| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455457 | A. Building<br>B. Wing | 12/31/2021 |

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| Fort Worth Wellness & Rehabilitation | 2129 Skyline Dr<br>Fort Worth, TX 76114 |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>44006<br><br>Based on interview and record review, the facility failed to implement their written policies and procedures that prohibit and prevent abuse for 1 of 8 residents (Resident #1) reviewed for abuse.<br><br>The facility failed to report to HHSC and law enforcement Resident #1's allegation of sexual abuse by CNA A for more than 9 days after the allegation was made to the facility's Abuse Coordinator.<br><br>This failure could place residents at risk for abuse.<br><br>The findings included:<br><br>(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 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A record review of the facility's policy entitled Abuse- Reportable Events, dated May 2017, revealed It is the policy of this home to prohibit resident abuse or neglect in any form, and to report in accordance with the law any incident/event in which there is cause to believe a resident's physical or mental health or welfare has been or may be adversely affected by abuse or neglect caused by another person. Definitions: Abuse, Involuntary seclusion, Mental/Psychological Abuse, Physical Abuse, Sexual Abuse, Verbal Abuse, Neglect, Misappropriation of property/financial Abuse, Exploitation, Suspicion of a crime against a resident. The home's administrator will conduct and investigate allegations of crimes, suspected abuse, neglect, or misappropriation of property, and will provide notification and release of information to the proper authorities, in accordance with federal and state regulations. The home's administration will designate a qualified staff member as the Abuse Coordinator. Procedure: 1. Screening, 2. Training, 3. Prevention, 4. Identification, 5. Investigation, 6. Protection, and 7. Reporting. 5. Investigation: The Charge Nurse will: Notify the Administrator or if unavailable, the Director of nurses will be notified. Begin taking written statements from the person reporting the allegations or suspicion and any witnessed including staff, family, and/or residents. Ask any witness to wait for the Administrator or the person on-call to arrive at the home. If an employee is involved, the employee will be detained and removed from their assigned duties until they are interviewed by the Administrator or person on-call or other appropriate staff. The person on-call will: Notify the Administrator and/or Director of nurses. Review the temps taken in the investigation. Take appropriate action if an employee is involved in the allegation or suspension of abuse. This will include removing the employee from duty and will be placed on investigation suspension. Abuse Coordinator will: Review all aspects of the investigation as soon as possible. Ensure that all reports are complete and appropriate authorities have been notified including the notification of the local law enforcement related to any crimes against a resident. Complete the investigation and direct any disciplinary action required. Complete the State Provider Investigation Report (5 day report). Review corrective action (s). Inform the resident or his/her representative of the findings of the investigation and corrective action taken. Refer all occurrences to the QAPI Committee to be analyzed to determine what change or changes are needed, if any, to the facilities policies and procedures to prevent further occurrences. 7. Reporting: a. All alleged allegations of abuse will be reported to the appropriate state agency and to all other agencies as required by regulation. b. Local law enforcement will be notified of any: -Reportable crime against a resident.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 12/28/21 at 1:02 PM with Resident #1, she stated CNA A and CNA B went into her room to change her a couple of weeks ago between 2:00-3:00 AM. Resident #1 stated they changed her, and it was no issue. She stated CNA B walked towards the door to leave the room and CNA A stated he needed to change her gown and proceeded to remove her gown. Resident #1 stated CNA B stopped and stood by the door. Resident #1 stated she was blind in her right eye, but didn't believe the gown was soiled, so she asked CNA A why he needed to change her gown. She stated he didn't respond. Resident #1 stated while CNA A removed her gown, she kept asking him why he was taking her gown off. She stated CNA A laughed and squeezed both of her breast with both of his hands. Resident #1 stated she froze for a moment, then told CNA A to stop. She stated she wanted to scream but just couldn't make a noise. Resident #1 stated CNA A continued to laugh. She stated CNA B stood by the door while this happened. Resident #1 stated CNA A put a new gown on her and both CNAs left the room. She stated she told all the staff who came in her room to help her. Resident #1 stated she told LVN C, Med Aide D, and CNA E. Resident #1 stated LVN F came into her room to talk about it and she explained to her what happened. Resident #1 stated LVN F seemed shocked and brought CNA B into her room. She stated LVN F asked CNA B about the incident and he denied it happened. Resident #1 stated while she explained what happened CNA B kept saying what are you talking about and belittled her as if he didn't know about the incident. Resident #1 stated she felt very hurt that CNA B did not tell the truth because he was always very nice to her and she felt safe with him. She stated CNA A and CNA B are like brothers and she knew CNA B was covering for CNA A. Resident #1 stated a few hours later LVN F came back in her room and asked questions. She stated the way LVN F spoke to her made her feel as if she didn't believe her, so she told her never mind it didn't happen . Resident #1 stated she couldn't remember exactly what LVN F said or asked, but she felt as if she wasn't taking her serious and made her feel as if she was delusional. Resident #1 stated the next day the DON and Administrator went to her room and asked what happened. She stated she told them about the incident, but she felt they did not take her seriously. Resident #1 stated the Administrator asked her why she didn't scream, she stated she told him she tried to scream but couldn't. Resident #1 stated she told the DON and Administrator about another incident that happened about a year ago with CNA A. Resident #1 stated about a year ago CNA A went into her room, lowered her bed, and turned her real hard. She stated she blacked out. Resident #1 stated when she woke up, he was standing over her and her private area (vagina) felt different, as if it had been touched. She stated she did she did not report it to the facility because she didn't remember him touching her private area, but she knew her private area had been touched because of the way it felt and she remembered blacking out. Resident #1 stated she did not like CNA A changing her because she felt he cleaned her private area to long and wiped too much. She stated it just did not feel right. Resident #1 stated after she explained both incidents to the DON and Administrator they acted as if they didn't know what happened to her as if she was mixed up and delusional about being violated.<br><br>In an interview on 12/29/21 at 1:34 PM with CNA G, she stated she provided care to Resident #1 about two-three weeks ago and she told her there was an incident with CNA A. CNA G stated Resident #1 told her CNA A and CNA B went into her room to change her. CNA G stated she told her CNA A changed her gown and grabbed her breast. CNA G stated Resident #1 told her CNA B stood at the door. CNA G stated she reported the incident to the DON.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 12/29/21 at 1:59 PM with LVN C, she stated she had a good relationship with Resident #1, so the DON asked her if Resident #1 mentioned an incident with staff regarding sexual abuse. LVN C stated she told the DON she did not say anything to her. LVN C stated when she went to feed Resident #1, she asked her had anyone ever touched her inappropriately in the facility. LVN C stated she told her CNA A and CNA B came into her room and when she opened her eyes CNA A stood over her and her private area (vagina) felt weird . LVN C stated Resident #1 told her CNA B stood by the door. LVN C stated she never said CNA A grabbed her breast and he only touched her private area. LVN C stated the next day Resident #1 told her about the incident again, but this time she stated it happened a year ago. LVN C stated the details of what happened was the same, she only changed the timeframe. LVN C stated Resident #1 was very verbal, did not have cognitive issues, and had no known psychiatric issues, such as delusions. LVN C stated she was very concerned because she was really with it and had the ability to recall things accurately, so she was really worried this incident occurred. She stated she reported to the DON each day what Resident #1 told her.