STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035217	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehab at Scottsdale Village Square	2620 North 68th Street Scottsdale, AZ 85257

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47341 Based on clinical record review, resident/staff interviews, facility documentation and policy review and the State Agency (SA) complaint tracking system, the facility failed to protect the rights of one resident (#23) to be free from sexual abuse and one resident (#3) to be free from physical abuse by a staff; and failed to ensure one resident (#45) by another resident (#9). The deficient practice resulted in psychosocial harm to resident #23 and had placed resident #3 and other residents at increased risk for further abuse, serious injury, harm and psychosocial harm. As a result, the condition of Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified. The census was 100. Findings include: On July 31, 2024 at 3:23 p.m., the condition of IJ was identified. The administrator was informed of the facility's failure to ensure residents were free from sexual and physical abuse by staff was found. The administrator presented the removal plan on July 31, 2024 at 6:33 p.m. The administrator was informed that the removal plan was not acceptable and failed to include when an assessment will be completed for the affected residents (#23 and #3); what the plan was with the alleged certified nurse assistant (CNA/#66) to prevent further abuse; when the in-service training for staff would begin and expected to be complete; identify the staff that would complete the in-service training; and, actions the facility will take if a staff did not complete the required in-service/training. A revised removal plan was received on July 31, 2024 at 7:22 p.m. The administrator was informed that the removal plan was accepted at 7:30 p.m. The accepted removal plan included the following: -When an assessment will be completed for the affected residents (#23 and #3); -What the plan was with the alleged certified nurse assistant (CNA/#66) to prevent further abuse; -When the in-service training for staff would begin and expected to be complete; identify the staff that would complete the in-service training; -Actions the facility will take if a staff did not complete the required in-service/training; (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

- Inservice training on abuse for all staff to include contract and volunteers will be completed;

-Medical and Psych evaluation for the affected residents (#23 and #3);

-Provision of emotional support sitters for the affected residents (#23 and #3);

-Interviews with all residents to ensure any unreported abuse is reported and investigated;

-A new administrator was hired; and,

-The alleged perpetrator was terminated.

-All findings and results of audits will be reported to QAPI.

On August 1, 2024 at 1:22 p.m., the condition of IJ was removed after multiple observations were conducted of the facility implementing their removal plan which included resident and staff interviews, personnel record review, in-service training of staff and review of documentation provided by the facility.

Regarding Resident #23

Resident #23 admitted to the facility on [DATE] with diagnoses of schizoaffective disorder, bipolar type, dementia and anxiety disorder.

The ADL (activities of daily living) care plan dated December 21, 2023 revealed that the resident had an ADL self-care performance deficit related to schizophrenia and bipolar disorder that cause her to display resistive to care behaviors. Interventions included to encourage resident to participate to the fullest extent possible with each interaction; provide supportive care, assistance with mobility as needed and document assistance as needed.

The care plan dated January 8, 2024 included the resident had a behavior problem related to yelling, crying, resistive to medications and care, inciting peers and delusional statements. Interventions included to anticipate and meet the resident needs, intervene as necessary to protect the rights and safety of others, divert attention, and monitor behavior episodes and attempt to determine underlying cause.

The quarterly Minimum Data Set (MDS) assessment dated [DATE] included a Brief Interview for Mental Status (BIMS) score of 12 indicating that the resident had moderate cognitive impairment. The assessment included that resident was coded for delusions and verbal behavioral symptoms directed towards others.

The behavior note dated June 16, 2024 included the resident refused to get up from bed; and that, when she needed assistance, she would yell at the top of her lungs for attention.

