STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525409	A. Building B. Wing	01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine View Care Center	400 County Rd R Black River Falls, WI 54615

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 34400 Based on interview and record review the facility failed to ensure residents were free from abuse. R1 had a known history of inappropriately touching female residents. R1 was observed touching R2 and R3 in an inappropriate manner. On 12/1/22 R1 was witnessed to touch R3's arm and breast. The facility failed to: perform an assessment of R3; document monitoringm of R3's for behavior changes; ensure R3 and other resident safety after incident; and update R3's care plan timely. On 12/2/22, R1 was witnessed to kiss R2. On 12/10/22, R1's care plan was not followed and R1 was unsupervised and witnessed by staff in R2's room with R2's pants down. The facility was aware of R1 behaviors of inappropriate physical/sexual contact with other residents. R1 is unable to consent to sexual activity based on his cognitive status, R1 had inappropriate contact with other residents, the facility did not complete a sexual consent assessment for R1. The facility failed to protect others from abuse by R1 on 12/1/22, 12/2/22 and 12/10/22. The facility's failure to provide adequate protection from abuse from R1 to R2 and R3 and other residents, created a finding of Immediate Jeopardy which began on 12/1/22. NHA A (Nursing Home Administrator) was notified of the immediate jeopardy on 12/20/22 at 4:41 PM. The Immediate Jeopardy was not removed at the conclusion of survey. Evidenced by: R1 was admitted to the facility on [DATE] with diagnoses including: Mild cognitive impairment of uncertain etiology, age related cognitive behaviors, and bilateral hearing loss. On 11/18/22, a diagnosis of Alzheimer's dementia was added to R1's record by R1's physician. On 12/5/22, R1 was diagnosed with Dementia with associated psychotic-agitated behavior. R1 has an APOAHC (Activated Power of Attorney for Health Care). On 11/15/22, R1's admission MDS (Minimum Data Set) assessment notes a BIMS (Brief Interview for Mental Status) score of 2, indicating severe cognitive impairment. Section E of the MDS notes R1 wandering behaviors occurred daily. Section G notes R1 is independent in transfers, ambulation, and locomotion on the unit. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Care Plan from 11/25/22 included, Keep resident in line of sight when up, this approach was discontinued on R1's Care Plan on 12/13/22. R1's Care Plan notes; (dated 11/10/22) Problem: need for appropriate sexual expression/display of affection, (dated 12/13/22) Approaches (dated 12/13/22): ~Nurses-One to one, redirect immediately, be mindful of personal space and uninvited entrances into others space ~Monitor personal boundaries and document redirecting needed and any inappropriate behaviors, document interventions, involve family ~Provide ample 1:1 (one to one) and/or independent activities with meaningful tasks (see activity care plan), social distance from opposite sex (i.e. provide appropriate boundaries between opposite sex). ~Monitor/intervene immediately prior to socially inappropriate touching and close talking to others, remind of personal boundaries. ~If defiant/aggressive behavior occurs, try reality orientation, involve family, validate concerns and emotions and remind of appropriate behaviors/actions . ~Nurse aide-one to one, redirect immediately, report immediately to nurse . Review of R1 record notes R1 specific behaviors are monitored each shift as follows: -On 11/8/22, the facility monitored R1 for exit seeking (R1 is a known wanderer and is independent in ambulation), with these behaviors documented as occurring 0-60 times per day 11/22/22-12/19/22. -On 11/22/22, the facility added monitoring R1 for behaviors of socially inappropriate touching of peers. Documentation shows these behaviors occurred 0-68 times per day between 11/22/22-12/19/22. -On 11/22/22, the facility added monitoring R1 for behaviors of socially inappropriate touching or sexual comments to staff. Documentation shows these behaviors occurred 0-50 times per day between 11/22/22-12/19/22. -On 12/5/22, the facility added monitoring R1 for targeted behavior of Persistent anger: pushing, slapping or other aggressive behavior toward staff. Socially inappropriate/disruptive shoving furniture, kicking doors. Documentation shows these behaviors occurring 0-58 times per day from 12/5/22-12/19/22. Review of R1's Nursing Notes include in part: ~On 12/1/22 at 8:36 PM, Holding hands with another resident. Leans in close to hear what is being said . Sitting close to same resident that he was holding hands with. Needed reminders that 'we need to keep our hands to our self.' Son was here and stayed for awhile and also aided in keeping distance. Was redirected and good spirits. Started on Hydroxyzine this evening. No attempts to touch others just wanting to hold their hands. Will continue to monitor. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	~On 12/2/22 at 10:18 PM, R1 was pacing in the unit. Staff had him in line of sight and was only about 3 feet from him at all times during this .staff redirected resident out of other rooms on the unit. After this he continues to be very close to female resident, he leaned in and kissed a resident on the cheek when talking with her. When staff attempted to intervene, R1 began to push, shove, grab and squeeze writer's hands. He threatened to hit this writer multiple times 'I am going to knock you out' .Son was called twice, and he was here by 7:00 pm .did take his evening medicine with son present. The facility submitted a self-report to the State Agency regarding R1 kissing R2 on 12/2/22. R1's care plan was not immediatley updated, there is no documentation of new interventions to protect R1 from having contact with R2 or other residents immediately put in place after this event. 39849 Example 1: R3 was admitted to the facility on [DATE] with diagnoses that include, in part: Alzheimer's disease; Unspecified Dementia; Restlessness and agitation; Major Depressive Disorder; Vascular dementia; and Need for Continuous Supervision. R3's most recent MDS (Minimum Data Set) with a target date of 11/18/22, documents a BIMS (Brief Interview of Mental Status) score of 2, which indicates, severe cognitive impairment. R3's CNA (Certified Nursing Assistant) Care Card dated 12/19/22, includes, in part: *Ensure to alert nurse of any exit attempts. *Can be agitated as day progresses. *Stop sign on door as she becomes upset when other residents wander into her room. *Altered interpersonal response to others. *Redirect from easily agitated residents to avoid negative behavior from others. R3's care plan includes, in part: *9/2/22: Special Care Remarks: Ensure to alert nurse of any exit attempt immediately. *12/5/22: Special Care Remarks: Can become agitated as the day progresses .Stop sign on door as she becomes upset when other residents wander into her room .Redirect from easily agitated residents to avoid negative behavior from others. Review of the Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report, with a Report Submitted Date of 12/1/22, indicates the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Summary of Incident: Allegation Type: Abuse: Hitting, slapping, threats of harm, assault, humiliation .Brief Summary of Incident: Resident A (R1) reached out toward Resident B (R3) and touched them on the arm and also touched their breast. Resident A (R1) has a tendency toward physical contact (rubbing shoulders/arms, patting backs) and their hand has slipped. Review of the Misconduct Incident Report, with a Report Submitted Date of 12/8/22, documents the following: .Summary of Incident: Is date and time when occurred known? No Date discovered: 12/1/22. Briefly describe the incident .Resident A (R1) reached out toward Resident B (R3) and touched them in the arm and inadvertently touched the side of their breast with the back of their hand. Resident A (R1) has a tendency toward physical contact which may include rubbing shoulders, arms, and patting backs of others. Describe the effect . Resident B (R3) has no recollection of event nor change in mood or affect. Explain what steps the entity took upon learning of the incident to protect the affected person(s) and others from further potential misconduct .Interviews of residents - no concerns. Interviews of staff - no concerns. Both residents care plans updated. Line of sight to continue. Family and staff providing 1:1 during the afternoon/evening hours when resident tends to wander more. Education for effective redirection. Referral made to MD for assessment and new orders . Review of R3's nursing notes for 12/1/22 through 12/4/22 show no documentation other than vital signs and pain rating. On 12/20/22 at 8:20AM Surveyor interviewed DON B (Director of Nursing) and showed DON B the nursing notes in the facility's electronic health record. Surveyor asked DON B if this was all the charting for R1 or if there is documentation elsewhere, as there were no actual assessments, documentation of the incident, notes about the resident, just the vitals and pain ratings. DON B indicated, No, that is what's there, what you're seeing is what there is. Further record review shows no specific documentation for the following: *Assessment of R3 on 12/1/22. *Immediate Interventions specific for R3. *Post sexual abuse allegation behavior monitoring for R3. Of note, R3's Care plan update was not completed until 12/5/22, four days after the initial incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/19/22 at 3:35PM, Surveyor interviewed CNA H (Certified Nursing Assistant) and asked what she could recall about what happened on 12/1/22 between R3 and R1. CNA H indicated R3 was sitting at the end of the table and R1 was by the exit door in the dayroom. CNA H indicated, I went to get him and he walks so fast, he came by like this. CNA demonstrated how and were R1 was moving in the dayroom. R3 had her elbows on the table with her hands together. CNA H continued, R1 walked by and touched her arm with the back of his hand and them went lower on the side of her breast with the back of his hand. I called his name and he looked up and smiled and kept walking toward the nurse's office, where SW I (Social Worker) was on the phone. Surveyor asked CNA H what she did next. CNA H indicated she reported the incident to SW I. CNA H indicated that she also reported to LPN E (Licnsed Practical Nurse) right away. Surveyor asked CNA H if she was given any instructions. CNA H indicated, she didn't recall. CNA H indicated R1 touched R3 on the side of her breast with the back of his hand. Surveyor asked CNA H what she did to ensure R3 was safe. CNA H indicated, I went and asked her how she was and she said she was fine but that she didn't trust him (R1). Surveyor asked CNA H what was done to ensure R1 didn't go back by R3 again. CNA H indicated, he didn't go back by her, she would snap, we would have known, she told him, don't come by me again. Surveyor asked CNA H how she ensured R3 and other residents were safe. CNA H indicated, we watched him (R1). Surveyor asked CNA H, how did you watch him. CNA H indicated, I was out here. Surveyor asked CNA H, you never went into a resident room that night. CNA H indicated, well, the nurse was here too. Surveyor asked CNA H if she was with R3 or R1 one hundred percent of the time after the incident to know he didn't reapproach. CNA H indicated she wasn't with either of them one hundred percent of the time after it happened. Surveyor asked CNA H how then she knew he did not reapproach. CNA H indicated, we would have known, she (R3) would have yelled. On 12/19/22 at 4:59PM, Surveyor interviewed LPN E and asked if she normally works on the memory care unit. LPN E indicated, yes, we have a few patients on the other wing as well. Surveyor asked LPN E if she recalled working when an incident between R3 and R1 occurred. LPN E indicated, no. Surveyor asked LPN E if she recalled anyone informing her of an incident where R1 may have touched R3's breast. LPN E indicated, no, I don't recall that. LPN E indicated she does not believe she was working 12/1/22, however, did not have her schedule at the time to of this call to verify. Of note, the schedule provided by the facility showed a v next to LPN E's name, which surveyor was informed indicates vacation. It is unclear which nursing staff CNA H reported the incident to. On 12/20/22 at 9:52AM Surveyor interviewed SW I and was asked about the incident between R1 and R3 on 12/1/22. SW I indicated, I do know I was back there at the time it happened. From my understanding it wasn't an intentful inappropriate touch. Surveyor asked SW I how she would know if it was intentional. SW I indicated, just because of the way she was sitting at the table with her arms on the table, her elbows were on the table. Where I was his (R1) back was to me and I saw him reach over and bend towards her. SW I demonstrated sitting in the chair and leaning towards floor. I didn't see him touch her, but we separated them. SW I indicated R1's back was to her. He was busy, active all day long, so I took him to the other hub. Surveyor asked SW I to clarify if R1 was sitting or walking by when he touched R3. SW I indicated, he was standing and he was walking by her. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor asked if anyone reported to her that R1 had touched R3. SW I indicated, I can't even answer that, I don't know what the terms were when reported to me that were used. If he did or didn't touch her breast. Surveyor asked SW I what she reported to DON B that would make them reference in the self-report that R3's breast was touched. SW I indicated, I don't remember. Surveyor asked SW I how long she was in the memory care unit after the incident happened. SW I indicated, I don't know when I left, could have been ten minutes, could have been a half hour. Surveyor asked SW I what was done to ensure resident safety after the incident. SW I indicated, they kept R1 separated. They kept R3 where she always is and kept R1 in the other hub. R1's son was here that night too, after the incident, and was with him, not sure exactly how long he stayed that night, but he usually stays until R1's ready for bed. Surveyor asked SW I if R1's son is his POA. SW I indicated, yes. Surveyor asked SW I if R1's son was informed of the incident. SW I indicated, I don't know. Surveyor asked SW I if an incident like this should be reported to the POA. SW I indicated, yes. Surveyor asked SW I if she remembered when she reported this incident to DON B. SW I indicated, no. Surveyor asked SW I if she had any notes or a soft file that may include that information. SW I indicated, no. Surveyor asked SW I if she documented any of the information about the incident in the chart. SW I indicated, no. Surveyor asked SW I if she should have documented in the chart. SW I indicated, yeah, probably. Surveyor asked SW I if she is trained to report incidents like this immediately. SW I indicated, yes, it was still unclear if it was breast or not. Surveyor asked SW I if there is a potential incident where a resident could have touched another resident's breast, should it be reported immediately so it can be investigated. SW I indicated, yes. On 12/19/22 at approximately 12:00PM, Surveyor interviewed RN F (Registered Nurse) and asked if she normally works on the memory care unit. RN F indicated she works 2 days on the memory care unit and 3 days on the other units. Surveyor asked RN F if she was aware of any inappropriate touching between R3 and R1. RN F indicated no. Surveyor asked RN F if she was aware of any other interventions in place for R3 as of 12/1/22 other than the stop sign on her room. RN F indicated, not anything different than the last few weeks. Honestly, I didn't know anything happened between R1 and R3. RN F added, R3 sits with R2 and another resident and the three of them are kind of a thing, they have a friendship and sit at tables and visit. Surveyor asked RN F if R3 ever approaches R1 or if R1 ever approaches R3. RN F indicated, no. RN F indicated R1 had been separated and after that happened he went home with his son on 12/10/22 and 12/11/22 and came back on Monday 12/12/22. I didn't work with him until that Friday 12/16/22 and he was 1:1 then. Surveyor asked RN F why R1 was separated. RN F indicated there was an incident on 12/10/22 and so his son took him home because of the incident. (See example 2.) On 12/19/22 at 4:40PM Surveyor interviewed LPN D and asked if he recalled working 12/1/22 on the memory care unit and if he had any information about an incident between R3 and R1. LPN D indicated he would have been gone by 2pm. I don't recall an incident between R3 and R1. Surveyor asked LPN D if anyone had informed him of an incident between R3 and R1. LPN D indicated he had never been told of one. LPN D indicated it may have been LPN E it was reported to. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor asked LPN D if he normally works on the memory care unit. LPN D indicated yes and that he is the dementia care coordinator. Surveyor asked LPN D if he would have expected to be informed of an incident between residents as the coordinator. LPN D indicated, yes. Surveyor asked LPN D if he was aware of any specific interventions that were in place for R1 on 12/1/22. LPN D indicated, we always keep an eye on him but I don't recall if there was anything specific on that date. I know there was 1:1 after another incident. On 12/19/22 Surveyor interviewed LPN G, who indicated she was the Clinical Nurse Manager, and asked how often she works on the memory care unit. LPN G indicated, it depends on when the nurse isn't there. I'll be working there tonight. Surveyor asked LPN G if she was aware of an incident between R3 and R1. LPN G indicated, I know she (R3) doesn't like him by her. Surveyor asked LPN G how she knows this. LPN G indicated, because when he (R1) comes by her she would say get away from me. Surveyor asked LPN G how long ago she had witnessed this. LPN G indicated, not in the last week or so that I've heard. On 12/19/22 at 11:32AM, Surveyor interviewed CNA J and asked if he was aware of any incidents between R3 and R1. CNA J indicated, nothing about R3 and R1. Only R1 and R2 (See Example 2). CNA J added that sometimes there is only one CNA on the unit and one nurse and that R1 is 1:1. Surveyor asked CNA J how 1:1 is completed if they have to go into a room to assist another resident. CNA J indicated, someone comes back now. Surveyor asked CNA J how long they have been sending someone to help in those instances. CNA J indicated, the last couple days. Surveyor asked CNA J if he had been given any guidance on interventions or things to do for R3. CNA J indicated, no. On 12/19/22 at 10:38AM Surveyor interviewed CNA K and asked if she has worked with R1 and R3. CNA K indicated, yes. Surveyor asked CNA K if she was aware of a incident between R1 and R3. CNA K indicated she was not. Surveyor asked CNA K if she was given any education on abuse recently. CNA K indicated last week ANHA C (Assistant Nursing Home Administrator) called her pertaining to R1 being 1:1. CNA K indicated she was informed that R1 is 1:1 and staff is to be with him at certain times and it's usually two hour increments. Surveyor asked CNA K if she was given guidelines on anything for R3. CNA K indicated she worked on the memory care unit yesterday and didn't see anything specific, unless she missed it. On 12/19/22 at 3:23PM, ANHA C provided surveyor with a three page typed document that notes Interviews conducted on 12/2/22, at the top. ANHA C indicated, the document is staff interviews. The document contains 10 names with times after the names and the following 3 questions under each name: Have you seen R1 touch any other residents inappropriately? Has he touched you on the buttocks, groin, or chest?; What would you do if that happened? There is no information on the document of who the listed names are; signatures from the interviewees indicating they provided this information; or information on who the other resident was that was involved in the incident with R1. Surveyor asked ANHA C what self-report these are in relation too. ANHA C indicted they were from the incident with R3 and R1. Surveyor asked ANHA C how this would be known as neither R3's name nor the incident date was included on the document. ANHA C indicated, from the date and pointed to the 12/2/22 date at the top of the document. ANHA C also provided a diagram that was drawn on notebook paper and states it is showing the path of the CNA (Certified Nursing Assistant) walking with R1 and where R3 was sitting. ANHA C indicates, the CNA was CNA H and that as R1 was walking by and that is when the incident happened. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/20/22 at 12:45PM ANHA C provided Surveyor with a typed document and indicated this was a witness statement from CNA H. CNA H's name is typed at the top with the date and time of 12/1/22 @ 5:55pm. The statement notes the following: CNA H was in MCU (Memory Care Unit) walking to the left of R1. R1 was walking by R3, who was sitting at the table. When walking by he went to touch her and touched her in the arm and brushed against her breast and continued walking. He went to the opposite side of the unit. CNA ensured safety of residents and made sure R3 was ok. Of note, there is no signature or indication from CNA H, on the document, that this is the statement she provided. On 12/20/22 at 11:05AM Surveyor interviewed ANHA C and asked if all staff with the potential to care for R1 and R3 should be made aware of the incident so they are aware there is potential for continued contact? ANHA C indicated, yes. Surveyor asked ANHA C if she is aware of how and when staff were made aware of this incident. ANHA C indicated, when I was asking the question if they knew of any other residents being touched they would say, why are you asking me this and that would lead to informing them about who the incident was with. Surveyor asked ANHA C what was done immediately after the incident to protect R3 and other residents. ANHA C indicated she would have to check the care plan. On 12/20/22 at 9:20AM Surveyor interviewed DON B and asked how resident safety was ensured after the incident with R1 and R3. DON B indicated she would have to check. Surveyor offered a copy of the self-report for review to DON B. DON B asked, this is the full report you were given. Surveyor indicated, yes. Surveyor asked DON B if there was more that wasn't provided. DON B indicated, I don't know. DON B indicated staff and family were providing 1:1 with R1 the evening of the incident. Surveyor asked DON B if she was aware of what was done for R3. DON B indicated, I don't. DON B added, I do know ANHA C said R3 didn't remember the incident the next day and I haven't seen any changes, she's been at baseline. Surveyor asked DON B if there is documentation of monitoring R3. DON B indicated they should have been documenting on daily acute charting for mood/behavior after. Surveyor requested copies of this charting. Surveyor asked DON B if a physical assessment was performed on R3 or other residents, like a skin sweep, to ensure their were no signs or symptoms of abuse. DON B indicated, not to my knowledge. Surveyor asked DON B if she would expect something like that to be done for residents who couldn't tell you if they had been abused. DON B indicated because R1 was in line of site, I'm confident he hadn't abused anyone else. Surveyor asked DON B if R3 should have had a skin/overall assessment. DON B indicated, probably, but it was such a light touch. Surveyor asked DON B how they could know if he had done anything to her, that may not have been witnessed, if an assessment wasn't done. DON B indicated, because he was on line of site. Surveyor asked DON B if she was sure he was in line of site at all times. DON B indicated, yes, I'm confident, I'm back there a lot. Surveyor asked DON B if R3's care plan was updated after the incident. DON B indicated, I know there was a change but I can't remember. Surveyor asked DON B for follow up on the care plan. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor asked DON B what the overall process is for an abuse investigation. DON B indicated the expectation if is its alleged or actual is that it gets reported immediately. Generally the next closest supervisor, so usually the charge nurse, but I have had employees go directly to the social worker, me, the NHA. So if it goes to a social worker or charge nurse then it comes to me and I go to NHA A. Surveyor asked DON B if she goes directly to NHA A. DON B indicated I have been co-reporting to NHA A and ANHA C. DON B indicated, once noted, first thing is to address safety concern and remove resident. It also depends on the situation; first thing is to maintain safety whatever that looks like for that incident; then get staff statements. Surveyor asked if staff write their own witness statements. DON B indicated, no, our corporate philosophy is to have us talk to the staff and transcribe their statement. Surveyor asked DON B if those should be in the investigation. DON B indicated, yes, exactly. Surveyor asked DON B if it should be a statement and not just questions they ask the staff. DON B indicated, typically that's not me. If it's the person that witnessed it, I would expect a statement. Typically, ANHA C and NHA A are leads, not sure if it is ANHA C or NHA A at this point. Ancillary staff may be just questions. Surveyor asked DON B what happens next. DON B indicated, then we start working through the algorithm to see if it's reportable or not, do we remove employees, things like that. If reportable we start the reporting process. If not, we would look through it for what else is needed for that particular incident: audits; changes to care plans; further investigation; education. Surveyor asked DON B if this incident should be documented in either R1's or R3's chart or both. DON B indicated, it's going to depend on what it is. Surveyor asked DON B if she could elaborate. DON B indicated, typically what we enter into ECS (Facility's electronic health record) is what is pertaining to the resident's health. So if there is something that is needed like an assessment, behavior tracking/monitoring, you would see that but otherwise the incident itself would be on paper in a file. Surveyor asked DON B what time the incident happened. DON B indicated, I was under the impression it occurred between 4:30pm and 5:00pm. Surveyor asked DON B how she knew the time of the incident. DON B indicated, because SW I informed me of the incident. I was not informed of the incident until the next morning. Of note, no documentation referenced by DON B was provided to surveyors. On 12/20/22 at 9:40AM DON B showed surveyor on R3's care plan a revision made on 12/5/22 that she had placed brackets around on a paper copy. The information in brackets, notes: Redirect from easily agitated residents to avoid negative behavior from others. Surveyor asked DON B if this intervention would be considered personalized for R3. DON B indicated, not really. Surveyor asked DON B if this statement is on other residents care plans. DON B indicated, probably. On 12/19/22 at 2:45PM 45PM Surveyor interviewed ANHA C (Assistant Nursing Home Administrator) regarding the process for completion of self-reports. ANHA C indicated, with any self-report for potential abuse, resident to resident, anything that could fall under abuse we have the flow chart we use for, is it willful, is it not. Surveyor asked ANHA C if she used the flowchart with the 3 self-report investigations. ANHA C indicated, I believe we did with R3, I will have to look before I can give an answer. Surveyor requested ANHA C to provide the flow charts used for the investigations. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/19/22 at 3:30PM, ANHA C notified Surveyor that no flowsheets were completed for the resident to resident self-reports. On 12/20/22 at 11:05AM Surveyor interviewed ANHA C and asked what is done during an abuse investigation if the resident is non-interviewable. ANHA C indicated, we would contact families, let them know the situation, ask families where they would like us to go with that situation. Surveyor asked ANHA C what she meant by this. ANHA C indicated, if they want police contacted. Surveyor asked ANHA C if she leaves it up to the family to decide if police are contacted. ANHA C indicated, in certain situations. Surveyor asked ANHA C if there were further things that are done for the non-interviewable residents. ANHA C indicated, we interview staff to see if other residents have been affected. We would still interview the non-interviewable residents to ask if they feel safe, if they feel comfortable with housemates, I still would try to interview. We watch for signs of changes in affect, eating, changes in day to day participation, mood. Surveyor asked ANHA C if she would expect that type of monitoring to be documented. ANHA C indicated, yes, I would. Surveyor asked ANHA C if she would expect staff to perform skin assessments to see if non-interviewable residents have any signs of concerning areas for abuse that they may not be able to verbalize. ANHA C indicated, yes. Surveyor asked ANHA C if those should be documented. ANHA C indicated, yes. Surveyor asked ANHA C if she would expect the resident who has the alleged abuse happen to, to have a skin assessment. ANHA C indicated, yes. Surveyor asked ANHA C if an investigation is completed without items such as: assessments of residents; the time the NHA is notified; complete staff education, do you have all the key components of a thorough investigation. ANHA C indicated, no. Of note, no further information or documentation regarding monitoring for R3 after the incident was provided to the surveyor. 44552 Example 2: R2 was admitted to the facility on [DATE] with a diagnoses including Dementia, Major Depressive Disorder, Anxiety Disorder, Acute Stress Reaction, and Age-Related Cognitive Decline. R2's most recent MDS with ARD (Assessment Reference Date) of 9/23/22, indicated R2's cognition was severely impaired with a BIMS (Brief Interview for Mental Status) score of 01 out of 15. R2's CNA Assignment Sheet, dated 12/19/22, indicates staff are to alert nurse of any exit attempts immediately. If she becomes upset with others provide her a safe quiet place to allow her to vent. STOP sign on door as she gets agitated when others wander into her room, maintain social distancing when in common areas to reduce risk of altered interpersonal response to others .Maintain social distancing when in common areas to reduce risk of altered interpersonal response to others. Redirect from easily agitated residents to avoid negative behavior from others. DO NOT allow resident to hold hands, hug, kiss or otherwise be generally affectionate with opposite sex. Should always be supervised in a common area. Redirect as needed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's Comprehensive Care Plan includes, in part, 12/13/22 PROBLEM: Resident seeking opposite sex attention with or without intent. Approaches included Nurses- redirect, engage and encourage activity participation, provide independent activities, utilize daily itinerary, monitor exit seeking, social distance from male resident, document anxiety and tearful moments, report inappropriate/concerning behaviors to DON/Administrator immediately. Ensure 1:1 at all time with male resident that she may be seeing to provide well being and dignity for all involved, intervene as needed. Nurse Aide- redirect, engage and encourage activity participation, provide independent activities, utilize daily itinerary, monitor exit seeking, social distance from male resident, document anxiety and tearful moments report inappropriate/concerning behaviors to charge nurse, and DON/Administrator immediately. Ensure 1:1 at all time with male resident that she may be seeking to provide well being and dignity for all involved, intervene as needed. 12/13/22 Maintain appropriate display of affection in social setting, maintain personal dignity, continue with quality of life, no episodes of inappropriate sexual behaviors. 12/9/22 Special Care Remarks: May allow resident to hold hands, hug, kiss or otherwise be generally affectionate with R1 per POA, this should always be supervised in a common area. A progess note from 1 [TRUNCATED]

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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** 39849 Based on interview and record review the facility did not ensure all alleged violations involving mistreatment, neglect, or abuse were reported to other officials in accordance with State law through established procedures for 1 of 3 residents reviewed for abuse (R3). R3 was touched on her breast by another resident and the incident was not reported to the Legal Guardian, nor to other officials. This is evidenced by: The Facility Policy, titled, Resident Safety Abuse Policy, with a revision date of 2/2022, includes, in part: Purpose: It is the policy of our facility to maintain a work and living environment that is professional and free from threat and/or occurrence of harassment, abuse (verbal, physical, mental or sexual), neglect, corporal punishment, involuntary seclusion, physical or chemical restraints not required to treat the resident's medical symptoms, exploitation and misappropriation of resident property. Providing a safe environment is one of the most basic and essential duties of the facility .Residents have the right to be free from abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, visitors, friends, or other individuals .SEXUAL ABUSE is non-consensual sexual contact of any type with a resident. Determination of the resident's ability to consent must be determined. The facility Policy titled, Change in Residents Condition/Status: Resident, Physician and Family/Legal Representative Notification/Consultation, with a revision date of 8/2021, includes, in part: Purpose: The facility will promptly notify (and consult with, when appropriate) the resident, the resident's attending physician and the resident's legal representative or interested family member of changes in the resident's condition and/or status .5. Unless otherwise instructed by the competent resident, the Licensed Nurse will notify the resident's family or legal representative when .b. There is suspected or alleged abuse . R3 was admitted to the facility on [DATE] with diagnoses that include, in part: Alzheimer's disease, unspecified dementia, restlessness and agitation, major depressive disorder, vascular dementia, and need for continuous Supervision. R3's most recent Minimum Data Set (MDS) with a target date of 11/18/22, documents a Brief Interview for Mental Status (BIMS) score of 2, which indicates, severe cognitive impairment. Review of the Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report, with a Report Submitted Date of 12/1/22, indicates, .Brief Summary of Incident: Resident A (R1) reached out toward Resident B (R3) and touched them on the arm and also touched their breast. Resident A (R1) has a tendency toward physical contact (rubbing shoulders/arms, patting backs) and their hand has slipped. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Misconduct Incident Report, with a Report Submitted Date of 12/8/22, documents, .5. Law Enforcement Involvement: Was law enforcement contacted or involved? No . On 12/20/22 at 11:05 AM Surveyor interviewed ANHA C (Assistant Nursing Home Administrator) and asked if a staff member reports a resident touched another resident's breast, should that allegation be investigated as an allegation of sexual abuse. ANHA C indicated, yes. Surveyor asked ANHA C if an allegation of sexual abuse should be reported to police. ANHA C indicated, yes. Surveyor asked ANHA C if the POA (Powers of Attorney) for R1 should have been notified of the incident. ANHA C indicated, yes. Surveyor asked ANHA C if she has any evidence that they were notified. ANHA C indicated she would have to look. No further evidence regarding notification of the POA or Law Enforcement was provided to the surveyor by the facility.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39849 Based on interview and record review, the facility failed to thoroughly investigate incidents of sexual abuse and take steps to prevent further abuse for 2 of 3 abuse violations reviewed (involving R1, R2, and R3) of a total sample of 3 residents. On 12/1/2022, the facility became aware of a sexual abuse allegation involving R1 and R3 and a thorough investigation was not completed. This is evidenced by: The Facility Policy, titled, Resident Safety Abuse Policy, with a revision date of 2/2022, includes, in part, . PROCEDURE FOR INVESTIGATION: a. All alleged violations, will be thoroughly investigated and all investigations are conducted by or coordinated through facility administration. b. When appropriate, the Quality Assurance Performance Improvement (QAPI) Leader and/or the supervisor on duty will assess the resident ., and properly document the date, time, and location of the reported or suspected incident. There may be circumstances, such as sexual abuse, when a specifically-trained professional should be utilized if available . d. The supervisor will ensure that the resident(s) is/are protected from further potential abuse, neglect, exploitation or mistreatment while the investigation is in progress . f. The residents' attending physician, facility medical director, corporate management and family will be notified as soon as possible . i. All witnesses or involved parties will be interviewed giving their own description of the incident and will be recorded by the QAPI Leader and/or supervisor on duty. These records will become part of the permanent investigation file. i. The QAPI Leader and/or supervisor on duty will interview the residents as well as any nursing, housekeeping, laundry, dietary, activity, or social service staff, any visitors or others who may have knowledge of the occurrence or who may have been in the vicinity at the time the incident happened . l. The Administrator will be the custodian of all documents generated during the course of the investigation. m. The facility must have evidence that all alleged violations are thoroughly investigated . Findings Include: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1 was admitted to the facility on [DATE] with diagnoses including: cognitive impairment of uncertain etiology, age related cognitive behaviors, bilateral hearing loss. On 12/5/22, R1 was diagnosed with dementia with associated psychotic-agitated behavior. R1 has an APOA (Activated Power of Attorney) for health care. Of note, concerns had been identified when R1 had inappropriate contact with other residents on 11/16/22 and wandering behaviors into other resident rooms between 11/18/22 and 11/21/22, with citations issued on 11/21/22. R1 was moved to the Memory Care Unit on 11/18/22. On 11/15/22, R1's admission Minimum Data Set (MDS) assessment notes a Brief Interview for Mental Status (BIMS) score of 2, indicating severe cognitive impairment. Section E of the MDS notes R1 wandering behaviors occurred daily. Section G notes R1 is independent in transfers, ambulation, and locomotion on the unit. R3 was admitted to the facility on [DATE] with diagnoses that include, in part: Alzheimer's disease; Unspecified Dementia; Restlessness and agitation; Major Depressive Disorder; Vascular dementia; and Need for Continuous Supervision . R3's most recent MDS with a target date of 11/18/22, documents a BIMS score of 2, which indicates, severe cognitive impairment. Review of the Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report, with a Report Submitted Date of 12/1/22, indicates the following: .Summary of Incident: Allegation Type: Abuse: Hitting, slapping, threats of harm, assault, humiliation Brief Summary of Incident: Resident A (R1) reached out toward Resident B (R3) and touched them on the arm and also touched their breast. Resident A (R1) has a tendency toward physical contact (rubbing shoulders/arms, patting backs) and their hand has slipped. Of note, the original Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report, with DRAFT noted across the document, and no Report Submitted Date, that was originally provided to surveyors indicated the above information, as well as, an additional sentence: Resident frequently touches others. Review of the Misconduct Incident Report, with a Report Submitted Date of 12/8/22, documents the following: .2. Summary of Incident: Is date and time when occurred known? No Of note, Date occurred, Time Occurred, and Is occurred date and time estimated are blank. Date discovered: 12/1/22. Briefly describe the incident .Resident A (R1) reached out toward Resident B (R3) and touched them in the arm and inadvertently touched the side of their breast with the back of their hand. Resident A (R1) has a tendency toward physical contact which may include rubbing shoulders, arms, and patting backs of others. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Describe the effect . Resident B (R3) has no recollection of event nor change in mood or affect. Explain what steps the entity took upon learning of the incident to protect the affected person(s) and others from further potential misconduct .Interviews of residents - no concerns. Interviews of staff - no concerns. Both residents care plans updated. Line of sight to continue. Family and staff providing 1:1 during the afternoon/evening hours when resident tends to wander more. Education for effective redirection. Referral made to MD for assessment and new orders. Specific location where the incident happened is blank. 3. Affected Person Information: R3 is listed. Of note, the area for R3's Guardian information is blank. On 12/19/22, Surveyor interviewed LPN D, LPN E, RN F, LPN G, CNA J, and CNA K, and all indicated they were not aware of an incident between R3 and R1. On 12/19/22 at 3:23PM, ANHA C provided surveyor with a three-page, typed document that notes, Interviews conducted on 12/2/22, at the top. ANHA C indicated, the document is staff interviews. The document contains ten names with times after the names and the following three questions under each name: Have you seen R1 touch any other residents inappropriately?; Has he touched you on the buttocks, groin, or chest?; What would you do if that happened? There is no information on the document of who the listed names are; signatures from the interviewees indicating they provided this information; or information on who the other resident was that was involved in the incident with R1. Surveyor asked ANHA C what self-report these are in relation too. ANHA C indicted they were from the incident with R3 and R1. Surveyor asked ANHA C how this would be known as R3's name nor the incident date was included on the document. ANHA C indicated, from the date and pointed to the 12/2/22 date at the top of the document. ANHA C also provided a diagram that was drawn on notebook paper and states it is showing the path of the CNA (Certified Nursing Assistant) walking with R1 and where R3 was sitting. ANHA C indicates, the CNA was CNA H and that as R1 was walking by that is when the incident happened. On 12/20/22 at 8:04AM Surveyor interviewed LPN D. Surveyor showed LPN D the document dated 12/2/22 with his interview questions. Surveyor asked LPN D, when you were asked the questions on 12/2/22 about R1 touching another resident inappropriately, who did you believe was the original resident that was being referred to. LPN D indicated, R2, when you brought up R3 before, I was like what? On 12/20/22 at 8:07AM Surveyor interviewed LPN G. Surveyor showed LPN G the document dated 12/2/22 with her interview questions. Surveyor asked LPN G, when you were asked the questions on 12/2/22 about R1 touching another resident inappropriately, who did you believe was the original resident that was being referred to. LPN G indicated, I didn't know who they were referring to. I've never seen him touch anyone inappropriately. It doesn't mean it didn't happen, but I've never seen it. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/19/22 at 3:35PM, Surveyor interviewed CNA H and asked what she did to ensure R3's safety after the incident with R1 on 12/1/22. CNA H indicated, I went and asked her how she was and she said she was fine but that she didn't trust him. Surveyor asked CNA H what was done to ensure R1 didn't go back by R3 again. CNA H indicated, he didn't go back by her, she would snap, we would have known, she told him, don't come by me again. Surveyor asked CNA H how she ensured R3 and other resident's safety. CNA H indicated, we watched him. Surveyor asked CNA H, how did you watch him. CNA H indicated, I was out here. Surveyor asked CNA H, you never went into a resident room that night. CNA H indicated, well, the nurse was here too. Surveyor asked CNA H if she was with R3 or R1 one hundred percent of the time after the incident to know he didn't reapproach. CNA H indicated she wasn't with either of them one hundred percent of the time after it happened. Surveyor asked CNA H how then she knew he did not reapproach. CNA H indicated, we would have known, she would have yelled. On 12/20/22 at 9:20AM Surveyor interviewed DON B and asked what would constitute a thorough investigation. DON B indicated, witness statements; other staff and resident interviews; look at pieces of information. Surveyor asked if staff write their own witness statements. DON B indicated, no, our corporate philosophy is to have us talk to the staff and transcribe their statement. Surveyor asked DON B if those should be in the investigation. DON B indicated, yes, exactly. Surveyor asked DON B if it should be a statement and not just questions they ask the staff. DON B indicated, typically that's not me. If it's the person that witnessed it, I would expect a statement. Surveyor asked DON B what her role is in these incidents. DON B indicated, assist in reporting; doing assessments if they need to be done; sometimes it could be helping with staff interviews; care plan changes if needed. Really, it's ANHA C, NHA A, and VPO L (Vice President of Operations) gets called on all self-reports. Surveyor asked DON B if witness statements should have been obtained. DON B indicated, yes. Surveyor asked DON B how resident safety was ensured after the incident with R1 and R3. DON B indicated she would have to check. Surveyor offered a copy of the self-report for review to DON B. DON B indicated, this is the full report you were given. Surveyor indicated, yes. Surveyor asked DON B if there was more that wasn't provided. DON B indicated, I don't know. DON B indicated, staff and family were providing 1:1 with R1 that evening. Surveyor asked DON B if she was aware of what was done for R3. DON B indicated, I don't. DON B added, I do know ANHA C said R3 didn't remember the incident the next day and I haven't seen any changes, she's been at baseline. Surveyor asked DON B if there is documentation of monitoring for R3. DON B indicated, they should have been documenting on daily acute charting for mood/behavior after. Surveyor requested copies of this charting. Surveyor asked DON B if a physical assessment was performed on R3 or other residents, like a skin sweep, to ensure there were no signs or symptoms of abuse. DON B indicated, not to my knowledge. Surveyor asked DON B if she would expect something like that to be done for residents who couldn't tell you if they had been abused. DON B indicated, because he was in line of site, I'm confident he hadn't abused anyone else. Surveyor asked DON B if R3 should have had a skin/overall assessment. DON B indicated, probably, but it was such a light touch. Surveyor asked DON B how they could know if he had done anything to her, that may not have been witnessed, if an assessment wasn't done. DON B indicated, because he was on line of site. Surveyor asked DON B if she was sure he was in line of site at all times. DON B indicated, yes, I'm confident, I'm back there a lot. Of note, no acute charting documentation referenced by DON B was provided to surveyors. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/20/22 at 9:52AM Surveyor interviewed SW I and asked what she could share about what happened between R1 and R3 on 12/1/22. SW I indicated, I do know I was back there at the time it happened. From my understanding it wasn't an intentful inappropriate touch. Surveyor asked SW I how she would know if it was intentional. SW I indicated, just because of the way she was sitting at the table with her arms on the table, her elbows were on the table. Where I was, his back was to me and I saw him reach over and bend towards her. SW I is sitting in chair and leaning towards floor. I didn't see him touch her, but we separated them. He was busy, active all day long, so I took him to the other hub. It was a zoo back there. Surveyor asked SW I to clarify if R1 was sitting or walking by when he toucher R3. SW I indicated, no he was standing and he was walking by her. Surveyor asked SW I, did you see him touch R3. SW I indicted, no, because his back was to me. Surveyor asked if anyone reported to her that R1 had touched R3. SW I indicated, I can't even answer that, I don't know what the terms were when reported to me that were used. If he did or didn't touch her breast. Surveyor asked SW I what she reported to DON B that would make them reference in the self report that R3's breast was touched. SW I indicated, I don't remember. Surveyor asked SW I how long she was in the memory care unit after the incident happened. SW I indicated, I don't know when I left, could have been ten minutes, could have been a half hour. Surveyor asked SW I what was done to ensure resident safety after the incident. SW I indicated, they kept R1 separated. They kept R3 where she always is and kept R1 in the other hub. R1's son was here that night too, after the incident, and was with him, not sure exactly how long he stayed that night, but he usually stays until he's ready for bed. Surveyor asked SW I if she documented any of the information about the incident in the chart. SW I indicated, no. Surveyor asked SW I if she should have documented in the chart. SW I indicated, yeah, probably. Of note, there was no witness statement from SW I provided to the surveyors. On 12/20/22 at 11:05AM Surveyor interviewed ANHA C and asked what the key items are that should be included when completing an investigation of abuse. ANHA C indicated, we do staff interviews with pertinent staff and ask pertinent questions. Surveyor asked, when you complete staff interviews, are you providing them with a piece of paper with the questions or are you asking them the questions yourselves. ANHA C indicated, we ask them ourselves. ANHA C continued, we interview residents if resident to resident. Surveyor asked ANHA C what is done if the resident is non-interviewable. ANHA C indicated, we would contact families, let them know the situation, ask families where they would like us to go with that situation. Surveyor asked ANHA C what she meant by this. ANHA C indicated, if they want police contacted. Surveyor asked ANHA C if she leaves it up to the family to decide if police are contacted. ANHA C indicated, in certain situations. Surveyor asked ANHA C if there were further things that are done for the non-interviewable residents. ANHA C indicated, we interview staff to see if other residents have been affected. We would still interview the non-interviewable residents to ask if they feel safe, if they feel comfortable with housemates, I still would try to interview. We watch for signs of changes in affect, eating, changes in day to day participation, mood. Surveyor asked ANHA C if she would expect that type of monitoring to be documented. ANHA C indicated, yes, I would. Surveyor asked ANHA C if she would expect staff to perform skin assessments to see if non-interviewable residents have any signs of concerning areas for abuse that they may not be able to verbalize. ANHA C indicated, yes. Surveyor asked ANHA C if those should be documented. ANHA C indicated, yes. Surveyor asked ANHA C if she would expect the resident who has the alleged abuse happen to them, to have a skin assessment. ANHA C indicated, yes. Surveyor asked ANHA C if an investigation is completed without items such as: assessments of residents; the time the NHA is notified; complete staff education, do you have all the key components of a thorough investigation. ANHA C indicated, no. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor asked ANHA C what was done immediately after the incident to protect R3 and other residents. ANHA C indicated she would have to check the care plan. Of note, no further information was provided to surveyor in regard to this from ANHA C. Surveyor asked ANHA C who is responsible for obtaining witness statements. ANHA C indicated, me. Surveyor asked ANHA C if she recalled obtaining witness statements for this incident. ANHA C indicated that she had one for CNA H. Surveyor requested this. On 12/20/22 at 9:40AM DON B showed surveyor, on R3's care plan, a revision made on 12/5/22 that she had placed brackets around on a paper copy. The information in brackets, notes: Redirect from easily agitated residents to avoid negative behavior from others. Surveyor asked DON B if this intervention would be considered personalized for R3. DON B indicated, not really. Surveyor asked DON B if this statement is on other resident's care plans. DON B indicated, probably. Of note, 12/5/22 was four days after the date of the incident. On 12/20/22 at 12:45PM ANHA C provided Surveyor with a typed document and indicated this was a witness statement from CNA H. CNA H's name is typed at the top with the date and time of 12/1/22 @ 5:55pm. The statement notes the following: [name]CNA H was in MCU (Memory Care Unit) walking to the left of R1. R1 was walking by R3, who was sitting at the table. When walking by he went to touch her and touched her in the arm and brushed against her breast and continued walking. He went to the opposite side of the unit. CNA ensured safety of residents and made sure R3 was ok. Of note, there is no signature or indication from CNA H, on the document, that this is the statement she provided. On 12/20/22 at 9:01AM two skin assessments were provided to the surveyor by the DON for R3. One is dated 11/30/22 and indicates, no skin issues. The other is dated 12/7/22 and indicates, no skin issues. No skin assessment for the date of the incident, 12/1/22, was provided to the surveyor. The facility did not provide evidence of the following: *Physical Assessments for R2 and R3. *Skin Checks for non-interviewable residents to assess for other possible incidents of abuse. *Obtaining all Witness Statements. *Investigation Summaries *Post-incident Monitoring Documentation 44552 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to conduct a thorough investigation regarding the incidents that occurred on 12/2/22 and 12/10/22 between R1 and R2. The facility failed to complete a physical assessment and monitor R2 after both incidents to ensure R2 was not experiencing psychosocial affects. The facility failed to complete body checks for residents who are unable to verbally communicate to ensure they did not experience abuse or unwanted touch. The facility failed to interview all staff that were involved in the incident. R2 was admitted to the facility on [DATE] with a diagnoses including Dementia, major depressive disorder, anxiety disorder, acute stress reaction, and age-related cognitive decline. R2's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 9/23/22, indicated R2's cognition was severely impaired with a BIMS (Brief Interview for Mental Status) score of 01 out of 15. R2's CNA (Certified Nursing Assistant) Assignment Sheet, dated 12/19/22, indicates, R2 needs assist of 1 for showering and personal cares. Ensure to alert nurse of any exit attempts immediately. Benefits from social stimulation during the day and into evening hours. If she becomes upset with others provide her a safe quiet place to allow her to vent. Encourage her to lay down for rest periods throughout the day, especially after lunch or when anxious, STOP sign on door as she gets agitated when others wander into her room, maintain social distancing when in common areas to reduce risk of altered interpersonal response to others . Encourage erect posture and rest in the afternoon to aid in reduction of agitation, Maintain social distancing when in common areas to reduce risk of altered interpersonal response to others. Redirect from easily agitated residents to avoid negative behavior from others. DO NOT allow resident to hold hands, hug, kiss or otherwise be generally affectionate with opposite sex. Should always be supervised in a common area. Redirect as needed. R2's Comprehensive Care Plan includes, in part, 12/13/22 PROBLEM: Resident seeking opposite sex attention with or without intent. RELATED TO: urge to companionship with male resident(s), low BIMS. 12/16/22 MANIFESTED BY: actively seeking male resident encouraging male resident to hold her hands, hugging male resident, displaying jealousy, kissing, and joined exit seeking. Nurses- redirect, engage and encourage activity participation, provide independent activities, utilize daily itinerary, monitor exit seeking, social distance from male resident, document anxiety and tearful moments, report inappropriate/concerning behaviors to DON/Administrator immediately. Ensure 1:1 at all time with male resident that she may be seeing to provide well being and dignity for all involved, intervene as needed. Nurse Aide- redirect, engage and encourage activity participation, provide independent activities, utilize daily itinerary, monitor exit seeking, social distance from male resident, document anxiety and tearful moments report inappropriate/concerning behaviors to charge nurse, and DON/Administrator immediately. Ensure 1:1 at all time with male resident that she may be seeking to provide well being and dignity for all involved, intervene as needed. 