STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395564	A. Building B. Wing	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Ridge Rehabilitation & Healthcare Center	500 West Hospital Street Taylor, PA 18517

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of clinical records, select facility policies, and incident/accident reports and observations and staff interviews it was determined that the facility failed to ensure that one resident (Resident 2) out of six sampled was free from sexual abuse and harassment perpetrated by another resident (Resident 1). The failure of the facility to prevent Resident 1 from repeatedly sexually abusing Resident 2 placed Resident 2 and other female residents residing on the dementia unit in immediate jeopardy to their safety due to the potential for future episodes of sexual abuse and harassment to occur. Findings include: A review of the facility's current Abuse policy, no review date noted, revealed that Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. The facility's goal is to achieve and maintain an abuse free environment. Assessing residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issues. Clinical record review revealed that Resident 1 was admitted to the facility May 12, 2022. Pre admission hospital documentation dated December 30, 2021, revealed that the resident had a history of advanced dementia and presented to the hospital with behavioral changes. The hospital documentation noted that he has been wandering out of his house and made a neighbor touch him inappropriately. His wife does not feel she can keep him safe. She is power of attorney and believes he needs to be placed in a home. Review of Resident 1's admission Minimum Data Set Assessment (MDS- a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 18, 2022, revealed that the resident was severely cognitively impaired with a BIMS (brief interview for mental status - a screening tool to assess cognitive function) score of 3 (a score of 0-7 indicates severe impairment) and was independent with ambulation. Clinical record review revealed that Resident 2 was admitted to the facility on [DATE] with a diagnosis of dementia and a history of wandering behaviors in the facility. A review of Resident 2's quarterly MDS assessment dated [DATE], revealed that she was severely cognitively impaired and was also independent with ambulation. (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to nursing documentation throughout the month of May 2022, both Resident 1 and 2 displayed wandering behavior and independently ambulated on the dementia unit. Both Residents 1 and 2 resided on the same hallway of the locked dementia unit at the time of the survey ending June 23, 2022. Nursing documentation since Resident 1's admission on May 12, 2022, indicated that Resident 1 was frequently seen ambulating around and/or near Resident 2 on the dementia unit. A review of nursing documentation and information received from the local Area Agency on Aging, on May 31, 2022 at 11 AM Resident 1 was observed fondling Resident 2's breasts in the day room. The residents were separated and every 15 minute watches of Resident 1 were initiated. A review of a facility incident investigation, information submitted by the facility dated June 14, 2022, and a Pennsylvania Department of Health report form for investigation of alleged abuse, neglect and misappropriation of property dated June 14, 2022 at 12:55 PM revealed that Employee 2 (nurse aide) came out of a resident room and saw Resident 2 playing with the privacy curtain in a resident room. Employee 2 then observed that Resident 1 was standing behind Resident 2 with his hands down the front of her pants. Employee 2 immediately separated the residents and took Resident 2 to the activity room. Both residents were assessed by licensed nursing staff and placed on every 15 minute observation. However, Resident 1 had been on an every 15 minute observation by staff at the time of the incident, which proved to be an ineffective intervention. There was no documented evidence at the time the survey ending June 23, 2022, that staff had performed the every 15 minute observation of Resident 1 on June 14 2022. There was no record of the every 15 minute checks of Resident 1 conducted on June 14, 2022, available at the time of the survey ending June 23, 2022. An observation on June 23, 2022 at 8 AM, revealed that Resident 1 was awake and lying in his bed in his room. Resident 2 was observed ambulating in her room on the same hallway. At 8:10 AM, Resident 1 was observed leaving his room. He found Resident 2 in her room and took her by the hand and walked her into his room. When staff observed this surveyor following the residents back into Resident 1's room, a staff member then also followed the surveyor into Resident 1's room. The staff member then removed Resident 2 from Resident 1's room. An observation of the every 15 minute watch sheets for June 23, 2022, revealed that a watch sheet had not been completed for the prior 11 PM to 7 AM shift. The 7 AM to 3 PM sheet had not been started as of 8:45 AM when the surveyor reviewed the record. There was no documented evidence that facility staff were consistently conducting the every 15 minute observations of Resident 1. During an interview conducted on June 23, 2022, at 8:45 AM with Employee 3 (LPN), Employee 3 confirmed that Resident 1's every 15 minute watch sheet had not been completed for the prior 11 PM to 7AM shift and also had not been completed from 7 AM to the time of the interview. Employee 3 stated that the nurse aide staff assigned to Resident 1 was responsible for monitoring the resident every 15 minutes and to document completion of the task. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an inteview June 23, 2022 at 8:50 AM Employee 1 (nurse aide) stated that he was assigned to Resident 1 during this shift. He further stated that Resident 1 was on an every 15 minute watch. Employee 1 stated that he was busy getting other residents out of bed and ready for breakfast. He confirmed that as of 8:45 AM, he had not yet monitored Resident 1's whereabouts and did not start or complete the every 15 minute watch sheet since his shift began at 7 AM. A review of Resident 1's care plan for inappropriate sexual behavior, inappropriate touching related to cognitive impairment initiated June 16, 2022, after the second incident of inappropriate sexual contact with Resident 2 revealed interventions to administer medications as ordered, avoid conversations/television/radio that could encourage/or initiate inappropriate behavior and supervise in social gathering/recreation programs. There was no documented evidence at the time of the survey that Resident 1's pre admission inappropriate sexual behavior was identified and addressed on the resident's baseline or comprehensive care plan immediately upon the resident's admission or after the resident's initial inappropriate sexual behavior towards Resident 2 on May 31, 2022. The approach of every 15 minute checks of the resident was not included on the resident's care plan. An interview with the director of nursing (DON) at 1:30 PM on June 23, 2022, confirmed that the facility was aware of Resident 1's history of inappropriate sexual behavior that occurred prior to his admission to the facility at the time of his admission on May 12, 2022. She confirmed that this sexual behavior was not identified on the resident's plan of care. She further confirmed that the facility did not report Resident 1's sexual abuse of Resident 2 on May 31, 2022, to the State Survey Agency. She also confirmed that the facility was unable to demonstrate that staff had consistently performed the every 15 minute observations of Resident 1 as planned after the incident of sexual abuse on May 31, 2022, which was also verified by the incomplete records, surveyor observations during the survey and staff interviews. Immediate Jeopardy was called on June 23, 2022, due to the facility's failure to ensure that residents on the locked dementia unit were protected from the potential for further sexual abuse by Resident 1 with a known history of repeated sexual assault of a female resident on the dementia unit. The facility staff failed to sufficiently supervise Resident 1's whereabouts and activities to prevent sexual abuse and harassment of Resident 2, which placed Resident 2 and other residents residing on the unit in immediate jeopardy due to the potential for abuse to continue to occur. The facility was notified of the Immediate Jeopardy on June 23, 2022, at 12:15 PM and the IJ template provided to the facility at 12:15 PM. An immediate plan of correction was requested and received on June 23, 2022. The plan included: Resident 1 was placed on 1:1 supervision, documentation sheets will be completed by the staff providing the service. The sheets will be checked every shift by the charge nurse and monitored for compliance. The RN supervisor will complete random observations to assure that 1:1 and Q15 minutes are completed as assigned. Completion date June 23, 2022 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Education initiated on sexual abuse to all facility staff while they arrive on shift (days, evenings and nights), implementation of baseline care plan, updating care plan post event and execution of intervention of 1:1 and every 15 minute observation. Completion date June 23, 2022 The Immediate Jeopardy was lifted on June 23, 2022, at 4:30 PM when implementation of the plan of correction was verified. 483.13 - Resident Behavior and Facility Practices, 10-1-1998 edition 28 Pa. Code 201.29(a)(b)(d) Resident rights 28 Pa. Code 211.12 (a)(c)(d)(1)(5) Nursing services 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 211.5 (f)(g)(h) Clinical records

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of clinical records and staff interviews it was revealed that the facility failed to report to an incident of sexual abuse perpetrated by one resident (Resident 1) out of 5 sampled to the State Survey Agency. Findings include: A review of the clinical record revealed that Resident 1 was admitted to the facility May 12, 2022. The resident ambulates independently and resided on the facility's locked dementia unit. Pre admission hospital documentation dated December 30, 2021, revealed that Resident 1 had a history of advanced dementia and presented to the hospital with behavioral changes. The hospital documentation noted that He has been wandering out of his house and made a neighbor touch him inappropriately. His wife does not feel she can keep him safe. She is power of attorney and believes he needs to be placed in a home. A review of the clinical record revealed that Resident 2 was admitted to the facility on [DATE], with a diagnosis of dementia and a history of wandering behaviors in the facility. A review of the clinical records of Residents 1 and 2, revealed documentation following Resident 1's admission on May 1, 2022, that Resident 1 was often ambulating around Resident 2. Both residents resided on the same hallway on the facility's dementia unit. Review of Resident 1's admission MDS (Minimum Data Set Assessment - a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 18, 2022, revealed that the resident was severely cognitively impaired with a BIMS (brief interview for mental status - a screening tool to assess cognitive function) of 3 (a score of 0-7 indicates severe impairment) and was independent with ambulation. A review of Resident 2's quarterly MDS assessment dated [DATE], revealed that the resident was severely cognitively impaired and was independent with ambulation. A review of nursing documentation and a report of need from the area on aging dated May 31, 2022, at 11 AM revealed that Resident 1 was observed fondling Resident 2's breasts in the day room. The residents were separated and every 15 minute watches were initiated on Resident 1. There was no indication that the facility reported the incident to the State regulatory agency. When interviewed on June 23, 2022, at 2 p.m, the licensed nursing home administrator and Director of Nursing Services confirmed that they had not reported the incident to the required agencies. 483.13 - Resident Behavior and Facility Practices, 10-1-1998 edition 28 Pa. Code 201.18(e)(1) Management. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.14 (c) Responsibility of Licensee 28 Pa. Code 201.29(a)(c)(d) Resident Rights