The behavior notes dated June 19, 2024 included that resident was alert and oriented, refused to wake up from bed and reported that she was not feeling well; and that, the resident was heard yelling and screaming that her back hurts.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A psych follow-up note dated June 26, 2024 revealed that the resident was yelling and screaming during ADLs and hygiene care. A behavior note dated July 9, 2024 included the resident stayed in bed the rest of the afternoon and evening; and that, the resident was yelling and screaming for no reason at all and was redirected with positive impact. The behavior note dated July 11, 2024 revealed resident yelled and screamed with no reason and was redirected with positive impact. The psych follow-up note dated July 17, 2024 revealed that the resident was demanding and had false accusation behaviors on July 12, 2024; was screaming during care and continued to ask to be changed and moved then did not want the care on July 13, 2024; was screaming in her room for no reason on July 14, 2024; was demanding and refused to get up for breakfast and had false accusation behaviors on July 16, 2024; and, was crying and screaming during care, cries when lifted or touched and complained of pain during shift on July 17, 2024. A behavior note dated July 23, 2024 included that the resident was yelling and screaming with no reason and was redirected with positive impact. The psych follow-up note dated July 24, 2024 revealed that the resident was crying and panic during care and had complaints of pain all over her body when touched on July 20, 2024; was yelling on and off through the night and was very agitated on July 23, 2024; and, was screaming during cares even when no contact was made to her and made false allegations on July 24, 2024. The order-administration noted dated July 26, 2024 included that the resident was complaining of being anxious and reported that she had heart pain during the night shift; and was unable to be redirected with 1:1 attention or snack. The eINTERACT note dated July 31, 2024 revealed that the resident reported allegations of sexual abuse by staff. Intervention included 1:1 and 72-hour psychosocial emotional distress monitoring. The social services note dated July 31, 2024 included that resident reported feeling anxiety and uneasiness that had increased recently. Review of the SA complaint tracking system revealed an anonymous report that a resident reported an allegation of sexual abuse by a certified nurse assistant (CNA) and none of it was reported to State or even addressed by management. An interview conducted with the social services director (SSD/staff #44) and social service staff (#12) conducted on July 31, 2024 at 10:15 a.m., both staffs stated that typically in an abuse situation they would make scheduled visits to the resident to make sure they feel safe and ask if they have any concerns. Both staffs said that they might file a grievance about the incident and the interdisciplinary team will brainstorm what was happening and develop new interventions. In an interview with social services (SS/staff #12) conducted on July 31, 2024 the SS stated that she did not receive any reports of abuse for resident #23 or Resident #3 and were not tracking them or completing any follow up. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted on August 1, 2024 at 11:00 a.m. with the alleged CNA (staff #66), who stated that he had never provided any care, nor had been assigned to resident #23; but, he worked on the unit the resident was for the past 4 to 5 months. Later in the interview, the alleged CNA said that he assisted another CNA in using the Hoyer lift to transfer resident #23; and that, he often interacted with the resident in the dayroom if she needed a small item brought to her. Further, the alleged CNA said that resident #23 often calls male staff sexy; and that, sometimes the resident was rude and sometimes was very nice. In an interview with resident #23 conducted on July 31, 2024 at 11:07 a.m., the resident stated that the alleged CNA (staff #66) rubbed on her breasts, and inserted his finger in her vagina during a brief change; and that it had happened up to 10 times in the past several months. The resident stated that she told the DON a week and a half ago, but she never received any updates about her allegations. Further, the resident stated that she had to see the alleged CNA often because the alleged CNA continued to provide care to her roommate after she reported the incident. In an interview with a behavior health staff (BHS/staff #88) conducted on July 31, 2024 at 11:53 a.m. staff #88 stated that resident #23 made a lot of false accusations such as staff was leaving her unattended, and that, the resident felt that the staff go too fast, and were also hurting her during care. Staff #88 stated that the resident did not make any allegations of physical or sexual abuse; and that, the resident's allegation of sexual abuse against the alleged CNA was false accusation because the alleged CNA denied hurting the resident when the alleged CNA was asked. An interview was conducted on July 30, 2024 at 12:35 p.m. with the complainant who stated that she spoke with resident #23 who reported that the alleged CNA was staff #66; and that, the incident happened on July 21, 2024 and it was reported to her by 3 CNAs. Further, the complainant stated that the alleged CNA was allowed to work with residents after the allegation of sexual abuse was reported to the DON and the unit manager. In an interview conducted on July 31, 2024 at 1:04 p.m., the unit manager (staff #55) stated that on July 22, 2024, the charge nurse had come and reported to her the allegation of sexual abuse made by resident #23. The unit manager stated that she went to talk to the resident; but that, the resident was very behavioral. The unit manager said that there was lot of false allegations from the resident who was in cares in pairs as a result of this. Further, the nurse manager stated that she reported the allegations of sexual abuse to the DON; and that, according to the CNAs, the resident reported that the alleged CNA (staff #66) had groped her breasts and fingered her. The unit manager stated she had never heard anything negative about the alleged CNA. In a later interview with the unit manager conducted on July 31, 2024 the unit manager stated that there was an incident with another CNA who felt harassed by the alleged CNA; and that, human resources (HR) and administration had to reprimand the alleged CNA. During an interview with the DON conducted on July 31, 2024 at 1:25 p.m., the DON stated that if there was report of a staff sexually abusing someone she would report it within two hours to the SA. She also said that the protocol post incident for a suspected sexual abuse allegation was to monitor vitals, check to make sure resident was okay and see if they have any changes, social services will follow up with the resident. Regarding resident #23, the DON said that she was not aware of any staff complaints or reports; and that, she did not report anything regarding resident #23 to SA or the police. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with another CNA (staff #99) conducted on July 31, 2024 at 2:04 p.m. Staff #99 stated that resident #23 reported to another CNA that the alleged CNA (staff #66) would touch her inappropriately. Staff #99 stated that she went back to resident #23 to verify the information because many residents on the unit tend to get very confused. Staff #99 stated that resident #23 repeated the allegations to her and she then reported the allegations made to the nurse and unit manager. Further, staff #99 said that the DON ultimately had everyone write statements regarding the incident. In an interview with the DON conducted on July 31, 2024 at 4:16 p.m., the DON stated she had investigated the allegation of sexual abuse of resident #23; and that, the alleged CNA (staff #66) was sent home early on July 21, 2024 and returned on July 23, 2024 when he brought in his statement regarding resident #23. She stated that the alleged CNA was allowed to return because she had completed her investigation. The DON further stated that her investigation included an interview with the alleged CNA (staff #66), interview with staff who witnessed the incident, interview the resident, her roommate, and one person in the room to the left of them. Regarding Resident #3 -Resident #3 was admitted on [DATE] with diagnoses of generalized anxiety disorder, major depressive disorder, and Parkinson's disease. The quarterly MDS assessment dated [DATE] included a BIMS score 5 indicating that the resident had severe cognitive impairment. The MDS also included that the resident had physical and verbal behavioral symptoms directed towards others. The weekly skin check dated July 10, 2024 revealed skin was intact, warm and had a turgor within normal limits The weekly skin check dated July 17, 2024 included that the resident had a healing old small skin tear on the right forearm. The nurse progress note dated July 21, 2024 revealed that the certified nursing assistants (CNA) reported to the nurse that the resident had a bruise to his left wrist, scratches to his right arm, and a blister or pressure injury on his right shoulder. A weekly skin check dated July 23, 2024 included an abrasion to right shoulder, a scratch to right arm, and had a bruise to the left arm. Review of the SA complaint tracking system revealed an anonymous report that on July 21, 2024 the CNAs reported that the CNA the night before had been seen being so rough with a resident that resulted in left bruises and scratches on his arm and wrist. Per the report, the incident reported the incident to management who did not do anything about it. An interview on July 31, 2024 at 9:57 a.m. was conducted with a CNA (staff #22) who stated that she and another CNA (staff #33) walked into the day room on July 21, 2024 when they saw the alleged CNA (staff #66) pushed a table against resident #3. Staff #22 stated that the resident was found to have a bruise on his back and his arm; and that she reported the incident to the DON the following morning. Staff #22 further stated that the DON had her write a statement regarding the details of the incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with the alleged CNA (staff #66) conducted on July 31, 2024 at 11:00 a.m., the alleged CNA stated that he recalled that resident #3 was sitting in a wheelchair at the dining table; and that the resident was out of control and was kicking, punching, and grabbing. The alleged CNA stated that the resident stood up which resulted in his wheelchair to flip backwards so the alleged CNA pushed the table into the resident, and then placed a chair beside the resident because the resident was aggressive. The alleged CNA stated that resident was boxed in the wall with the table in front, on the side and a chair on the other side, while the resident sat in his wheelchair. He stated the nurse told him to do this and he did not note any bruises or scratches on the resident. The alleged CNA said that he was never suspended after the incident, but he was told to go home 30 minutes before his shift ended. He stated that he met with Human Resources (HR) and the DON who told him to write a statement regarding the incident. During an interview with the DON on July 31, 2024 at 4:16 p.m., the DON stated that resident #3 had an abrasion on his back and right side and bruising on his hands which were likely resulted from the resident swinging his arms and being agitated. She stated she had an incident report for the incident; however, she was not able to provide a copy of the incident report. The DON also stated that she did not consider the event reportable because of the resident's history of agitation and swinging of his arms and sitting up in his wheelchair repeatedly. Regarding Residents #45 and #9 -Resident #45 was admitted on [DATE] with diagnoses of dementia without behavioral/psychotic and mood disturbance and anxiety. The care plan initiated on November 29. 