res #6 was in Res #2's room with his arm under Res #2's blanket touching his private area. CMA #1 stated she moved her med cart outside of Res #2's door. She said she saw Res #6 with his arm under the blanket and appeared to be in his private area. She stated she then went in the room and stood by the bed, and at that time Res #6's slowly moved his arm back and began patting Res #2's hand at the edge of the bed. She stated Res #6's demeanor went from serious to laughing and loudly talking to Res #2. She stated she talked to Res #2, who was unable to speak, for a minute then went back to her cart. The CMA stated Res #6 continued playing and patting Res #2, rubbing his hands on Res #2's face, touching his lips, and using a stuffed animal to attack him playfully. She stated Res #6 kept looking to see if I was there and after about 10 minutes Res #6 left. She stated she then reported to her charge nurse, RN #1, immediately. The CMA stated she heard the RN contact the DON at approximately 9:30 a.m. After the phone call I was told to keep an eye on Res #6 but we can not say anything to Res #6. The CMA stated the RN told her the DON was going to notify the abuse coordinator (SSD). The CMA stated Res #6 went back to Res #2's room a couple of times before lunch that she knew. She stated she tried to watch him the best she could, but she had meds to give, and the CNAs were trying to watch also. She stated after lunch Res #6 returned to Res #2's room and his back was to the door and he wasn't aware she was there. She stated Res #6's arm and hand was again under the blanket and as she began to tell Res #6 that their hand was under the blanket, they moved their arm back and began patting Res #2's hand again and Res #6 stated, He likes that. She stated Res #6 then pulled his hand out from under the blanket and I went back to the hallway to observe. She stated Res #6 looked over their shoulder a few times and saw that she was there and then left the room. CMA #1 stated after that, at 2:12 p.m., she sent a text to the DON, because she felt something should be done. She said she then texted the abuse coordinator. She stated the abuse coordinator said there was nothing that could be done and that it was hearsay. The CMA stated the abuse coordinator told her without proof she couldn't say anything to Res #6. The CMA stated she shared her concern that they should protect the resident until it was investigated. The CMA stated she told the abuse coordinator other staff had made comments about how strange it was that Res #6 was in Res #2's room multiple times a day. The CMA stated the abuse coordinator became defensive towards her and told her it was hearsay. The CMA stated she asked the abuse coordinator if this was a state reportable and she stated it was. She stated the abuse coordinator stated it was just like another instance that often happens when Res #5 touches Res #4's breast and she can't consent, but nothing can be done because it's hearsay. The CMA stated she was not aware of occurrences involving Res #4 and #5. CMA #1 stated she asked the abuse coordinator if that also should be a state reportable that needed to be investigated and the abuse coordinator told her it had been and did not need CMA #1 telling her how to do her job.<br><br>On 02/17/23 at 9:45 a.m., Res #2's representative stated she was not notified of an allegation of abuse involving her loved one. The representative stated Res #2 was not able to consent and it was inappropriate for another resident to have their hands under his covers.<br><br>On 02/17/23 at 10:29 a.m., Res #6 was observed in the day area in a wheelchair next to Res #2's wheelchair. Res #6 noticed surveyor at the nurses station and began laughing and rocking Res #2's wheelchair from side to side by the handles on the back of the wheelchair briefly before leaving the day area.<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 - Some | On 02/17/23 at 11:38 a.m., the DON was interviewed. She stated on Saturday, the 11th, RN#1 called her around 10:00 a.m. and said there was an allegation of abuse against Res #6 involving Res #2. She said CNA #1 and CMA #1 had said Res #6 had his hand under Res #2's blanket. The DON stated she then called the abuse coordinator and told her. The DON stated CMA #1 called her later in the day because she was worried it wasn't being taken care of. The DON stated she was instructed to contact the abuse coordinator. The DON stated she suggested to not allow the resident to go back into Res #2's room, but was told by the abuse coordinator that he could go in there, he just had to be watched. The DON was asked if she had done an investigation. She stated the abuse coordinator was the one who did the investigations and had not directed her to do any interviews. The DON was asked if Res #2 was protected after the allegation was made? She stated they protected him by telling the staff to make frequent observations when Res #6 was in Res #2's room. She stated Res #2 should be protected while the investigation was on going. The DON stated she was directed by the abuse coordinator to allow Res #6 to go in the room but to ensure he is observed. She was asked if other residents should have been interviewed and she stated, Yes. The DON was asked if there should have been a more timely investigation started and she stated, Yes.