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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS	F 000		

The State Agency (SA) conducted a Complaint Investigation (CI MS #23713) and a Facility Reported Incident (FRI #23859), at the facility, from 1/2/24 through 1/5/24. During the survey, the SA determined the facility was in compliance with the requirements for participation in Medicare and Medicaid. The SA investigated the complaint for sexual abuse and cited F600.

The facility's failure to provide adequate supervision and monitoring allowed Resident #2 to be in his room with his pants unzipped and penis exposed with Resident #1, who was a cognitively impaired and vulnerable person, in his bed with her clothing pulled down exposing her genital area. This placed Resident #1 and other vulnerable residents in a situation likely to cause serious injury, harm, impairment, or death.

The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 12/21/23 when Resident #2 exhibited inappropriate sexual behaviors and the facility did not provide supervision or monitoring to protect cognitively impaired and vulnerable residents.

The IJ and SQC existed at:

CFR §483.12 Freedom from Abuse, Neglect, and Exploitation - F600 - Scope/Severity "J"

The facility Administrator was notified of the IJ and SQC on 1/3/24 at 5:10 PM.

Based on the facility's implementation of corrective actions on 12/22/23, the SA determined the IJ and SQC to be Past

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

Electronically Signed | 01/19/2024

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F 000	Continued From page 1 Non-Compliance (PNC) and the IJ was removed on 12/23/23, prior to the SA's first entrance on 1/2/24. The census at the time of survey was 145, and the facility held a license for 184.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to protect a resident (Resident #1) from sexual abuse by another resident (Resident #2) for one (1) of four (4) sampled residents. Resident #1 The facility's failure to provide adequate supervision and monitoring allowed Resident #2 to be in his room with his pants unzipped and penis exposed with Resident #1, who was a cognitively impaired and vulnerable person, in his bed with her clothing pulled down exposing her	F 600	Past noncompliance: no plan of correction required.	

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genital area. This placed Resident #1 and other vulnerable residents in a situation likely to cause serious injury, harm, impairment, or death.

The situation was determined to be an Immediate Jeopardy (IJ) that began on 12/21/23 when Resident #2 exhibited inappropriate sexual behaviors. The facility Administrator was notified of the IJ and Substandard Quality of Care (SQC) on 1/3/24 at 5:10 PM and was provided an IJ Template.

Based on the facility's implementation of corrective actions on 12/22/23, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 12/23/23, prior to the SA's entrance on 1/2/24.

Findings Include:

A review of the facility's policy, "Abuse and Neglect-Clinical Protocol," revised July 2017, revealed, " ...1. "Abuse" is defined ...as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish ...Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes ...sexual abuse ...3. "Sexual abuse" is defined ...as "non-consensual sexual contact of any type with a resident ..."

A record review of the facility's investigation revealed on 12/22/23 at 9:22 AM, Resident #1 was observed lying on Resident #2's bed with her pants partially pulled down. Resident #2 was lying over Resident #1 with pants on, zipper of jeans unzipped. The residents were immediately

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separated and assessed. Resident #1 was transferred to a local hospital, and Resident #2 was transferred to a behavioral health unit.

On 1/2/24 at 9:52 AM, during an interview with the Administrator, he confirmed Resident #1 was found to be in Resident #2's bed with her pants pulled down, and Resident #2 was on top of the resident with his pants unzipped. After observing the video surveillance, the administrator revealed that Resident #1 was in Resident #2's room for seven (7) minutes and 30 seconds with the door open. The Administrator stated Resident #1 had a history of roaming and wandering the memory care unit. The Administrator also confirmed that Resident #2 was admitted on 12/20/23, but on 12/21/23, he was touching himself and was being treated for hypersexuality before the incident occurred on 12/22/23.

During a phone interview on 1/2/24 at 10:56 AM, with Resident #1's Resident Representative (RR), he confirmed the facility notified him that his wife was found in a resident room, in the bed with her pants pulled down. The other resident was lying on top of her with his penis exposed. Following the incident, his wife was brought to the local hospital for an evaluation. The RR stated his wife has Dementia, that she is unable to speak, and always roams the unit. He confirmed that before her Dementia diagnosis, Resident #1 was modest and would not expose herself to anyone in that way. The RR stated she was not being watched and that the facility was aware of her roaming into rooms.

During an interview on 1/2/24 at 11:31 AM, the Assistant Director of Nurses (ADON) #2 stated on 12/22/23 at 9:30 AM, she was summoned to

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Resident #2's room by Certified Nurse Aide (CNA) #1. She observed Resident #1 lying on her back in the resident's bed, with her pants pulled down to her knees with Resident #2 on top of her with his penis exposed. The ADON immediately separated the residents, and both were examined. Resident #1 was transferred to a local hospital, and Resident #2 was transferred to a behavioral health unit. The ADON confirmed on 12/21/23 that Resident #2 demonstrated hypersexual behavior consisting of pulling his penis out of his pants and trying to touch nursing staff with his penis. The physician was notified of his behavior on 12/21/23 and new orders were received to administer Geodon 10 milligrams (MG) for two (2) doses and Provera 10 MG by mouth daily. She explained that Resident #1 always roamed and wandered in the hallways and into other resident rooms and required frequent redirections. She stated that before this incident, Resident #1 had never exposed herself to staff or other residents.