2023 revealed the resident had impaired cognitive function/dementia or impaired thought processes related to dementia. The quarterly MDS assessment dated [DATE] included a BIMS score 7 indicating the resident had severe cognitive impairment. The care plan with revision date of July 4, 2024 included the resident had behavior problems such as intrusive with peers, had sexually inappropriate behaviors such as alluring men to her room and wandered at night into other resident rooms. The goal was that the resident will have fewer episodes of behavior. Interventions included 1:1, to monitor behavior episodes and attempt to determine underlying cause. A late entry health status note dated July 14, 2024 included that on July 13, 2024 there was physical touching between two residents. The documentation did not include description of the incident. The behavior note dated July 14, 2024 included that the resident had exit seeking behavior throughout the shift, going to each gate and attempted to open them. The documentation included that redirection was effective. A physician order dated July 14, 2024 included for every 15 minutes checks for 3 days. A health status note dated July 15, 2024 included that on July 13, 2024 physical touching between two residents were noted. However, the documentation did not include description of the incident (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The physician order dated July 15, 2024 revealed that the resident was on alert charting two times a day for 3 days for sexually inappropriate behaviors. The behavior note dated July 15, 2024 included the resident was on 1:1 care. The physician order dated July 16, 2024 included for 1:1 every shift for every 15 minutes checks for 3 days. The orders-administration note dated July 16, 2024 revealed that the resident had a room change and was on alert charting to include any concerns, issues and interventions for sexually inappropriate behaviors. The alert note dated July 16, 2024 included that the resident was on 1:1 due to sexually inappropriate behaviors. The alert note dated July 17, 2024 revealed that the resident continued on alert charting for room change; and that. The resident was extremely agitated throughout the entire shift. The documentation included that the resident argued with staff that she needed to go over the fence back to her home and she had things she needed to do. The discharge summary note dated July 23, 2024 included that the resident was discharged from the facility at 12:00 p.m. There was no documentation found in the clinical record that the resident was assessed for any consensual relationship with resident #9. -Resident #9 was admitted on [DATE] with diagnosis of mild vascular dementia with other behavioral disturbance. The admission MDS assessment dated [DATE] revealed a BIMS score of 7 indicating the resident had severe cognitive impairment. The MDS also coded for hallucinations, delusion, physical and verbal behaviors towards others. The care plan with revision date of June 5, 2024 included the resident had impaired cognitive function or dementia or impaired though processes related to vascular dementia. Interventions included to administer medication as ordered and to monitor and document for side effects and effectiveness. The orders-administration note dated July 9, 2024 included that the resident had verbal behaviors towards others such as threatening comments, screaming, yelling, cursing, name calling, racial slurs/comments and sexually inappropriate comments. The physician orders dated July 10, 2024 for an anticonvulsant to treat his verbal and physical aggression related to dementia. The psych follow-up note dated July 10, 2024 included that the resident was alert and oriented to person, uncooperative, disruptive, showed impulsivity, had impaired judgment and insight. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A behavior note dated July 10, 2024 included that the resident started yelling at another resident because the other resident sat in the recliner close to the table. Another behavior note dated July 10, 2024 included that the resident was upset and became verbally aggressive and began posturing toward the other resident. Per the documentation, staff intervened and redirected the other resident from the table. A nursing note dated July 11, 2024 included that the resident continued to be on alert charting for new medication. Per the documentation, the resident was pacing the unit and yelled at staff regarding locked doors; and that, the resident was redirected back to the table in the dayroom. The physician progress note dated July 11, 2024 revealed that the resident was alert and oriented x 1; and, had a diagnosis of dementia with behaviors. The order-administration notes dated July 11, 2024 included that the resident had behaviors directed at others such as public sexual acts, disrobing in public and throwing or smearing bodily waste. The documentation also included that the resident had been intrusive with a female peer (resident #45), and had been separated 10 times; and, the resident believed that resident #45 was his girlfriend. However, review of the clinical record revealed no documentation that resident #9 was assessed for consensual relationship with the other resident (#45). A late entry health status note dated July 14, 2024 included that on July 13, 2024, physical touching between two residents were noted. The documentation did not include description of the details of the incident. The behavior note dated July 14, 2024 included that the resident was found in the room of resident #45 and he was laying in the bed of resident #45 by a CNA. Per the documentation, the resident did not answer when the CNA asked him what he was doing in the room and bed of resident #45. The care plan with revision date of July 24, 2024 included that the resident had a behavior problem. Interventions included to discuss the resident's behavior, explain/reinforce why behavior was inappropriate and/or unacceptable to the resident, minimize behavior episodes and attempt to determine underlying cause, and to anticipate and meet the resident's needs. The behavior note dated July 15, 2024 included that the resident was wandering the unit asking different residents and staff where fell ow resident was located. The orders-administration note dated July 15, 2024 revealed that the resident was on alert charting for 72 hours for sexually inappropriate behavior. Per the documentation resident stayed in his room all morning, came out for lunch and went looking for the resident (#45). The psych follow-up note dated July 17, 2024 included that the resident was found to be sexually inappropriate with another resident; and that, the resident was moved to another unit. His care plan initiated on June 2, 2024 did not address his sexually inappropriate behaviors. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with resident #45 was attempted on July 31, 2024 but was not successful because the resident was not able to answer questions. In an interview with the power of attorney/ responsible party for resident #45 conducted on July 31, 2024 at 8:20 a.m. she stated that the facility had never done an evaluation, informal or otherwise, to assess whether or not resident #45 was able to consent into a sexual relationship with anyone. She stated resident #45 has dementia and intellectual ability to pick sexual partners; and, was not able to independently pick her clothing each day; and that, she had made all treatment decisions for resident #45 in the last 2 years. Regarding the incident, the POA stated that she spoke with resident #45 about the incident and the resident was shocked and was not able to recall the events. An interview was conducted on July 31, 2024 at 10:15 a.m. with the Social Services SS/staff #12) and the social services director (SSD/staff #44) who both stated that social services did not determine or complete any assessments whether or not residents #45 and #9 were capable of giving consent to engage in a consensual sexual relationship. The SS also said that the assessment and determination would also be up to the DON, the administrator as well as the psychiatric provider. The SS stated that in her personal opinion cognitive function would be the criteria to disqualify a resident from being able to have a consensual relationship. In an interview with the psychiatric provider conducted on July 31, 2024 at 10:38 a.m., the psychiatric provider said that both residents (#45 and #9) had no cognitive capacity to make a medical decision including a sexual or intimate relationship decision. An interview with Licensed Practical Nurse (LPN/staff #10) was conducted on July 31, 2024 at 10:52 a.m. The LPN stated that if she saw any two residents engaged in sexual intercourse she would immediately separate two residents ensure both residents were safe and then report the incident immediately to the Director of Nursing (DON) and family if applicable. She stated staff may start 15-minute checks on the involved residents; and, she would consider this incident as an abuse allegation until she got more information or completed an investigation on the incident. An interview was conducted on July 31, 2024 at 1:02 p.m. with resident #9 who stated that he had a consensual relationship and had sexual intercourse one or two times with resident #45. He stated there had been no conversation about the relationship with the doctor before or after the relationship. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with the DON (staff #90) conducted on July 31, 2024, the DON stated that per regulations residents can have a sexual relationship with other residents; and it depends on the resident's cognitive ability to consent. She stated that the resident's POA can consent to it as well. The DON said a resident would be disqualified from being able to consent if the resident was are not able to give consent and/or the resident was not okay with it. She stated that the assessment of resident's ability to give consent to consensual sexual relationship would be done by a nurse and the DON; and, this would be documented in resident's clinical record. She stated if two residents were found engaging in sexual intercourse, it would not be initially assumed to as sexual abuse. The DON said that there would be an investigation and that was how the facility would make sure both residents were safe; and, it would not be reported to the State Agency (SA) or police. Regarding the incident between resident #45 and #9, the DON stated that she recalled an incident between both residents (#45 and #9) but she cannot recall if the incident was about the sexual intercourse. She stated that a CNA reported to her on the night of July 13, 2024 that when the CNA went into room of resident #45, she found resident #45 performing oral sex on resident #9. The DON said that both residents were assessed at that time regarding whether both residents could consent. However, the DON said that both residents were not assessed prior to this incident. She stated the assessment for the ability of both residents to consent should be found in the progress note in the clinical record. During the interview, a review of the clinical record for both residents was conducted with the DON who stated that there was no documentation found in the clinical record of both resident #45 and #9 of the assessment to consent to consensual sexual relationship. The facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, with revision date of April 2021, it stated that residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The facility policy on Abuse, Neglect, Misappropriation- Reporting and investigating with last revision date of September 2022 revealed that any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035217	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehab at Scottsdale Village Square	2620 North 68th Street Scottsdale, AZ 85257