<br><br>On 02/17/23 at 11:47 a.m., CNA #1 was interviewed over the phone. She stated on 02/11/23 around 8:30 to 8:45 a.m., she was passing ice to a room across the hall from Res #2's room. She said she heard a noise from Res #2's room and when she looked in the room, she witnessed Res #6 at Res #2's bedside with his arm under the covers. She said she could tell his hand was moving in the middle of the bed and the whole bed was shaking. She stated the blanket was moving. She stated Res #2 was unable to rotate, move, or even speak, and he had a weird look on his face. She stated Res #6's arm and hand were moving super fast under the blanket. She said you could tell what he was doing. There was nothing else he could have been doing. When Res #6 heard my cart he took his hand out from the blanket. She stated she was distraught and had a sick feeling. She stated she then went to tell RN #1 and she told me she didn't know how to go about asking him or doing anything about it. I had been assigned showers all day and then went to help one of my co-workers in the showers. She stated when she came back to check on Res #2, Res #6 was still in the room. She stated she felt like nothing was being done because Res #6 was still in there so she asked CMA #1 to check on Res #2 because she could not continue to watch him and CMA #1 did go. CNA #1 stated that later CMA #1 told her that Res #6 had finally left so finally left so she went in to check on Res #2 and checked his brief to see if he was soiled. She stated anyone who had changed Res #2 knew it was hard to loosen his diaper because of his contractures. She stated when she checked him the brief was super loose in the front main area where the peri-area was. She stated the resident was so contracted he was not able to put his hands down there and normally his brief was not moved like that. CNA #1 was asked if she had been interview by the administration. She said the DON had called her yesterday. (No documentation was provided related to an interview with CNA #1.) The CNA #1 stated the DON had explained to her that Res #6 had been there for a whole year and that was the first time that anything had been reported to her. The CNA stated she told her that just because that's the first time she had reported it doesn't mean it's the first time. The CNA stated there was an agency lady that had been there much longer and had told her and CMA #1 that she had reported it repeatedly. CNA #1 stated Res #2 was not the first one that it had happened to, it had also happened to Res #3, Res #2's roommate. (Res #3 unable to be interviewed related to severly impaired cognition.)<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 - Some | On 02/17/23 at 1:16 p.m., CNA #2 was interviewed over the phone. CNA #2 stated Res #6 was in Res #2's room multiple times a day and thought it was odd. She stated there were times she had walked by Res #2's room and it looked like Res #6's hand was under the cover but was hard to tell if you're just walking by. She stated sometimes when they would walk in Res #6 would get startled and then leave. CNA #2 stated she did see his hand under the covers for sure once last weekend but couldn't tell what he was doing. She stated Res #6 messes with Res #2's face and was actually kinda rough with him, touching him too hard on his face and on his chest. The CNA stated Res #6 pats Res #2 and sometimes he rubs his chest really hard, I guess he was trying to get him to laugh. She stated no one said to not let Res #6 go in there, they just told us to watch him, and see what Res #6 was doing. The CNA stated if we're busy we can't just stand there and watch him all the time and no one was assigned to watch him that she knew of. She stated anytime he would have been in there he would have been in there alone.