<br><br>In an interview on 12/29/21 at 3:09 PM with CNA I, she stated Resident #1 accused CNA A of sexual abuse about a week ago. She stated on 12/17/21, CNA E came to her very upset during their shift and stated Resident #1 reported to her that CNA A grabbed her breast. CNA I stated CNA E asked her what to do and she told her to report it to the charge nurse (LVN F). She stated CNA E told her Resident #1 did not want her to report it to LVN F because she didn't trust her. CNA I stated she told CNA E they had to report it to LVN F because she was the charge nurse on duty and the DON was not there. She stated she and CNA E reported the incident to LVN F but told her Resident #1 did not want to talk to her. CNA I stated she asked LVN F, if she could just contact the Administrator, who was the Abuse Coordinator, and let him talk to Resident #1. CNA I stated LVN F did not contact the Abuse Coordinator and called the DON. CNA I stated LVN F had the DON on speaker and she heard the DON tell LVN F to ask Resident #1 did CNA H put this in your head, did you hear CNA H say this, and is this why you were reporting this. CNA I stated she stood by Resident #1's door and she heard LVN F go into the room and say those things to Resident #1. She stated she heard Resident #1 say she just wanted to drop it. CNA I stated the next few days Resident #1 was constantly crying. She stated she asked Resident #1 why she was crying, and she told her she was sad because CNA A violated her. CNA I stated Resident #1 told her CNA A did incontinence care and felt her breast when he changed her gown. She stated she wanted to clarify, so she asked Resident #1 did he accidently touch her breast when he was putting on her gown. CNA I stated Resident #1 said no and he actually grabbed her breast. She stated Resident #1 also told her she felt when CNA A provided incontinence care, he took too long to clean her, and it didn't feel right. CNA I stated Resident #1 appeared very upset and said people tried to make her think she was delusional. CNA I stated she felt bad for Resident #1 because she was physically disabled but she was in her right mind. She said she had worked with Resident #1 for over a year and she had never appeared to be mentally unstable or delusional. CNA I stated she did report this to the DON.<br><br>On 12/29/21 at 4:01 PM, contact to CNA E via phone was attempted and was unsuccessful.<br><br>On 12/29/21 at 4:04 PM, contact to LVN F via phone was attempted and was unsuccessful.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 12/29/21 at 4:17 PM with the Activity Director, she stated on 12/20/21 she was doing rounds and went to talk Resident #1. She stated Resident #1 told her she had been sexually abused by CNA A. The Activity Director stated Resident #1 told her there was an incident in which she passed out and when she came to, CNA A was there, and her private area felt funny. She stated she asked Resident #1 did she report it and she said no because she felt crazy. The Activity Director stated Resident #1 said recently CNA A did it again and grabbed her breast. She stated Resident #1 said she told the Administrator and the DON, but she felt they belittled her and did not believe her, so she told them it didn't happen. The Activity Director stated she immediately contacted the Administrator via phone. She stated he told her he had already completed an investigation and talked to the DON and they determined it did not happen and for her to complete a grievance. The Activity Director stated she completed a grievance form and slide it under the Administrator's office door. The Activity Director stated the next morning she spoke to the DON about the incident. She stated the DON told her she believed Resident #1 made it up because when they talked to her she changed and said it didn't happen . The Activity Director stated she told the DON Resident #1 changed her statement because she felt they did not believe her or took her serious. The Activity Director stated the DON brought the Administrator into the office and she explained to him why Resident #1 changed her statement. The Activity Director stated the DON and Administrator seemed to come to a decision they did not believe Resident #1, but they never clearly stated if they would or wouldn't report to the state . The Activity Director stated she noticed a change in Resident #1's behavior. She stated Resident #1 seemed withdrawn and sad . The Activity Director stated she had no knowledge of the allegations made by Resident #1 until she did rounds on 12/20/21. She stated it made sense why Resident #1's behavior had changed .<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 12/29/21 at 5:47 PM with the DON, she stated if a resident reported abuse or neglect, she was supposed to immediately report it to the Administrator, who was the Abuse Coordinator. She stated on Sunday night (12/19/21), she received a call from the charge nurse (LVN F), who reported Resident #1 told CNA E that CNA A had grabbed her breast. The DON stated she had LVN F put her on speaker and go into Resident #1's room. The DON stated she asked Resident #1 what happened. She stated Resident #1 stated she had a flashback of when she first came to the facility and someone touched her. The DON stated she didn't say who touched her and she didn't ask her who touched her. The DON stated she asked Resident #1 had this occurred recently and Resident #1 stated no. She stated Resident #1 said she felt safe. The DON stated she immediately contacted the Administrator. She stated the Administrator told her to make sure CNA A was not working on Resident #1's hall and they would talk to Resident #1 in the morning . The DON stated the next morning, she, the Administrator, and the Social Worker, went to talk to Resident #1. She stated Resident #1 said she believed she fainted and when she woke up CNA A stood above her and believed he touched her. The DON stated Resident #1 kept using the word flashback and was unclear when the incident occurred. She stated she asked Resident #1 what she recalled about the incident and she stated she only remembered he stood over her and laughed. The DON stated she started an investigation and took statements from the staff. She stated later that day (12/20/21) the Activity Director went into her office and told her Resident #1 reported to her, CNA A touched her. She stated she told the Activity Director they had already started an investigation. The DON stated she did not recall any staff member telling her Resident #1 changed her story because she and the Administrator didn't believe her; nor, did she recall asking staff to clarify if Resident #1 repeated what she was told by CNA H. The DON stated she was aware the Administrator did not report the incident to the state or law enforcement. She stated she felt she didn't need to report to the state because Resident #1 told her she now felt safe and didn't feel a need to further look into it. The DON stated there was another resident and staff member who accused CNA A of sexual abuse. The DON stated the risk of not reporting sexual abuse was it could happen to another resident. She stated if a resident made an allegation of sexual abuse and then changed it, the incident should still be reported to the state.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 12/29/21 at 6:20 PM with the Administrator/Abuse Coordinator, he stated if a resident reported abuse, then he should investigate it and then report it , if appropriate. He stated by appropriate, he meant if he thought it actually happened. The Administrator stated he was made aware Resident #1 stated CNA A sexually abused her. He stated on Sunday night (12/19/21) he received a call from the DON. The Administrator stated the DON told him Resident #1 said CNA A touched her inappropriately but Resident #1 wasn't sure if it happened the previous day or year ago. He stated the DON said Resident was unclear and kept saying it could have been a flashback. The Administrator stated he asked the DON what she thought about the situation and she said she didn't believe it happened, so he told her they would talk about it in the morning. He stated the next morning, he, the DON, and the Social Worker interviewed Resident #1. The Administrator stated Resident #1 said a year ago she felt uncomfortable with CNA A because he stood over her when she woke up. He stated Resident #1 said CNA A never touched her, but then changed and said the day before CNA A touched her. The Administrator stated CNA A and CNA B went into her room to do incontinence care. He stated Resident #1 said CNA B left the room and then CNA A touched her breast. The Administrator stated he asked Resident #1 if she felt safe and she said yes. He stated he did not report the allegation to the state or law enforcement because he investigated it, felt it did not happen, so he did not report it. The Administrator stated his investigation included interviewing Resident #1, reading statements wrote by CNA A and CNA B, and he discussed it with the DON. He stated in both CNA A and CNA B's statement they stated CNA A left the room first and then CNA B left, so he found the allegation to be unsubstantiated. The Administrator stated, he also based his decision on Resident #1 going back and forth without a definitive response whether CNA A touched her or not and due to the DON saying she didn't believe the allegation because the resident used the word flashback. Based on this, the Administrator stated he determined the incident was unfounded, so it did not need to be reported to the state or law enforcement. He stated he was unaware of any other residents who accused CNA A of sexual abuse. He stated he did not review CNA A's personnel file. The Administrator stated he was aware of a staff member who alleged sexual abuse against CNA A. He stated he did not know the facility's official policy on reporting abuse. He stated he is new to the facility and came from another state . He stated the risk of not reporting abuse was it could happen to another resident.