On 1/2/24 at 12:30 PM, an interview with the Medical Director revealed that he was aware that on 12/21/23, Resident #2 had hypersexual behavior, which included masturbation and fondling of his genitalia. On 12/21/23, his nurse practitioner prescribed Geodon and Provera for his hypersexual behavior with interventions to re-direct.

On 1/2/24 at 12:37 PM, an interview with the Licensed Masters Social Worker (LMSW) confirmed Resident #1 wandered, paced, and ambulated throughout the unit and required supervision and redirection frequently. Resident #2 was admitted on 12/20/23 and had no signs of being hypersexual or exposing himself.

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During an interview on 1/2/24 at 1:08 PM, CNA #1 confirmed on 12/22/23, while making rounds, he observed Resident #1 to be in Resident #2's room. She was positioned in his bed with her pants pulled down below her knees, exposing her genitalia. Resident #2 was positioned on the top of her with his pants on, but his penis was exposed and pulled out of his pants. He immediately notified the nurse and separated the residents. CNA #1 explained that Resident #1 had roamed the hallways, walked into other residents' rooms, and required frequent redirection since she was admitted to the facility.

On 1/3/24 at 11:16 AM, in an interview with CNA #2, she stated that Resident #1 walked throughout the unit all day and hugged the staff. Resident #1 required supervision because she would enter other residents' rooms and must be redirected frequently throughout the shift. She stated on 12/22/23, while serving breakfast, she entered Resident #2's room and his privacy curtain was closed. He was masturbating and his penis was exposed. Resident #2 told her to "come closer, let me hold you." CNA #2 reported the incident to ADON #2.

On 1/3/24 at 12:02 PM, an interview with Psychiatric /Nurse Practitioner revealed Resident #1 was rubbing up against other residents inappropriately and rocking her body on other staff, residents, and visitors. She explained that Resident #1 required frequent supervision.

During an interview on 1/4/24 at 11:58 AM, Registered Nurse (RN) #1 revealed that while she was performing a body audit on Resident #2 on 12/21/23, he was rubbing her on her mid-back.

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After she redirected him, he stopped. Then, as she was performing the body audit on his front side, he grabbed her around her neck. RN #1 called out for assistance and License Practical Nurse (LPN) #1 and CNA #3 entered and observed the resident touching himself and masturbating. They redirected him, and then he stopped. She explained that Resident #1 roamed the unit all day and required supervision from staff.

On 1/4/24 at 12:12 PM, an interview with CNA #3 confirmed that on 12/21/23, both LPN #1 and herself were requested to Resident #2's room by RN #1, and they observed Resident #2 trying to touch RN #1 with his exposed penis. They all re-directed Resident #2, and he stopped. She explained that Resident #1 continuously ambulated through the locked unit and would go into other resident rooms.

On 1/4/24 at 12:30 PM, an interview with LPN #1 revealed that on 12/21/23 she heard RN #1 calling for assistance in Resident #2's room. Resident #2 was exposing himself and masturbating in front of all three staff that were present, and they all re-directed him. Following the incident, the physician, and Director of Nurses (DON) were notified and the facility received new medication orders for Resident #2.

During an interview on 1/4/23 at 2:00 PM, the DON confirmed that on 12/21/23, when Resident #2 was having his hypersexual activities, the facility should have put more interventions in place to protect the residents and provided increased supervision to all residents in the memory care unit.

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Resident #1

A record review of the "Face Sheet" revealed the facility admitted Resident #1 on 8/24/23 with diagnoses that included Alzheimer's disease.

A record review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/30/23, revealed Resident #1 required a staff interview to assess cognition, and she was rarely/never understood.

A record review of the "Emergency Department Encounter", dated 12/22/23, revealed, " ...Patient was apparently found in bed naked at her nursing home with another individual. The husband is unsure as to what happened ...Patient has advanced Alzheimer's and cannot consent ..."

Resident #2

A record review of the "Face Sheet" revealed the facility admitted Resident #2 on 12/20/23 with diagnoses that included Psychosis and Schizophrenia.

A record review of the "Progress Notes" for Resident #2, signed by the Medical Director on 1/3/24, revealed, " ...Since coming into the facility he has been noted to have hypersexual behavior which includes masturbation and fondling of his genitalia. Per pharmacist recommendations, we initiated Geodon 10 mg ...Provera 10 mg ...on 12/21/23 ..."

A record review of Resident #2's, "Departmental Notes," revealed on 12/21/23 at 11:35 AM, " ... resident pulled his penis out and tried to touch the nurse and staff ..." Signed by: LPN #1.

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A record review of Resident #2 "Departmental Notes" revealed on 12/22/23 at 10:21 AM, " ...Wandering resident entered the resident's room, CNA summoned RN to the room, lying on top of other resident unclothed; nurse and CNA separated the residents, one on one initiated with the resident. Resident was seen masturbating by staff earlier this shift, while giving resident his medication, resident reached for nurse's private area ..." Signed by: ADON #2.