<br><br>On 02/17/23 at 2:03 p.m., the SSD/abuse coordinator was interviewed. The abuse coordinator stated she was aware of the allegation of abuse involving Res #6 and Res #2. She stated the DON notified her Saturday the 11th. She stated she was told that "some staff" had seen Res #6 in Res #2's room with his hand under the cover. The abuse coordinator stated she told the DON to tell the staff that the door remains open and when Res #6 visits Res #2 the staff were to go in there. The abuse coordinator was asked if she had the staff remove Res #6 from Res #2's room. She stated, No mam, because because it was an allegation, did they ask [Res name deleted] where was his hand was, did they witness him in the groin area, they said no, I said ok. The abuse coordinator was asked if she interviewed all the staff working the shift when the allegation was reported. She said she asked for statements, but nobody came forward, just CMA #1. She stated she called CNA #1 but she did not return the call. She stated she received statements from CMA #1, Res #6, CNA #4, CMA #3, and LPN #1. She was asked if she documented her attempt and she said she did not. She was asked if she came to the facility on Saturday the 11th or Sunday the 12th to start the investigation. She stated she came in on Monday to begin the investigation. She stated the DON came into the facility at 6:00 on Sunday. The abuse coordinator was informed that the DON stated that she was not directed to do any of the investigations. The abuse coordinator was asked if two days after the allegation was a timely start of the investigation of sexual abuse. The Abuse coordinator stated, My opinion I was protecting [Res #2 name deleted] by telling them to stay in the room and I notified my proper people, the administrator. The abuse coordinator was asked if she interviewed any residents and she responded, Res #6. She was asked if she considered it a thorough investigation if you interview the alleged only? She stated she interviewed Res #6 because he was the one the allegation was against. She stated she didn't interview other residents. She stated Res #2 and Res #3 are nonverbal. The abuse coordinator was asked how the staff were to know to watch Res #6. She stated she trusted her DON to relay that information. The abuse coordinator was then informed that multiple staff did not know to watch Res #6 if he went into Res #2's room.<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 - Some | On 02/17/23 at 3:55 p.m., the administrator was interviewed. The administrator stated she was aware of the allegation of abuse involving Res #6 and Res #2. She stated the DON reported it to her Saturday, the 11th, in the afternoon. She stated the DON was the one who completed the reportables most of the time. She stated the DON at least does the initial report and she would do the final when the investigation was complete. The administrator was asked why the allegation of abuse was not reported within the two hour time frame. She stated she thought the DON had taken care of it on Sunday, the 12th. She sated it should have been done on Saturday. The administrator was asked if the resident was protected while the investigation was pending. The administrator stated CMA #1 was not for certain what she actually witnessed, that's why we told her to stay in there and not allow Res #6 into the room by himself. The administrator stated when they called her on the weekend she tried to make sure they protected the resident and it was not happening again. The administrator was asked whose responsibility was it to watch the resident? She stated the abuse coordinator told them to make sure there was a staff in the room at all times. She stated usually we have only certain number who are supposed to work and we had too many so she told CMA #1 to make sure that someone watched him. The administrator was asked if the investigation was timely and thorough. She stated the abuse coordinator started the investigation and told them what to do and then the DON came in on Sunday the 12th which made me feel better. She stated when she came in on Monday she called CMA #1 and put her on speaker with the abuse coordinator. The administrator stated that what got her alarmed was that Res #6 kept coming back. She stated she didn't get to talk to CNA #1 because she was agency. The administrator was asked what the tasks were for the abuse coordinator. She stated For years, this is now going to change, she does the investigation and we do the reportable. She has never done the reportable. The people report to [abuse coordinator name deleted] and she does the investigation and I help. The administrator was asked if she thought the investigation should have started on Saturday the 11th? She stated the statements were dated the 13th. She stated she told the DON to get a hold of CNA #1 and we didn't get anything from her timely. She stated the investigation should have started on Saturday. She stated when the DON came in on Sunday she intentionally came in to make sure that nothing would repeat from Saturday and eventually she told me she talked to RN #1. The administrator was asked about resident interviews. The administrator stated the DON told her she didn't do any because the residents in the room were non-verbal. She stated she told the DON to conduct interviews with at least three random residents in the hallway.