STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255114	A. BUILDING _____ B. WING _____	C 09/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND NURSING AND REHABILITATION CENTER	4036 HIGHWAY 8 EAST CLEVELAND, MS 38732

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

The State Agency (SA) conducted a Complaint Investigation (CI) MS #17054 from 09/09/2020 through 09/14/2020. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA substantiated CI MS #17054 for the sexual abuse of a resident. The SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited regulatory deficiencies related to CI MS #17054 at F600, F609, F656, and F742.

The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 09/11/2020, which began on 08/28/2020, regarding the sexual abuse of a resident.

On Friday August 28, 2020 at 12:35 AM, a staff member was rounding and walked past a resident's room and witnessed Resident #1 on top of Resident #2 in her bed, without her consent, moving his body in a sexual manner. After removal of Resident #1 from on top of Resident #2, staff observed Resident #2's adult brief pulled to the side, and blood on the brief. An assessment of Resident #2 at the hospital verified injuries consistent with sexual assault.

The facility failed to develop and implement the care plan of Resident #1 following an instance of sexual inappropriateness documented by his Psychiatric provider in June of 2019, to include chasing staff around the facility being sexually inappropriate, impulsivity, and difficulty being redirected with intermittent outbursts requiring Ativan IM (intramuscular) due to his level of

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/11/2020

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F 000	Continued From page 1	F 000		

aggression and potential harm to self and others. The facility failed to provide close supervision and appropriate behavioral interventions for Resident #1, who was also known to wander in and out of other residents' rooms, and who had multiple recent inpatient stays at a local geri-psych unit for physical and verbal aggression to other residents. The facility also failed to report the incident timely, within two (2) hours of the sexual abuse with injury.

The facility's failure to provide supervision and to devise appropriate monitoring and surveillance for all residents to prevent abuse was likely to cause harm, injury, impairment, or death. The noncompliance with protection, behavioral interventions, along with appropriate monitoring and surveillance to prevent abuse of all residents, resulted in a cognitively impaired resident, Resident #2, being non-consensually, sexually abused by Resident #1.

On 09/11/2020 at 2:05 PM, the SA notified the facility's Administrator, Director of Nursing (DON), and Nurse Consultant of the IJ and SQC.

IJ and SQC existed at:

42 CFR(s): 483.12(a)(1) - Freedom from Abuse, Neglect, and Exploitation, (F600)

42 CFR(s): 483.12(c)(4) - Reporting of Alleged Violations of Abuse, Neglect, and Exploitation, (F609)

42 CFR(s):483.40(b)(1) - Treatment/Services for Mental/Psychosocial Concerns, (F742)

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F 000	Continued From page 2 IJ existed at: 42 CFR(s): 483.21(b) - Develop/Implement Comprehensive Care Plans, (F656) The facility submitted an acceptable Removal Plan on 09/12/2020, in which the facility alleged all corrective actions were completed on 09/12/2020 at 3:30 PM. The SA validated the facility's Removal Plan on 09/14/2020, and determined the IJ was removed on 09/14/2020, prior to exit. Therefore, the scope and severity for 42 CFR(s): 483.12(a)(1) - Freedom from Abuse, Neglect, and Exploitation, (F600); 42 CFR(s): 483.12(c)(4) - Reporting of Alleged Violations of Abuse, Neglect, and Exploitation, (F609); 42 CFR(s): 483.21(b) - Develop/Implement Comprehensive Care Plans, (F656) and; 42 CFR(s): 483.40(b)(1) - Treatment/Services for Mental/Psychosocial Concerns, (F742); were lowered from "J" to a scope and severity of a "D", while the facility develops and implements a plan of correction and monitors the effectiveness of the systematic changes to ensure the facility sustains compliance with regulatory requirements. The facility held a license for 118 beds, and had a census of 105, at the time of the complaint survey.	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	F 600		10/27/20

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F 600	Continued From page 3 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 record review, facility policy review, and staff interview, the facility failed to protect Resident #2, a cognitively impaired resident, from non-consensual, sexual abuse by Resident #1, for one (1) of five (5) residents reviewed for abuse, neglect, and exploitation, Resident #2. On Friday, August 28, 2020 at 12:35 AM, a staff member, Nursing Aide (NA) #1, was rounding and walked past a resident's room and witnessed Resident #1 on top of Resident #2 in her bed. NA #1 ran into the room, pulled back the privacy curtain, and witnessed Resident #1 on top of Resident #2, holding her hands above her head with his left hand, and his right hand (which was not visible) holding his penis and attempting to guide it into Resident #1's vagina, all while making sexually mannered movements with his pelvis. Resident #2 was crying and saying, "please stop it, please stop it". NA #1 began to call Resident #1's name and told him to stop, while physically trying to remove him from Resident #2's bed. When she couldn't move him, NA #1 ran to the door and screamed for help. As the nurse, Licensed Practical Nurse (LPN) #1, came up the hallway to Resident #2's room, he saw Resident #1 run out of the room with his	F 600	Please consider this Plan of Correction as Cleveland Nursing and Rehabilitation, LLC credible allegation of compliance. This plan of correction constitutes a written allegation of substantial compliance under Federal Medicare & Medicaid requirements. Submission of this plan of correction is not an admission that a deficiency exist or that the facility agrees they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our residents and are submitted solely as a requirement of the provisions of Federal and State law. 1 Resident #2 was assessed by the Director of Nursing on 8/28/20 with no negative findings prior to Resident #2 being transferred to the emergency room (ER) for evaluation. Resident #2 was assessed on 8/28/20 by the Certified Nurse Practitioner with no negative findings after being transferred back to the facility from the ER. The Social Service Director (SSD) conducted a psychosocial wellbeing	

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F 600	Continued From page 4 pants down, and underwear visible, holding onto the sides of his pants to keep them from falling off. An assessment of Resident #2 was immediately done by LPN #1 with the assistance of NA #1. Resident #2's brief had been torn and pulled to the side, with a small area of blood near the tab of the brief, and another small spot of blood on the front, outside of the brief. There was no outward appearance of injury to her perineal area. A physician's order was obtained to send Resident #2 to the hospital to be assessed, and she was found to have a labial abrasion and skin tears to her perineal area and to her vagina consistent with sexual assault. Resident #1 was immediately placed on 1:1 and was subsequently transferred to a geri-psych unit later that afternoon. A record review revealed that Resident #1 had been involved in multiple incidents of physical and verbal aggression toward other residents and staff in the facility and had been resistant to care since the day of his admission on 03/14/2019. One instance of physical aggression even facilitated a room change to separate him from his former roommate. A psychiatric progress note, dated 06/06/2019, revealed, an in-facility visit due to behavioral aggression. It noted Resident #1 to be socially inappropriate, disruptive to the facility, chasing staff around the facility, being sexually inappropriate and difficult to redirect at times. The note further stated he was having issues with impulsivity and being sexually inappropriate with ongoing behavioral aggression and agitation not remedied by his routine regimen. Intermittent outbursts required Ativan IM (intramuscularly) due to his level of aggression and potential to harm	F 600	evaluation with Resident #2 on 8/28/20. The SSD monitored Resident #2 thereafter for five (5) days a week times one (1) week, then three (3) days a week times one (1) week, then one (1) month later. The SSD findings revealed no negative impact related to Resident #2's psychosocial wellbeing. The nursing staff monitored Resident #2 daily times sixteen (16) days for any adverse findings related to Resident #1. The nursing staff monitored findings revealed no negative impact related to Resident #2's incident on 8/28/20 with Resident #1. Resident #1 was immediately placed on one-to-one monitoring with staff until transferred to a behavioral health unit on 8/28/20. Resident #1 did not return to the facility. 2 All residents have the potential to be affected. 3 On 9/11/20 Cognitive Residents were interviewed by the Executive Director and/or Director of Nursing in regards to abuse/neglect. Results indicated that twenty-five (25)cognitive residents were interviewed with none of the 25 residents reporting any inappropriate sexual behavior. A 100% assessment for signs and symptoms of abuse and neglect on cognitive impaired Residents was completed on 9/12/2020 by the Director of Nursing and/or Unit Manager. Results indicated sixty-six (66) cognitive impaired residents assessed with no negative findings. On 9/11/20 an in-service was	

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F 600	Continued From page 5 self and others. Review of Resident #1's care plans, and Departmental Notes revealed he wanders in and out of other resident's rooms frequently, he can be hard to redirect, becoming agitated and aggressive at times. There was no mention of Resident #1's impulsivity, chasing staff, or sexually inappropriate behaviors in his care plan or Social Services notes. The facility's failure to protect Resident #2 from inappropriate sexual behaviors by Resident #1, resulted in Resident #2 being sexually abused on 08/28/2020 by Resident #1, and placed other residents at risk in a situation that was likely to cause serious injury, harm, impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 09/11/2020, which began on 08/28/2020, when Resident #1 exhibited inappropriate sexual behavior towards Resident #2, who is a cognitively impaired resident. On 08/28/2020, Resident #1 was witnessed on top of Resident #2 in her bed, attempting to engage in non-consensual sexual activity. The facility failed put measures and interventions in place to protect residents from sexual behaviors exhibited by Resident #1. The facility's Administrator, Director of Nursing (DON), and Nurse Consultant were notified of the IJ and SQC on 09/11/2020 at 2:05 PM. The facility submitted a Removal Plan on 09/12/2020 at 3:30 PM, in which the facility alleged all corrective actions to remove the IJ were completed.	F 600	initiated by the Executive Director for all staff on abuse, neglect, supervision, and monitoring residents who exhibit aggressive and to immediately report behaviors to the Charge Nurse to implement interventions, and communicate with the Director of Nursing or Registered Nurse (RN) Supervisor/ Charge Nurse to determine the frequency of increased supervision based upon the assessment of the Resident. All staff was in-serviced prior to working their next shift. On 9/12/20 a facility abuse and neglect procedural policy review was conducted by the Quality Assurance Committee which consisted of but not limited to the ED, DON, SSD, Medical Director, Unit Manager, and the nurse supervisor. The findings revealed no policy changes. 4 Beginning on 9/14/20 the Executive Director initiated rounds five (5) times a week times six (6) weeks to observe for any Resident exhibiting aggressive and inappropriate sexual behaviors. Any concerns were immediately corrected. Beginning 9/21/20 the Director of Nursing initiated monitoring weekly times six (6) weeks of the round observation audits. The Executive Director forwarded the results of the monitoring to the monthly Quality Assurance Committee. The Quality Assurance Committee determines the frequency of audits and monitoring based upon results achieved, in addition to making recommendations, and changes	