The facility submitted the following Corrective Action Plan on 1/4/24:

Based on the facility's implementation of corrective actions on 12/22/23, the State Agency (SA) determined the deficiency to be Past Non-Compliance (PNC) and the deficiency was corrected on 12/23/23, before the SA's entrance on 1/2/24.

On 12/22/23, at 9:22 AM, resident #1 entered resident #2's room, where both residents were found in the same bed. Resident #1 was lying on bed with pants partially pulled down. Resident#2 over her with pants on, zipper of jeans unzipped.

On 12/22/23 Administrator was notified of the incident on the memory care unit. On 1/3/24 at 5:10 PM the facility was placed in Immediate Jeopardy for "F600, The facility failed to monitor and supervise Resident #2 with known inappropriate sexual behaviors to ensure other residents were free from abuse."

On 12/22/23 at 9:29 AM, Resident #1 and Resident #2 were immediately separated and assessed for injury by staff nurse and Director of

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Nursing on 12/22/2023. Director of Nurses assessed for psycho-social and emotional concerns with no adverse outcomes.

On 12/22/23 at 9:29 AM, Resident #2 placed one-on-one immediately until placement at behavioral health unit on 12/22/2023.

On 12/22/23, at 10:30 AM (DON) notified Medical Director and Resident Representatives notified.

On 12/22/23 at 10:00 AM (DON) initiated 100% body audits on all residents residing on the memory care unit to which no adverse findings were identified.

On 12/22/23 (DON) notified the state dept of health, and attorney general's office, and police dept by 12/23/23.

On 12/22/23, at 12:00 AM the (DON) initiated in-service on all staff regarding abuse prevention.

On 12/22/23, the (DON) and Assessment nurse initiated interviewing residents residing on the memory care unit on 12/22/23 where no residents indicated any abuse or neglect concerns.

On 12/22/23 at 12:30 PM, the Emergency Quality Assurance (QA) Committee meeting which includes Administrator, Medical Director, Director of Nurses/Infection Preventionist, Admission Nurse, Assistant Director of Nurses 1, Consultant Nurse 1, and Assistant Administrator was held 12/22/2023 to discuss interventions, abuse prevention policy and procedures including 12/22/23 incident. Any identified as requiring increased supervision and monitoring and interventions can include notify psych nurse

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practitioner, notifying family, offering alternative stimulation including diet, activity, and social and environmental interventions.

On 12/22/23, at 12:00 PM care plan reviews were initiated on all residents residing on the memory care unit by Minimum Data Set Nurse and those identified updated immediately.

The facility alleges all corrective actions were completed on 12/22/23 and Immediate Jeopardy removed on 12/23/23.

The SA validated the facility's corrective actions on 1/5/24:

On 1/5/24, the SA validated through interviews and record reviews, Resident #1 and Resident #2 were immediately separated and assessed for injury by staff nurse and Director of Nursing on 12/22/2023. Director of Nurses assessed for psycho-social and emotional concerns with no adverse outcomes.

On 1/5/24, the SA validated through interviews and record reviews; on 12/22/23 at 9:29 AM, Resident #2 was placed one-on-one immediately until a placement at the behavioral health unit on 12/22/2023.

On 1/5/24, the SA was validated through interviews and record reviews; on 12/22/23, at 10:30 AM (DON), the Medical Director and Resident Representatives were notified.

On 1/5/24, the SA validated through interviews and record reviews; on 12/22/23 at 10:00 AM (DON), initiated 100% body audits on all residents residing in the memory care unit, to which no

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adverse findings were identified.

On 1/5/24, the SA validated through interviews and record reviews, on 12/22/23 (DON) notified the state dept of health, and attorney general's office, and police dept by 12/23/23.

On 1/5/24, the SA validated through interviews and record reviews on 12/22/23, at 12:00 PM the (DON) initiated in-service on all staff regarding abuse prevention.

On 1/5/24, the SA validated through interviews and record reviews , on 12/22/23, the (DON) and Assessment nurse initiated interviewing residents residing on the memory care unit on 12/22/23 where no residents indicated any abuse or neglect concerns.

On 1/5/24, the SA validated through interviews and record reviews, on 12/22/23 at 12:30 PM, the Emergency Quality Assurance (QA) Committee meeting which includes Administrator, Medical Director, Director of Nurses/Infection Preventionist, Admission Nurse, Assistant Director of Nurses 1, Consultant Nurse 1, and Assistant Administrator was held 12/22/2023 to discuss interventions, abuse prevention policy and procedures including 12/22/23 incident. Any identified as requiring increased supervision and monitoring and interventions can include notify psych nurse practitioner, notifying family, offering alternative stimulation including diet, activity, and social and environmental interventions.

On 1/5/24, the SA validated through interviews and record reviews, on 12/22/23, at 12:00 PM care plan reviews were initiated on all residents residing on the memory care unit by Minimum

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F 600	Continued From page 12 Data Set Nurse and those identified updated immediately.	F 600		