<br><br>46387<br><br>2. Res #4 had diagnoses which included cerebral infarction, major depressive disorder, dementia, and bipolar disorder.<br><br>A quarterly MDS, dated [DATE], documented Res #4 was severely cognitively impaired, required limited to extensive assistance of one staff with ADLs, and utilized a walker and wheelchair for mobility.<br><br>A nurse progress note, dated 12/28/22 at 1:00 p.m., documented Res #5 was incontinent of bowel and bladder by choice. The note documented Res #5 was able to toilet self but refused and enjoyed being changed by staff. The note documented Res #5 made inappropriate comments to staff during care.<br><br>A nurse progress note, dated 12/29/22 at 1:00 p.m., d [TRUNCATED] |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>29358<br><br>Based on record review and interview, the facility failed to be administered in a manner that enables it to use its resources effectively to maintain the highest practicable physical, mental, and psychosocial well-being for two (#2, 4, 5, and #6) of six residents sampled. The facility failed to ensure:<br><br>a. residents were free from sexual abuse.<br><br>b. allegations of abuse were reported to OSDH within two hours.<br><br>c. results of investigations of alleged violations were reported to OSDH within five working days.<br><br>d. residents' representatives were notified of allegations of abuse.<br><br>e. allegations of abuse were reported to law enforcement not later than 24 hours.<br><br>f. residents were protected from further sexual abuse.<br><br>g. investigations related to sexual abuse were timely and thorough.<br><br>The Resident Census and Conditions of Residents documented 36 residents resided in the facility.<br><br>Findings:<br><br>1. A facility Incident/Accident Report, dated 12/31/22 at 7:30 p.m., documented in parts, .Resi to front lobby via w/c, another resi rolled [up] next to her inappropriately attempted to put his hands in this resi's pants also lifted her shirt [up] attempting to touch breast . The incident report documented the physician and family were notified. The incident report documented in the additional comments/steps to prevent recurrence section, the other resident was moved away from Res #4. The incident report was documented as prepared by LPN #1 and signed by the DON, medical director, and administrator.<br><br>On 02/17/23 at 11:29 a.m., the DON stated the incident on 12/31/22 was the first incident but a second had occurred approximately two weeks ago in which Res #4 had again been touched inappropriately by Res #5. The DON stated there was no report to OSDH after the incident on 12/31/22 because it was alleged as an attempted inappropriate touching, and not actual touching. The DON stated neither event was reported to OSDH. She stated as far as she was aware an investigation of the second incident was not completed. She stated there was no long-term intervention placed to prevent further incidents. She stated after the second incident Res #4 and Res #5 were separated and there was no monitoring or intervention placed. She stated the facility did not follow its abuse policy.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 02/17/23 at 2:03 p.m., the abuse coordinator was interviewed related to Res #4 and #5. She stated she did not fill out the incident report from 12/31/22. She stated she did not speak with the staff following the incident as she trusted the DON to take care of it. She stated she does not do any state reportable incident reports for the facility. She stated she was told by the DON that the family was notified. She stated the incident from 12/31/22 was not brought to her attention as the DON did it all on her own. She stated the DON resolved the situation by herself and the abuse coordinator was not involved. She stated she was not aware of any incident from two weeks ago. She stated CNA #3 did not report to her.<br><br>On 02/17/23 at 3:55 p.m., the administrator stated the incident related to Res #4 and #5 on 12/31/22 was reported to her as an attempt at inappropriate touching. She stated she instructed the staff to start one-to-one observation on Res #5 and ensure residents were separated. She stated she told the staff the rest of the investigation would be completed later. She stated when she arrived in the facility the following Monday the DON told her that it was taken care of. She stated she did not report the incident from 12/31/22 to OSDH because the DON told her it was completed. She stated she did not report the incident from two weeks ago to OSDH because she was not aware of it until notified by surveyors. She stated information like this should be communicated to staff during report. She stated this behavior by Res #5 should not be ongoing and had she known of the second incident would have contacted the resident's physician for further intervention.