STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255269	A. BUILDING _____ B. WING _____	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	**1301 BELK BOULEVARD OXFORD, MS 38655**

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F 000	INITIAL COMMENTS	F 000		

**Amended 2567 to correct the exit date of the survey to 4/29/21 to include the extended survey to obtain additional documentation and interviews.

The State Agency (SA) conducted an annual recertification survey along with complaint investigations MS #17603, MS #17393, MS #17028, MS #17167, MS #16746, and MS #16626 from 4/5/20 to 4/9/20. The SA re-entered the facility on 4/29/21 for an extened survey to obtain additional documentation and interviews. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA substantiated MS #16626 for failure to assess and failure to investigate, prevent, and correct alleged violation. The SA cited F609 and F610. The SA did not substantiate MS #16746 for Quality of Care and Infection Control, MS #17028 for staffing and Infection Control, MS #17167 for Abuse, MS #17393 for Quality of Care, Rehabilitation, and Accidents, and MS #17603 for Quality of Care, with no citations related to these complaints.

The SA indentified an Immediate Jeopardy (IJ) that began on 4/6/20, when the facility failed to use wipes appropriate for disinfecting a multi use bedside fingerstick glucometer for Resident #15, Resident #27, and Resident #122. The use of 75% alcohol wipes, instead of the manufacturer recommended disinfectant wipes, was likely to cause serious harm, injury, or death by causing the transmission of blood-borne pathogens to any resident receiving bedside fingerstick blood glucose testing.

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

Electronically Signed | 05/12/2021

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F 000	Continued From page 1 The facility's failure to ensure the multi resident use glucometer was cleaned and disinfected, prior to use and between residents, placed Residents #15, #27, and #122 and the other 32 residents who required the use of a glucometer to check blood sugar, in a situation that was likely to cause serious injury, harm, impairment, or death. The SA notified the Administrator on 4/7/21, at 9:20AM of the IJ and provided the IJ Template to the Administrator. . The Immediate Jeopardy existed at 42 CFR(s): 483.80 (a)(1)(2)(4)(e)(f)-Infection Prevention and Control (F880). The facility submitted an acceptable Removal Plan on 4/8/21, in which the facility alleged all corrective actions were completed by 4/8/21 and the IJ was removed on 4/9/21. The SA vaildated the Removal Plan on 4/9/21 and determined the IJ was removed 4/9/21, prior to exit, therefore the scope and severity for 42 CFR 483.80 was lowered from a "K" to a level "E", while the facilty developed a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The facility also cited deficiencies at F576, F677, F684, F760, F773, and F880. The facility held a license for 180 beds, with a census of 126 at the time of the survey.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		5/27/21

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F 609	Continued From page 2 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interview and facility policy review, the facility failed to report an allegation of physical abuse timely for one (1) of 38 residents screened for abuse. Resident #21 Findings Include:	F 609	-Immediately upon notification by former Social Worker of allegation of abuse, all staff on the unit of Resident #21 were in-serviced on August 13, 2020 on the proper treatment of residents by the Unit Manager. Upon notification of this allegation of abuse, Registered Nurse Risk Manager performed an assessment of Resident #21 on August 21, 2020 for	