<br><br>In an interview on 12/29/21 at 5:32 PM with CNA B, he stated the DON asked him to write a statement about the day he and CNA A changed Resident #1. CNA B stated Resident #1 required two people to change her, so he asked CNA A to help. CNA B stated he rolled Resident #1 over and CNA A wiped her and put a new diaper under her. He stated after CNA A placed the diaper under Resident #1, he left the room and CNA B finished assisting Resident #1. CNA B stated he did not change Resident #1's gown. He stated he did not see CNA A re-enter Resident #1's room. CNA B stated he had never known CNA A to be accused of sexual abuse by a resident or staff member.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 12/30/21 at 8:48 AM with CNA A, he stated he was accused by Resident #1 of touching her breast. CNA A stated he did not touch Resident #1's breast and he was shocked she accused him of this. CNA A stated he was asked by CNA B to help change Resident #1. He stated he only rolled Resident #1 over and he did not wipe her. CNA A stated CNA B wiped Resident #1. He stated as soon as the incontinence care was completed, he left the room. CNA A stated Resident #1's gown was soiled and needed to be changed, but he left CNA B in the room to do that. He stated he heard Resident #1 accused him of returning to her room and touching her. CNA A stated he never returned to her room. CNA A stated he believed CNA H coached Resident #1 to make the abuse allegation because she worked Resident #1's hall the same day she made the allegation. CNA A stated he had worked at other nursing facility and had never been accused of sexual abuse. CNA A changed his response and stated he isn't sure and did not recall. CNA A then stated he was upset he was told not to report to work until further notice, because he did not do the things he was accused of. He stated he believed he was being retaliated against because the facility was in trouble for not reporting these allegations to the state .<br><br>In an interview on 12/30/21 at 10:48 PM with the Social Worker, he stated on 12/20/21 it was brought to his attention by the Administrator and DON, Resident #1 had reported CNA A went into her room and touched her breast on 12/19/21. He stated he, the DON, and the Administrator interviewed her on 12/20/21. The Social Worker stated Resident #1 said CNA A grabbed her breast. He stated Resident #1 first stated it happened a year ago and then changed it to a couple of days ago. The Social Worker stated she was unclear of timeframes. The Social Worker stated it was discussed between he, the DON, and the Administrator about the incident being reported but the Administrator never directly stated he was going to report the incident. The Social Worker stated he didn't officially know if the DON reported it, but he assumed the DON would report it because in this type of business he is supposed to report. He stated he learned today the incident was not reported. The Social Worker stated if he had been aware the incident wasn't reported, then he would have immediately reported it . He stated he had been conducting safe surveys all morning and no other residents had reported any abuse or neglect. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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** 44006<br><br>Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, are reported immediately, but not later than 2 hours after the allegation is made, to HHSC for one (Resident #1) of six residents reviewed for Abuse.<br><br>The facility failed to report to HHSC Resident #1's allegation of sexual abuse by CNA A for more than 9 days after the allegation was made to the facility's Abuse Coordinator.<br><br>This failure could place residents at risk of abuse.<br><br>A record review of the facility's policy entitled It is the policy of this home to prohibit resident abuse or neglect in any form, and to report in accordance with the law any incident/event in which there is cause to believe a resident's physical or mental health or welfare has been or may be adversely affected by abuse or neglect caused by another person. Definitions: Abuse, Involuntary seclusion, Mental/Psychological Abuse, Physical Abuse, Sexual Abuse, Verbal Abuse, Neglect, Misappropriation of property/financial Abuse, Exploitation, Suspicion of a crime against a resident. The home's administrator will conduct and investigate allegations of crimes, suspected abuse, neglect, or misappropriation of property, and will provide notification and release of information to the proper authorities, in accordance with federal and state regulations. The home's administration will designate a qualified staff member as the Abuse Coordinator. Procedure: 1. Screening, 2. Training, 3. Prevention, 4. Identification, 5. Investigation, 6. Protection, and 7. Reporting. 5. Investigation: The Charge Nurse will: Notify the Administrator or if unavailable, the Director of nurses will be notified. Begin taking written statements from the person reporting the allegations or suspicion and any witnessed including staff, family, and/or residents. Ask any witness to wait for the Administrator or the person on-call to arrive at the home. If an employee is involved, the employee will be detained and removed from their assigned duties until they are interviewed by the Administrator or person on-call or other appropriate staff. The person on-call will: Notify the Administrator and/or Director of nurses. Review the temps taken in the investigation. Take appropriate action if an employee is involved in the allegation or suspension of abuse. This will include removing the employee from duty and will be placed on investigation suspension. Abuse Coordinator will: Review all aspects of the investigation as soon as possible. Ensure that all reports are complete and appropriate authorities have been notified including the notification of the local law enforcement related to any crimes against a resident. Complete the investigation and direct any disciplinary action required. Complete the State Provider Investigation Report (5 day report). Review corrective action (s). Inform the resident or his/her representative of the findings of the investigation and corrective action taken. Refer all occurrences to the QAPI Committee to be analyzed to determine what change or changes are needed, if any, to the facilities policies and procedures to prevent further occurrences. 7. Reporting: a. All alleged allegations of abuse will be reported to the appropriate state agency and to all other agencies as required by regulation. b. Local law enforcement will be notified of any: -Reportable crime against a resident.<br><br>(continued on next page) |

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| | 455457 | A. Building<br>B. Wing | 12/31/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Fort Worth Wellness & Rehabilitation | 2129 Skyline Dr<br>Fort Worth, TX 76114 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident #1's electronic face sheet, revealed Resident #1 was an [AGE] year-old female admitted into the facility on [DATE] and was diagnosed Cerebrovascular Disease, Other Fracture of Upper End of Right Tibia Subsequent Encounter For Closed Fracture with Routine Healing, Unspecified Abnormalities of Gait and Mobility, Vascular Dementia Without Behavior Disturbance, and Major Depressive Disorder.<br><br>Record review of Resident #1's Quarterly MDS dated [DATE] revealed Resident #1's BIMS score was 8, which indicated the resident's cognition was moderately impaired.<br><br>In an interview on 12/28/21 at 1:02 PM with Resident #1, she stated CNA A and CNA B went into her room to change her a couple of weeks ago between 2:00-3:00 AM. Resident #1 stated they changed her, and it was no issue. She stated CNA B walked towards the door to leave the room and CNA A stated he needed to change her gown and proceeded to remove her gown. Resident #1 stated CNA B stopped and stood by the door. Resident #1 stated she was blind in her right eye, but didn't believe the gown was soiled, so she asked CNA A why he needed to change her gown. She stated he didn't respond. Resident #1 stated while CNA A removed her gown, she kept asking him why he was taking her gown off. She stated CNA A laughed and squeezed both of her breast with both of his hands. Resident #1 stated she froze for a moment, then told CNA A to stop. She stated she wanted to scream but just couldn't make a noise. Resident #1 stated CNA A continued to laugh. She stated CNA B stood by the door while this happened. Resident #1 stated CNA A put a new gown on her and both CNAs left the room. She stated she told all the staff who came in her room to help her. Resident #1 stated she told LVN C, Med Aide D, and CNA E. Resident #1 stated LVN F came into her room to talk about it and she explained to her what happened. Resident #1 stated LVN F seemed shocked and brought CNA B into her room. She stated LVN F asked CNA B about the incident and he denied it happened. Resident #1 stated while she explained what happened CNA B kept saying what are you talking about and belittled her as if he didn't know about the incident. Resident #1 stated she felt very hurt that CNA B did not tell the truth because he was always very nice to her and she felt safe with him. She stated CNA A and CNA B are like brothers and she knew CNA B