12/13/22 Maintain appropriate display of affection in social setting, maintain personal dignity, continue with quality of life, no episodes of inappropriate sexual behaviors. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report dated 12/02/2022, states, in part, Time occurred: 07:00PM Brief Summary of Incident: Staff was walking with Resident A (R1), Resident A (R1) leaned over and kissed Resident B (R2) on the cheek. Resident A (R1) returned to their room with direct observation. Son in attendance. MD notified for clinical work up. Resident B (R2) and family with no concerns. DESCRIBE THE EFFECT: Resident B (R2) has no recollection of event and has no concerns. No Change in mood nor affect. EXPLAIN what steps the entity took upon learning of the incident to protect the affected person(s) and others from further potential misconduct: Resident interviews- no concerns, staff interviews- no concerns, both resident care plans updated. Line of sight to continue. Family and staff providing 1:1 during the afternoon/evening hours when resident tends to wander more. Education for effective redirection. Referral made to MD for assessment and new orders. Follow up referral to MD with additional medication management. It is important to note, after the first incident on 12/02/2022, there was no monitoring completed to ensure R2 did not experience any psychosocial affects from the incident. There were no assessments to consent to sexual activity completed for either R2 or R3. The facility failed to identify three residents that were interviewed were unable to verbally answer, there were no body checks completed to ensure these residents did not experience abuse or unwanted touch. There was no education provided to staff after the first incident. The facility did not provide education to staff until 12/8/22 and 12/9/22: Redirection of residents Education provided to staff: Effective redirection for MCU (Memory Care Unit) residents (focus on R1 and R2) Staff sign off sheet dated 12/08/22 and 12/09/22. Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report dated 12/10/2022, states, in part, Time: 01:10 PM Brief Summary of Incident: Resident A (R1) observed in Resident B's (R2) room with Resident B's (R2) pants lowered. Nurse observed Resident A (R1) on opposite side of unit just prior to staff observing residents together. Residents families aware and just recently agreed to the two having a relationship as both have been seeking each other out for companionship. Briefly Describe the incident- Resident A (R1) observed in Resident B's (R2) room with Resident B's (R2) pants lowered, when Med Tech arrived Resident B (R2) said oops, pulled up their under garments and went over to their bed. Resident A (R1) was escorted out of the room. Families in agreement for residents to have a relationship with each other. BIMS score of Resident A (R1)- 2 BIMS score of Resident B (R2)- 1. Time frame of 3.5-4 minutes. DESCRIBE THE EFFECT that the incident had on the affected person, the person's reaction to the incident, and the reaction of others who witnessed the incident: Resident B (R2) has no ill effects. Resident B (R2) behaviors for seeking out Resident A (R1) have decreased and remains easily redirectable. EXPLAIN what steps the entity took upon learning of the incident to protect the affected person(s) and others from further potential misconduct: Residents separated immediately. Ensured safety of all residents DON and Administrator notified immediately. Resident A (R1) put on direct observation. Police notified. Resident A (R1) left facility for the weekend. Families notified. Interviewed staff- no new events, no concerns. Physician contacted for further review. Resident returned to facility Monday 12/12 at 10:30am and new intervention put into place of 1:1. One-to One Education provided to staff: One to one with R1 expectations, when assigned and leaving, must find another staff member to relieve the duty. Staff member is within arms reach at all times while awake, and during sleeping hours must be able to visualize exit of room. Staff sign off sheet dated 12/12/22, 12/13/22, and 12/14/22. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It is important to note, after the second incident on 12/10/2022, there was no monitoring completed to ensure R2 did not experience any psychosocial affects from the incident. There were no assessments to consent to sexual activity completed for either R2 or R1. The facility failed to identify three residents that were interviewed were unable to verbally answer, there were no body checks completed to ensure these residents did not experience abuse or unwanted touch. The Police Report and the Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report do not match, in the Police Report and through interviews it was identified that both residents had their pants down and R1 had his hands on both of R2's breasts. On 12/19/22 at 10:50 AM, RN (Registered Nurse) F indicated staff just recently received training on abuse and the different types of abuse. RN F indicated they received education on the importance of reporting and on-going 1:1 supports and ensuring visual sight of residents. RN F indicated that R1 is now 1:1 and this means that he must be within arm's reach of a staff member that is assigned to him. RN F indicated for all resident-to-resident altercations staff must separate the residents, ensure a safe environment, and immediately report the incident. RN F indicated management discusses interventions and then will relay what the interventions are to staff. RN F indicated nursing staff are not involved in deciding appropriate interventions. RN F indicated they will assign extra staff to ensure safety for residents. RN F indicated she was the staff that was with R1 on 12/10/22. RN F indicated she was watching and keeping R1 in line of sight on 12/10/22 from around 6:45AM to 11:40AM. RN F indicated the DON (Director of Nursing) called and had her leave the Memory Care Unit because she needed to do something in regard to another resident testing positive for influenza. RN F indicated she didn't ask any other staff to keep R1 in line of sight when she left the area. RN F indicated there was a CNA, Med Tech, Housekeeper, and an LPN (Licensed Practical Nurse) from Corporate. RN F indicated she saw the Corporate LPN walk past her (RN F) at the main nurses station. RN F indicated that she questioned the LPN leaving and felt it wasn't the best moment to leave the Memory Care Unit since she (RN F) was not back there. LPN indicated she had to check in to her hotel and left. RN F indicated the incident between R1 and R2 occurred a little after 1PM shortly after lunch time. RN F indicated that Housekeeper R heard a noise that sounded off and went to R2's bedroom. Housekeeper R yelled for Med Tech S. RN F indicated that no one interviewed her regarding this incident. RN F indicated she felt they should have since she was the nurse in charge that day. RN F indicated R1 will touch staff when they are assisting him with personal cares. RN F indicated they asked R1 a few hours later if he remembered R2 and what her name is. RN F indicated R1 didn't remember the incident or R2's name. Surveyor asked RN F what was put in place to support R2 after this incident. RN F indicated we didn't do anything to support R2 after the incident. She wanted to go back and be with him. Surveyor asked if R2's POA (Power of Attorney) was notified. RN F indicated she was sure that management did that. Surveyor asked RN F what the facility process was for the victim in any abuse situation. RN F indicated they will chart, keep watch and monitor that resident. RN F indicated they may send the person to the hospital for an exam as well. RN F indicated they would keep doing the extra monitoring and charting for a month and this would be in the resident's progress notes. RN F indicated this was not done for R2 because they felt she wanted it. Surveyor asked RN F in there was a sexual consent assessment completed with R2. RN F was unsure if this was completed but didn't believe so. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/19/22 at 12:30 PM, LPN (Licensed Practical Nurse) G indicated she was the staff that was assisting R1 during the first investigation with R2. LPN G indicated she was walking with R1, R1 bent down and kissed R2 on the cheek. LPN G indicated she immediately stepped in between the two residents and redirected. R1 became mad and started yelling and swearing at LPN G. R2 was giggling. LPN G indicated that R1 and R2 will look for each other and seek each other out. LPN G indicated the incident happened so quickly. LPN G indicated R1's POA will come and sit with him. There is always one CNA and one nurse back in the Memory Care Unit, more recently there is now a 1:1 with R1 as well. LPN G indicated after the incident she ensured both residents were safe. LPN G indicated she ensured that R2 still felt safe, and she was doing different activities after incident. LPN G is unaware if a sexual consent assessment was completed for both residents. On 12/19/22 at 1:30 PM, Housekeeper R indicated she was the staff person that first witnessed the 12/10/22 incident with R1 and R2. Housekeeper R indicated there was a strange noise, walked in to R2's bedroom, and saw the two residents. Housekeeper R indicated she saw R2 standing in front of R1, his hands on her breasts, R1 had his pants down, and it looked like R2 was pulling up her pants. Housekeeper R indicated she was so shocked she said, Holy shit. Housekeeper R indicated she did not leave the room and yelled for assistance. Housekeeper R indicated that the Med Tech came and assisted with the situation. Housekeeper R indicated R2 went and laid down in her bed, R2 looked like she was embarrassed, and asked if she was in trouble. Housekeeper R indicated there were two staff in the Memory Care Unit at that time. Housekeeper R indicated there was a Med Tech and a CNA. The Med Tech was in another room charting and the CNA was assisting another resident. Housekeeper R indicated she feels the 1:1 with R1 is helping the situation and that R1 does try to get close to some of the female residents. Housekeeper R indicated she has known R1 to stand a little too close to some of the residents and irritate them but that the other two female residents R1 seems interested in will either glare at him or tell him to get away from them. Housekeeper R indicated R2 does get upset and will cry and call staff names because [TRUNCATED]

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34400 Based on observation, interview, and record review, the facility failed to provide adequate supervision and assistive devices to prevent accidents for 3 of 3 residents (R1, R2, and R3) reviewed for supervision and resident to resident altercation. R1 has a known history of inappropriately touching other residents. The facility implemented an intervention of line of sight supervision. That supervision was not consistently provided allowing R1 the opportunity to again seek out residents and inappropriately touch them on multiple dates. After 3 incidents, all of which occurred while R1 was supposed to be under line of sight supervision, the facility implemented 1 to 1 supervision. Observations found staff would not keep R1 within their line of sight and would not ensure R1 was within arms reach. During one of these observations, R1 was able to seek out a resident he had a previous incident with. The facility's failure to provide adequate supervision for R1, with known physical and sexual contact with other residents, created a finding of Immediate Jeopardy (IJ) that began on [DATE]. On [DATE] at 4:41 PM NHA A (Nursing Home Administer), and ANHA C (Assistant Nursing Home Administrator) were notified of the IJ concern. The immediate jeopardy was not removed at the conclusion of the survey. This is evidenced by: The facility's Elopement and Wandering Management Policy updated ,d+[DATE] includes in part: It is the policy of this facility to make every reasonable effort to provide for the safety and security of residents at risk for elopement . Resident wandering behaviors must be assessed and monitored in order to protect the safety and welfare of residents . 