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F 609	Continued From page 3 Review of the facility's policy, dated 11-28-2017, titled "Requirements For Reporting Abuse of Residents and Covered Individuals", revealed, Policy: Advanced Healthcare Management (AHM) facilities shall ensure adherence to all Centers for Medicare and Medicaid Services (CMS) and State policies and procedures for reporting incidents and complaints. AHM shall ensure that all covered individuals are aware of their responsibilities for reporting suspected abuse under section 1150 B of the Affordable Care Act (ACT). Procedure: Each covered individual shall be made aware of his/her reporting obligations... Abuse, Neglect, and Exploitation: Substantiated, as well as suspected abuse, neglect, and exploitation will be reported: By phone within 24 hours... In writing within 72 hours. Abuse, neglect and exploitation shall be reported to: State Department of Health Licensure Division, and the State Attorney General's Office." Resident #21 Review of Resident #21's Face Sheet revealed she was admitted to the facility on 07-14-2020 with diagnoses of Atrial Fibrilation (A-fib), Diabetes Mellitus , Hyperlipidemia, Dementia without Behaviors, Depression, and Cardiomegaly. Review of Resident #21's most recent Minimum Data Set (MDS) dated for 01-06-2021, revealed she had a Brief Interview of Mental States (BIMS) score of 9, required extensive assistance of one person for her activities of daily living (ADLs), had a Foley catheter in place and was occasionally incontinent of bowel.	F 609	signs and evidence of injury or bruising. The Social Worker and the Administrator that did not report in a timely manner are no longer employed by this Facility. The Risk Manager and Social Workers have been in-serviced on May 13, 2021 by current Administrator of the importance of reporting and investigating all allegations of abuse in a timely manner and in accordance with state and federal regulations. -The Facility has determined that all residents have the potential to be affected. -RN Staff Educator initiated an in-service on May 17, 2021 with all staff on the policy and procedure of compliance with reporting allegations of Abuse/Neglect/Exploitation. All incidents of Abuse and/or neglect will be reviewed in the morning standup meeting, this will become part of the daily standup meeting beginning May 20, 2021. -On May 21, 2021, the Quality Assurance Nurses initiated audits on five residents weekly for two months. These residents will be interviewed to ensure that any concerns voiced are identified, promptly investigated, and reported in a timely manner. Findings for this audit as well as all reports of abuse and/or neglect will be reviewed to ensure reporting guidelines are followed at the Quality Assurance Committee beginning May 27, 2021 and will continue monthly until such time consistent substantial compliance has	

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F 609	Continued From page 4	F 609		

Review of the "Grievance Investigation" dated 08-13-2020, revealed, "Resident reported to therapy on two different days with two different therapists that she was being treated rough by Certified Nurse Aide (CNA). On 08-10-2020 at 6:44 AM, she reported that the aide was rough with her. When asked if she was hurt, resident shut down stating she did not want to get anyone in trouble. On 08-12-2020, resident stated that she needed to go to the restroom and the CNA did not make it in time. Resident stated CNA was very mad because she had an accident. Resident stated CNA was very rough with her, pulling her arm and hit her. Resident was unable to provide the CNA's name. Date: 08-13-2020 at 9:48 AM. Reported to Therapy by Resident."

Review of an additional "Grievance Investigation" dated 08-20-2020, revealed, "Details of Investigation: Grievance provided to nurse on unit. Corrective Action taken: In-service provided to staff. Resident denied no other needs or concerns at this time. Date Corrective Action Completed: 08-13-2020. Notification of Results: Resident was notified of results and was in agreement. Denied having any other needs or concerns. Name of Investigator: (Formal Name) SSD... Completed on 08-20-2020 at 3:16 PM."

Review of the facility's "Statement on Accident/Incident", dated 08-21-2020 revealed, "This nurse went into residents room this morning to follow up on an incident that was just reported to me. I went into room and talked with resident to see if everything was going good and if she ever, felt like she was afraid of someone hurting her or if they had hurt her in the past. Resident is confused and pleasant. Resident stated to me that no one had hurt her and she felt safe here. I

been met.

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F 609	Continued From page 5	F 609		

assured her that if something happened that she could tell me and not worry about getting anyone in trouble. This nurse talked resident that we would be in and out checking on her and that if she needed anything to let us know." The form was signed with (formal name) Risk Management Nurse on 08-21-2020.

Review of the facility's document titled "MFCU (Mississippi Federal Crime Unit) Crimes Web Submission" dated Friday, August 21, 2020 at 5:00 PM revealed, "New Record Received at AGO... Incident Narrative: Resident reported she was being treated rough by a CNA when she had an accident voiding on herself with CNA did not get her to the restroom in time. Said CNA pulled her arm and hit her. Staff were unable to substantiate as resident was unable to provide name of CNA."

Review of the facility's "Fax Transmittal Sheet" dated 08-24-2020 at 3:45 PM, revealed an investigation was submitted to the "MDOH" (Mississippi Department of Health) by the Risk Management Nurse.

Review of an addition fax transmission sheet, dated 08-28-2020 at 10:40 AM, revealed an "Investigation of Possible Abuse on (formal name)" was transmitted to the Mississippi State Department of Health.