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F 600	Continued From page 6 The State Agency (SA) validated the facility's Removal Plan on 09/14/2020 and determined the IJ was removed on 09/12/2020. Therefore, the scope and severity for 42 CFR(s):483.12(a)(1) - Free from Abuse, Neglect, and Exploitation, (F600) was lowered from a "J" to a scope and severity of a "D" level, while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of the facility's "Abuse Prevention Policy", last revised 11/2017, revealed, the facility is committed to protecting the residents from abuse by anyone. Definitions included: Abuse - willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse may be resident-to-resident, staff-to-resident, family-to-resident, or visitor-to-resident. Sexual Abuse - This includes but is not limited to sexual harassment, sexual coercion or sexual assault, or non-consensual sexual contact of any type with a resident. Employees will be trained through orientation and on-going sessions on issues related to abuse prohibition practices such as: appropriate interventions to deal with aggressive and/or catastrophic reaction of residents, and what constitutes abuse. To protect residents, suspected or substantiated cases of resident abuse shall be thoroughly investigated, documented, and reported to the physician, families and/or representatives, and as required by state guidelines. In addition, the facility will follow Section 1150B of the Social Security Act's time limits for reporting a reasonable suspicion of	F 600	as needed.	

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crime (immediately but no later than 2 hours if abuse or serious bodily injury and 24 hours for all others). In addition to reporting to the State Agency, a reasonable suspicion of crime or allegation of abuse is to be reported to at least one law enforcement agency. It is the responsibility of all staff to provide a safe environment for the residents.

The State Agency (SA) was unable to interview Resident #1, as he remained in a geri-psych unit during the survey.

Review of Resident #1's Quarterly Minimum Data Set (MDS), dated 07/30/2020, revealed, he had a Brief Interview for Mental Status (BIMS) score of 5, which indicated severe cognitive impairment. Resident #1 had unclear speech and was sometimes understood in making concrete requests. He was usually able to understand most conversation. Resident #1 had behaviors of psychosis marked. Resident #1 required no assistance with walking in his room, and supervision when walking in the corridors. He had diagnoses of Aphasia, Bipolar Disorder, Schizophrenia, and Vascular Dementia, receiving both antipsychotic and antidepressant medications.

During an observation and interview on 09/09/2020 at 2:45 PM, with Resident #2, she was resting in her bed with her eyes closed. She opened her eyes when her name was spoken and smiled. When asked how she was feeling she responded, "I'm okay baby, I'm doin' okay". When asked if anyone had ever hurt her, if male residents ever came into her room, and if she was ever afraid, she replied the same answer every time, "Oh no baby, I'm fine". Resident #2

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was smiling and friendly.

Review of Resident #2's Admission 5-day Minimum Data Set (MDS), dated 03/23/2020, revealed, she had a BIMS score of one (1), which indicated severe cognitive impairment, making her not interviewable. She had unclear mumbled words, sometimes understood, and sometimes understands what is being said to her. Resident #2 required limited assistance to eat, and extensive to total assistance for the remainder of her activities of daily living (ADL's). She had a diagnosis of Unspecified Dementia Without Behavioral Disturbances and received an antipsychotic medication.

On 09/09/2020 at 12:30 PM, during an interview with Nursing Aide (NA) #1, she stated on the morning of 08/28/2020 at approximately 12:35 AM, she was doing her walking rounds to check on her residents. NA #1 stated she was working with another male aide on the South unit. She revealed she was to check on the female residents, and the male aide was to check on all the male residents during rounds. NA #1 stated as she passed Resident #2's room, lightening struck outside and lit up the room. She stated that she saw a pair of brown pants on top of the bed, with the buttocks up and knew it wasn't Resident #2. NA #1 stated she could hear Resident #2 crying and saying, "Please stop it, please stop it." She stated that she ran into the room and pulled back the privacy curtain to see Resident #1 on top of Resident #2, in her bed. She revealed, Resident #1,with his left hand, he had both of Resident #2's hands pinned above her head, and with his right hand, he appeared to be holding his penis and attempting to place it in Resident #2's vagina. NA #1 stated the whole time, Resident #1

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F 600	Continued From page 9	F 600		

was making a sexual "humping" motion with his pelvis. NA #1 stated she began screaming Resident #1's name and put her hand on his arm trying to remove him off Resident #2, while screaming for him to stop and get off Resident #2. She revealed, Resident #1 was a large man, well over 200 pounds. She stated when Resident #1 wouldn't listen to her and she couldn't remove him from the bed, she ran into the doorway and started screaming for help. She stated LPN #1 heard her and came running toward the room. NA #1 stated as LPN #1 neared the doorway of Resident #2's room, Resident #1 ran out the door past her and jumped in his bed, pulling the blankets up to his chin, and pretended to be snoring. She stated, LPN #1 asked Resident #2 if she was hurt and she said, "Nothing happened, he just tried to have me." NA #1 revealed she assisted LPN #1 with assessing Resident #2, and found her nightgown pulled to the side, and her adult brief torn loose on one side and pulled open and over to the side. She stated there was a spot of blood, about a quarter size near the "tab" of the brief, and another spot of blood that same size on the outside front of the brief. NA #1 stated she assisted LPN #1 in doing a perineal exam, looking at her thighs and vaginal area, and didn't see any blood from the outside. She revealed Resident #2 was sick and had an IV (intravenous) line in to get some fluids for dehydration and a lack of appetite. NA #1 stated they both looked at Resident #2's IV to see if it was bleeding, but it wasn't, and the IV remained intact. She stated Certified Nursing Assistant (CNA) #1 was told to stay with Resident #1 as a 1:1 until management staff could get there. She revealed Resident #2 was sent to the hospital to be checked out, but before she left for the hospital, the Director of Nursing (DON) and the police arrived and

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interviewed Resident #1 and Resident #2.

On 09/09/2020 at 2:10 PM, during an interview with LPN #1, he stated, at around 12:45 AM on 08/28/2020, he was at the nurses' station and heard NA #1 screaming for someone to help her. He stated as he was running down the hall to Resident #2's room, he saw Resident #1 walking quickly out of Resident #2's doorway, past NA #1 and go into his room. LPN #1 revealed Resident #1's pants were down, with his underwear exposed, and he was holding his pants up. He stated NA #1 told him she had seen Resident #1 in the bed on top of Resident #2 trying to stick his penis in her vagina. LPN #1 also stated, NA #1 told him, from her angle, she couldn't see his penis, but it appeared that Resident #1 was trying to hold it with one hand, and he was holding Resident #2's hands/arms down with his other hand. LPN #1 revealed that Resident #2 was very tiny and Resident #1 was a bigger guy. He revealed NA #1 helped him to assess Resident #2. LPN #1 confirmed Resident #2's brief was torn and there was a small spot of blood on the side of it. LPN #1 stated Resident #1 was still crying when he got to the room. He revealed that he asked Resident #2 if she had been hurt, and she said, "Nothing happened, he just tried to have me." LPN #1 stated there was no evidence of injury from the outside of her peri-area or on her thighs. He revealed CNA #1 had been sitting with Resident #1. LPN #1 revealed that he asked Resident #1 why he had been in Resident #2's room, but he wouldn't answer any of his questions. LPN #1 stated he called the DON and told her what NA #1 had seen, and of his assessment. LPN #1 stated within a few minutes, the DON arrived along with the police, and shortly afterwards, the ambulance came to pick up

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Resident #2 to have her checked out. LPN #1 stated the police came in to talk to Resident #1 while he was in there. He stated, they (police) asked Resident #1 if he was in Resident #2's room and if he had hurt her, and Resident #1 replied "yes", but then he refused to answer anymore questions, stating "I ain't saying nothing." LPN #1 revealed, when he left at the end of his shift, Resident #1 still had a 1:1 staff member with him, and Resident #2 had not returned from the hospital.

The State Agency (SA) attempted to reach the CNA #1 several times, but was not able to speak to him for interview.

On 09/09/2020 at 3:00 PM, a joint interview with the Administrator and DON, revealed, the DON stated she had received a call around 1:00 AM on 08/28/2020 from LPN #1 that Resident #1 was found in Resident #2's room, leaned over her bed holding her left hand with his left hand, and he was making sexual movements with his buttocks. The DON revealed she arrived at the facility at the same time as the police. The DON revealed, when the ambulance was notified to come pick up Resident #2, they (ambulance service) notified the police before the facility had an opportunity to. The DON revealed she began getting statements and did an assessment of both residents before the ambulance transferred Resident #2 to the hospital. The DON stated she notified the doctor of her findings from the assessments, and she notified the RPs (Responsible Parties) for both residents. She stated Resident #1 was placed on 1:1 observation until he was transferred to a behavior unit in Memphis, TN later that afternoon. Both the Administrator and DON stated it was unpredictable behavior for Resident #1, and they

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both felt he had not had sex with Resident #2 because his pants appeared up from the back, and NA #1 never saw Resident #1's actual penis or him penetrating Resident #2. An assessment of Resident #2 revealed no blood on her peri-area or any visible injury. They both stated there had never been a sexual problem with Resident #1 prior to this incident, and they felt they had stopped him before he could assault her. The Administrator stated Resident #1 had care plans for being aggressive and had several resident to resident incidents where he slapped them, but nothing ever sexual. The Administrator verified Resident #1 had been sent out in April and December of 2019, and January and June 2020 for physically aggressive altercations with other residents on the South Unit. When the Administrator and DON were asked what interventions were put into place after his physically aggressive behaviors with other residents, the DON stated he was on hourly checks by staff, and the Administrator indicated that was more for Resident #1's elopement risk because he refused to wear a "wander-guard" and was known to walk all over the building, and sometimes in and out of other residents rooms. When the SA asked if either of them had read the Hospital report from the Emergency Room, and the Progress note dated 06/06/2019 that were all in the investigative folder they gave to the State Agency surveyor, neither of them answered. The SA read aloud the hospital report, which stated Resident #2 was non-verbal and exhibited signs and symptoms of abuse, sustained painful groin injuries which included an abrasion to her left inner labia, a tear to her perineal area, and vaginal tears. Her diaper with blood and urine was kept for evidence, and a rape kit was done. When the SA asked them both if during their