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47341 Based on clinical record reviews, resident/staff interviews, facility documentation and policy review and the State Agency (SA) complaint tracking system, the facility failed to report allegations of abuse to the State Agency, Adult Protective Services (APS) and local law enforcement for three residents (#23, #3 and #45). The sample was 3. The deficient practice could result in abuse not identified and investigated and place all residents at risk for further abuse. Findings include: Regarding Resident #23 Resident #23 admitted to the facility on [DATE] with diagnoses of schizoaffective disorder, bipolar type, dementia and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] included a Brief Interview for Mental Status (BIMS) score of 12 indicating that the resident had moderate cognitive impairment. The assessment included that resident was coded for delusions and verbal behavioral symptoms directed towards others. A psych follow-up note dated June 26, 2024 revealed that the resident was yelling and screaming during ADLs and hygiene care. The psych follow-up note dated July 17, 2024 revealed that the resident was demanding and had false accusation behaviors on July 12, 2024; was screaming during care and continued to ask to be changed and moved then did not want the care on July 13, 2024; was screaming in her room for no reason on July 14, 2024; was demanding and refused to get up for breakfast and had false accusation behaviors on July 16, 2024; and, was crying and screaming during care, cries when lifted or touched and complained of pain during shift on July 17, 2024. The psych follow-up note dated July 24, 2024 revealed that the resident was crying and panic during care and had complaints of pain all over her body when touched on July 20, 2024; was yelling on and off through the night and was very agitated on July 23, 2024; and, was screaming during cares even when no contact was made to her and made false allegations on July 24, 2024. The order-administration noted dated July 26, 2024 included that the resident was complaining of being anxious and reported that she had heart pain during the night shift; and was unable to be redirected with 1:1 attention or snack. The eINTERACT note dated July 31, 2024 revealed that the resident reported allegations of sexual abuse by staff. Intervention included 1:1 and 72-hour psychosocial emotional distress monitoring. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035217	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Rehab at Scottsdale Village Square		STREET ADDRESS, CITY, STATE, ZIP CODE 2620 North 68th Street Scottsdale, AZ 85257	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Actual harm Residents Affected - Few	Review of the SA complaint tracking system revealed an anonymous report that a resident reported an allegation of sexual abuse by a certified nurse assistant (CNA) and none of it was reported to State or even addressed by management. The documentation included that the alleged date of incident was July 13, 2024. However, there was no evidence found that an allegation of sexual abuse for resident #23 was reported to appropriate local agencies such as the SA, police, Adult Protective Services (APS), Ombudsman and the police. In an interview with social services (SS/staff #12) conducted on July 31, 2024 the SS stated that she did not receive any reports of abuse for resident #23 or Resident #3 and were not tracking them or completing any follow up. An interview was conducted on August 1, 2024 at 11:00 a.m. with the alleged CNA (staff #66), who stated that he had never provided any care, nor had been assigned to resident #23; but, he worked on the unit the resident was for the past 4 to 5 months. Later in the interview, the alleged CNA said that he assisted another CNA in using the Hoyer lift to transfer resident #23; and that, he often interacted with the resident in the dayroom if she needed a small item brought to her. Further, the alleged CNA said that resident #23 often calls male staff sexy; and that, sometimes the resident was rude and sometimes was very nice. In an interview with resident #23 conducted on July 31, 2024 at 11:07 a.m., the resident stated that the alleged CNA (staff #66) rubbed on her breasts, and inserted his finger in her vagina during a brief change; and that it had happened up to 10 times in the past several months. The resident stated that she told the DON a week and a half ago, but she never received any updates about her allegations. Further, the resident stated that she had to see the alleged CNA often because the alleged CNA continued to provide care to her roommate after she reported the incident. In an interview with a behavior health staff (BHS/staff #88) conducted on July 31, 2024 at 11:53 a.m. staff #88 stated that resident #23 made a lot of false accusations such as staff was leaving her unattended, and that, the resident felt that the staff go too fast, and were also hurting her during care. Staff #88 stated that the resident did not make any allegations of physical or sexual abuse; and that, the resident's allegation of sexual abuse against the alleged CNA was false accusation because the alleged CNA denied hurting the resident when the alleged CNA was asked. Staff #88 said that he was a mandatory reported but he did not report this incident to anyone. An interview was conducted on July 30, 2024 at 12:35 p.m. with the complainant who stated that she spoke with resident #23 who reported that the alleged CNA was staff #66; and that, the incident happened on July 21, 2024 and it was reported to her by 3 CNAs. Further, the complainant stated that the alleged CNA was allowed to work with residents after the allegation of sexual abuse was reported to the DON and the unit manager. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035217	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024