Review of the facility's "Investigation of Possible Abuse on (Formal Name)" dated 08-21-2020, revealed, "... " On 08-13-20, therapist was informed by resident that CNA was treating her rough on two different occassions. Resident stated that the aide was rough with her one morning and when therapist asked if she was

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F 609	Continued From page 6	F 609		

hurt, resident shut down and stated that she didn't want to get anyone in trouble. Then two days later she stated she needed to go to the restroom and the CNA did not make it in time and that the CNA was mad at her for having an accident and was rough with her, pulling her arm and hit her. Resident unable to provide name or a description of what she looked like. Nursing staff immediately assessed resident for any bruising or injuries when therapist reported this to staff. Nursing staff also started an in-service with staff about treating residents with respect and treat them as if they are our family as well as answering all lights as soon as possible and putting light back into reach of resident. On 08-21-20, administration was made aware of the incidents and did an investigation. (Formal Name) Risk Management Nurse went to resident's room to speak with her about the incidents and to see what happened...Upon record review, staff interview and resident interview, no abuse or neglect is suspected or substantiated."

On 04-07-2021 at 3:38 PM, during an interview with the Speech Language Therapist (SLT), and head of the therapy department, she stated, she vaguely remembers the incident. She stated the therapy department was supposed to report to Social Services and then they take it from there. "For some reason they told nursing instead". They did not report it to the administrator after it happened, they thought nursing would do it. When asked by the SA if they had followed the facility's policy for reporting alleged physical abuse, she stated, "no, for some reason, it didn't get reported to the administrator like it should have." When asked by the SA why the allegation was not reported the first time it was made on 08-10-2020, instead of waiting until the second

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F 609	Continued From page 7	F 609		

report on 08-13-2020 she stated, "I don't know, I guess things must have been crazy that day, and it got missed."

During an interview with Resident #21, on 04-08-2021 at 4:11 PM, she indicated things were going well and she was doing fine. When asked by the SA if staff were treating her well, she stated, "yeah, it ' s all good". When asked by the SA if anyone had been rough or mean to her, she said, "not that I can think of, for a long time." The SA asked if someone had been mean to her a long time ago, she stated, "I can ' t remember, it may have been someone else you are thinking of." She continued on to state that she was happy at the facility, and felt safe there. She did not appear to have any recollection of the incident she reported eight (8) months prior.

On 04-09-2021 at 9:00 AM, during a dual interview with the Administrator and Risk Management Nurse, the SA reviewed the contents of the investigation folder with them both. The original allegation of abuse was on 08-10-2020, according to the "Investigation of Possible Abuse on (Formal Name)" dated 08-21-2020. No investigation dated 08-10-2020 was present. The Administrator stated, no investigation was done on that day because therapy did not let anyone know the allegation was made. The Administrator also stated "the allegation made on 08-13-2020 was addressed as a grievance, and not an allegation of abuse, so it was not reported to administration as it should have been. When both allegations were not reported to the Administrator, they were then not reported verbally to the Department of Health or the AG (Attorney General) within 24 hours of the allegation. Additionally, a week later, when the

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F 609	Continued From page 8	F 609		

SSD slid the grievance form under the administrator's door, I was just here as a consultant, and neither of us, looked at what it was, as we were discussing other business at the time. After I had left the facility that day, he called me to tell me it was an allegation of abuse, written up on a grievance form by the SSD. When he read it to me, I told him we needed to report it immediately to the State and we started the formal investigation process..." The Risk Management Nurse indicated that was a correct statement. She was notified by the administrator and went down to interview Resident #3 about the details of her allegation. Both the Administrator and Risk Management Nurse agreed, when the allegation of physical abuse was first made on 08-10-2020 at 6:44 AM, the therapy department should have notified the Administrator and did not. When the resident made the second allegation of physical abuse on 08-13-2020, the therapy department should have reported it to the Administrator and did not, and RN#3, should have reported it to the Administrator and did not. A week later, when the SSD learned of the allegation of physical abuse, on 08-20-2020 at 3:16 PM, she should have immediately reported it to the Administrator instead of just sliding a grievance form under the door, and she did not. On 08-21-2020 at 5:00 PM, more than twenty-four hours after the SSD received the allegation of abuse, the Administrator reported the allegation to the AG's office, however, a report was not called in or faxed to the MSDH until 08-24-2020 at 3:45 PM. The finalized investigation was not faxed to the MSDH until 08-28-2020 at 10:40 AM, which was 18 days following the initial allegation of abuse by Resident #3.