<br><br>2. A facility Incident/Accident Report, signed by RN #1 and the DON on 02/13/23, documented an incident date of 02/11/23 at 10:20 a.m. The report documented the following: CNA #1 reported to RN on duty that she saw Res #6 with his hand under the covers of Res #2. CNA #1 did not see anything inappropriate. CNA #1 said she had a feeling. The RN reported to the DON who immediately reported to the abuse coordinator (SSD). The door was open and CMA #1 stated she asked Res #6 why his hand was under the covers. Res #6 said he was patting Res #2's hand. The steps taken to prevent recurrence was staff were informed to make frequent observations if residents were together and keep the door open.<br><br>A facility Resident Abuse Investigation Report Form, dated 02/15/23, documented an incident date of 02/11/23 and time unknown. The form documented CMA #1 reported an allegation of sexual abuse involving Res #6, the accused, and Res #2, the alleged victim. The form read in part, .Summary of witnesses .see attached (No other witnesses came forward) . CMA #1's statement dated 02/12/23 was attached. (The first staff to report was CNA #1 who reported to RN #1.) CNA #1's interview and/or statement was not provided. The form read in part, .Corrective action taken ., the line was blank. The form read in part, .Did the resident and/or the representative participate in determining the appropriate corrective action that was taken? . The form documented, No, Resident is non verbal. The form documented the administrator was notified on 02/11/23 at 2:23 p.m., the resident representative was notified on 02/15/23 at 12:40 p.m. and the law enforcement agency was notified on 02/15/23 at 11:00 a.m. The report form had a hand written signature by the SSD/abuse coordinator on the signature line for the Investigating Representative.<br><br>An initial and final 283 Incident Report Form, to OSDH, had a facsimile date of 02/16/23 at 10:50 a.m. The report documented an incident date of 02/11/23. The report documented a CMA's allegation of another resident's hand under Res #2's blanket but did not see anything suspicious. The other resident, the alleged perpetrator, was not named on the report. Part C of the report documented after an investigation no form of abuse or mistreatment noted. The report had the DON's electronic signature.<br><br>(continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 02/17/23 at 11:38 a.m., the DON was interviewed. She stated on Saturday, the 11th, RN#1 called her around 10:00 a.m. and said there was an allegation of abuse against Res #6 involving Res #2. She said CNA #1 and CMA #1 had said Res #6 had his hand under Res #2's blanket. The DON stated she then called the abuse coordinator and told her. The DON stated CMA #1 called her later in the day because she was worried it wasn't being taken care of. The DON stated she was instructed to contact the abuse coordinator. The DON stated she suggested to not allow the resident to go back into Res #2's room, but was told by the abuse coordinator that he could go in there, he just had to be watched. The DON was asked if she had done an investigation. She stated the abuse coordinator was the one who did the investigations and had not directed her to do any interviews. The DON was asked if Res #2 was protected after the allegation was made? She stated they protected him by telling the staff to make frequent observations when Res #6 was in Res #2's room. She stated Res #2 should be protected while the investigation was on going. The DON stated she was directed by the abuse coordinator to allow Res #6 to go in the room but to ensure he is observed. She was asked if other residents should have been interviewed and she stated, Yes. The DON was asked if there should have been a more timely investigation started and she stated, Yes.<br><br>On 02/17/23 at 2:03 p.m., the SSD/abuse coordinator was interviewed. The abuse coordinator stated she was aware of the allegation of abuse involving Res #6 and Res #2. She stated the DON notified her Saturday the 11th. She stated she was told that "some staff" had seen Res #6 in Res #2's room with his hand under the cover. The abuse coordinator stated she told the DON to tell the staff that the door remains open and when Res #6 visits Res #2 the staff were to go in there. The abuse coordinator was asked if she had the staff remove Res #6 from Res #2's room. She stated, No mam, because because it was an allegation, did they ask [Res name deleted] where was his hand was, did they witness him in the groin area, they said no, I said ok. The abuse coordinator was asked if she interviewed all the staff working the shift when the allegation was reported. She said she asked for