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investigation, they discovered what had caused the abrasions to her labia and the skin tears to her perineal area and vagina, the Administrator stated, "he (Resident #1) did have some long fingernails, that could have done it." When asked by the SA if digital penetration was considered sexual abuse according to the facility's policy, she stated, "yes." The SA then read aloud the Progress note written on 06/06/2019 by Resident #1's psychiatric provider which stated the chief complaint to be behavioral aggression. The progress note revealed Resident #1 to be assessed and evaluated as a result of behavioral disturbances, difficulty redirecting, and socially inappropriate behaviors that are disruptive to the facility. He continues to chase staff around the facility and is sexually inappropriate at times and difficult to redirect. Resident #1 was "+ (positive) for impulsivity and sexually inappropriate." Under the "Assessment" portion of the note, it stated, Resident #1's ongoing behavioral aggression and agitation was not remedied by routine regimen and intermittent outbursts required Ativan IM due to the level of aggression and potential to harm self or others. The DON stated that she remembered him chasing staff around, and he even chased the Nurse Practitioner around while she was here, but she didn't remember him being sexually inappropriate. The Administrator then asked the DON to step out of the room because she needed to talk to the SA. Once the DON left the room, the Administrator asked to read the progress note the SA had just read to them. After the SA handed her the note, she folded it in half and placed it under her note book and stated, "You can forget you ever saw that piece of paper for me, right?" The SA stated, that she could not and needed the documentation back from her. The Administrator stood up, slid the folded paper

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back to me and stated, "God damn it, I copied the wrong papers. I screwed up and made a big mistake. Oh God, Oh God, this is horrible, my boss is gonna kill me for giving you the wrong papers. I meant to give you the progress note from October or November, not that one. That's another IJ on my watch. She is liable to send me to the house for good. Oh God, Oh God, this is bad, this is gonna be terrible." She then walked out of the conference room.

On 09/10/2020 at 3:35 PM, during an interview with Nurse Practitioner (NP) #1, she stated, she remembered being at the facility and being told Resident #1 was chasing staff, because he had chased her around the unit as she was making her rounds. She stated she didn't feel threatened by him doing this because he wasn't sexually inappropriate with her and she was not a vulnerable adult. NP #1 stated she couldn't remember the name of the staff member that had talked to her about his sexual behaviors, however, she remembers them needing to use Ativan injections to keep him calm. She stated it had been 15 months ago and she didn't remember all the details, however, in her dealings with Resident #1 since then, he had been pleasant and agreeable during their visits.

On 09/10/2020 at 4:10 PM, during an interview with the Medical Director (MD), he stated, he had been Resident #1's primary medical doctor prior to him being placed in the nursing facility, and during his stay. The MD revealed he had not been made aware of any sexual behaviors until this incident, however, he knew he had a proclivity to being physically aggressive. He stated he was made aware of the incident early in the morning on 08/28/2020, and a NP had come

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to assess Resident #2 after she returned from the hospital to ensure she was doing okay.

Record review of Resident #2's "Departmental Notes", dated 08/28/2020 at 3:13 AM, signed by LPN #1 revealed: At 12:45 AM, a CNA reported that resident (Resident #1) was found standing over resident's bed. Upon assessment resident had diaper unfastened. Separated per CNA. Small amount of blood on diaper. No visible trauma to vaginal area. No pain voiced. Denies any discomfort. Denies anything happened. Responsible Party (RP) #2 notified when RP #1 didn't answer. MD notified. New order to transfer to ER for evaluation. At 2:30 AM officers arrive et question both parties. At 2:50 AM (Name of ambulance) service called, one male and one female attendee assisted resident to stretcher. No signs and symptoms of distress.

Record review of Resident #2's "Departmental Notes", dated 08/28/2020 at 6:57 AM, signed by LPN #2, revealed: Around 6:45 AM resident returned to facility from (Name of Hospital) due to sexual assault.

Record review of Resident #1's "Departmental Notes", dated 08/28/2020 at 3:06 AM, and signed by LPN #1, revealed: At 12:45 AM, resident observed in RM (room) S30W with clothing down with hand on his penis on top of resident (Resident #2) per CNA. Resident questioned per writer and law enforcement times four (4) on what he was doing across hallway. Resident wouldn't answer clearly enough to be understood. RP notified of resident's action. Voiced some understanding. Resident joking and smiling when officers exited building. Denies any pain or discomfort.

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An addendum to this note, dated 08/28/2020 at 3:31 AM, signed by LPN #1, revealed, One on one initiated.

Review of Resident #1's Behavior/Pain Medication Monitoring Summary, dated 07/08/2020, revealed: Current behaviors as easily agitated, refusing/resisting care, mood changes, verbal aggression, and being manipulative. He was noted to still have these behaviors. A follow up was added on 07/30/2020, which revealed a medication change from Seroquel to Klonopin because of behaviors.

Review of Resident #1's Care Plan, with a Problem Onset date of 03/15/2019, revealed, "Problem/Need: I am on BMP (Behavior Management Plan) for easily agitated, manipulative, mood change, verbal/physical aggression, attention seeking, wandering in other rooms, refuse care. Goal and Target Date: Resident will decrease behaviors by next ARD. Approaches: Redirect behaviors as they occur, social visit as needed, approach resident in a calm manner, review medication monthly, observe resident for changes in mood behavior and psychosocial well-being, provide with activities of interest and encourage participation, consult psychiatrist as needed, and SCU as needed. There was no mention of sexually inappropriate behaviors, interventions pertaining to being sexually inappropriate, or monitoring Resident #1's whereabouts due to wandering in other residents' rooms.

Review of Resident #1's care plan, with a Problem Onset date of 03/14/2019, revealed, Problem/Need: Resident is at risk for wandering

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and elopement. Resident refuses to wears a wanderguard bracelet AEB (as evidenced by) several times. Goal & Target date: Resident will have no successful elopement, and resident will not leave facility without staff knowledge. Approaches: Monitor resident whereabouts every hour, redirect wandering and elopement behaviors, and alert staff to resident is wandering behavior.

During an interview, on 09/10/2020 at 10:30 AM, with the Administrator, she stated, Resident #1 was scheduled to come back to the facility today. She revealed that she had called his family and the Geri-psych unit and asked for them to seek alternative placement for him.

During an interview, on 09/11/2020 at 11:15 AM, with the Administrator, she stated that she had spoken with Resident #1's family and they had found another place for him to go and he would not be returning to the facility. The Administrator stated that the family was coming to pick up his belongings that afternoon.

The facility submitted a Removal Plan for the IJ. Review of the Removal Plan revealed the facility took the following actions to remove the IJ:

The ED called an emergency QAPI-QA meeting, on 9/12/20 at 3:15 PM, to discuss IJ's called during a complaint investigation. In attendance at the emergency QAPI-QA meeting was the ED, DON, Registered Nurse (RN), RN Supervisor, and vice president of Tara Cares. Attendance by phone was the Social Service Director (SSD), Medical Director (MD), and Psychiatric Nurse Practitioner. Topics of discussion during the meeting were the aforementioned allegation of

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resident to resident abuse. Policy review was performed on Abuse /Neglect, Behavior management, Care plan development and implementation, monitoring and supervision of wandering residents, notification of incidents to Mississippi State Department of Health with no revisions needed. A protocol was implemented for review of physician progress notes. Topics discussed were additional training and education of staff for abuse, monitoring and supervision of residents, reporting incidents, care plans, and behavior management. Also discussed was the auditing charts for all residents with sexual behavior, care plans, wandering and interviewed all residents and staff for any reports of sexual abuse.

1. To meet the immediate need of Resident #2, staff assessed for any injury at the facility, and was transferred to the hospital to be evaluated by a physician. Resident #2 was provided emotional support post incident by the SSD on 08/28/2020, was added to acute charting starting 08/28/20 indicative of nurses' monitoring and Resident # 2 was assessed by NP on 08/28/20 after returning to the facility with no negative findings.

2. Resident # 1 was immediately placed on 1:1 surveillance by a staff member until he was transported to a Geri-psych. Resident # 1 was then discharged from the facility with his family on 9.10.2020.

3. On 8/28/2020 at 4:20 AM the DON notified Mississippi State Department of Health of the incident. 08/28/20 at 12:50AM the EMS notified the local police department of the incident. Police arrived at facility with EMS and investigated incident. On 09/02/20 at 3:46 PM the ED

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submitted the final investigation to the Attorney General's Office.

4. An in service was initiated on 09/11/2020 at 3:00 PM by the DON for all staff present in the building on abuse and neglect, monitoring and supervision of residents and care plan implementation and development. In service to include reporting changes in behaviors for wandering residents who exhibit aggressive behaviors immediately to the Charge Nurse and initiating interventions. The Charge Nurse will communicate with the DON or RN Supervisor to determine the frequency of increased supervision based on the assessment of the residents. All staff will be in serviced prior to working the next shift. In-service was completed on 61 of 109 staff.

5. On 09/11/2020 at 5:00 PM, an in service was conducted by the Regional Clinical Operations Nurse for the ED and DON to ensure reporting abuse allegations no later than 2 hours to regulatory agencies. The remaining department heads will be in service on next the scheduled shift.

6. On 09/11/2020 at 3:00 PM, the ED completed 100% audit for residents who exhibited wandering to determine any negative behavior that could be potentially harmful to other residents. Results were that 9 of 9 records reviewed and 0 found to wander and exhibit behaviors that were potentially harmful to others.

7. On 9/11/2020, the ED completed interviews with all cognitive residents to identify any reports of sexual inappropriate conduct. Results were 25 of 25 residents interviewed and all responded "No".