was covering for CNA A. Resident #1 stated a few hours later LVN F came back in her room and asked questions. She stated the way LVN F spoke to her made her feel as if she didn't believe her, so she told her never mind it didn't happen . Resident #1 stated she couldn't remember exactly what LVN F said or asked, but she felt as if she wasn't taking her serious and made her feel as if she was delusional. Resident #1 stated the next day the DON and Administrator went to her room and asked what happened. She stated she told them about the incident, but she felt they did not take her seriously. Resident #1 stated the Administrator asked her why she didn't scream, she stated she told him she tried to scream but couldn't. Resident #1 stated she told the DON and Administrator about another incident that happened about a year ago with CNA A. Resident #1 stated about a year ago CNA A went into her room, lowered her bed, and turned her real hard. She stated she blacked out. Resident #1 stated when she woke up, he was standing over her and her private area (vagina) felt different, as if it had been touched. She stated she did she did not report it to the facility because she didn't remember him touching her private area, but she knew her private area had been touched because of the way it felt and she remembered blacking out. Resident #1 stated she did not like CNA A changing her because she felt he cleaned her private area to long and wiped too much. She stated it just did not feel right. Resident #1 stated after she explained both incidents to the DON and Administrator they acted as if they didn't know what happened to her as if she was mixed up and delusional about being violated.<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 - Few | In an interview on 12/29/21 at 1:34 PM with CNA G, she stated she provided care to Resident #1 about two-three weeks ago and she told her there was an incident with CNA A. CNA G stated Resident #1 told her CNA A and CNA B went into her room to change her. CNA G stated she told her CNA A changed her gown and grabbed her breast. CNA G stated Resident #1 told her CNA B stood at the door. CNA G stated she reported the incident to the DON.<br><br>In an interview on 12/29/21 at 1:59 PM with LVN C, she stated she had a good relationship with Resident #1, so the DON asked her if Resident #1 mentioned an incident with staff regarding sexual abuse. LVN C stated she told the DON she did not say anything to her. LVN C stated when she went to feed Resident #1, she asked her had anyone ever touched her inappropriately in the facility. LVN C stated she told her CNA A and CNA B came into her room and when she opened her eyes CNA A stood over her and her private area (vagina) felt weird . LVN C stated Resident #1 told her CNA B stood by the door. LVN C stated she never said CNA A grabbed her breast and he only touched her private area. LVN C stated the next day Resident #1 told her about the incident again, but this time she stated it happened a year ago. LVN C stated the details of what happened was the same, she only changed the timeframe. LVN C stated Resident #1 was very verbal, did not have cognitive issues, and had no known psychiatric issues, such as delusions. LVN C stated she was very concerned because she was really with it and had the ability to recall things accurately, so she was really worried this incident occurred. She stated she reported to the DON each day what Resident #1 told her.<br><br>In an interview on 12/29/21 at 3:09 PM with CNA I, she stated Resident #1 accused CNA A of sexual abuse about a week ago. She stated on 12/17/21, CNA E came to her very upset during their shift and stated Resident #1 reported to her that CNA A grabbed her breast. CNA I stated CNA E asked her what to do and she told her to report it to the charge nurse (LVN F). She stated CNA E told her Resident #1 did not want her to report it to LVN F because she didn't trust her. CNA I stated she told CNA E they had to report it to LVN F because she was the charge nurse on duty and the DON was not there. She stated she and CNA E reported the incident to LVN F but told her Resident #1 did not want to talk to her. CNA I stated she asked LVN F, if she could just contact the Administrator, who was the Abuse Coordinator, and let him talk to Resident #1. CNA I stated LVN F did not contact the Abuse Coordinator and called the DON. CNA I stated LVN F had the DON on speaker and she heard the DON tell LVN F to ask Resident #1 did CNA H put this in your head, did you hear CNA H say this, and is this why you were reporting this. CNA I stated she stood by Resident #1's door and she heard LVN F go into the room and say those things to Resident #1. She stated she heard Resident #1 say she just wanted to drop it. CNA I stated the next few days Resident #1 was constantly crying. She stated she asked Resident #1 why she was crying, and she told her she was sad because CNA A violated her. CNA I stated Resident #1 told her CNA A did incontinence care and felt her breast when he changed her gown. She stated she wanted to clarify, so she asked Resident #1 did he accidently touch her breast when he was putting on her gown. CNA I stated Resident #1 said no and he actually grabbed her breast. She stated Resident #1 also told her she felt when CNA A provided incontinence care, he took too long to clean her, and it didn't feel right. CNA I stated Resident #1 appeared very upset and said people tried to make her think she was delusional. CNA I stated she felt bad for Resident #1 because she was physically disabled but she was in her right mind. She said she had worked with Resident #1 for over a year and she had never appeared to be mentally unstable or delusional. CNA I stated she did report this to the DON.<br><br>On 12/29/21 at 4:01 PM, contact to CNA E via phone was attempted and was unsuccessful.<br><br>On 12/29/21 at 4:04 PM, contact to LVN F via phone was attempted and was unsuccessful.<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 - Few | In an interview on 12/29/21 at 4:17 PM with the Activity Director, she stated on 12/20/21 she was doing rounds and went to talk Resident #1. She stated Resident #1 told her she had been sexually abused by CNA A. The Activity Director stated Resident #1 told her there was an incident in which she passed out and when she came to, CNA A was there, and her private area felt funny. She stated she asked Resident #1 did she report it and she said no because she felt crazy. The Activity Director stated Resident #1 said recently CNA A did it again and grabbed her breast. She stated Resident #1 said she told the Administrator and the DON, but she felt they belittled her and did not believe her, so she told them it didn't happen. The Activity Director stated she immediately contacted the Administrator via phone. She stated he told her he had already completed an investigation and talked to the DON and they determined it did not happen and for her to complete a grievance. The Activity Director stated she completed a grievance form and slide it under the Administrator's office door. The Activity Director stated the next morning she spoke to the DON about the incident. She stated the DON told her she believed Resident #1 made it up because when they talked to her she changed and said it didn't happen . The Activity Director stated she told the DON Resident #1 changed her statement because she felt they did not believe her or took her serious. The Activity Director stated the DON brought the Administrator into the office and she explained to him why Resident #1 changed her statement. The Activity Director stated the DON and Administrator seemed to come to a decision they did not believe Resident #1, but they never clearly stated if they would or wouldn't report to the state . The Activity Director stated she noticed a change in Resident #1's behavior. She stated Resident #1 seemed withdrawn and sad . The Activity Director stated she had no knowledge of the allegations made by Resident #1 until she did rounds on 12/20/21. She stated it made sense why Resident #1's behavior had changed .<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 - Few | In an interview on 12/29/21 at 5:47 PM with the DON, she stated if a resident reported abuse or neglect, she was supposed to immediately report it to the Administrator, who was the Abuse Coordinator. She stated on Sunday night (12/19/21), she received a call from the charge nurse (LVN F), who reported Resident #1 told CNA E that CNA A had grabbed her breast. The DON stated she had LVN F put her on speaker and go into Resident #1's room. The DON stated she asked Resident #1 what happened. She stated Resident #1 stated she had a flashback of when she first came to the facility and someone touched her. The DON stated she didn't say who touched her and she didn't ask her who touched her. The DON stated she asked Resident #1 had this occurred recently and Resident #1 stated no. She stated Resident #1 said she felt safe. The DON stated she immediately contacted the Administrator. She stated the Administrator told her to make sure CNA A was not working on Resident #1's hall and they would talk to Resident #1 in the morning . The DON stated the next morning, she, the Administrator, and the Social Worker, went to talk to Resident #1. She stated Resident #1 said she believed she fainted and when she woke up CNA A stood above her and believed he touched her. The DON stated Resident #1 kept using the word flashback and was unclear when the incident occurred. She stated she asked Resident #1 what she recalled about the incident and she stated she only remembered he stood over her and laughed. The DON stated she started an investigation and took statements from the staff. She stated later that day (12/20/21) the Activity Director went into her office and told her Resident #1 reported to her, CNA A touched her. She stated she told the Activity Director they had already started an investigation. The DON stated she did not recall any staff member telling her Resident #1 changed her story because she and the Administrator didn't believe her; nor, did she recall asking staff to clarify if Resident #1 repeated what she was told by CNA H. The DON stated she was aware the Administrator did not report the incident to the state or law enforcement. She stated she felt she didn't need to report to the state because Resident #1 told her she now felt safe and didn't feel a need to further look into it. The DON stated there was another resident and staff member who accused CNA A of sexual abuse. The DON stated the risk of not reporting sexual abuse was it could happen to another resident. She stated if a resident made an allegation of sexual abuse and then changed it, the incident should still be reported to the state.