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F 0609

Level of Harm - Actual harm

Residents Affected - Few

In an interview conducted on July 31, 2024 at 1:04 p.m., the unit manager (staff #55) stated that on July 22, 2024, the charge nurse had come and reported to her the allegation of sexual abuse made by resident #23. The unit manager stated that she went to talk to the resident; but that, the resident was very behavioral. The unit manager said that there was lot of false allegations from the resident who was in cares in pairs as a result of this. Further, the nurse manager stated that she reported the allegations of sexual abuse to the DON; and that, according to the CNAs, the resident reported that the alleged CNA (staff #66) had groped her breasts and fingered her. The unit manager stated she had never heard anything negative about the alleged CNA.

During an interview with the DON conducted on July 31, 2024 at 1:25 p.m., the DON stated that if there was report of a staff sexually abusing someone she would report it within two hours to the SA. She also said that the protocol post incident for a suspected sexual abuse allegation was to monitor vitals, check to make sure resident was okay and see if they have any changes, social services will follow up with the resident. Regarding resident #23, the DON said that she was not aware of any staff complaints or reports; and that, she did not report anything regarding resident #23 to SA or the police.

An interview with another CNA (staff #99) conducted on July 31, 2024 at 2:04 p.m. Staff #99 stated that resident #23 reported to another CNA that the alleged CNA (staff #66) would touch her inappropriately. Staff #99 stated that she went back to resident #23 to verify the information because many residents on the unit tend to get very confused. Staff #99 stated that resident #23 repeated the allegations to her and she then reported the allegations made to the nurse and unit manager. Further, staff #99 said that the DON ultimately had everyone write statements regarding the incident.

During another interview with the DON (staff #90) conducted on July 31, 2024, the DON stated that per regulations residents can have a sexual relationship with other residents; and it depends on the resident's cognitive ability to consent. She stated that the resident's POA can consent to it as well. The DON said a resident would be disqualified from being able to consent if the resident was are not able to give consent and/or the resident was not okay with it. She stated that the assessment of resident's ability to give consent to consensual sexual relationship would be done by a nurse and the DON; and, this would be documented in resident's clinical record. She stated if two residents were found engaging in sexual intercourse, it would not be initially assumed to as sexual abuse. The DON said that there would be an investigation and that was how the facility would make sure both residents were safe; and, it would not be reported to the State Agency (SA) or police.

Regarding Resident #3

-Resident #3 was admitted on [DATE] with diagnoses of generalized anxiety disorder, major depressive disorder, and Parkinson's disease.

The quarterly MDS assessment dated [DATE] included a BIMS score 5 indicating that the resident had severe cognitive impairment. The MDS also included that the resident had physical and verbal behavioral symptoms directed towards others.