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8. On 9/11/2020 at 4:30 PM, the ED and DON completed a 100% chart audit on residents for review of care plans on all residents to identify residents with exhibited sexual behaviors. Results of the audit was 11 of 105 residents were noted with sexual behaviors and none were directed towards other residents. Results were 105 of 105 of charts audited had appropriate interventions in place.

9. On 9/11/2020 at 4:30PM, the ED and DON, audited 100% of active medical records' psych progress to determine if any implementations were warranted. No issues were identified, or implementations warranted of 105 of 105 records reviewed.

The facility alleges that all corrective actions to remove the Immediate Jeopardy identified on 09/11/2020 was completed as of 09/12/2020 at 3:30PM, for removal of the Immediate Jeopardy (IJ) on 9/12/2020.

On 09/14/2020, the SA validated through staff interview, resident interview, record review, and in-service reviews that the facility had implemented the following measures to remove the IJ:

The SA verified through staff interview and QAPI/QA meeting minutes review the meeting occurred and all topics to include the IJ, policy review, in-service education on abuse and neglect, chart audits, care plan revisions, and resident interviews were discussed to be implemented.

1. The SA validated through record review,

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Resident #2 was assessed at the facility, sent to the Emergency Room, has a care plan for emotional support from Social Services, and was assessed upon her return to the facility by the NP.

2. The SA validated through record review and staff interview, Resident #1 was placed on 1:1 until his transport to a Geri-psych unit. He was discharged from the facility on 09/10/2020.

3. The SA validated through record review and staff interview the reporting of the incident to the State Department of Health, EMS and Police Department notification, and a final investigation was sent to the Department of Health on 09/02/2020.

4. The SA validated through in-service sign in review, content review, and staff interview that an in-service was held for staff for all topics aforementioned on 09/11/2020 at 3:00 PM.

5. The SA validated through in-service sign in sheet and content review, as well as staff interview, an in-service was held with administration on timely reporting as of 09/11/2020 at 5:00 PM.

6. The SA validated through record review and staff interview the completion of an audit of care plans for resident who wander and have aggressive behaviors. No issues were found during the audit.

7. The SA validated through resident interviews and staff interviews, all cognitively aware residents were interviewed regarding inappropriate sexual conduct and 25 of 25 stated it had not occurred.

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F 600	Continued From page 22 8. The SA validated through record review and staff interview a 100% chart audit for residents exhibiting sexual behaviors was completed, and none have behaviors directed at other residents. 9. The SA validated through record review and staff interview a 100% chart audit of psychiatric progress notes was completed and none were found with issues that needed addressed, or implementation of new orders. The SA validated on 09/14/2020, that all corrective actions had been taken by the facility to remove the IJ during the survey on 09/12/2020. The IJ was removed on 09/12/2020.	F 600		
F 609 SS=J	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §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	F 609		10/27/20

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F 609	Continued From page 23 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, policy review, and staff interviews, the facility failed to report an incident of sexual abuse within the required two hour timeframe, for one (1) of five (5) residents reviewed, Resident #2. On Friday August 28, 2020 at 12:35 AM, a staff member witnessed Resident #1 on top of Resident #2 in her bed. Resident #1 was on top of Resident #2, holding her hands above her head with his left hand, and his right hand (which was not visible) holding his penis and attempting to guide it into Resident #1's vagina, all while making sexually mannered movements with his pelvis. An assessment of Resident #2 was immediately done. Her brief had been torn and pulled to the side, with a small area of blood near the tab of the brief, and another small spot of blood on the front, outside of the brief. There was no outward appearance of injury to her perineal area. A physician's order was obtained to send Resident #2 to the hospital to be assessed, and she was found to have a labial abrasion and skin tears to her perineal area and to her vagina consistent with sexual assault. Resident #1 was immediately placed on 1:1 and was subsequently transferred to a Geri-psych unit later that afternoon.	F 609	1 Resident #2 was assessed on 8/28/20 by the Director of Nursing (DON). Resident #2 had no ill effects from the facility's failure to notify state agencies within the required two (2) hour time frame. 2 All Residents have the potential to be affected by this deficient practice. 3 On 9/11/20 an in-service was conducted by the Regional Clinical Operations Nurse for the Executive Director (ED) and the DON to ensure reporting of abuse allegations are reported within two (2) hours to the regulatory agencies. A staff in-service was initiated on 9/11/20 for licensed nurses and department heads by staff development and/or the DON on ensuring that alleged violations involving abuse and/or neglect are reported immediately to ensure that reporting to the state agencies occur within two (2) hours. The Director of Nursing conducted incident and accident audits five (5) times a week times six (6) weeks to ensure any	

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F 609	Continued From page 24 The allegation of sexual abuse was called into the State Department of Health by the Director of Nursing (DON) on 08/28/2020 at 4:22 AM, three (3) hours and forty-two (42) minutes after the alleged incident. The facility did not follow established policy and procedure for reporting allegations of resident abuse, neglect and/or exploitation. The failure of the facility to notify the appropriate State agencies in a timely manner of an allegation of abuse, placed residents at risk for the likelihood or serious injury, harm, impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 09/11/2020, which began on 08/28/2020 when Resident #1 was witnessed on top of Resident #2 in her bed, attempting to engage in non-consensual sexual activity. The facility failed to notify the appropriate agencies of an alleged incident of sexual abuse, within the required two hour timeframe. The facility ' s Administrator, Director of Nursing (DON), and Nurse Consultant were notified of the IJ on 09/11/2020 at 2:05 PM. The facility submitted a Removal Plan on 09/12/2020 at 3:30 PM, in which the facility alleged all corrective actions to remove the IJ were completed. The State Agency (SA) validated the facility's Removal Plan on 09/14/2020 and determined the IJ was removed on 09/12/2020. Therefore, the scope and severity for CFR(s): 483.12(c)(1) - Reporting of Alleged Violations, (F609) was lowered from a "J" to a scope and severity of a "D" level, while the facility develops and implements a plan of correction and monitors the	F 609	incidents requiring state agency notifications were reported timely beginning 9/14/20. Any concerns were immediately corrected. No negative findings noted. On 9/12/20 a facility abuse and neglect procedural policy review was conducted by the Quality Assurance Committee which consisted of but not limited to the ED,DON, SSD, Medical Director, Unit Manager, and the nurse supervisor. The findings revealed no policy changes. 4 The Director of Nursing forwards the results of the audits to the Executive Director. Beginning 9/21/20 the Executive Director initiated monitoring weekly times six (6) weeks of the incident and accident audits. The Executive Director forwarded the results of the monitoring to the monthly Quality Assurance Committee. The Quality Assurance Committee determines the frequency of audits and monitoring based upon results achieved, in addition to making recommendations and changes as needed.	

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effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.

Findings include:

Review of the facility's "Abuse Prevention Policy", last revised 11/2017, revealed, the facility is committed to protecting the residents from abuse by anyone. Definitions included: Abuse - willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse may be resident-to-resident, staff-to-resident, family-to-resident, or visitor-to-resident. Sexual Abuse - This includes but is not limited to sexual harassment, sexual coercion or sexual assault, or non-consensual sexual contact of any type with a resident. To protect residents, suspected or substantiated cases of resident abuse shall be thoroughly investigated, documented, and reported to the physician, families and/or representatives, and as required by state guidelines. In addition, the facility will follow Section 1150B of the Social Security Act's time limits for reporting a reasonable suspicion of crime (immediately but no later than two (2) hours if abuse or serious bodily injury and 24 hours for all others). In addition to reporting to the State Agency, a reasonable suspicion of crime or allegation of abuse is to be reported to at least one law enforcement agency. It is the responsibility of all staff to provide a safe environment for the residents. Any instances of employee disregard for the policies and procedures of this facility are cause for corrective action up to and including suspension, termination, and reporting to licensing agencies.

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On 09/09/2020 at 12:30 PM, during an interview, with Nursing Aide (NA) #1, she stated on the morning of 08/28/2020 at approximately 12:35 AM, she observed Resident #1 on top of Resident #2, in her bed.

On 09/09/2020 at 2:10 PM, during an interview with LPN #1, he stated, at around 12:45 AM on 08/28/2020, he was at the nurse's station and heard NA #1 screaming for someone to help her. He stated NA #1 told him she had seen Resident #1 in the bed on top of Resident #2 trying to stick his penis in her vagina. LPN #1 stated NA #1 helped him assess Resident #2. LPN #1 stated he called the DON and told her what NA #1 had seen, and of his assessment. He stated, within a few minutes, the DON arrived, along with the police, and shortly after that the ambulance came to pick up Resident #2 to have her checked out. LPN #1 stated, when he left at the end of his shift, Resident #1 still had a 1:1 staff member with him, and Resident #2 had not returned from the hospital.

On 09/09/2020 at 3:00 PM, a joint interview with the Administrator and DON revealed, the DON had received a call around 1:00 AM on 08/28/2020 by LPN #1 that Resident #1 was found in Resident #2's room leaned over her bed holding her left hand with his left hand, and he was making sexual movements with his buttocks. The DON arrived at the same time as the police. When the ambulance was notified to come pick up Resident #2, they notified the police before the facility had an opportunity to, and so the police showed up at the same time the DON did, and the ambulance showed up a few minutes later. The DON stated she began getting statements and did an assessment of both residents before

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the ambulance transferred Resident #2 to the hospital. The DON revealed she notified the doctor of her findings from the assessments, and she notified the RP's (Responsible Parties) for both residents. She stated Resident #1 was placed on a 1:1 until he was transferred to a behavior unit later that afternoon.

Record review of Resident #2's "Departmental Notes", dated 08/28/2020 at 3:13 AM, signed by LPN #1, revealed: At 12:45 AM CNA reported that resident (Resident #1) was found standing over Resident #2's bed. MD notified. New order to transfer to ER for evaluation. At 2:30 AM officers arrived and questioned both parties. At 2:50 AM (Name of Ambulance) service was called.

A record review of Resident #2's "Departmental Notes", dated 08/28/2020 at 6:57 AM, signed by LPN #2, revealed: Around 6:45 AM Resident #2 returned to facility from (Name of Hospital) due to sexual assault.