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F 609	Continued From page 9 On 04-07-2021 the MSDH notified the SA there were no recorded phone reports called in from the facility during the month of August 2020, and they received the first faxed notification of the allegation of abuse on 08-25-2020.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interview and facility policy review, the facility failed to thoroughly investigate an allegation of physical abuse for one (1) of 38 residents reviewed for abuse. Resident #21. Findings Include: Review of the facility policy dated 11-28-2017, titled, "Abuse an Neglect: Recognizing and	F 610	-Immediately upon notification by former Social Worker of allegation of abuse, the staff working on the unit of Resident #21 were in-serviced on the proper treatment of residents by the Unit Manager on August 13, 2020. Upon notification of this allegation of abuse, Registered Nurse Risk Manager performed an assessment of Resident #21 on August 21, 2020 for signs and evidence of injury or bruising	5/27/21

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F 610	Continued From page 10	F 610		

Reporting" revealed, "Policy: All allegations, observations or suspected cases of abuse, neglect, or exploitation that occur in the facility shall be reported to the Administrator, and investigated by the facility. It is the policy of this facility that the following steps will be followed in reporting abuse, neglect, or exploitation: Investigation, Reporting, and Action. Procedure: Investigate the alleged incident in order to accurately relay details... Any report of abuse, neglect or exploitation will be investigated by the Administrator, Director of Nursing, Social Services, Q. A. (Quality Assurance) Committee, and Facility Security. Investigation shall include but is not limited to: Questioning the resident involved when appropriate, questioning all staff members working in that area at the time of the incident, who might have knowledge of the reported complaint, written statements by all staff questioned, signed by the staff member, the resident's statement - may be written by a staff member, by family questioned, by visitors questioned. Action shall be taken based on the investigation..."

Resident #21

Review of Resident #21's Face Sheet revealed she was admitted to the facility on 07-14-2020 with diagnoses of A-fib, Diabetes Milletus , Hyperlipidemia, Dementia with Behaviors, Depression, Metabolic Encephalopathy, and Cardiomegaly.

Review of Resident #21's most recent Minimum Data Set (MDS) dated for 01-06-2021, revealed she had a Brief Interview of Mental States (BIMS) score of 9, required extensive assistance of one person for her activities of daily living (ADL's),

with no injuries or bruising noted. The Social Worker and Administrator that were responsible for not reporting the incident in a timely manner are no longer employed by this Facility. The Risk Manager and current Social Workers have been in-serviced by the current Administrator on compliance with reporting allegations of Abuse/Neglect/Exploitation on May 13, 2021.

-The facility has determined that all residents have the potential to be affected by this deficient practice.

-An in-service was initiated by the Registered Nurse Staff Educator starting on May 14, 2021 with all staff addressing circumstances that require reporting for timely investigations and their responsibilities related to investigations. All incidents of Abuse and/or neglect will be reviewed in the morning standup meeting, this will become part of the daily standup meeting beginning May 20, 2021. An in-service was also conducted by Administrator with the Risk Manager, Social Workers and Therapy Staff on Compliance with Reporting Allegations of Abuse/Neglect/Exploitation on May 13, 2021.

-On May 21,2021, the Quality Assurance Nurses began audits on five residents weekly for one month, every other week for one month and monthly for one month. Findings from these audits as well as any report of abuse will be taken to the Quality