The nurse progress note dated July 21, 2024 revealed that the certified nursing assistants (CNA) reported to the nurse that the resident had a bruise to his left wrist, scratches to his right arm, and a blister or pressure injury on his right shoulder.

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NAME OF PROVIDER OR SUPPLIER Rehab at Scottsdale Village Square		STREET ADDRESS, CITY, STATE, ZIP CODE 2620 North 68th Street Scottsdale, AZ 85257	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Actual harm Residents Affected - Few	A weekly skin check dated July 23, 2024 included an abrasion to right shoulder, a scratch to right arm, and had a bruise to the left arm. Review of the SA complaint tracking system revealed an anonymous report that on July 21, 2024 the CNAs reported that the CNA the night before had been seen being so rough with a resident that resulted in left bruises and scratches on his arm and wrist. Per the report, the incident reported the incident to management who did not do anything about it. An interview on July 31, 2024 at 9:57 a.m. was conducted with a CNA (staff #22) who stated that she and another CNA (staff #33) walked into the day room on July 21, 2024 when they saw the alleged CNA (staff #66) pushed a table against resident #3. Staff #22 stated that the resident was found to have a bruise on his back and his arm; and that she reported the incident to the DON the following morning. Staff #22 further stated that the DON had her write a statement regarding the details of the incident. In an interview with the alleged CNA (staff #66) conducted on July 31, 2024 at 11:00 a.m., the alleged CNA stated that he recalled that resident #3 was sitting in a wheelchair at the dining table; and that the resident was out of control and was kicking, punching, and grabbing. The alleged CNA stated that the resident stood up which resulted in his wheelchair to flip backwards so the alleged CNA pushed the table into the resident, and then placed a chair beside the resident because the resident was aggressive. The alleged CNA stated that resident was boxed in the wall with the table in front, on the side and a chair on the other side, while the resident sat in his wheelchair. He stated the nurse told him to do this and he did not note any bruises or scratches on the resident. The alleged CNA said that he was never suspended after the incident, but he was told to go home 30 minutes before his shift ended. He stated that he met with Human Resources (HR) and the DON who told him to write a statement regarding the incident. There was no evidence found that this incident was reported to appropriate local agencies such as the SA, police, Adult Protective Services (APS), Ombudsman and the police. During an interview with the DON on July 31, 2024 at 4:16 p.m., the DON stated that resident #3 had an abrasion on his back and right side and bruising on his hands which were likely resulted from the resident swinging his arms and being agitated. She stated she had an incident report for the incident; however, she was not able to provide a copy of the incident report. The DON also stated that she did not consider the event reportable because of the resident's history of agitation and swinging of his arms and sitting up in his wheelchair repeatedly. Regarding Residents #45 and #9 -Resident #45 was admitted on [DATE] with diagnoses of dementia without behavioral/psychotic and mood disturbance and anxiety. The quarterly MDS assessment dated [DATE] included a BIMS score 7 indicating the resident had severe cognitive impairment. (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	The care plan with revision date of July 4, 2024 included the resident had behavior problems such as intrusive with peers, had sexually inappropriate behaviors such as alluring men to her room and wandered at night into other resident rooms. The goal was that the resident will have fewer episodes of behavior. Interventions included 1:1, to monitor behavior episodes and attempt to determine underlying cause. A late entry health status note dated July 14, 2024 included that on July 13, 2024 there was physical touching between two residents. The documentation did not include description of the incident. A health status note dated July 15, 2024 included that on July 13, 2024 physical touching between two residents were noted. However, the documentation did not include description of the incident The physician order dated July 15, 2024 revealed that the resident was on alert charting two times a day for 3 days for sexually inappropriate behaviors. The orders-administration note dated July 16, 2024 revealed that the resident had a room change and was on alert charting to include any concerns, issues and interventions for sexually inappropriate behaviors. The alert note dated July 16, 2024 included that the resident was on 1:1 due to sexually inappropriate behaviors. -Resident #9 was admitted on [DATE] with diagnosis of mild vascular dementia with other behavioral disturbance. The admission MDS assessment dated [DATE] revealed a BIMS score of 7 indicating the resident had severe cognitive impairment. The MDS also coded for hallucinations, delusion, physical and verbal behaviors towards others. The orders-administration note dated July 9, 2024 included that the resident had verbal behaviors towards others such as threatening comments, screaming, yelling, cursing, name calling, racial slurs/comments and sexually inappropriate comments. The order-administration notes dated July 11, 2024 included that the resident had behaviors directed at others such as public sexual acts, disrobing in public and throwing or smearing bodily waste. The documentation also included that the resident had been intrusive with a female peer (resident #45), and had been separated 10 times; and, the resident believed that resident #45 was his girlfriend. A late entry health status note dated July 14, 2024 included that on July 13, 2024, physical touching between two residents were noted. The documentation did not include description of the details of the incident. The behavior note dated July 14, 2024 included that the resident was found in the room of resident #45 and he was laying in the bed of resident #45 by a CNA. Per the documentation, the resident did not answer when the CNA asked him what he was doing in the room and bed of resident #45. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Actual harm Residents Affected - Few	Despite documentation of the incident between resident #45 and #9, there was no evidence found that this incident was reported to appropriate local agencies such as the SA, police, Adult Protective Services (APS), Ombudsman and the police. In an interview with the psychiatric provider conducted on July 31, 2024 at 10:38 a.m., the psychiatric provider said that both residents (#45 and #9) had no cognitive capacity to make a medical decision including a sexual or intimate relationship decision. An interview with Licensed Practical Nurse (LPN/staff #10) was conducted on July 31, 2024 at 10:52 a.m. The LPN stated that if she saw any two residents engaged in sexual intercourse she would immediately separate two residents ensure both residents were safe and then report the incident immediately to the Director of Nursing (DON) and family if applicable. She stated staff may start 15-minute checks on the involved residents; and, she would consider this incident as an abuse allegation until she got more information or completed an investigation on the incident. An interview was conducted on July 31, 2024 at 1:02 p.m. with resident #9 who stated that he had a consensual relationship and had sexual intercourse one or two times with resident #45. He stated there had been no conversation about the relationship with the doctor before or after the relationship. During an interview with the DON (staff #90) conducted on July 31, 2024, the DON stated that if two residents were found engaging in sexual intercourse, it would not be initially assumed to as sexual abuse. The DON said that there would be an investigation and that was how the facility would make sure both residents were safe; and, it would not be reported to the State Agency (SA) or police. Regarding the incident between resident #45 and #9, the DON stated that she recalled an incident between both residents (#45 and #9) but she cannot recall if the incident was about the sexual intercourse. She stated that a CNA reported to her on the night of July 13, 2024 that when the CNA went into room of resident #45, she found resident #45 performing oral sex on resident #9. The DON said that both residents were assessed at that time regarding whether both residents could consent. However, the DON said that both residents were not assessed prior to this incident. She stated the assessment for the ability of both residents to consent should be found in the progress note in the clinical record. During the interview, a review of the clinical record for both residents was conducted with the DON who stated that there was no documentation found in the clinical record of both resident #45 and #9 of the assessment to consent to consensual sexual relationship. The facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, with revision date of April 2021, it stated that residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The policy also included that they will establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems; will implement measures to address factors that may lead to abusive situations, for example: instruct staff regarding appropriate ways to address interpersonal conflicts; and help staff understand how cultural, religious and ethnic differences can lead to misunderstanding and conflicts; will investigate and report any allegations within timeframes required by federal requirements; and, protect residents from any further harm during investigations.