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of clinical records, select incident and investigative reports, and employee job descriptions, it was determined that the facility's administration failed to effectively use its resources to promote resident safety and prevent abuse of one resident resident (Resident 2) perpetrated by another resident with known sexually inappropriate behavior at the time of admission to the facility and during the resident's stay in the facility (Resident 1). Findings included: A review of the clinical record of Resident 1 revealed admission to the facility May 12, 2022. Pre admission hospital documentation dated December 30, 2021, revealed that Resident 1 had a history of advanced dementia, presenting today with behavioral changes. He has been wandering out of the house and made a neighbor touch him inappropriately. His wife does not feel she can keep him safe. She is power of attorney and believes he needs to be placed in a home. Further clinical record review revealed that Resident 1 independently ambulates on the unit and resides on the locked dementia unit in the facility. Resident 2 was admitted to the facility on [DATE], with a diagnosis of dementia and a history of wandering behaviors in the facility. A review of nursing documentation and a report from the local Area on Aging dated May 31, 2022, at 11 AM revealed that Resident 1 was observed fondling Resident 2's breasts in the day room. The residents were separated and every 15 minute watches were initiated on Resident 1. A review of nursing documentation and a Pennsylvania Department of Health PB-22 investigation for abuse dated June 14, 2022, at 2:54 PM revealed that a nurse aide observed Resident 1 with his hands down the front of a Resident 2's pants. Resident 1 was placed on every 15 minute observations, around the clock from the time of the first resident to resident sexual encounter with Resident 2 on May 31, 2022. A review of this daily documentation of the every 15 minute checks available at the time of the survey of June 23, 2022, revealed that the staff failed to consistently perform these every 15 minute checks of Resident 1. At the time of the second incident of sexual abuse of Resident 2 on June 14, 2022, staff were not conducting the every 15 minute checks, which was confirmed by staff interview and review of documentation. An observation on June 23, 2022 at 8 10 AM Resident 1 was observed taking Resident 2 by the hand and ambulated with her into his room. The surveyor followed the two residents and when seeing the surveyor enter Resident 1's room, a staff member then followed the surveyor into Resident 1's room. The staff member then removed Resident 2 from Resident 1's room at that time. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the every 15 minute watch sheets, conducted at the time of the survey of June 23, 2022, revealed that staff had not completed the watch sheet during the prior 11 PM to 7 AM shift and had not yet started the watch sheet for the 7 AM to 3 PM as of 8:45 AM on June 23, 2022. During an inteview on June 23, 2022 at 8:45 AM Employee 1, a nurse aide, stated that he was assigned to Resident 1 during the 7 AM to 3 PM shift on June 23, 2022. He confirmed that Resident 1 was on an every 15 minute watch . Employee 1 stated that he was busy getting other residents out of bed and ready for breakfast. He confirmed that as of 8:45 AM, he had not yet checked Resident 1's whereabouts and did not start or complete the every 15 minute watch sheet yet during this shift of nursing duty. Immediate Jeopardy was identified on June 23, 2022, due to the facility's failure to ensure that residents on the locked dementia unit were protected from the potential for further sexual abuse by Resident 1 with a known history of repeated sexual assault of a female resident on the dementia unit. The facility staff failed to sufficiently supervise Resident 1's whereabouts and activities to prevent sexual abuse and harassment of Resident 2, which placed Resident 2 and other residents residing on the unit in immediate jeopardy due to the potential for abuse to continue to occur. A review of the job description for the Administrator, signed March 24, 2022, revealed that the purpose of the Administrator is to supervise clinical and administrative affairs of nursing homes and related facilities. Typical duties of nursing home administrators include overseeing staff and personnel, financial matters, medial care, medical supplies, facilities and other duties as specific positions demand. The position responsibilities included, explain the facility's policy's and procedures to employees, residents and family members and assist the departments in policy and procedure. Assure that adequate numbers of properly trained personnel are on duty at all times to meet the needs of the residents and comply with the regulations. The Job Description for Direction of Nursing Services dated May 26, 2022, revealed the purpose of the director of nursing is to provide professional knowledge and skills necessary to plan, organize, develop and direct the overall operation of the Resident care department in accordance with all current regulatory standards to ensure the highest degree of quality of care. This position has supervisory responsibility for all clinical related personnel. The deficiency cited under the Code of Federal Regulatory Groups for Long Term Care, Quality of Care (F600) 483.12(a)(1) Free from Abuse and Neglect, revealed that the NHA and DON failed to fulfill the essential job duties for ensuring the safety of the residents and adherence to regulatory guidelines. Refer F600 28 Pa. Code: 201.12 (a) Responsibility of licensee 28 Pa. Code: 201.18(b)(1) Management 28 Pa. Code: 201.18(b)(3) Management (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code:211.12(c)(d)(5) Nursing Services