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F 610	Continued From page 11 had a Foley catheter in place and was occasionally incontinent of bowel. Review of the "Grievance Investigation" dated 08-13-2020, revealed, "Resident reported to therapy on two different days with two different therapists that she was being treated rough by Certified Nurse Aide (CNA). On 08-10-2020 at 6:44 AM, she reported that the aide was rough with her. When asked if she was hurt, resident shut down stating she did not want to get anyone in trouble. On 08-12-2020, Resident stated that she needed to go to the restroom and the CNA did not make it in time. Resident stated CNA was very mad because she had an accident. Resident stated CNA was very rough with her, pulling her arm and hit her. Resident was unable to provide the CNA's name. Date: 08-13-2020 at 9:48 AM. Reported to Therapy by Resident." The corrective action taken was an in-service with staff on 08-13-2020 by RN #3. Review of the facility's "In-service Attendance Record" dated 08-13-2020, revealed, "Program Brief Description: We need to treat our residents with respect and treat them as if they are our family. Answer call light A.S.A.P. (As soon as possible) and keep light within reach." The in-service was presented by RN#3. There were 7 staff members on the in-service, six (6) were listed as CNA's and one signature had no title. Review of an additional "Grievance Investigation" dated 08-20-2020, revealed, "Resident reported to therapy on two different days with two different therapists that she was being treated rough by Certified Nurse Aide (CNA). On 08-10-2020 at 6:44 AM, she reported that the aide was rough with her. When asked if she was hurt, resident	F 610	Assurance Committee for review and recommendations beginning on May 27, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 610	Continued From page 12	F 610		

shut down stating she did not want to get anyone in trouble. On 08-12-2020, Resident stated that she needed to go to the restroom and the CNA did not make it in time. Resident stated CNA was very mad because she had an accident. Resident stated CNA was very rough with her, pulling her arm and hit her. Resident was unable to provide the CNA's name. Dated 08-13-2020 at 9:48 AM, Reported to: Therapy by the resident... Details of Investigation: Grievance provided to nurse on unit. Corrective Action taken: In-service provided to staff. Resident denied no other needs or concerns at this time. Date Corrective Action Completed: 08-13-2020. Notification of Results: Resident was notified of results and was in agreement. Denied having any other needs or concerns. Name of Investigator: (Formal Name) SSD... Completed on 08-20-2020 at 3:16 PM."

Review of the facility's "Statement on Accident/Incident", dated 08-21-2020 revealed, "This nurse went into residents room this morning to follow up on an incident that was just reported to me. I went into room and talked with resident to see if everything was going good and if she ever, felt like she was afraid of someone hurting her or if they had hurt her in the past. Resident is confused and pleasant. Resident stated to me that no one had hurt her and she felt safe here. I assured her that if something happened that she could tell me and not worry about getting anyone in trouble. This nurse talked resident that we would be in and out checking on her and that if she needed anything to let us know." The form was signed with (formal name) Risk Management Nurse on 08-21-2020.

Review of the facility's "Investigation of Possible Abuse on (Formal Name)" dated 08-21-2020,

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F 610	Continued From page 13	F 610		

revealed, "... On 08-13-20, therapist was informed by resident that CNA was treating her rough on two different occasions. Resident stated that the aide was rough with her one morning and when therapist asked if she was hurt, resident shut down and stated that she didn't want to get anyone in trouble. Then two days later she stated she needed to go to the restroom and the CNA did not make it in time and that the CNA was mad at her for having an accident and was rough with her, pulling her arm and hit her. Resident unable to provide name or a description of what she looked like. Nursing staff immediately assessed resident for any bruising or injuries when therapist reported this to staff. Nursing staff also started an in-service with staff about treating residents with respect and treat them as if they are our family as well as answering all lights as soon as possible and putting light back into reach of resident. On 08-21-20, administration was made aware of the incidents and did an investigation. (Formal Name) Risk Management Nurse went to resident's room to speak with her about the incidents and to see what happened. Resident is noted to have confusion with a BIMS of 8. (Formal Name) introduced herself to resident and asked how she was doing. Resident was then asked if she ever felt threatened or unsafe in her current environment and if anyone had ever harmed her. Resident stated no and that everything was good. (Formal Name) then assured resident that if something happened, then we needed to know about it so we could make sure it didn't happen again. Resident again stated that nothing happened, and she was not afraid of anyone. (Formal name) then informed resident that a therapist had informed staff on two different times where she stated a CNA had been rough with her and that she didn't want to get anyone in trouble.

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F 610	Continued From page 14	F 610		

(Formal Name) assured her if someone had been rough then they needed to be dealt with appropriately. (Resident formal Name) again stated that no one had been rough with her or hurt her and she was fine. (Formal Name) then assessed resident see any bruising or injuries at this time and none was noted. (Formal name) then informed resident that she would be in and out everyday checking on her and to please inform her or anyone else if she ever felt threatened or needed anything. Resident stated she would. Upon record review, staff interview and resident interview, no abuse or neglect is suspected or substantiated."