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47341 Based on clinical record reviews, resident/staff interviews, facility documentation and policy review, the facility failed to ensure allegations of abuse was thoroughly investigated. The sample was 3. The deficient practice could result in residents at continued risk for further abuse. Findings include: Regarding Resident #23 Resident #23 admitted to the facility on [DATE] with diagnoses of schizoaffective disorder, bipolar type, dementia and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] included a Brief Interview for Mental Status (BIMS) score of 12 indicating that the resident had moderate cognitive impairment. The assessment included that resident was coded for delusions and verbal behavioral symptoms directed towards others. The psych follow-up note dated July 17, 2024 revealed that the resident was demanding and had false accusation behaviors on July 12, 2024; was screaming during care and continued to ask to be changed and moved then did not want the care on July 13, 2024; was screaming in her room for no reason on July 14, 2024; was demanding and refused to get up for breakfast and had false accusation behaviors on July 16, 2024; and, was crying and screaming during care, cries when lifted or touched and complained of pain during shift on July 17, 2024. The psych follow-up note dated July 24, 2024 revealed that the resident was crying and panic during care and had complaints of pain all over her body when touched on July 20, 2024; was yelling on and off through the night and was very agitated on July 23, 2024; and, was screaming during cares even when no contact was made to her and made false allegations on July 24, 2024. The order-administration noted dated July 26, 2024 included that the resident was complaining of being anxious and reported that she had heart pain during the night shift; and was unable to be redirected with 1:1 attention or snack. The eINTERACT note dated July 31, 2024 revealed that the resident reported allegations of sexual abuse by staff. Intervention included 1:1 and 72-hour psychosocial emotional distress monitoring. Review of the SA complaint tracking system revealed an anonymous report that a resident reported an allegation of sexual abuse by a certified nurse assistant (CNA) and none of it was reported to State or even addressed by management. The documentation included that the alleged date of incident was July 13, 2024. However, there was no evidence found that an allegation of sexual abuse for resident #23 was reported to appropriate local agencies such as the SA, police, Adult Protective Services (APS), Ombudsman and the police. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was also no evidence that this allegation was thoroughly investigated to include the following: -Protection of residents from further abuse by the alleged CNA; -Review of documentation and evidence, interviews of the person reporting the incident, any witnesses, the affected resident or the resident's representative (if appropriate), other residents to whom the alleged CNA provided care and services; -Interview of the alleged CNA; and, -Review of all the events leading up to the alleged incident. In an interview with social services (SS/staff #12) conducted on July 31, 2024 the SS stated that she did not receive any reports of abuse for resident #23 or Resident #3 and were not tracking them or completing any follow up. An interview was conducted on August 1, 2024 at 11:00 a.m. with the alleged CNA (staff #66), who stated that he had never provided any care, nor had been assigned to resident #23; but, he worked on the unit the resident was for the past 4 to 5 months. Later in the interview, the alleged CNA said that he assisted another CNA in using the Hoyer lift to transfer resident #23; and that, he often interacted with the resident in the dayroom if she needed a small item brought to her. Further, the alleged CNA said that resident #23 often calls male staff sexy; and that, sometimes the resident was rude and sometimes was very nice. In an interview with resident #23 conducted on July 31, 2024 at 11:07 a.m., the resident stated that the alleged CNA (staff #66) rubbed on her breasts, and inserted his finger in her vagina during a brief change; and that it had happened up to 10 times in the past several months. The resident stated that she told the DON a week and a half ago, but she never received any updates about her allegations. Further, the resident stated that she had to see the alleged CNA often because the alleged CNA continued to provide care to her roommate after she reported the incident. In an interview with a behavior health staff (BHS/staff #88) conducted on July 31, 2024 at 11:53 a.m. staff #88 stated that resident #23 made a lot of false accusations such as staff was leaving her unattended, and that, the resident felt that the staff go too fast, and were also hurting her during care. Staff #88 stated that the resident did not make any allegations of physical or sexual abuse; and that, the resident's allegation of sexual abuse against the alleged CNA was false accusation because the alleged CNA denied hurting the resident when the alleged CNA was asked. Staff #88 said that he was a mandatory reported but he did not report this incident to anyone. An interview was conducted on July 30, 2024 at 12:35 p.m. with the complainant who stated that she spoke with resident #23 who reported that the alleged CNA was staff #66; and that, the incident happened on July 21, 2024 and it was reported to her by 3 CNAs. Further, the complainant stated that the alleged CNA was allowed to work with residents after the allegation of sexual abuse was reported to the DON and the unit manager. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview conducted on July 31, 2024 at 1:04 p.m., the unit manager (staff #55) stated that on July 22, 2024, the charge nurse had come and reported to her the allegation of sexual abuse made by resident #23. The unit manager stated that she went to talk to the resident; but that, the resident was very behavioral. The unit manager said that there was lot of false allegations from the resident who was in cares in pairs as a result of this. Further, the nurse manager stated that she reported the allegations of sexual abuse to the DON; and that, according to the CNAs, the resident reported that the alleged CNA (staff #66) had groped her breasts and fingered her. The unit manager stated she had never heard anything negative about the alleged CNA. During an interview with the DON conducted on July 31, 2024 at 1:25 p.m., the DON stated that if there was report of a staff sexually abusing someone she would report it within two hours to the SA. She also said that the protocol post incident for a suspected sexual abuse allegation was to monitor vitals, check to make sure resident was okay and see if they have any changes, social services will follow up with the resident. Regarding resident #23, the DON said that she was not aware of any staff complaints or reports; and that, she did not report anything regarding resident #23 to SA or the police. An interview with another CNA (staff #99) conducted on July 31, 2024 at 2:04 p.m. Staff #99 stated that resident #23 reported to another CNA that the alleged CNA (staff #66) would touch her inappropriately. Staff #99 stated that she went back to resident #23 to verify the information because many residents on the unit tend to get very confused. Staff #99 stated that resident #23 repeated the allegations to her and she then reported the allegations made to the nurse and unit manager. Further, staff #99 said that the DON ultimately had everyone write statements regarding the incident. During another interview with the DON (staff #90) conducted on July 31, 2024, the DON stated that per regulations residents can have a sexual relationship with other residents; and it depends on the resident's cognitive ability to consent. She stated that the resident's POA can consent to it as well. The DON said a resident would be disqualified from being able to consent if the resident was are not able to give consent and/or the resident was not okay with it. She stated that the assessment of resident's ability to give consent to consensual sexual relationship would be done by a nurse and the DON; and, this would be documented in resident's clinical record. She stated if two residents were found engaging in sexual intercourse, it would not be initially assumed to as sexual abuse. The DON said that there would be an investigation and that was how the facility would make sure both residents were safe; and, it would not be reported to the State Agency (SA) or police. Regarding Resident #3 -Resident #3 was admitted on [DATE] with diagnoses of generalized anxiety disorder, major depressive disorder, and Parkinson's disease. The quarterly MDS assessment dated [DATE] included a BIMS score 5 indicating that the resident had severe cognitive impairment. The MDS also included that the resident had physical and verbal behavioral symptoms directed towards others. The nurse progress note dated July 21, 2024 revealed that the certified nursing assistants (CNA) reported to the nurse that the resident had a bruise to his left wrist, scratches to his right arm, and a blister or pressure injury on his right shoulder. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Rehab at Scottsdale Village Square		STREET ADDRESS, CITY, STATE, ZIP CODE 2620 North 68th Street Scottsdale, AZ 85257	