2. For each resident identified as having wander behavior . an appropriate safety care plan . will be developed and implemented with specific approaches, preventative measures and measurable goals . Of note this policy addresses staff intervention for resident elopement and elopement attempts but does not specifically address how staff should respond to residents wandering into other residents rooms. R1 was admitted to the facility on [DATE] with diagnoses including: mild cognitive impairment of uncertain etiology, age related cognitive behaviors, and bilateral hearing loss. On [DATE], a diagnosis of Alzheimer's dementia was added to R1's record by R1's physician. On [DATE], R1 was diagnosed with dementia with associated psychotic-agitated behavior. R1 has an APOAHC (Activated Power of Attorney for Health Care). On [DATE], R1's admission MDS (Minimum Data Set) assessment notes a BIMS (Brief Interview for Mental Status) score of 2, indicating severe cognitive impairment. Section E of the MDS notes R1 wandering behaviors occurred daily. Section G notes R1 is independent in transfers, ambulation, and locomotion on the unit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Care Plan notes: ~Problem: need for appropriate sexual expression/display of affection (dated [DATE]), Related to touching peers and staff in affectionate manner with or without sexual intent, ex (example), cues to have hand held, habit of placing his hand on others back, placing hand on shoulders of others, close talking near peers faces due to impaired hearing, low BIMS (dated [DATE]). ~Approach (dated [DATE]): Nurses-One to one, redirect immediately, be mindful of personal space and uninvited entrances into others space . Monitor personal boundaries and document redirecting needed and any inappropriate behaviors, document interventions, involve family . provide ample 1:1 and/or independent activities with meaningful tasks (see activity care plan), social distance from opposite sex (i.e. provide appropriate boundaries between opposite sex). Monitor/intervene immediately prior to socially inappropriate touching and close talking to others, remind of personal boundaries. If defiant/aggressive behavior occurs, try reality orientation, involve family, validate concerns and emotions and remind of appropriate behaviors/actions. R1's Care Plan included an approach dated [DATE] to Keep resident in line of sight when up, this approach was discontinued on [DATE] when 1 to 1 was implemented. Review of R1 record notes R1 has specific behaviors which are monitored each shift as follows: -On [DATE], the facility monitored R1 for exit seeking (R1 is a known wanderer and is independent in ambulation), with these behaviors documented as occurring ,d+[DATE] times per day [DATE]-[DATE]. -On [DATE], the facility added monitoring R1 for behaviors of socially inappropriate touching of peers. Documentation shows these behaviors occurred ,d+[DATE] times per day between [DATE]-[DATE]. -On [DATE], the facility added monitoring R1 for behaviors of socially inappropriate touching or sexual comments to staff. Documentation shows these behaviors occurred ,d+[DATE] times per day between [DATE]-[DATE]. -On [DATE], the facility added monitoring R1 for targeted behavior of Persistent anger: pushing, slapping or other aggressive behavior toward staff. Socially inappropriate/disruptive shoving furniture, kicking doors. Documentation shows these behaviors occurring ,d+[DATE] times per day from [DATE]-[DATE]. R1's Nurses Notes include in part: -On [DATE], at 9:13 AM, . Resident moved to MCU (Memory Care Unit) [DATE] Resident in adjustment period. Wanders around MCU thinks one of the other residents is his deceased wife. Supervision needed at all times due to inappropriate touching of other residents. Have revised CP (Care Plan) addressing this and updated activity preferences. -On [DATE], at 9:13 AM, . Resident moved to MCU (Memory Care Unit) [DATE] Resident in adjustment period. Wanders around MCU thinks one of the other residents is his deceased wife. Supervision needed at all times due to inappropriate touching of other residents. Have revised CP (Care Plan) addressing this and updated activity preferences. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On [DATE], the facility notified R1's physician of R1 restlessness and difficulty sleeping, Melatonin was ordered. POA (Power of Attorney) was in agreement. -On [DATE] at 2:00 AM, Behavior: pushing/ Grabbing Pinching behavior occurred ,d+[DATE] days in the last 7 days. Verbal Threatening Cursing at Others' Behaviors occurred ,d+[DATE] days in the last 7 days . Impact of Resident: this note indicates the R1's behaviors puts R1 at significant risk for physical illness or injury, and puts others at significant risk for physical injury, significantly intrudes on the privacy or activity of others . Intervention: 1:1, assessed for pain . left alone and reapproached, music, offered snack, phone call to family, redirected . Behavior change: Behavior status has deteriorated since the last assessment. -On [DATE] at 4:02 PM, the facility sent a fax to R1's physician requesting a medication change related to anxious behaviors, agitation/aggression. -On [DATE], 3:20 AM, R1 was presenting with behaviors, staff were providing one to one for R1 at the time, the facility called 911 and R1 was sent emergently to the hospital for evaluation of agitated behaviors including swearing, yelling, attempting to enter other resident's rooms carrying and moving furniture. The facility received new orders to increase Seroquel to 50 MG every 12 hours. POA in agreement. On [DATE] at 10:50 AM, Surveyor interviewed CNA J (Certified Nursing Assistant) about R1's behaviors and what interventions are in place to protect other residents from R1. CNA J explained R1 was placed one to one supervision about a week ago, and that staff were assigned specific times to be within arm's reach of R1 and keep him from contact with other residents. CNA J stated there was a log sheet to document the one on ones. Surveyor asked what was in place before the one on ones were started, CNA J stated the staff kept R1 in direct line of sight and would redirect R1 if R1 came close to other residents. 39849 Example 1 The facility self-reported an incident related to R1 and R3 that occurred on [DATE]. The report indicated, R1 reached out toward R3 and touched them in the arm and inadvertently touched the side of their breast with the back of their hand. R1 has a tendency toward physical contact which may include rubbing shoulders, arms, and patting backs of others . The report indicated that both residents' care plans were updated and line of sight was to continue with family providing supervision during the afternoon and evening. R1's Nurse Progress Notes includes an entry on [DATE] at 3:10 PM, that the facility spoke to R1's physician regarding agitated aggressive behaviors, continued touching/reaching out physically to peers, physically combative with staff. R1's physician ordered to start hydroxyzine 25 MG (Milligrams) at bedtime for sleep and to improve mood and decrease behaviors, POA was in agreement with treatment plan. R3 was admitted to the facility on [DATE] and has a BIMS score of 2, which indicates, severe cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 3:35PM, Surveyor interviewed CNA H (Certified Nursing Assistant) and asked what she could recall about what happened on [DATE] between R3 and R1. CNA H indicated R3 was sitting at the end of the table and R1 was by the exit door in the dayroom. CNA H indicated, I went to get him and he walks so fast, he came by like this. CNA demonstrated how and where R1 was moving in the dayroom. R3 had her elbows on the table with her hands together. CNA H continued, R1 walked by and touched her arm with the back of his hand and then went lower on the side of her breast with the back of his hand. I called his name and he looked up and smiled and kept walking toward the nurse's office, where SW I (Social Worker) was on the phone. Surveyor asked CNA H what she did to ensure R1 didn't go back by R3 again. CNA H indicated, he didn't go back by her, she would snap, we would have known, she told him, don't come by me again. Surveyor asked CNA H how she ensured R3 and other residents safety. CNA H indicated, we watched him (R1). Surveyor asked CNA H, how did you watch him. CNA H indicated, I was out here. Surveyor asked CNA H if she was with R3 or R1 one hundred percent of the time after the incident to know he didn't reapproach. CNA H indicated she wasn't with either of them one hundred percent of the time after it happened. Surveyor asked CNA H how then she knew he did not reapproach. CNA H indicated, we would have known, she would have yelled. On [DATE] at 9:52AM Surveyor interviewed SW I and was asked about the incident between R1 and R3 on [DATE]. SW I indicated, I do know I was back there at the time it happened. From my understanding it wasn't an intentful inappropriate touch. Surveyor asked SW I how she would know if it was intentional. SW I indicated, just because of the way she was sitting at the table with her arms on the table, her elbows were on the table. Where I was his (R1) back was to me and I saw him reach over and bend towards her. SW I demonstrated sitting in the chair and leaning towards floor. I didn't see him touch her, but we separated them. SW I indicated R1's back was to her. He was busy, active all day long, so I took him to the other hub. Surveyor asked SW I to clarify if R1 was sitting or walking by when he touched R3. SW I indicated, he was standing and he was walking by her. Surveyor asked SW I what was done to ensure resident safety after the incident between R1 and R3 on [DATE]. SW I indicated, they kept R1 separated. They kept R3 where she always is and kept R1 in the other hub. R1's son was here that night too, after the incident, and was with him, not sure exactly how long he stayed that night, but he usually stays until he's ready for bed. On [DATE], Surveyor interviewed LPN D, LPN E, RN F, LPN G, CNA J, and CNA K and all indicated their schedules include working on the memory care unit and were not aware of an incident between R3 and R1. On [DATE] at 9:20AM Surveyor interviewed DON B and asked how resident safety was ensured after the incident with R1 and R3. DON B indicated, staff and family were providing 1:1 with R1 the evening of the incident. Surveyor asked DON B if she was aware of what was done for R3. DON B indicated, I don't. DON B added, I do know ANHA C said R3 didn't remember the incident the next day and I haven't seen any changes, she's been at baseline. Surveyor asked DON B if there is documentation of monitoring R3. DON B indicated, they should have been documenting on daily acute charting for mood/behavior after. Surveyor requested copies of this charting. No documentation referenced by DON B was provided to surveyors. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:05AM Surveyor interviewed ANHA C and asked if all staff with the potential to care for R1 and R3 should be made aware of the incident so they are aware there is potential for continued contact? ANHA C indicated, yes. Surveyor asked ANHA C if she is aware of how and when staff were made aware of this incident. ANHA C indicated, when I was asking the question if they knew of any other residents being touched they would say, why are you asking me this and that would lead to informing them about who the incident was with. Surveyor asked ANHA C what was done immediately after the incident to protect R3 and other residents. ANHA C indicated she would have to check the care plan. On [DATE] at 9:40AM DON B showed surveyor on R3's care plan a revision made on [DATE] which states, Redirect from easily agitated residents to avoid negative behavior from others. Surveyor asked DON B if this intervention would be considered personalized for R3. DON B indicated, not really. Surveyor asked DON B if this statement is on other residents care plans. DON B indicated, probably. The care plan revision provided to the Surveyor was documented on [DATE], four days after the date of the incident. 44552 Example 2 R1's Nure Progress Note on [DATE] at 10:18 PM states, R1 was pacing in the unit. Staff had him in line of sight and was only about 3 feet from him at all times .staff redirected resident out of other rooms on the unit. After this he continues to be very close to female resident, he leaned in and kissed a resident on the cheek when talking with her. When staff attempted to intervene, R1 began to push, shove, grab and squeeze writer's hands. He threatened to hit this writer multiple times I am going to knock you out .Son was called twice, and he was here by 7:00 pm R1 did take his evening medicine with son present. Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report dated [DATE], states, in part, Time occurred: 07:00PM .Staff was walking with R1, R1 leaned over and kissed R2 on the cheek. R1 returned to their room with direct observation. Son in attendance. MD notified for clinical work up. R2 and family with no concerns .EXPLAIN what steps the entity took upon learning of the incident to protect the affected persons and others from further potential misconduct: Resident interviews-no concerns, staff interviews-no concerns, both resident care plans updated. Line of sight to continue. Family and staff providing 1:1 during the afternoon/evening hours when resident tends to wander more. Education for effective redirection. Referral made to MD for assessment and new orders. Follow up referral to MD with additional medication management. Nurse Progress Note on [DATE] at 10:01 PM, R1 was evaluated at the hospital due to behavior display on unit, adverse interactions with staff and peers, resident behavior display with swearing and agitative episodes. New order for Seroquel 12 MG at HS (hour of sleep) times 5 days. POA aware and in agreement with treatment plan. There is no evidnece of any new immediate interventions to protect residents from inappropriate interaction with R1. Nurse Progress Note on [DATE] at 7:43 AM indicates the facility contacted R1's physician requesting medication change, new order received for Seroquel 25 MG po BID. POA in agreement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	There is no documentation indicating why this request was made. On [DATE] at 12:30 PM, LPN (Licensed Practical Nurse) G indicated she was the staff that was assisting R1 during the [DATE] incident. LPN G indicated she was walking with R1, R1 bent down and kissed R2 on the cheek. LPN G indicated she immediately stepped in between the two residents and redirected. R1 became mad and started yelling and swearing at LPN G. R2 was giggling. LPN G indicated that R1 and R2 will look for each other and seek each other out. LPN G indicated the incident happened so quickly. LPN G indicated R1's POA will come and sit with him. There is always one CNA and one nurse back in the Memory Care Unit, more recently there is now a 1:1 with R1 as well. LPN G indicated after the incident she ensured both residents were safe. LPN G indicated she ensured that R2 still felt safe, and she was doing different activities after incident. Example 3: Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report dated [DATE], states, in part, Time: 1:10 PM Brief Summary of Incident: Resident A (R1) observed in Resident B's (R2) room with Resident B's (R2) pants lowered. Nurse observed Resident A (R1) on opposite side of unit just prior to staff observing residents together. Residents families aware and just recently agreed to the two having a relationship as both have been seeking each other out for companionship. Briefly Describe the incident- Resident A (R1) observed in Resident B's (R2) room with Resident B's (R2) pants lowered, when Med Tech arrived Resident B (R2) said oops, pulled up their under garments and went over to their bed. Resident A (R1) was escorted out of the room. Families in agreement for residents to have a relationship with each other. BIMS score of Resident A (R1)- 2 BIMS score of Resident B (R2)- 1. Time frame of 3XXX,d+[DATE] minutes. DESCRIBE THE EFFECT that the incident had on the affected person, the person's reaction to the incident, and the reaction of others who witnessed the incident: Resident B (R2) has no ill effects. Resident B (R2) behaviors for seeking out Resident A (R1) have decreased and remains easily redirectable. EXPLAIN what steps the entity took upon learning of the incident to protect the affected person(s) and others from further potential misconduct: Residents separated immediately. Ensured safety of all residents DON and Administrator notified immediately. Resident A (R1) put on direct observation. Police notified. Resident A (R1) left facility for the weekend. Families notified. Interviewed staff- no new events, no concerns. Physician contacted for further review. Resident returned to facility Monday ,d+[DATE] at 10:30am and new intervention put into place of 1:1. On [DATE] at 1:30 PM, Surveyor spoke with Housekeeper R who was the first person to witness the [DATE] incident with R1 and R2. Housekeeper R indicated there was a strange noise, walked in to R2's bedroom, and saw the two residents. Housekeeper R indicated she saw R2 standing in front of R1, his hands on her breasts, R1 had his pants down, and it looked like R2 was pulling up her pants. Housekeeper R indicated she did not leave the room and yelled for assistance. Housekeeper R indicated that the Med Tech came and assisted with the situation. Housekeeper R indicated there were two staff in the Memory Care Unit at that time. Housekeeper R indicated there was a Med Tech and a CNA. The Med Tech was in another room charting and the CNA was assisting another resident. On [DATE] at 9:30AM, Med Tech S indicated she was one of the first staff to witness the [DATE] incident between R1 and R2. At 1:09PM she was completing charting in the charting/med room. She heard someone yell nurse, nurse, nurse. Med Tech S indicated she went to R2's bedroom, R1 was walking away and zipping his pants, R2 appeared to be pulling up her pants. R1 stated he was trying to pick up his hat and he attempted to go by R2. Housekeeper R stayed by R2. Med Tech S notified RN F. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor asked who was assigned to keep R1 in line of sight? Med Tech S indicated all staff are responsible for keeping track of residents. Med Tech S indicated R1 and R2 had just finished lunch. Surveyor asked Med Tech S what residents were doing after the incident. Med Tech S indicated R1 and R2 were sitting across from each other at a table, holding hands, and smiling at each other. Med Tech S indicated staff were keeping an eye on them. At the time of the [DATE] incident, R1 was to be on line of sight supervision. Based on the description provided, R1 was not being provided with that supervision. R1's care plan was updated on [DATE] (3 days after the incident) to include 1 to 1 supervision. Review of documentation for provision of one to one for R1 from [DATE] at 10:30 AM through [DATE] notes assigned staff completing one to ones for R1 in 2 hour increments 24 hours a day. On [DATE] at 10:45 AM, CNA J indicated R1 must be in line of sight and just recently there is now a staff that is designated just for R1, so he is now a 1:1 at all times. CNA J indicated he was not working on [DATE]. On [DATE] at 10:50 AM, RN F indicated that R1 is now 1:1 and this means that he must be within arms reach of a staff member that is assigned to him. RN F indicated for all resident-to-resident altercations staff must separate the residents, ensure a safe environment, and immediately report the incident. RN F indicated management discusses interventions and then will relay what the interventions are to staff. RN F indicated nursing staff are not involved in deciding appropriate interventions. RN F indicated they will assign extra staff to ensure safety for residents. RN F indicated she was the staff that was with R1 on [DATE]. RN F indicated she was watching and keeping R1 in line of sight on [DATE] from around 6:45AM to 11:40AM. RN F indicated the DON (Director of Nursing) called and had her leave the Memory Care Unit to assist elsewhere. RN F indicated she didn't ask any other staff to keep R1 in line of sight when she left the area. RN F indicated all of the staff in the Memory Care Unit are responsible for ensuring resident safety and supervision. 38882 Example 4: On [DATE] at 1:45 PM Surveyor observed R1 wiping tables with MM U (Maintenance Man). R2 ducked under the mesh stop sign in her doorway and entered the dining area. R1 stopped wiping tables and walked towards R2. MM U continued to finish wiping the table having his back to R1 and R2. R1 and R2 shook hands and R1 continued to hold R2's hand in his cupped hands. Surveyor asked MM U if he was working directly with R1. MM U turned around and yelled, Hey don't do that. Do not do that. No touching. MM U used his hand to separate R1's and R2's hands and then said, You cannot touch other residents. MM U indicated he is assigned to be one on one with R1 until 2:00 PM and this means he is to keep R1 from doing anything inappropriate with other residents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:05 PM during an interview LPN D and LPN G indicated the expectation for one on one is to stay nearby and be available to intervene if needed. LPN G indicated she tries to give R1 some space so she doesn't make him angry. LPN D indicated one on one staff must always have eyes on R1 and having your back to R1 is not one on one supervision. LPN G voiced to be in agreement. On [DATE] at 2:22 PM DON B indicated the staff assigned to be one on one with R1 is to be within arms reach of him at all times and if he wants to shake the hand of other residents in the common area she would allow him to do so. Surveyor asked about hand holding. DON B indicated residents have the right to intimacy. Surveyor asked DON B if one to one staff should have their backs turned to R1 when providing supervision. DON B indicated no. DON B indicated R1 should not be holding R2's hand, given the seriousness of the situation. Example 5: On [DATE] at 7:15 AM to 8:15 AM Surveyor observed SW I sitting at a table completing paperwork and working on her laptop while R1 was approximately 15 feet away removing lights and ornaments off of the Christmas tree in the facility's main entrance lounge. R9 was resting in a chair approximately 15 feet away from R1 in the opposite direction of SW I. Surveyor observed DON B walk through area and stop to talk with SW I at the table. Both staff were approximately 15 feet away from R1 and 30 feet away from R9. SW I did not stay within an arms reach and also did not keep R1 within sight as she turned to face DON B and while she completed her work. Example 6: On [DATE] at 8:16 AM to 8:43 AM Surveyor observed R1 sitting at a table eating breakfast. SW I was going table to table offering coffee and other food items to other residents throughout the dining room. There was a distance of up to 30 feet from her and R1. SW I also left the room and the unit to retrieve coffee and other food items while R1 was out of her line of sight and not within arms length or 1:1. Some of this time CNA J was within arms reach of R1 while he assisted another resident with her meal, but at times R1 did not have a staff member within arms reach of him. Example 7: On [DATE] at 8:47AM Surveyors observed SW I, R1, R8, R9, and R10 in the main entrance lounge. R1 was working on removing the Christmas lights off of the Christmas tree. R9 and R10 were playing cards at a table. R8 was working on a jigsaw puzzle. SW I was assigned to be 1 on 1 with R1. SW I walked out of the room into a nearby office. SW I was about 30 feet away from R1. R1 was about 15 feet away from the other 3 residents in the room. SW I was out of the room for over one minute. During the minute Surveyor observed ANHA C in the window of the main office talking to an unknown person. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 9:41 AM during an interview ANHA C indicated her expectation of 1 to 1 one is within arms reach and available to intervene immediately if needed. ANHA C indicated she too witnessed SW I leave the area while she was to be 1 to 1 with R1. Surveyor asked if SW I was in arms reach of R1. ANHA C indicated she was not. Surveyor asked if SW I was in a position to intervene immediately if R1 inappropriately approached any of the other 3 residents. ANHA C indicated she was not. Surveyor asked if ANHA C was in arms reach of R1 and if she was in a position to immediately intervene if R1 inappropriately interacted with the other 3 residents in the room. ANHA C indicated she was not an arm's length away from R1 and she was not in a position to immediately intervene if necessary. ANHA C indicated she would educate SW I immediately on the facility's expectations of 1 to 1.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 34400 Based on interview and record review, the facility is not administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable mental and psychosocial well-being of each resident. This deficient practice has the potential to affect all 45 residents residing at the facility at the time of the survey. The facility has had repeated incidents for allegations of resident abuse and resident safety since 06/30/22, with repeat citations issued. NHA A (Nursing Home Administrator) has allowed ANHA C (Assistant Nursing Home Administrator) to receive resident abuse/safety incident reports, submit reports to the State Agency, and complete abuse investigations since May of 2022 without proof of oversight by NHA A, resulting in repeated concerns regarding resident abuse/safety. ANHA C is not licensed as a Nursing Home Administrator. (Cross reference F609 & F610.) The facility did not ensure all residents were free from abuse incidents. (Cross Reference F600.) The facility has also been cited 3 times at F689 related to resident safety for accidents and supervision (9/15/22 at immediate jeopardy, 11/21/22 potential for harm, and 12/20/22 immediate jeopardy.) Additionally, staff and family members identify ANHA C as the NHA for the facility. This is evidenced by: The facility's Administrator Job Description includes in part: Responsible for directing the administration of healthcare facility within the authority of the management company . Develops or expands programs and services for medical and psycho/social rehabilitation and community health and welfare promotion for the aged at the specific facility . Develops and maintains written policies and procedures that govern the operation of the facility . Ensures continued compliance with current regulations on all levels including safety regulations . Responsible for 24-hour operation of facility . Reviews incident/accident reports and establishes effective accident prevention program . Complies with federal, state, local and Facility regulation and procedures . Certificates, Licenses, Registrations: Nursing Home Administrator license required . The facility's Assistant Administrator Job Description includes in part: Assists in the direction of administration of health care facility with the authority of the management company . Assists in the maintenance of written policies and procedures that govern the operation of the facility .Certificates, Licenses, Registrations: Nursing Home Administrators license. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Resident Safety Abuse Policy revised 2/22, states in part: . 8. Reporting Suspected Violations . a. The supervisor on duty shall IMMEDIATELY safeguard the resident(s) and immediately report all alleged violations involving abuse, neglect, mistreatment, exploitation, including injuries of unknown source . to the facility administrator. The Administrator will notify the DON and/or others as appropriate. b. The administrator will report a reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from the facility to the State Agency and one or more law enforcement entities . 9. Procedure for Investigation: .The Administrator will be the custodian of all documents generated during the investigation. 10. Other administrative duties: . e. If an alleged violation is verified, the administrator will ensure appropriate corrective action is taken. Findings: On 12/19/22 at 2:45PM, Surveyor interviewed ANHA C (Assistant Nursing Home Administrator) asking about the facility process for completion of self-reports including allegations of abuse. ANHA C stated, if something occurs, staff contact the DON (Director of Nursing) then ANHA C. Surveyor asked if ANHA C is available 24/7? ANHA C reported she is available and that she is contacted by staff at home if needed. ANHA C reported she lets NHA A (Nursing Home Administrator) know immediately of concerns. ANHA C stated if it's something that needs to be investigated immediately, ANHA C would give direction to staff over the phone and then generally call NHA A on her 45-minute drive to the facility. ANHA C indicated, with any self-report for potential abuse, resident to resident, anything that could fall under abuse, the facility has a flow chart to use which determines if the abuse is willful or not. Surveyor asked ANHA C if she used the flowchart with the 3 self-report investigations the survey team was reviewing? ANHA C stated, I believe we did with R3, I will have to look before I can give an answer. Surveyor requested ANHA C to provide the flow charts used for the investigations. On 12/19/22 at 3:30PM, ANHA C notified Surveyor that no flowsheets were completed for the resident-to-resident incidents/self-reports involving R1, R2, and R3, dated 12/1/22, 12/2/22, or 12/10/22. On 12/20/22 at 8:40 AM, Surveyor interviewed CNA M (Certified Nursing Assistant) about abuse reporting. CNA M stated he would report abuse to his nurse on the unit, the DON (Director of Nursing,) and the Administrator. Surveyor asked CNA M who was the administrator, CNA M stated the administrator is (name) ANHA C. On 12/20/22 at 8:45 AM, Surveyor interviewed LPN D (Licensed Practical Nurse) about reporting behaviors or abuse. LPN D stated ANHA C is notified if something happens, and on the weekends, LPN D will notify ANHA C and DON B (Director of Nursing.) Surveyor asked LPN D about LPN D's documentation in R1's record on 12/14/22 at 1:23 PM noting R1's behaviors which states in part: .The administrator was in the room also and resident wanted to sit in her lap . Surveyor asked LPN D who the documentation referred to, LPN D stated (name) ANHA C. On 12/20/22 at 9:10 AM, Surveyor interviewed FM T (Family Member) about who he communicates with regarding concerns for R1. FM T stated he talks to the administrator (name - ANHA C), (name) DON B and (name) SW I (Social Worker). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/20/22 at 8:28, Surveyor interviewed CNA M and asked who she identifies as the nursing home administrator for the facility. CNA M indicated ANHA C. On 12/20/22 at 8:33AM, Surveyor interviewed CNA N and asked who she identifies as the nursing home administrator for the facility. CNA N indicated ANHA C. On 12/20/22 at 8:36AM, Surveyor interviewed Housekeeping O and asked who she identifies as the nursing home administrator for the facility? Housekeeping O indicated ANHA C. On 12/20/22 at 10:30 AM, Surveyor interviewed NHA A about who conducts investigations for allegations of abuse at the facility. NHA A stated ANHA C and SW I (Social Worker) have been completing investigations since 5/22, with one person taking resident interviews and one taking staff. Surveyor asked what qualifies ANHA C to take on the role of conducting investigations of allegations of abuse. NHA A stated she and ANHA C had completed training for abuse investigations. NHA A stated she oversees the facility's investigations to ensure they are done timely and touches all areas. Surveyor asked NHA A who was responsible to make sure abuse investigations were complete, and that the facility was in compliance; NHA A stated she was. Surveyors shared concerns to NHA A that investigation files the facility provided for Surveyors to review for self-reports involving R1 and R2 on 12/1/22 and 12/10/22, and R3 on 12/2/22 were incomplete, for example: draft documents in file rather than originals, missing interviews, missing education documentation, care plan updates. NHA A indicated she would provide the documents for Surveyors. On 12/20/22, NHA A provided copies of education for Investigating and Reporting Allegation of Misconduct provided to SW I on 11/1/22, NHA A and ANHA C on 3/24/22. NHA A also provided copy of education on Preventing and Investigating Abuse/Neglect and Mistreatment dated 7/6/22, for NHA A, ANHA C, and SW I. Surveyor asked for documentation that NHA A completed a review of investigations involving R1, R2, and R3, no further information was provided. The facility has received multiple citations for accidents and supervision. The facility has failed to ensure resident safety and maintain resident safety. Most recently the facility was cited at F689 for failure to ensure resident supervision after R1 was noted to have inappropriate sexual interaction with female residents R2 and R3. (Cross Reference F600 and F689.) The facility has had repeated citations for abuse reporting, investigating, and accidents and supervision. Management staff should be aware of regulatory requirements for reporting and completing a thorough abuse investigation. NHA A has delegated the duties of abuse reporting and investigating to ANHA C and SW I and should be completing oversight of this delegated task to ensure abuse reporting and investigation is completed per regulatory language. Furthermore, ANHA C is not a licensed NHA, and staff indicate they report to ANHA C, and she is the functioning NHA. NHA A is the NHA on record. The facility has failed to ensure it is effectively and efficiently using resources to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525409	A. Building B. Wing	01/04/2023

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39849 Based on interview and record review, the facility did not maintain Medical Records on each resident that are complete, accurately documented, readily accessible, and systematically organized in accordance with accepted professional standards and practices for 3 residents (R1, R2, and R3) of a total sample of 3 residents. R2 and R3 had an inapporpriate encounters with R1. Staff did not document these incidents in the residents' medical records. Evidenced by: The Facility Policy titled, Nurse Charting Guidelines, with a revision date of 7/19, includes in part: Purpose: To ensure an accurate and comprehensive resident medical record, the facility licensed nurses will document on all residents per the following protocol. Protocol: .4. Nurse charting general documentation guidelines: .f. Incident investigation Reports: Never document the existence of an incident investigation report in your nurse's notes. The incident investigation report is an internal document intended to facilitate improvement of processes and systems at the facility. If a nurse records a note mentioning that an incident investigation report was done, the internal form could now be subject to discovery by external attorneys if litigation arises in the future . Example 1: R3 was admitted to the facility on [DATE] with diagnoses that include, Alzheimer's disease, unspecified dementia, restlessness and agitation, vascular dementia, and need for continuous supervision Review of the Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report, with a Report Submitted Date of 12/1/22, indicates, .Brief Summary of Incident: Resident A (R1) reached out toward Resident B (R3) and touched them on the arm and also touched their breast. Resident A (R1) has a tendency toward physical contact (rubbing shoulders/arms, patting backs) and their hand has slipped. There is no specific documentation in R3's Nurses Notes regarding the facility submitted self-report to the State Agency regarding R1 inappropriately touching R3's arm and breast. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/20/22 at 8:20AM Surveyor interviewed DON B and showed DON B the nursing notes in the facility's electronic health record. Surveyor asked DON B if this was all the charting for R1 or if there is documentation elsewhere, as there were no actual assessments, documentation of the incident, notes about the resident, just the vitals and pain ratings. DON B indicated, No, that is what's there, what you're seeing is what there is. On 12/20/22 at 9:20AM Surveyor interviewed DON B and asked if this incident should be documented in either R1's or R3's chart or both. DON B indicated, it's going to depend on what it is. Surveyor asked DON B if she could elaborate. DON B indicated, typically what we enter into ECS (Facility's electronic health record) is what is pertaining to the resident's health. So if there is something that is needed like an assessment, behavior tracking/monitoring, you would see that but otherwise the incident itself would be on paper in a file. Surveyors requested documentation of items not found in record review, however, no further evidence was provided. 34400 Example 2: -The facility submitted a self-report to the State Agency regarding R1 inappropriately touching R3's arm and breast which occurred on 12/1/22. -The facility submitted a self-report to the State Agency regarding R1 going into R2's room on 12/10/22, unsupervised by staff, and staff found R1 having inappropriate contact with R2. R1's record review shows no documentation of these incidents involving R1, no assessment of R1, no immediate interventions or corrective actions in R1's record related specifically to these incidents. R1's record notes the facility was monitoring and reporting behaviors to the physician, and R1's adjusting medications. R1's record notes R1 was sent on LOA (leave of absence) with his son on 12/10/22, and R1's care plan was updated on 12/13/22 to include one to one supervision to R1. However, R1's record does not reflect any specific incident for these changes. On 12/20/22 at 10:10 AM, Surveyor interviewed DON B (Director of Nursing) regarding the lack of documentation and new interventions to protect R1 from other residents in R1's record for self-reports of incidents involving R1 on 12/1/22 with R3, the incidents self reported involving R1 and R2 on 12/2/22 and 12/10/22. DON B indicated that the corporate office has directed facility staff, that unless the incident affects residents' health status it is not documented in the resident record. 44552 Example 3: R2 was admitted to the facility on [DATE] with a diagnoses including dementia, major depressive disorder, anxiety disorder, acute stress reaction, and age-related cognitive decline. On 12/2/22, the facility submitted a self-report to the State Agency regarding a resident kissing R2. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/22, the facility submitted a self-report to the State Agency regarding a resident going into R2's room and inappropriately touching R2. Record review shows no documentation of these events, no assessments for R2, and no mention of immediate interventions in R2's medical records.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 34400 Based on interview and record review, the facility's Quality Assurance Committee failed to systematically identify, report, track, and take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. The Quality Assurance Committee did not identify and correct quality of care deficiencies regarding the investigation and reporting of suspect abuse, neglect, and exploitation and did not ensure the facility sustained corrective actions once an action plan was created for R1. The facility failed to ensure their action plan of adequate supervision was maintained. This deficient practice has the potential to affect all 45 residents at the facility. Since the facility's recertification survey on 6/30/22, the facility has been cited at F609 2 times (11/1/22 and 12/20/22) for deficiencies related to the reporting of abuse. The facility was cited at F610 3 times (6/30/22, 11/1/22, and 12/20/22) for deficiencies related to the investigation and prevention of abuse. The facility was also cited 3 times at F689 related to resident safety for accidents and supervision (9/15/22 at immediate jeopardy, 11/21/22 potential for harm, and 12/20/22 immediate jeopardy.) Cross reference F609, F610, F689. The facility's Resident Safety Abuse Policy, updated on 2/22 includes in part: . 9. Procedure for Investigation: . m. The facility must have evidence that all alleged violations are thoroughly investigated. n. These documents will be identified as QAPI documents and will be reviewed by the QAPI (Quality Assurance Process Improvement) Committee for re-evaluation of the policies and procedures and for revision to the same policies and procedures if warranted to prevent re-occurrence. The facility's QAPI Plan dated as revised on 2017 and reviewed 2021, states in part: .Our QAPI plan include the policies and procedures use to: .Identify and prioritize problems and opportunities for improvement, systematically analyze underlying causes of systemic problems and adverse events. Develop corrective action or performance improvement activities . Findings: R1 had known behaviors of wandering into other resident rooms and touching other residents inappropriately on 12/1/22, 12/2/22, and 12/10/22. R1 also had daily aggressive and inappropriate behaviors toward staff documented in R1's record since 11/21/22. On 12/20/22 at 12:10 PM, Surveyor interviewed NHA A (Nursing Home Administrator) asking if the facility had brought concerns of abuse, abuse reporting, abuse investigations, and R1's behaviors to the QAPI Committee. NHA A stated no, that the facility had a scheduled QAPI meeting for 12/22/22 and provided a copy of the QAPI Agenda to discuss many items including Deficient areas of F689 (Resident Safety and Supervision), F609 (Abuse Reporting) and F610 (Abuse Investigations). Surveyor asked for any QAPI information regarding the facility's corrective actions related to R1 abuse allegations and resident safety. NHA A stated she would have to contact corporate office for the information. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor asked NHA A if the facility had an ad hoc (for immediate correction) QAPI meeting regarding abuse and the incidents involving R1? NHA A stated no, but the team met and developed a plan which included having R1 go home with his son for the weekend of 12/10/22 and returning on 12/12/22 with 1:1 supervision and education provided to all staff. On 12/20/22 at 1:10 PM, NHA A provided a document to Surveyor entitled QAPI Written Summary Template to Prove Past Noncompliance dated 12/12/22, which specifically addresses a quality issue of R1 was not within line of sight for approximately 4 minutes, identified on 12/10/22. This document indicates on check list: directed audit to be completed, identified the root cause through root cause analysis activities, Implemented 1:1 with (R1.) This document also notes a comprehensive performance improvement plan was developed on 12/12/22. Implemented on 12/12/22 . The performance improvement plan was successful and corrected the quality issue on 12/2/22 . Ongoing monitoring involving 1:1 with (R1) expectations when assigned and leaving, must find another staff member to relieve the duty. Staff member is always within arm's reach while awake, and during sleeping hours must be able to visualize exit of room, will be conducted by assigned employee 3 times weekly for the next 3 months and 1 time weekly for 3 additional months. It should be noted the facility was initially cited at immediate jeopardy at past non-compliance for F689 albeit the facility failed to ensure R1 received adequate supervision and was found to be in current noncompliance on 1/4/23 when the State Agency completed the partial extended survey. As part of the removal plan, the facility stated R1 would receive supervision to include 1 to 1 supervision within arm's length. The facility failed to ensure it sustained corrective actions to include R1 is receiving adequate supervision as evidenced by observation during the partial extended survey. (Cross Reference F689.) Upon request, the facility did not provide any additional QAPI documentation related to Abuse, Abuse Reporting and Investigation, or Resident Supervision. The facility failed to systematically identify, report, track, and ensure that improvements are realized and sustained. The Quality Assurance Committee did not identify and correct quality of care deficiencies regarding the investigation and reporting of suspect abuse, neglect, and exploitation and did not ensure the facility sustained corrective actions once an action plan was created for R1. The facility failed to ensure their action plan of adequate supervision was maintained.