statements, but nobody came forward, just CMA #1. She stated she called CNA #1 but she did not return the call. She stated she received statements from CMA #1, Res #6, CNA #4, CMA #3, and LPN #1. She was asked if she documented her attempt and she said she did not. She was asked if she came to the facility on Saturday the 11th or Sunday the 12th to start the investigation. She stated she came in on Monday to begin the investigation. She stated the DON came into the facility at 6:00 on Sunday. The abuse coordinator was informed that the DON stated that she was not directed to do any of the investigations. The abuse coordinator was asked if two days after the allegation was a timely start of the investigation of sexual abuse. The Abuse coordinator stated, My opinion I was protecting [Res #2 name deleted] by telling them to stay in the room and I notified my proper people, the administrator. The abuse coordinator was asked if she interviewed any residents and she responded, Res #6. She was asked if she considered it a thorough investigation if you interview the alleged only? She stated she interviewed Res #6 because he was the one the allegation was against. She stated she didn't interview other residents. She stated Res #2 and Res #3 are nonverbal. The abuse coordinator was asked how the staff were to know to watch Res #6. She stated she trusted her DON to relay that information. The abuse coordinator was then informed that multiple staff did not know to watch Res #6 if he went into Res #2's room.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375513 | A. Building<br>B. Wing | 02/18/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Golden Rule Home | 38801 Hardesty Road<br>Shawnee, OK 74801 |

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

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|---|---|
| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 02/17/23 at 3:55 p.m., the administrator was interviewed. The administrator stated she was aware of the allegation of abuse involving Res #6 and Res #2. She stated the DON reported it to her Saturday, the 11th, in the afternoon. She stated the DON was the one who completed the reportable's most of the time. She stated the DON at least does the initial report and she would do the final when the investigation was complete. The administrator was asked why the allegation of abuse was not reported within the two hour time frame. She stated she thought the DON had taken care of it on Sunday, the 12th. She sated it should have been done on Saturday. The administrator was asked if the resident was protected while the investigation was pending. The administrator stated CMA #1 was not for certain what she actually witnessed, that's why we told her to stay in there and not allow Res #6 into the room by himself. The administrator stated when they called her on the weekend she tried to make sure they protected the resident and it was not happening again. The administrator was asked whose responsibility was it to watch the resident? She stated the abuse coordinator told them to make sure there was a staff in the room at all times. She stated usually we have only certain number who are supposed to work and we had too many so she told CMA #1 to make sure that someone watched him. The administrator was asked if the investigation was timely and thorough. She stated the abuse coordinator started the investigation and told them what to do and then the DON came in on Sunday the 12th which made her feel better. The administrator stated when she came in on Monday she called CMA #1 and put her on speaker with the abuse coordinator. The administrator stated that what got her alarmed was that Res #6 kept coming back. She stated she didn't get to talk to CNA #1 because she was agency. The administrator was asked what the tasks were for the abuse coordinator. She stated For years, this is now going to change, she did the investigation and we did the reportable, the abuse coordinator had never completed the reportable. The people report to [abuse coordinator name deleted] and she does the investigation and I help. The administrator was asked if she thought the investigation should have started on Saturday the 11th? She stated she told the DON to get a hold of CNA #1 and we didn't get anything from her timely. She stated the investigation should have started on Saturday. She stated when the DON came in on Sunday she intentionally came in to make sure that nothing would repeat from Saturday and eventually she told me she talked to RN #1. The administrator was asked about resident interviews. The administrator stated the DON told her she didn't do any resident interviews because the residents in the room were non-verbal. She stated she told the DON to conduct interviews with at least three random residents in the hallway. |