<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 - Few | In an interview on 12/29/21 at 6:20 PM with the Administrator/Abuse Coordinator, he stated if a resident reported abuse, then he should investigate it and then report it , if appropriate. He stated by appropriate, he meant if he thought it actually happened. The Administrator stated he was made aware Resident #1 stated CNA A sexually abused her. He stated on Sunday night (12/19/21) he received a call from the DON. The Administrator stated the DON told him Resident #1 said CNA A touched her inappropriately but Resident #1 wasn't sure if it happened the previous day or year ago. He stated the DON said Resident was unclear and kept saying it could have been a flashback. The Administrator stated he asked the DON what she thought about the situation and she said she didn't believe it happened, so he told her they would talk about it in the morning. He stated the next morning, he, the DON, and the Social Worker interviewed Resident #1. The Administrator stated Resident #1 said a year ago she felt uncomfortable with CNA A because he stood over her when she woke up. He stated Resident #1 said CNA A never touched her, but then changed and said the day before CNA A touched her. The Administrator stated Resident #1 said CNA A and CNA B went into her room to do incontinence care. He stated Resident #1 said CNA B left the room and then CNA A touched her breast. The Administrator stated he asked Resident #1 if she felt safe and she said yes. He stated he did not report the allegation to the state or law enforcement because he investigated it, felt it did not happen, so he did not report it. The Administrator stated his investigation included interviewing Resident #1, reading statements wrote by CNA A and CNA B, and he discussed it with the DON. He stated in both CNA A and CNA B's statement they stated CNA A left the room first and then CNA B left, so he found the allegation to be unsubstantiated. The Administrator stated, he also based his decision on Resident #1 going back and forth without a definitive response whether CNA A touched her or not and due to the DON saying she didn't believe the allegation because the resident used the word flashback. Based on this, the Administrator stated he determined the incident was unfounded, so it did not need to be reported to the state or law enforcement. He stated he was unaware of any other residents who accused CNA A of sexual abuse. He stated he did not review CNA A's personnel file. The Administrator stated he was aware of a staff member who alleged sexual abuse against CNA A. He stated he did not know the facility's official policy on reporting abuse. He stated he is new to the facility and came from another state . He stated the risk of not reporting abuse was it could happen to another resident.<br><br>In an interview on 12/29/21 at 5:32 PM with CNA B, he stated the DON asked him to write a statement about the day he and CNA A changed Resident #1. CNA B stated Resident #1 required two people to change her, so he asked CNA A to help. CNA B stated he rolled Resident #1 over and CNA A wiped her and put a new diaper under her. He stated after CNA A placed the diaper under Resident #1, he left the room and CNA B finished assisting Resident #1. CNA B stated he did not change Resident #1's gown. He stated he did not see CNA A re-enter Resident #1's room. CNA B stated he had never known CNA A to be accused of sexual abuse by a resident or staff member.<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 - Few | In an interview on 12/30/21 at 8:48 AM with CNA A, he stated he was accused by Resident #1 of touching her breast. CNA A stated he did not touch Resident #1's breast and he was shocked she accused him of this. CNA A stated he was asked by CNA B to help change Resident #1. He stated he only rolled Resident #1 over and he did not wipe her. CNA A stated CNA B wiped Resident #1. He stated as soon as the incontinence care was completed, he left the room. CNA A stated Resident #1's gown was soiled and needed to be changed, but he left CNA B in the room to do that. He stated he heard Resident #1 accused him of returning to her room and touching her. CNA A stated he never returned to her room. CNA A stated he believed CNA H coached Resident #1 to make the abuse allegation because she worked Resident #1's hall the same day she made the allegation. CNA A stated he had worked at other nursing facility and had never been accused of sexual abuse. CNA A changed his response and stated he isn't sure and did not recall. CNA A then stated he was upset he was told not to report to work until further notice, because he did not do the things he was accused of. He stated he believed he was being retaliated against because the facility was in trouble for not reporting these allegations to the state .<br><br>In an interview on 12/30/21 at 10:48 PM with the Social Worker, he stated on 12/20/21 it was brought to his attention by the Administrator and DON, Resident #1 had reported CNA A went into her room and touched her breast on 12/19/21. He stated he, the DON, and the Administrator interviewed her on 12/20/21. The Social Worker stated Resident #1 said CNA A grabbed her breast. He stated Resident #1 first stated it happened a year ago and then changed it to a couple of days ago. The Social Worker stated she was unclear of timeframes. The Social Worker stated it was discussed between he, the DON, and the Administrator about the incident being reported but the Administrator never directly stated he was going to report the incident. The Social Worker stated he didn't officially know if the DON reported it, but he assumed the DON would report it because in this type of business he is supposed to report. He stated he learned today the incident was not reported. The Social Worker stated if he had been aware the incident wasn't reported, then he would have immediately reported it . He stated he had been conducting safe surveys all morning and no other residents had reported any abuse or neglect. |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44006<br><br>Based on interview and record review the facility failed in response to allegations of abuse, to ensure that all alleged violations were thoroughly investigated and prevent further abuse from occurring while the investigation is in progress for one (Resident #1) of eight residents reviewed for abuse.<br><br>The facility failed to identify the allegation of abuse and allowed the alleged perpetrator to remain on duty at the facility for more than 9 days after the allegation was made to the facility's Abuse Coordinator.<br><br>This failure could place residents at risk for abuse.<br><br>An Immediate Jeopardy (IJ) was identified on 12/30/21. While the IJ was removed on 12/31/21, the facility remained out of compliance at a scope of isolated with actual harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems.<br><br>Findings included:<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A record review of the facility's policy entitled It is the policy of this home to prohibit resident abuse or neglect in any form, and to report in accordance with the law any incident/event in which there is cause to believe a resident's physical or mental health or welfare has been or may be adversely affected by abuse or neglect caused by another person. Definitions: Abuse, Involuntary seclusion, Mental/Psychological Abuse, Physical Abuse, Sexual Abuse, Verbal Abuse, Neglect, Misappropriation of property/financial Abuse, Exploitation, Suspicion of a crime against a resident. The home's administrator will conduct and investigate allegations of crimes, suspected abuse, neglect, or misappropriation of property, and will provide notification and release of information to the proper authorities, in accordance with federal and state regulations. The home's administration will designate a qualified staff member as the Abuse Coordinator. Procedure: 1. Screening, 2. Training, 3. Prevention, 4. Identification, 5. Investigation, 6. Protection, and 7. Reporting. 