Review of Resident #21's nurses notes between the dates of 08-10-2020, when the first abuse allegation was made to a therapist, and 08-22-2020, the day after the allegation of abuse was made known to administration, showed no assessment for injury of Resident #21, on either 08-13-2020 by RN#3, or on 08-21-2020 by the Risk Management Nurse, as stated in the investigation.

On 04-07-2021 at 3:38 PM, during an interview with the Speech Language Therapist (SLT), and head of the therapy department, she stated, she stated she vaguely remembers the incident, and the therapy department was supposed to report to Social Services and then they take it from there. "For some reason they told nursing instead", and she did an in-service with the staff on the floor at the time. They did not report it to the administrator after it happened, they thought nursing would do it. When asked by the SA if they had followed the facility's policy for reporting alleged physical abuse, she stated, "no, for some reason, it didn't get reported to the administrator

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F 610	Continued From page 15	F 610		

like it should have." When asked by the SA why the allegation was not reported the first time it was made on 08-10-2020, instead of waiting until the second report on 08-13-2020 she stated, "I don't know, I guess things must have been crazy that day, and it got missed."

On 04-07-2020 at 3:45 PM, during an interview with the Risk Management Nurse, she stated, "Everything we have done for the investigation, including interviews, should be in the file I gave you. We keep all the information together in a folder."

During an interview with Resident #21, on 04-08-2021 at 4:11 PM, she indicated things were going well and she was doing fine. When asked by the SA if staff were treating her well, she stated, "yeah, it ' s all good". When asked by the SA if anyone had been rough or mean to her, she said, "not that I can think of, for a long time." The SA asked if someone had been mean to her a long time ago, she stated, "I can ' t remember, it may have been someone else you are thinking of." She continued on to state that she was happy at the facility, and felt safe there. She did not appear to have any recollection of the incident she reported eight (8) months prior.

On 04-09-2021 at 9:00 AM, during a dual interview with the Administrator and Risk Management Nurse, the SA reviewed the contents of the investigation folder with them both. We discussed the original allegation of abuse was on 08-10-2020, according to the "Investigation of Possible Abuse on (Formal Name)" dated 08-21-2020. No investigation dated 08-10-2020 was present in the folder. The Administrator stated, no investigation was done

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F 610	Continued From page 16	F 610		

on that day because therapy did not let anyone know the allegation was made. The Administrator also stated "the allegation made on 08-13-2020 was addressed as a grievance, and not an allegation of abuse, so it was not reported to administration as it should have been. A week later, when the SSD slid a piece of paper under the administrator's door, I was just here as a consultant, and picked up the piece of paper and he placed in on his desk. Neither of us, looked at what it was, as we were discussing other business at the time. After I had left the facility that day, he called me to tell me it was an allegation of abuse, written up on a grievance form by the SSD. When he read it to me, I told him we needed to report it immediately to the State and we started the formal investigation process. I believe the lack of reporting of this issue is the reason she lost her job, and is no longer working with the company." The Risk Management Nurse indicated that was a correct statement. She stated, "I usually do a better job with the investigations, and acknowledged there were no statements given by the therapists, there should have been two assessments for possible injury recorded, that were not done." Both acknowledged more than just Resident #21 should have been interviewed, since she couldn't remember a name or description after a weeks time, and additional residents with BIMS above 12 that lived in the same area of the facility should have been interviewed to see if anyone had been rough with them. Staff working at the time of the allegation should have been interviewed and statements given from any of the therapists who heard the allegations made.

The facility provided proof of abuse in-servicing for all the therapists currently working in the

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F 610	Continued From page 17	F 610		

therapy department, by presenting certificates of completion, all dated between the dates of 08-12-2020 through 08-15-2020, making them aware of the proper protocol for reporting allegations of abuse, and who to report them to.

The facility provided proof of abuse in-servicing upon hire on 10-22-2018, for the SSD that was terminated and unavailable for interview.

RN#3 was no longer employed by the facility, and was not available for interview. The facility provided proof via signature of her initial training on abuse reporting during her orientation on 08-28-2017, and two recent nursing in-services, covering multiple topics, to include abuse reporting, on 07-23-2020, an again on 08-10-2020, making her aware of the proper protocol for reporting allegations of abuse, and who to report them to.