On 09/11/2020 at 3:40 PM, during a phone interview with the Director of the Complaint Unit for Health Facilities Licensure & Certification in Jackson, Mississippi, she validated the call log as receiving a phone call from the DON on 08/28/2020 at 4:22 AM. There were no other calls from the facility noted on the call log. An email confirming the date and time was sent for the State Agency (SA) to review.

The facility submitted a Removal Plan for the IJ. Review of the Removal Plan revealed the facility took the following actions to remove the IJ:

The ED called an emergency QAPI-QA meeting on 09/12/2020 at 3:15 PM to discuss IJ's called

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during a complaint investigation. In attendance at the emergency QAPI-QA meeting was the ED, DON, Registered Nurse (RN), RN Supervisor, and vice president of Tara Cares. Attendance by phone was the Social Service Director (SSD), Medical Director (MD), and Psychiatric Nurse Practitioner. Topics of discussion during the meeting were the aforementioned allegation of resident to resident abuse. Policy review was performed on Abuse /Neglect, Behavior management, Care plan development and implementation, monitoring and supervision of wandering residents, notification of incidents to Mississippi State Department of Health with no revisions needed. A protocol was implemented for review of physician progress notes. Topics discussed were additional training and education of staff for abuse, monitoring and supervision of residents, reporting incidents, care plans, and behavior management. Also discussed was the auditing charts for all residents with sexual behavior, care plans, wandering and interviewed all residents and staff for any reports of sexual abuse.

1. To meet the immediate need of Resident #2, staff assessed for any injury at the facility, and was transferred to the hospital to be evaluated by a physician. Resident #2 was provided emotional support post incident by the SSD on 08/28/2020, was added to acute charting starting 08/28/2020 indicative of nurses' monitoring and Resident # 2 was assessed by NP on 08/28/2020 after returning to the facility with no negative findings.

2. Resident # 1 was immediately placed on 1:1 surveillance by a staff member until he was transported to a Geri-psych. Resident # 1 was then discharged from the facility with his family on

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09/10/2020.

3. On 8/28/2020 at 4:20 AM the DON notified Mississippi State Department of Health of the incident. 08/28/2020 at 12:50 AM the EMS notified the local police department of the incident. Police arrived at facility with EMS and investigated incident. On 09/02/2020 at 3:46 PM the ED submitted the final investigation to the Attorney General's Office.

4. An in service was initiated on 09/11/2020 at 3:00 PM by the DON for all staff present in the building on abuse and neglect, monitoring and supervision of residents and care plan implementation and development. In service to include reporting changes in behaviors for wandering residents who exhibit aggressive behaviors immediately to the Charge Nurse and initiating interventions. The Charge Nurse will communicate with the DON or RN Supervisor to determine the frequency of increased supervision based on the assessment of the residents. All staff will be in serviced prior to working the next shift. In-service was completed on 61 of 109 staff.

5. On 09/11/2020 at 5:00 PM an in service was conducted by the Regional Clinical Operations Nurse for the ED and DON to ensure reporting abuse allegations no later than 2 hours to regulatory agencies. The remaining department heads will be in service on next the scheduled shift.

6. On 09/11/2020 at 3:00 PM the ED completed 100 % audit for residents who exhibited wandering to determine any negative behavior that could be potentially harmful to other residents. Results were that 9 of 9 records

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reviewed and 0 found to wander and exhibit behaviors that were potentially harmful to others.

7. On 09/11/2020 the ED completed interviews with all cognitive residents to identify any reports of sexual inappropriate conduct. Results were 25 of 25 residents interviewed and all responded "No".

8. On 09/11/2020 at 4:30 PM, the ED and DON completed a 100% chart audit on residents for review of care plans on all residents to identify residents with exhibited sexual behaviors. Results of the audit was 11 of 105 residents were noted with sexual behaviors and none were directed towards other residents. Results were 105 of 105 of charts audited had appropriate interventions in place.

9. On 9/11/2020 at 4:30 PM, the ED and DON audited 100% of active medical records' psych progress to determine if any implementations were warranted. No issues were identified, or implementations warranted of 105 of 105 records reviewed.

The facility alleges that all corrective actions to remove the Immediate Jeopardy identified on 09/11/2020 was completed as of 09/12/2020 at 3:30 PM, for removal of the Immediate Jeopardy (IJ) on 09/12/2020.

On 09/14/2020, the SA validated through staff interview, resident interview, record review, and in-service reviews that the facility had implemented the following measures to remove the IJ:

The SA verified through staff interview and

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QAPI/QA meeting minutes review the meeting occurred and all topics to include the IJ, policy review, in-service education on abuse and neglect, chart audits, care plan revisions, and resident interviews were discussed to be implemented.

1. The SA validated through record review, Resident #2 was assessed at the facility, sent to the Emergency Room, has a care plan for emotional support from Social Services, and was assessed upon her return to the facility by the NP.

2. The SA validated through record review and staff interview, Resident #1 was placed on 1:1 until his transport to a Geri-psych unit. He was discharged from the facility on 09/10/2020.

3. The SA validated through record review and staff interview the reporting of the incident to the State Department of Health, EMS and Police Department notification, and a final investigation was sent to the Department of Health on 09/02/2020.

4. The SA validated through in-service sign in review, content review, and staff interview that an in-service was held for staff for all topics aforementioned on 09/11/2020 at 3:00 PM.

5. The SA validated through in-service sign in sheet and content review, as well as staff interview, an in-service was held with administration on timely reporting as of 09/11/2020 at 5:00 PM.

6. The SA validated through record review and staff interview the completion of an audit of care plans for resident who wander and have

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F 609	Continued From page 32 aggressive behaviors. No issues were found during the audit. 7. The SA validated through resident interviews and staff interviews, all cognitively aware residents were interviewed regarding inappropriate sexual conduct and 25 of 25 stated it had not occurred. 8. The SA validated through record review and staff interview a 100% chart audit for residents exhibiting sexual behaviors was completed, and none have behaviors directed at other residents. 9. The SA validated through record review and staff interview a 100% chart audit of psychiatric progress notes was completed and none were found with issues that needed addressed, or implementation of new orders. The SA validated on 09/14/2020, that all corrective actions had been taken by the facility to remove the IJ during the survey on 09/12/2020. The IJ was removed on 09/12/2020.	F 609		
F 656 SS=J	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		10/27/20

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F 656	Continued From page 33 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on facility policy and procedure review, staff interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan related to Behaviors, for one (1) of five (5) resident care plans reviewed, Resident #1. On 06/06/2019, Nurse Practitioner (NP) #1	F 656	1 Resident #1 care plan was updated on 8/28/20 based on first occurrence of inappropriate sexual behavior. Resident #1 has been discharged from the facility. 2 All Residents have the potential to be	

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F 656	Continued From page 34 assessed and evaluated Resident #1 at the facility, for a chief complaint of Behavioral Aggression. The progress note revealed, Resident #1 was being assessed and evaluated as a result of behavioral disturbances, difficulty redirecting, and socially inappropriate behaviors that were disruptive to the facility. NP #1 wrote Resident #1 "continues to chase staff around the facility. Sexually inappropriate at times difficult to redirect." Further review of the note revealed, Resident #1 was positive (+) for impulsivity, sexually inappropriate. Chases staff around the facility. Ongoing behavioral aggression and agitation not remedied by routine regimen. Intermittent outbursts require Ativan IM due to level of aggression and potential to harm self and others." A record review of Resident #1's care plan revealed the sexually inappropriate behavior, and impulsivity was not care planned. On Friday, August 28, 2020 at 12:35 AM, a staff member was rounding and walked past a resident's room and witnessed Resident #1 on top of Resident #2 in her bed, without her consent, moving his body in a sexual manner. After removal of Resident #1 from on top of Resident #2, staff observed Resident #2's adult brief pulled to the side, and blood on the brief. Assessment of Resident #2 at the hospital verified injuries consistent with sexual assault. The facility failed to care plan and provide close supervision and appropriate Behavioral Interventions for Resident #1. The facility's failure to develop and implement a comprehensive person-centered care plan to address sexually inappropriate behaviors, and the impulsivity of Resident #1, and for staff to be aware of these behaviors and not put	F 656	affected. 3 A 100% care plan audit was initiated on 9/11/20 by the Director of Nursing for residents who exhibit sexual inappropriate behaviors to ensure that these behaviors were not directed at other residents. The care plan audit revealed that all 105 of 105 resident audited were appropriately care planned. An in-service was initiated on 9/11/20 by the Executive Director for the Director of Nursing, licensed nurses, and Interdisciplinary Team (IDT), consisting of but not limited to Social Services, Dietary, and Activities to ensure that all residents who exhibited sexual inappropriate behavior had applicable care plans with interventions in place. 4 The Director of Nursing initiated audits of twenty (20) charts per week times six (6) weeks to ensure that care plans are developed and implemented for Residents with sexually inappropriate behaviors. Any concerns are immediately addressed. The Director of Nursing forwarded the results of the audits to the Executive Director. Beginning 9/21/20 the Executive Director initiated monitoring weekly times six (6) weeks of the care plan audits. The Executive Director forwarded the results of the monitoring to the monthly Quality Assurance Committee. The Quality Assurance Committee determines the frequency of audits and monitoring based upon results achieved, in addition to making recommendation and changes as	

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interventions in place to prevent further abuse, placed Resident #2 and other residents in a situation that was likely to cause serious harm, injury, impairment or death.

The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 09/11/2020. Resident #1 exhibited inappropriate sexual behavior towards Resident #2, who is a cognitively impaired resident. On 08/28/2020, Resident #1 was witnessed on top of Resident #2 in her bed, attempting to engage in non-consensual sexual activity. The facility failed to care plan and put measures and interventions in place to protect residents from sexual behaviors exhibited by Resident #1.

The facility's Administrator, Director of Nursing (DON), and Nurse Consultant were notified of the IJ and SQC, on 09/11/2020 at 2:05 PM. The facility submitted a Removal Plan on 09/12/2020 at 3:30 PM, in which the facility alleged all corrective actions to remove the IJ were completed.