5. Investigation: The Charge Nurse will: Notify the Administrator or if unavailable, the Director of nurses will be notified. Begin taking written statements from the person reporting the allegations or suspicion and any witnessed including staff, family, and/or residents. Ask any witness to wait for the Administrator or the person on-call to arrive at the home. If an employee is involved, the employee will be detained and removed from their assigned duties until they are interviewed by the Administrator or person on-call or other appropriate staff. The person on-call will: Notify the Administrator and/or Director of nurses. Review the temps taken in the investigation. Take appropriate action if an employee is involved in the allegation or suspension of abuse. This will include removing the employee from duty and will be placed on investigation suspension. Abuse Coordinator will: Review all aspects of the investigation as soon as possible. Ensure that all reports are complete and appropriate authorities have been notified including the notification of the local law enforcement related to any crimes against a resident. Complete the investigation and direct any disciplinary action required. Complete the State Provider Investigation Report (5 day report). Review corrective action (s). Inform the resident or his/her representative of the findings of the investigation and corrective action taken. Refer all occurrences to the QAPI Committee to be analyzed to determine what change or changes are needed, if any, to the facilities policies and procedures to prevent further occurrences. 7. Reporting: a. All alleged allegations of abuse will be reported to the appropriate state agency and to all other agencies as required by regulation. b. Local law enforcement will be notified of any: -Reportable crime against a resident.<br><br>Record review of Resident #1's electronic face sheet, revealed Resident #1 was an [AGE] year-old female admitted into the facility on [DATE] and was diagnosed Cerebrovascular Disease, Other Fracture of Upper End of Right Tibia Subsequent Encounter For Closed Fracture with Routine Healing, Unspecified Abnormalities of Gait and Mobility, Vascular Dementia Without Behavior Disturbance, and Major Depressive Disorder.<br><br>Record review of Resident #1's Quarterly MDS dated [DATE] revealed Resident #1's BIMS score was 8, which indicated the resident's cognition was moderately impaired.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on 12/28/21 at 1:02 PM with Resident #1, she stated CNA A and CNA B went into her room to change her a couple of weeks ago between 2:00-3:00 AM. Resident #1 stated they changed her, and it was no issue. She stated CNA B walked towards the door to leave the room and CNA A stated he needed to change her gown and proceeded to remove her gown. Resident #1 stated CNA B stopped and stood by the door. Resident #1 stated she was blind in her right eye, but didn't believe the gown was soiled, so she asked CNA A why he needed to change her gown. She stated he didn't respond. Resident #1 stated while CNA A removed her gown, she kept asking him why he was taking her gown off. She stated CNA A laughed and squeezed both of her breast with both of his hands. Resident #1 stated she froze for a moment, then told CNA A to stop. She stated she wanted to scream but just couldn't make a noise. Resident #1 stated CNA A continued to laugh. She stated CNA B stood by the door while this happened. Resident #1 stated CNA A put a new gown on her and both CNAs left the room. She stated she told all the staff who came in her room to help her. Resident #1 stated she told LVN C, Med Aide D, and CNA E. Resident #1 stated LVN F came into her room to talk about it and she explained to her what happened. Resident #1 stated LVN F seemed shocked and brought CNA B into her room. She stated LVN F asked CNA B about the incident and he denied it happened. Resident #1 stated while she explained what happened CNA B kept saying what are you talking about and belittled her as if he didn't know about the incident. Resident #1 stated she felt very hurt that CNA B did not tell the truth because he was always very nice to her and she felt safe with him. She stated CNA A and CNA B are like brothers and she knew CNA B was covering for CNA A. Resident #1 stated a few hours later LVN F came back in her room and asked questions. She stated the way LVN F spoke to her made her feel as if she didn't believe her, so she told her never mind it didn't happen . Resident #1 stated she couldn't remember exactly what LVN F said or asked, but she felt as if she wasn't taking her serious and made her feel as if she was delusional. Resident #1 stated the next day the DON and Administrator went to her room and asked what happened. She stated she told them about the incident, but she felt they did not take her seriously. Resident #1 stated the Administrator asked her why she didn't scream, she stated she told him she tried to scream but couldn't. Resident #1 stated she told the DON and Administrator about another incident that happened about a year ago with CNA A. Resident #1 stated about a year ago CNA A went into her room, lowered her bed, and turned her real hard. She stated she blacked out. Resident #1 stated when she woke up, he was standing over her and her private area (vagina) felt different, as if it had been touched. She stated she did she did not report it to the facility because she didn't remember him touching her private area, but she knew her private area had been touched because of the way it felt and she remembered blacking out. Resident #1 stated she did not like CNA A changing her because she felt he cleaned her private area to long and wiped too much. She stated it just did not feel right. Resident #1 stated after she explained both incidents to the DON and Administrator they acted as if they didn't know what happened to her as if she was mixed up and delusional about being violated.<br><br>In an interview on 12/29/21 at 1:34 PM with CNA G, she stated she provided care to Resident #1 about two-three weeks ago and she told her there was an incident with CNA A. CNA G stated Resident #1 told her CNA A and CNA B went into her room to change her. CNA G stated she told her CNA A changed her gown and grabbed her breast. CNA G stated Resident #1 told her CNA B stood at the door. CNA G stated she reported the incident to the DON.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on 12/29/21 at 1:59 PM with LVN C, she stated she had a good relationship with Resident #1, so the DON asked her if Resident #1 mentioned an incident with staff regarding sexual abuse. LVN C stated she told the DON she did not say anything to her. LVN C stated when she went to feed Resident #1, she asked her had anyone ever touched her inappropriately in the facility. LVN C stated she told her CNA A and CNA B came into her room and when she opened her eyes CNA A stood over her and her private area (vagina) felt weird . LVN C stated Resident #1 told her CNA B stood by the door. LVN C stated she never said CNA A grabbed her breast and he only touched her private area. LVN C stated the next day Resident #1 told her about the incident again, but this time she stated it happened a year ago. LVN C stated the details of what happened was the same, she only changed the timeframe. LVN C stated Resident #1 was very verbal, did not have cognitive issues, and had no known psychiatric issues, such as delusions. LVN C stated she was very concerned because she was really with it and had the ability to recall things accurately, so she was really worried this incident occurred. She stated she reported to the DON each day what Resident #1 told her.<br><br>In an interview on 12/29/21 at 3:09 PM with CNA I, she stated Resident #1 accused CNA A of sexual abuse about a week ago. She stated on 12/17/21, CNA E came to her very upset during their shift and stated Resident #1 reported to her that CNA A grabbed her breast. CNA I stated CNA E asked her what to do and she told her to report it to the charge nurse (LVN F). She stated CNA E told her Resident #1 did not want her to report it to LVN F because she didn't trust her. CNA I stated she told CNA E they had to report it to LVN F because she was the charge nurse on duty and the DON was not there. She stated she and CNA E reported the incident to LVN F but told her Resident #1 did not want to talk to her. CNA I stated she asked LVN F, if she could just contact the Administrator, who was the Abuse Coordinator, and let him talk to Resident #1. CNA I stated LVN F did not contact the Abuse Coordinator and called the DON. CNA I stated LVN F had the DON on speaker and she heard the DON tell LVN F to ask Resident #1 did CNA H put this in your head, did you hear CNA H say this, and is this why you were reporting this. CNA I stated she stood by Resident #1's door and she heard LVN F go into the room and say those things to Resident #1. She stated she heard Resident #1 say she just wanted to drop it. CNA I stated the next few days Resident #1 was constantly crying. She stated she asked Resident #1 why she was crying, and she told her she was sad because CNA A violated her. CNA I stated Resident #1 told her CNA A did incontinence care and felt her breast when he changed her gown. She stated she wanted to clarify, so she asked Resident #1 did he accidently touch her breast when he was putting on her gown. CNA I stated Resident #1 said no and he actually grabbed her breast. She stated Resident #1 also told her she felt when CNA A provided incontinence care, he took too long to clean her, and it didn't feel right. CNA I stated Resident #1 appeared very upset and said people tried to make her think she was delusional. CNA I stated she felt bad for Resident #1 because she was physically disabled but she was in her right mind. She said she had worked with Resident #1 for over a year and she had never appeared to be mentally unstable or delusional. CNA I stated she did report this to the DON.<br><br>On 12/29/21 at 4:01 PM, contact to CNA E via phone was attempted and was unsuccessful.<br><br>On 12/29/21 at 4:04 PM, contact to LVN F via phone was attempted and was unsuccessful.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on 12/29/21 at 4:17 PM with the Activity Director, she stated on 12/20/21 she was doing rounds and went to talk Resident #1. She stated Resident #1 told her she had been sexually abused by CNA A. The Activity Director stated Resident #1 told her there was an incident in which she passed out and when she came to, CNA A was there, and her private area felt funny. She stated she asked Resident #1 did she report it and she said no because she felt crazy. The Activity Director stated Resident #1 said recently CNA A did it again and grabbed her breast. She stated Resident #1 said she told the Administrator and the DON, but she felt they belittled her and did not believe her, so she told them it didn't happen. The Activity Director stated she immediately contacted the Administrator via phone. She stated he told her he had already completed an investigation and talked to the DON and they determined it did not happen and for her to complete a grievance. The Activity Director stated she completed a grievance form and slide it under the Administrator's office door. The Activity Director stated the next morning she spoke to the DON about the incident. She stated the DON told her she believed Resident #1 made it up because when they talked to her she changed and said it didn't happen . The Activity Director stated she told the DON Resident #1 changed her statement because she felt they did not believe her or took her serious. The Activity Director stated the DON brought the Administrator into the office and she explained to him why Resident #1 changed her statement. The Activity Director stated the DON and Administrator seemed to come to a decision they did not believe Resident #1, but they never clearly stated if they would or wouldn't report to the state . The Activity Director stated she noticed a change in Resident #1's behavior. She stated Resident #1 seemed withdrawn and sad . The Activity Director stated she had no knowledge of the allegations made by Resident #1 until she did rounds on 12/20/21. She stated it made sense why Resident #1's behavior had changed .<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on 12/29/21 at 5:47 PM with the DON, she stated if a resident reported abuse or neglect, she was supposed to immediately report it to the Administrator, who was the Abuse Coordinator. She stated on Sunday night (12/19/21), she received a call from the charge nurse (LVN F), who reported Resident #1 told CNA E that CNA A had grabbed her breast. The DON stated she had LVN F put her on speaker and go into Resident #1's room. The DON stated she asked Resident #1 what happened. She stated Resident #1 stated she had a flashback of when she first came to the facility and someone touched her. The DON stated she didn't say who touched her and she didn't ask her who touched her. The DON stated she asked Resident #1 had this occurred recently and Resident #1 stated no. She stated Resident #1 said she felt safe. The DON stated she immediately contacted the Administrator. She stated the Administrator told her to make sure CNA A was not working on Resident #1's hall and they would talk to Resident #1 in the morning . The DON stated the next morning, she, the Administrator, and the Social Worker, went to talk to Resident #1. She stated Resident #1 said she believed she fainted and when she woke up CNA A stood above her and believed he touched her. The DON stated Resident #1 kept using the word flashback and was unclear when the incident occurred. She stated she asked Resident #1 what she recalled about the incident and she stated she only remembered he stood over her and laughed. The DON stated she started an investigation and took statements from the staff. She stated later that day (12/20/21) the Activity Director went into her office and told her Resident #1 reported to her, CNA A touched her. She stated she told the Activity Director they had already started an investigation. The DON stated she did not recall any staff member telling her Resident #1 changed her story because she and the Administrator didn't believe her; nor, did she recall asking staff to clarify if Resident #1 repeated what she was told by CNA H. The DON stated she was aware the Administrator did not report the incident to the state or law enforcement. She stated she felt she didn't need to report to the state because Resident #1 told her she now felt safe and didn't feel a need to further look into it. The DON stated there was another resident and staff member who accused CNA A of sexual abuse. The DON stated the risk of not reporting sexual abuse was it could happen to another resident. She stated if a resident made an allegation of sexual abuse and then changed it, the incident should still be reported to the state.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on 12/29/21 at 6:20 PM with the Administrator/Abuse Coordinator, he stated if a resident reported abuse, then he should investigate it and then report it , if appropriate. He stated by appropriate, he meant if he thought it actually happened. The Administrator stated he was made aware Resident #1 stated CNA A sexually abused her. He stated on Sunday night (12/19/21) he received a call from the DON. The Administrator stated the DON told him Resident #1 said CNA A touched her inappropriately but Resident #1 wasn't sure if it happened the previous day or year ago. He stated the DON said Resident was unclear and kept saying it could have been a flashback. The Administrator stated he asked the DON what she thought about the situation and she said she didn't believe it happened, so he told her they would talk about it in the morning. He stated the next morning, he, the DON, and the Social Worker interviewed Resident #1. The Administrator stated Resident #1 said a year ago she felt uncomfortable with CNA A because he stood over her when she woke up. He stated Resident #1 said CNA A never touched her, but then changed and said the day before CNA A touched her. The Administrator stated Resident #1 said CNA A and CNA B went into her room to do incontinence care. He stated Resident #1 said CNA B left the room and then CNA A touched her breast. The Administrator stated he asked Resident #1 if she felt safe and she said yes. He stated he did not report the allegation to the state or law enforcement because he investigated it, felt it did not happen, so he did not report it. The Administrator stated his investigation included interviewing Resident #1, reading statements wrote by CNA A and CNA B, and he discussed it with the DON. He stated in both CNA A and CNA B's statement they stated CNA A left the room first and then CNA B left, so he found the allegation to be unsubstantiated. The Administrator stated, he also based his decision on Resident #1 going back and forth without a definitive response whether CNA A touched her or not and due to the DON saying she didn't believe the allegation because the resident used the word flashback. Based on this, the Administrator stated he determined the incident was unfounded, so it did not need to be reported to the state or law enforcement. He stated he was unaware of any other residents who accused CNA A of sexual abuse. He stated he did not review CNA A's personnel file. The Administrator stated he was aware of a staff member who alleged sexual abuse against CNA A. He stated he did not know the facility's official policy on reporting abuse. He stated he is new to the facility and came from another state . He stated the risk of not reporting abuse was it could happen to another resident.<br><br>In an interview on 12/29/21 at 5:32 PM with CNA B, he stated the DON asked him to write a statement about the day he and CNA A changed Resident #1. CNA B stated Resident #1 required two people to change her, so he asked CNA A to help. CNA B stated he rolled Resident #1 over and CNA A wiped her and put a new diaper under her. He stated after CNA A placed the diaper under Resident #1, he left the room and CNA B finished assisting Resident #1. CNA B stated he did not change Resident #1's gown. He stated he did not see CNA A re-enter Resident #1's room. CNA B stated he had never known CNA A to be accused of sexual abuse by a resident or staff member.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on 12/30/21 at 8:48 AM with CNA A, he stated he was accused by Resident #1 of touching her breast. CNA A stated he did not touch Resident #1's breast and he was shocked she accused him of this. CNA A stated he was asked by CNA B to help change Resident #1. He stated he only rolled Resident #1 over and he did not wipe her. CNA A stated CNA B wiped Resident #1. He stated as soon as the incontinence care was completed, he left the room. CNA A stated Resident #1's gown was soiled and needed to be changed, but he left CNA B in the room to do that. He stated he heard Resident #1 accused him of returning to her room and touching her. CNA A stated he never returned to her room. CNA A stated he believed CNA H coached Resident #1 to make the abuse allegation because she worked Resident #1's hall the same day she made the allegation. CNA A stated he had worked at other nursing facility and had never been accused of sexual abuse. CNA A changed his response and stated he isn't sure and did not recall. CNA A then stated he was upset he was told not to report to work until further notice, because he did not do the things he was accused of. He stated he believed he was being retaliated against because the facility was in trouble for not reporting these allegations to the state .