The State Agency (SA) validated the facility's Removal Plan on 09/14/2020 and determined the IJ was removed on 09/12/2020. Therefore, the scope and severity for CFR(s):483.21(b)(1) - Develop/Implement Comprehensive Care Plan, (F656) was lowered from a "J" to a scope and severity of a "D" level, while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.

Findings include:

needed.

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Review of the facility's "Comprehensive Person-Centered Care Plans" policy, last updated 03/2018, revealed: Each resident will have a person-centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care. The Interdisciplinary Tearm (IDT) along with the resident and/or Resident Representative will identify resident problems, needs, strengths, life history, preferences, and goals. For each problem, need or strength a resident-centered goal is developed. Goals should be measurable. The comprehensive care plan can be reviewed and/or revised at quarterly intervals in conjunction with the completion of MDS quarterly, significant change and annual assessments per the Resident Assessment Instrument (RAI) manual. Upon a change in condition, the comprehensive care plan or Baseline Care Plan will be updated, or an Instant Care Plan will be initiated if applicable.

Review of Resident #1's comprehensive care plan, revealed, the incident that occurred on 06/06/2019 of chasing staff around the facility, sexually inappropriate behavior and impulsivity had not been care planned, nor interventions put into place on his existing behavior care plans to address these behaviors.

Review of Resident #1's Departmental Notes, and Behavior/Pain Medication Monitoring Summaries indicated no mention of the incident recorded on the Psychiatric NP's progress note on 06/06/2019 in which Resident #1 was said to be chasing staff around the facility, being sexually inappropriate, and impulsive.

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During an interview, with the Minimum Data Set (MDS) Coordinator/Care Plan Nurse, on 09/10/2020 at 12:20 PM, she verified there was no care plan for Resident #1 being sexually inappropriate, chasing staff or being impulsive. She stated that she was unaware of those behaviors occurring, she had not been told by staff, and had not read the progress note where those behaviors were mentioned. She revealed there were care plans for his other behavioral issues, however, none of them mentioned his behaviors from 06/06/2019. She stated that each department was responsible for creating and revising their own care plans. She stated a behavior care plan should have been started by Social Services after the incident and revised as needed.

During an interview, with the Social Service Director (SSD) for the South Unit, on 09/10/2020 at 12:48 PM, he indicated that he had been made aware of the sexual assault of Resident #2 by Resident #1 on 08/28/2020. He stated he was not made aware of the behaviors recorded on the progress note from 06/06/2019, and due to that, they were not care planned. He stated the normal routine for a progress note was for the charge nurse to receive them when they arrive at the facility, read over them and then notify the appropriate departments as needed of the information within them. He feels the note didn't get read and was just filed into the chart without notification of any departments. The SSD did indicate Resident #1 had a significant history of being physically aggressive with other residents on several occasions, and with staff in resisting care, and he had multiple care plans to address his aggressive behaviors, and his medications were tracked for gradual dose reductions,

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however, there was no formal behavior management program for him. When asked by the State Agency (SA) what interventions were put into place after each of Resident #1's aggressive physical altercations with other residents, he stated, they would separate him from the other resident, and usually sent him out to the psychiatric unit for medication adjustments. When asked by the SA if they increased the frequency in which they observed and supervised him, he stated they had him on one (1) hour checks due to his refusal to wear a wander guard and walking all over the facility, however, it was not to address his behaviors. The SSD stated that he had not seen Resident #1 be sexually inappropriate to any other residents prior to the incident of sexual assault on 08/28/2020.

No observation of Resident #1 was obtained during the extended survey of 09/10/2020 through 09/14/2020. Resident #1 had been transferred to a Geri-psych unit on 08/28/2020.

The facility submitted a Removal Plan for the IJ. Review of the Removal Plan revealed the facility took the following actions to remove the IJ:

The ED called an emergency QAPI-QA meeting, on 09/12/2020 at 3:15 PM, to discuss IJ's called during a complaint investigation. In attendance at the emergency QAPI-QA meeting was the ED, DON, Registered nurse (RN), RN Supervisor, and vice president of Tara Cares. Attendance by phone was the Social Service Director (SSD), Medical Director (MD), and Psychiatric Nurse Practitioner. Topics of discussion during the meeting were the aforementioned allegation of resident to resident abuse. Policy review was performed on Abuse /Neglect, Behavior

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management, Care plan development and implementation, monitoring and supervision of wandering residents, notification of incidents to Mississippi State Department of Health with no revisions needed. A protocol was implemented for review of physician progress notes. Topics discussed were additional training and education of staff for abuse, monitoring and supervision of residents, reporting incidents, care plans, and behavior management. Also discussed was the auditing charts for all residents with sexual behavior, care plans, wandering and interviewed all residents and staff for any reports of sexual abuse.

1. To meet the immediate need of Resident #2, staff assessed for any injury at the facility, and was transferred to the hospital to be evaluated by a physician. Resident #2 was provided emotional support post incident by the SSD on 08/28/2020, was added to acute charting starting 08/28/2020 indicative of nurses' monitoring and Resident # 2 was assessed by NP on 08/28/2020 after returning to the facility with no negative findings.

2. Resident # 1 was immediately placed on 1:1 surveillance by a staff member until he was transported to a Geri-psych. Resident # 1 was then discharged from the facility with his family on 09/10/2020.

3. On 8/28/2020 at 4:20 AM, the DON notified Mississippi State Department of Health of the incident. 08/28/20 at 12:50 AM, the EMS notified the local police department of the incident. Police arrived at facility with EMS and investigated incident. On 09/02/2020 at 3:46 PM the ED submitted the final investigation to the Attorney General's Office.

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4. An in service was initiated, on 09/11/2020 at 3:00 PM, by the DON for all staff present in the building on abuse and neglect, monitoring and supervision of residents and care plan implementation and development. In service to include reporting changes in behaviors for wandering residents who exhibit aggressive behaviors immediately to the Charge Nurse and initiating interventions. The Charge Nurse will communicate with the DON or RN Supervisor to determine the frequency of increased supervision based on the assessment of the residents. All staff will be in serviced prior to working the next shift. In-service was completed on 61 of 109 staff.

5. On 09/11/2020 at 5:00 PM an in service was conducted by the Regional Clinical Operations Nurse for the ED and DON to ensure reporting abuse allegations no later than 2 hours to regulatory agencies. The remaining department heads will be in service on next the scheduled shift.

6. On 09/11/2020 at 3:00 PM, the ED completed 100 % audit for residents who exhibited wandering to determine any negative behavior that could be potentially harmful to other residents. Results were that 9 of 9 records reviewed and 0 found to wander and exhibit behaviors that were potentially harmful to others.

7. On 09/11/2020, the ED completed interviews with all cognitive residents to identify any reports of sexual inappropriate conduct. Results were 25 of 25 residents interviewed and all responded "No".

8. On 09/11/2020 at 4:30 PM, the ED and DON

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completed a 100% chart audit on residents for review of care plans on all residents to identify residents with exhibited sexual behaviors. Results of the audit was 11 of 105 residents were noted with sexual behaviors and none were directed towards other residents. Results were 105 of 105 of charts audited had appropriate interventions in place.

9. On 09/11/2020 at 4:30 PM, the ED and DON audited 100% of active medical records' psych progress to determine if any implementations were warranted. No issues were identified, or implementations warranted of 105 of 105 records reviewed.

The facility alleges that all corrective actions to remove the Immediate Jeopardy identified on 09/11/2020 was completed as of 09/12/2020 at 3:30 PM, for removal of the Immediate Jeopardy (IJ) on 09/12/2020.

On 09/14/2020 the SA validated through staff interview, resident interview, record review, and in-service reviews that the facility had implemented the following measures to remove the IJ:

1. The SA validated through record review, Resident #2 was assessed at the facility, sent to the Emergency Room, has a care plan for emotional support from Social Services, and was assessed upon her return to the facility by the NP.

2. The SA validated through record review and staff interview, Resident #1 was placed on 1:1 until his transport to a Geri-psych unit. He was discharged from the facility on 09/10/2020.

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3. The SA validated through record review and staff interview the reporting of the incident to the State Department of Health, EMS and Police Department notification, and a final investigation was sent to the Department of Health on 09/02/2020.

4. The SA validated through in-service sign in review, content review, and staff interview that an in-service was held for staff for all topics aforementioned on 09/11/2020 at 3:00 PM.

5. The SA validated through in-service sign in sheet and content review, as well as staff interview, an in-service was held with administration on timely reporting as of 09/11/2020 at 5:00 PM.

6. The SA validated through record review and staff interview the completion of an audit of care plans for resident who wander and have aggressive behaviors. No issues were found during the audit.

7. The SA validated through resident interviews and staff interviews, all cognitively aware residents were interviewed regarding inappropriate sexual conduct and 25 of 25 stated it had not occurred.

8. The SA validated through record review and staff interview a 100% chart audit for residents exhibiting sexual behaviors was completed, and none have behaviors directed at other residents.