<br><br>In an interview on 12/30/21 at 10:48 PM with the Social Worker, he stated on 12/20/21 it was brought to his attention by the Administrator and DON, Resident #1 had reported CNA A went into her room and touched her breast on 12/19/21. He stated he, the DON, and the Administrator interviewed her on 12/20/21. The Social Worker stated Resident #1 said CNA A grabbed her breast. He stated Resident #1 first stated it happened a year ago and then changed it to a couple of days ago. The Social Worker stated she was unclear of timeframes. The Social Worker stated it was discussed between he, the DON, and the Administrator about the incident being reported but the Administrator never directly stated he was going to report the incident. The Social Worker stated he didn't officially know if the DON reported it, but he assumed the DON would report it because in this type of business he is supposed to report. He stated he learned today the incident was not reported. The Social Worker stated if he had been aware the incident wasn't reported, then he would have immediately reported it . He stated he had been conducting safe surveys all morning and no other residents had reported any abuse or neglect.<br><br>A record reveiw of the facility's staffing sheets revealed CNA A worked on 12/20/21, after the allegation was made on 12/19/21, and continued to work until 12/28/21.<br><br>This was determined to be an Immediate Jeopardy (IJ) on 12/30/21 at 3:05 PM. The Administrator was notified. The Administrator was provided with the IJ template on 12/30/21 at 3:15 PM.<br><br>The following Plan of Removal submitted by the facility was accepted on 12/31/21 at 12:20 PM:<br><br>On 12/30/2021 during a complaint survey, HHSC surveyor provided an IJ Template notification that the Survey Agency has determined that the conditions at the center constitute immediate jeopardy to resident health related to alleged sexual abuse of a resident by a staff member.<br><br>The notification of the alleged immediate jeopardy states as follows:<br><br>Abuse & Neglect<br><br>1. The facility failed to report a reasonable suspicion of a crime to the State Agency and the law enforcement entity in which the facility is located.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Identify residents who could be affected<br><br>All residents have the potential to be affected.<br><br>Identify responsible staff/ what action taken<br><br>1. Administrator submitted self-report to HHSC on 12/29/21 intake number 323767. [Local Law Enforcement] were notified, Officer came and left a case number of 2100013147<br><br>2. The alleged perpetrator was suspended pending investigation 12/29/21. No other alleged perpetrators have been identified. Investigation is ongoing.<br><br>3. Administrator began obtaining witness statements from staff and residents 12/29/21. During this process it was identified that the alleged incident was reported to DON by the evening shift nurse on Sunday 12/19/2021. However, the nurse did not witness the alleged incident.<br><br>4. Administrator and DON were in-serviced on Abuse & Neglect Policy and Texas HHSC LTCR Provider Letter PL19-17 by Regional Nurse Consultant on 12/29/21.<br><br>5. Safe surveys were conducted by Social Worker, and other management staff on interviewable residents in facility on 12/29/2021<br><br>6. Head to toe physical assessments were performed on non interviewable residents with no adverse findings on 12/29/21- 12/30/21 by Assistant Director of Nursing.<br><br>7. Head to toe physical assessment performed on resident with no adverse findings on 12/29/21 by DON.<br><br>8. Social Worker completed psychosocial assessment on resident 12/30/21 with no adverse effect noted.<br><br>In-Service conducted<br><br>Administrator and DON initiated in-servicing as follows:<br><br>1. Administrator and, DON were in-serviced on Abuse & Neglect Policy and Texas HHSC LTCR Provider Letter PL19-17 by Regional Nurse Consultant.<br><br>2. All staff will be in-serviced on Abuse & Neglect Policy by the director of nursing, assistant director of nursing and weekend supervisor.<br><br>3. All staff will complete Abuse & Neglect competency test.<br><br>4. The expected completion date will be 12/30/2021. Staff who have not been trained on Abuse & Neglect will not be allowed to work until they have completed required in-services.<br><br>Implementation of Changes<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The changes will be implemented by the administrator and director of nursing. The changes will be implemented on 12/30/2021and completed on 12/30/2021. The administrator or director of nursing will ensure competency through verbalization of understanding by staff.<br><br>Monitoring<br><br>1. Social worker/RN Supervisor will complete five safe surveys per day for two weeks then one per day for one month on interviewable residents.<br><br>2. Administrator and Director of Nursing will interview five staff members per day for two weeks then one staff member per day for one month for return demonstration for types of abuse and reporting requirements.<br><br>3. RVP and RNC will conduct ten random staff interviews per month x 30days and prn .<br><br>4. RVP or RNC will review grievances weekly for three months.<br><br>5. Any adverse outcomes will be reported to QAPI Committee<br><br>Involvement of Medical Director<br><br>The Medical Director was notified about the immediate Jeopardy on 12/30/2021.<br><br>Involvement of QA<br><br>An Ad Hoc QAPI meeting was held with the Medical Director, facility administrator, director of nursing, and social services director to review plan of removal on 12/30/21.<br><br>Who is responsible for implementation of process?<br><br>Administrator and, Director of Nursing will be responsible for implementation of New Process.<br><br>State Surveyor Monitored the plan of removal as follows:<br><br>Interviews were conducted across multiple shifts and departments on 12/31/21 from 12:30 PM to 3:00 PM with the Social Worker, Activity Director, Housekeeping Director, 2 RNs, 4 LVNs, and 6 CNAs, 2 Housekeeping and 1 Physical Therapist. They all indicated they were in-serviced on types of abuse, signs & symptoms of abuse, abuse prevention, abuse interventions, and reporting. They were able to identify different types of abuse and gave examples. They indicated all abuse was reportable immediately to the Administrator or designee. There were no concerns noted during the interviews .<br><br>A record review of the Daily Staffing Assignment, dated 12/31/21, and the Abuse & Neglect In-service Logs, dated 12/30/21 and 12/31/21, revealed all staff who were working, including the Administrator, DON, Social Worker, Activity Director, and Housekeeping Director, had been in-serviced and completed an Abuse Pre/Post Competency Test.<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 |
|---|---|---|---|
| | 455457 | A. Building<br>B. Wing | 12/31/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Fort Worth Wellness & Rehabilitation | 2129 Skyline Dr<br>Fort Worth, TX 76114 |

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 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on 12/31/21 at 1:33 PM with the DON, she stated she understood her mistake in not reporting this incident, after she learned the Administrator had not reported. She stated going forward if the Administrator refused to report abuse, she would immediately report it to the state and law enforcement and would also report to her superior that the Administrator did not report the allegations. The DON stated she had been in-serviced on the Abuse and Neglect policy and Texas HHSC LTCR Provider Letter PL19-17. The DON provided the types of abuses, signs & symptoms of abuse, and strategies for abuse prevention and intervention.<br><br>In an interview on 12/31/21 at 2:03 PM with the Administrator, he stated he made a mistake and in hindsight he should have reported the incident with Resident #1 to the state and law enforcement. He stated he cared about the residents and regardless if believed what they said, he would report all allegations of abuse. He stated going forward the facility would be conducting safe surveys and in-servicing staff on the abuse & neglect. The Administrator stated he was in-serviced on the Abuse and Neglect policy and Texas HHSC LTCR Provider Letter PL19-17 . He provided the types of abuses, signs & symptoms of abuse, and strategies for abuse prevention and intervention. The Administrator stated going forward when conducting investigations on abuse allegations, he would get multiple staff statements, complete safe surveys, and look for patterns of the behavior.<br><br>The Administrator and DON were informed the Immediate Jeopardy was removed on 12/31/21 at 3:30 PM. The facility remained out of compliance at a severity of actual harm that is not immediate jeopardy and a scope of isolated, due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place. |