9. The SA validated through record review and staff interview a 100% chart audit of psychiatric progress notes was completed and none were found with issues that needed addressed, or

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F 656	Continued From page 43 implementation of new orders. The SA validated on 09/14/2020, that all corrective actions had been taken by the facility to remove the IJ during the survey on 09/12/2020. The IJ was removed on 09/12/2020.	F 656		
F 742 SS=J	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to address the behaviors of Resident #1 in a manner to promote his psychosocial well-being and failed to acquire appropriate programs and services to meet the mental health and behavior needs for one (1) of five (5) residents reviewed for Behaviors and Mental Health services, Resident #1. The facility admitted Resident #1 from (Name of Behavior Unit) on 03/14/2019 with diagnoses which included Bipolar Disorder, Schizophrenia Unspecified, Vascular Dementia, and Insomnia. The facility sent him out to a Behavioral Health facility on several occasions, beginning four (4)	F 742	1 Resident #1 was immediately placed on one-to-one monitoring with staff on 8/28/20 until he was transferred to behavior health unit on 8/28/20. Resident #1 did not return to the facility. 2 All residents who have inappropriate sexual behaviors that require appropriate programs and services to meet the mental health behavioral needs have the potential to be affected. 3 An in-service was conducted on 9/11/20	10/27/20

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F 742	Continued From page 44 weeks after his admission, for increased behaviors, which included walking the hallways in his brief or without underwear, slapping another resident to the ground, chasing staff around the facility, impulsivity, and sexually inappropriate behaviors. On 08/28/2020, Resident #1 was sent out to a behavior unit for sexually assaulting Resident #2. The nursing home facility did not seek recommendations as to Behavioral interventions and/or Behavioral programs for the treatment of Resident #1. The nursing home facility did not make referrals to address the diagnosis of Schizophrenia, Bipolar Depression and Vascular Dementia with Aphasia. The facility employees had no directions and/or programs to implement within the facility in order to deescalate the aggressive language, aggressive physical behaviors, and sexually inappropriate behaviors of Resident #1. There was no documentation in the medical record of Resident #1 being monitored for any of his behaviors other than hourly checks for wandering and refusing to wear a wander guard. Numerous transfers to a Behavioral Health facility were not effective in the treatment and management of Resident #1's behaviors. The facility's failure to identify and prevent the escalating aggressions and sexually inappropriate behaviors toward staff and other residents lead to the sexual abuse of Resident #2, a cognitively impaired resident, by Resident #1. Abuse was caused to Resident #2 as a result of the facility's failure to appropriately address and devise behavioral management programs for Resident #1. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care	F 742	by the Director of Nursing for Social Services and licensed nurses to ensure that inappropriate sexual behaviors are addressed in a manner which promotes psychosocial well being and acquire appropriate programs and services to meet the mental health and behavioral needs of the residents. A 100% audit was conducted on 9/11/20 by the Social Services Department for all Residents who exhibit aggressive and sexual inappropriate behaviors to ensure targeted inappropriate sexual behaviors are addressed and appropriate services are provided. Results indicated nineteen (19) of the 105 residents were noted with aggressive or sexual inappropriate behaviors. All nineteen (19) of the residents identified had appropriate services provided to address any aggressive or sexually inappropriate behaviors. No negative findings noted. 4 Beginning 9/14/20 the Director of Nursing initiated a review of twenty (20)charts for behavior management programs weekly times six (6) weeks to ensure that appropriate programs and services are provided for Residents who exhibit aggressive and sexual inappropriate behaviors. Any concerns are immediately addressed. Beginning 9/21/20 the Executive Director initiated monitoring weekly times six (6) weeks of the chart audit for behavior management program to ensure that appropriate programs and services are provided for Residents who exhibit	

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F 742	Continued From page 45 (SQC) on 09/12/2020, which began on 08/28/2020. Resident #1 exhibited inappropriate sexual behavior towards Resident #2, who was a cognitively impaired resident. On 08/28/2020, Resident #1 was witnessed on top of Resident #2 in her bed, attempting to engage in non-consensual sexual activity. The facility failed to care plan and put measures and interventions in place to protect residents from sexual behaviors exhibited by Resident #1. The facility's Administrator, Director of Nursing (DON), and Nurse Consultant were notified of the IJ on 09/11/2020 at 2:05 PM. The facility submitted a Removal Plan on 09/12/2020 at 3:30 PM, in which the facility alleged all corrective actions to remove the IJ were completed. The State Agency (SA) validated the facility's Removal Plan on 09/14/2020 and determined the IJ was removed on 09/12/2020. Therefore, the scope and severity for CFR(s): 483.40(b)(1) - Treatment/Srvcs Mental/Psychosocial Concerns, (F742), was lowered from a "J" to a scope and severity of a "D" level, while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: A review of the facility's "Behavior Management and Psychopharmacological Medication Monitoring Protocol", last revised 03/2018, revealed: Policy: Residents who receive antipsychotic, antidepressant, sedative/hypnotic, or anti-anxiety medications are to be maintained at the safest, lowest dose necessary to manage	F 742	aggressive and sexual inappropriate behaviors. No negative findings noted. The Director of Nursing forwards the results of the audits to the Executive Director. The Executive Director forwards the audits to the monthly Quality Assurance Committee. The Quality Assurance Committee determines the frequency of audits and monitoring based upon results achieved, in addition to making recommendations and changes as needed.	

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the residents' condition. Residents will be reviewed routinely for effectiveness and monitored for side effects of these medications and will receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs. There will be an established behavior management committee that will meet routinely to review all residents mentioned above and others as the committee deems appropriate. Purpose: Residents with behaviors that are displayed routinely, that affect the resident's psychosocial well-being or that of other residents, or behaviors that can have potential for harm to self or others will be assessed with the development of a behavior program. Responsibility: Licensed nurses, interdisciplinary team, physician, director of nursing and the pharmacy consultant. Definitions: Behavioral Interventions are individualized non-pharmacological approaches to care that are provided as part of a supportive physical and psychosocial environment, and that are directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities as well as maintaining or improving a resident's mental, physical or psychosocial well-being. Procedure: Resident admitted on or currently receiving psycho-pharmacological medication: a) Determine the diagnosis with the physician that supports the use of this medication (include in the body of the medication order and on the diagnosis list). b) attempt to establish the length of time the resident has been on this medication. c) The IDT member will document in the IDT notes. d) The IDT will update the care plan to include the problem behavior, goals, and approaches. e) The planned interventions for each individual resident's behavior will be

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communicated to the appropriate staff members. Interventions and response will be documented. f) The Director of Nursing Services or designee will make the referral to the Behavior Management Committee. g) The committee will establish a behavior program and review behavior monitoring documentation. Appropriate updating and/or revisions to the care plan will ne done at this time ny the IDT. h) The committee will continue to routinely review the resident as long as the resident has an established behavior program and/or continues to receive psycho-pharmacological medication. i) The committee or Pharmacy Consultant will recommend the initiation, when applicable, of a gradual dose reduction, unless clinically contraindicated in an effort to maintain the resident at the lowest possible dose or to discontinue the medication. 2a) The attending physician will be notified to rule out medical causes, which may be contributing to the behavior. b) The interdisciplinary care team will update the care plan to include the problem behavior, goals and approaches. c) The director of nursing services or designee will make a referral to the behavior management committee. d) Continue to follow all steps under new admission procedure.

Review of Resident #1's "Departmental Notes" for the day of his admission, dated 03/14/2019 at 10:22 PM, revealed: 3:30 pm - Admitted to (Formal Name of Facility). Uncooperative at first to do assessment. CNA (Certified Nurse Aide) reported that resident was uncooperative at times with care and stated, "Fuck you!"

Review of Resident #1's "Departmental Notes", dated 04/07/2019 at 9:15 PM, revealed:

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"Resident has been ambulating this shift. He has been walking the halls with no underwear and isn't easy to redirect. He refuses all of medications,"

Review of Resident #1's "Departmental Notes", dated 04/08/2019 at 7:00 AM, revealed, Resident noted ambulatory to facility halls ad lib. Resident noted ambulatory to halls with shirt and pull-up only.

Review of Resident #1's "Departmental Notes", dated 04/14/2019 at 6:44 AM, revealed: Resident noted up ambulatory to facility halls towards end of shift. Resident noted with pullup and t-shirt on, Resident encouraged to put on pants with several attempts. Resident ignored attempts. Resident difficult to redirect at times.

Review of Resident #1's "Departmental Notes", dated 04/14/2019 at 2:04 PM, revealed, Resident aggressive when staff attempts to redirect him from going in other residents' rooms, resident gets agitated when encouraged to wear his clothes.

Review of Resident #1's "Departmental Notes" dated 04/15/2019 at 2:36 PM, revealed: Resident has been up wandering around facility. He is going in and out of other resident's rooms. He refuses to sit down to eat.

Review of Resident #1's "Departmental Notes", dated 04/15/2019 at 3:39 PM, revealed: Resident exhibiting increased agitation and physical aggression toward staff when attempting to redirect behaviors of wandering into other resident's rooms or attempting to provide ADL care. Resident is not easily redirected.

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Review of Resident #1's "Departmental Notes", dated 04/16/2019 at 1:51 PM, revealed: Resident has been up wandering around facility. He is alert. He is confused. He wanders into others rooms, he can be hard to redirect at times. he would not go into room and sit down, he got agitated.

Review of Resident #1's "Departmental Notes", dated 04/17/2019, revealed: Resident #1 had slapped another resident to the floor. The residents were kept separated and Resident #1 was sent to (Name of Psychiatric Unit) for further evaluation of his behaviors.

No behavioral management program was devised to address Resident #1's behaviors of wandering in and out of other resident's rooms, walking the halls of the facility without underwear and pants on, and escalating behaviors with difficulty in redirecting him. As a result, Resident #1 physically abused another resident and was sent out to a psychiatric facility on 04/17/2019, for medication management.

Review of Resident #1's "Departmental Notes", dated 04/30/2019 at 2:43 PM, revealed: Resident returned to facility from (Name of Psychiatric Unit) via (Name of Transportation Company) at approximately 2:30 PM, Resident refused to get off the van initially.

A review of Resident #1's Psychiatric Progress note, dated 06/06/2019, revealed: Chief Complaint: Behavioral Aggression. Subjective: 55 y/o (year old) AA (African American) male assessed and evaluated as a result of behavioral disturbances, difficulty redirecting, and socially

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inappropriate behaviors that are disruptive to the facility. Continues to chase staff around the facility. Sexually inappropriate at times difficult to redirect. Insight and Judgment remain grossly impaired. Objective: + (positive) for impulsivity sexually inappropriate. Chases staff around the facility. Assessment: Ongoing behavioral aggression and agitation not remedied by routine regimen. Intermittent outbursts require Ativan IM (intramuscularly) due to level of aggression and potential to harm self and others.

On 09/10/2020 at 3:35 PM, during an interview with Nurse Practitioner #1, the author of the Psychiatric Progress Note on 06/06/2019, she stated, she remembered being at the facility and being told Resident #1 was chasing staff, because he chased her around the unit as she was making her rounds. She stated she didn't feel threatened by him doing this because he wasn't sexually inappropriate with her and she was not a vulnerable adult. She couldn't remember the name of the staff member that had talked to her about his sexual behaviors, however, she remembered them needing to use Ativan injections to keep him calm.

No behavioral management program was devised to address Resident #1's behaviors of chasing staff around the facility, impulsivity, or sexually inappropriate behaviors with difficulty being redirected at times.

Review of Resident #1's "Departmental Notes" dated 12/01/2019, revealed: Resident #1 in dayroom and reported by another resident, that a resident was reaching for Resident #1's drink off the table and Resident #1 hit her Redirected Resident #1 not to hit other residents. Resident

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#1 nodded head in a yes motion in understanding.

No behavioral management program was devised to address the incident of physical aggression on 12/01/2019, with another resident. As a result, Resident #1 had another physically aggressive altercation with another resident on 01/19/2020 and was sent out again to a psychiatric unit for treatment.

Review of Resident #1's "Department Notes", dated 01/19/2020 at 1:18 PM, revealed: "9:15 AM reported by resident that this resident (Resident #1) had hit him in the face. This nurse asked this resident did he hit (Formal name) in his room. This resident (Resident #1) stated "yes"... orders from MD (Medical Director) to transfer to inpatient facility ..." Resident #1 returned to the facility on 01/27/2020.

No behavioral management program was devised to address the incident of physical aggression on 01/19/2020, with another resident. As a result, Resident #1 had another physically aggressive altercation with another resident on 02/08/2020.

Review of Resident #1's "Departmental Notes", dated 02/08/2020 at 4:00 PM, revealed: "At approx. 1400 hours (2:00 PM) front hall nurse notified this nurse that a resident stated this resident (Resident #1) slapped him last night and pushed him out the room. This nurse interviewed this resident (Resident #1) and (asked) him if he slapped (Formal name) and this resident (Resident #1) stated "hell no" ... Nurse asked if he pushed (Formal name) out of the room and this resident (Resident #1) shook head yes ...

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This resident (Resident #1) and (Formal name) were immediately separated with room change and placed one on one ..."

No behavioral management program was devised to address the incident of physical aggression on 02/08/2020, with another resident. As a result, Resident #1 had another physically aggressive altercation with another resident in early June 2020 and was sent out again to a psychiatric unit for treatment, with return to the facility on 06/12/2020.

No behavioral management program was devised to address the incident of physical aggression in early June 2020, with another resident.

A review of Resident #1's "Department Notes", dated 08/28/2020 at 3:06 AM, revealed: At 1245 AM Resident #1 observed in (Room Number) with clothing down with hand on his penis on top of Resident #2 per CNA. Resident #1 questioned per writer and law enforcement x 4 on what he was doing across the hallway. Resident wouldn't answer clearly. An addendum note was done on 08/28/2020 at 3:31 AM which revealed, "1 on 1 initiated."

On 09/09/2020 at 3:00 PM, during a joint interview with the Administrator and DON, the Administrator stated, Resident #1 had care plans for being aggressive and had several residents to resident incidents where he slapped them, but nothing ever sexual. The Administrator verified Resident #1 had been sent out in April and December of 2019 and January and June 2020 for physically aggressive altercations with other residents on the South Unit. When the

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Administrator and DON were asked what interventions were put into place after his physically aggressive behaviors with other residents, the DON stated he was on hourly checks by staff, and the Administrator indicated that was more for his elopement risk because he refused to wear a "wander-guard" and was known to walk all over the building, and sometimes in and out of other residents rooms.

During an interview with the Social Service Director (SSD) for the South Unit, on 09/10/2020 at 12:48 PM, he stated that he had been made aware of the sexual assault of Resident #2 by Resident #1 on 08/28/2020. He stated he was not made aware of the behaviors recorded on the progress note from 06/06/2019, and due to that, they were not care planned. The SSD did indicate Resident #1 had a significant history of being physically aggressive with other residents on several occasions, and with staff in resisting care, and he had multiple care plans to address his aggressive behaviors, and his medications were tracked for gradual dose reductions, however, there was no formal behavior management program for him. When asked by the State Agency (SA) what interventions were put into place after each of Resident #1's aggressive physical altercations with other residents, he stated they would separate him from the other resident, and usually sent him out the psychiatric unit for medication adjustments. When asked by the SA if they increased the frequency in which they observed and supervised him, he stated they had him on one (1) hour checks due to his refusal to wear a wander guard and walking all over the facility, however, it was not to address his behaviors. The SSD stated that he had not seen Resident #1 be sexually inappropriate to any

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other residents prior to the incident of sexual assault on 08/28/2020.

The facility submitted a Removal Plan for the IJ. Review of the Removal Plan revealed the facility took the following actions to remove the IJ:

The ED called an emergency QAPI-QA meeting, on 09/12/2020 at 3:15 PM, to discuss IJ's called during a complaint investigation. In attendance at the emergency QAPI-QA meeting was the ED, DON, Registered nurse (RN), RN Supervisor, and vice president of Tara Cares. Attendance by phone was the Social Service Director (SSD), Medical Director (MD), and Psychiatric Nurse Practitioner. Topics of discussion during the meeting were the aforementioned allegation of resident to resident abuse. Policy review was performed on Abuse /Neglect, Behavior management, Care plan development and implementation, monitoring and supervision of wandering residents, notification of incidents to Mississippi State Department of Health with no revisions needed. A protocol was implemented for review of physician progress notes. Topics discussed were additional training and education of staff for abuse, monitoring and supervision of residents, reporting incidents, care plans, and behavior management. Also discussed was the auditing charts for all residents with sexual behavior, care plans, wandering and interviewed all residents and staff for any reports of sexual abuse.

1. To meet the immediate need of Resident #2, staff assessed for any injury at the facility, and was transferred to the hospital to be evaluated by a physician. Resident #2 was provided emotional support post incident by the SSD on 08/28/2020,

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was added to acute charting starting 08/28/2020 indicative of nurses' monitoring and Resident # 2 was assessed by NP on 08/28/2020 after returning to the facility with no negative findings.

2. Resident # 1 was immediately placed on 1:1 surveillance by a staff member until he was transported to a Geri-psych. Resident # 1 was then discharged from the facility with his family on 09/10/2020.

3. On 8/28/2020 at 4:20 AM, the DON notified Mississippi State Department of Health of the incident. 08/28/2020 at 12:50 AM, the EMS notified the local police department of the incident. Police arrived at facility with EMS and investigated incident. On 09/02/2020 at 3:46 PM the ED submitted the final investigation to the Attorney General's Office.

4. An in service was initiated, on 09/11/2020 at 3:00 PM, by the DON for all staff present in the building on abuse and neglect, monitoring and supervision of residents and care plan implementation and development. In service to include reporting changes in behaviors for wandering residents who exhibit aggressive behaviors immediately to the Charge Nurse and initiating interventions. The Charge Nurse will communicate with the DON or RN Supervisor to determine the frequency of increased supervision based on the assessment of the residents. All staff will be in serviced prior to working the next shift. In-service was completed on 61 of 109 staff.

5. On 09/11/2020 at 5:00 PM, an in service was conducted by the Regional Clinical Operations Nurse for the ED and DON to ensure reporting

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abuse allegations no later than 2 hours to regulatory agencies. The remaining department heads will be in service on next the scheduled shift.

6. On 09/11/2020 at 3:00 PM, the ED completed 100% audit for residents who exhibited wandering to determine any negative behavior that could be potentially harmful to other residents. Results were that 9 of 9 records reviewed and 0 found to wander and exhibit behaviors that were potentially harmful to others.

7. On 09/11/2020, the ED completed interviews with all cognitive residents to identify any reports of sexual inappropriate conduct. Results were 25 of 25 residents interviewed and all responded "No".

8. On 09/11/2020 at 4:30 PM, the ED and DON completed a 100% chart audit on residents for review of care plans on all residents to identify residents with exhibited sexual behaviors. Results of the audit was 11 of 105 residents were noted with sexual behaviors and none were directed towards other residents. Results were 105 of 105 of charts audited had appropriate interventions in place.

9. On 09/11/2020 at 4:30 PM, the ED and DON audited 100% of active medical records' psych progress to determine if any implementations were warranted. No issues were identified, or implementations warranted of 105 of 105 records reviewed.

The facility alleges that all corrective actions to remove the Immediate Jeopardy identified on 09/11/2020 was completed as of 09/12/2020 at

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3:30 PM, for removal of the Immediate Jeopardy (IJ) on 09/12/2020.

On 09/14/2020, the SA validated through staff interview, resident interview, record review, and in-service reviews that the facility had implemented the following measures to remove the IJ:

1. The SA validated through record review, Resident #2 was assessed at the facility, sent to the Emergency Room, has a care plan for emotional support from Social Services, and was assessed upon her return to the facility by the NP.

2. The SA validated through record review and staff interview, Resident #1 was placed on 1:1 until his transport to a Geri-psych unit. He was discharged from the facility on 09/10/2020.

3. The SA validated through record review and staff interview the reporting of the incident to the State Department of Health, EMS and Police Department notification, and a final investigation was sent to the Department of Health on 09/02/2020.

4. The SA validated through in-service sign in review, content review, and staff interview that an in-service was held for staff for all topics aforementioned on 09/11/2020 at 3:00 PM.

5. The SA validated through in-service sign in sheet and content review, as well as staff interview, an in-service was held with administration on timely reporting as of 09/11/2020 at 5:00 PM.

6. The SA validated through record review and

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staff interview the completion of an audit of care plans for resident who wander and have aggressive behaviors. No issues were found during the audit.

7. The SA validated through resident interviews and staff interviews, all cognitively aware residents were interviewed regarding inappropriate sexual conduct and 25 of 25 stated it had not occurred.

8. The SA validated through record review and staff interview a 100% chart audit for residents exhibiting sexual behaviors was completed, and none have behaviors directed at other residents.

9. The SA validated through record review and staff interview a 100% chart audit of psychiatric progress notes was completed and none were found with issues that needed addressed, or implementation of new orders.

The SA validated on 09/14/2020, that all corrective actions had been taken by the facility to remove the IJ during the survey on 09/12/2020. The IJ was removed on 09/12/2020.