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A weekly skin check dated July 23, 2024 included an abrasion to right shoulder, a scratch to right arm, and had a bruise to the left arm. Review of the SA complaint tracking system revealed an anonymous report that on July 21, 2024 the CNAs reported that the CNA the night before had been seen being so rough with a resident that resulted in left bruises and scratches on his arm and wrist. Per the report, the incident reported the incident to management who did not do anything about it. An interview on July 31, 2024 at 9:57 a.m. was conducted with a CNA (staff #22) who stated that she and another CNA (staff #33) walked into the day room on July 21, 2024 when they saw the alleged CNA (staff #66) pushed a table against resident #3. Staff #22 stated that the resident was found to have a bruise on his back and his arm; and that she reported the incident to the DON the following morning. Staff #22 further stated that the DON had her write a statement regarding the details of the incident. In an interview with the alleged CNA (staff #66) conducted on July 31, 2024 at 11:00 a.m., the alleged CNA stated that he recalled that resident #3 was sitting in a wheelchair at the dining table; and that the resident was out of control and was kicking, punching, and grabbing. The alleged CNA stated that the resident stood up which resulted in his wheelchair to flip backwards so the alleged CNA pushed the table into the resident, and then placed a chair beside the resident because the resident was aggressive. The alleged CNA stated that resident was boxed in the wall with the table in front, on the side and a chair on the other side, while the resident sat in his wheelchair. He stated the nurse told him to do this and he did not note any bruises or scratches on the resident. The alleged CNA said that he was never suspended after the incident, but he was told to go home 30 minutes before his shift ended. He stated that he met with Human Resources (HR) and the DON who told him to write a statement regarding the incident. There was no evidence found that this incident was reported to appropriate local agencies such as the SA, police, Adult Protective Services (APS), Ombudsman and the police. There was also no evidence that this allegation was thoroughly investigated to include the following: -Protection of residents from further abuse by the alleged CNA; -Review of documentation and evidence, interviews of the person reporting the incident, any witnesses, the affected resident or the resident's representative (if appropriate), other residents to whom the alleged CNA provided care and services; -Interview of the alleged CNA; and, -Review of all the events leading up to the alleged incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON on July 31, 2024 at 4:16 p.m., the DON stated that resident #3 had an abrasion on his back and right side and bruising on his hands which were likely resulted from the resident swinging his arms and being agitated. She stated she had an incident report for the incident; however, she was not able to provide a copy of the incident report. The DON also stated that she did not consider the event reportable because of the resident's history of agitation and swinging of his arms and sitting up in his wheelchair repeatedly. Regarding Residents #45 and #9 -Resident #45 was admitted on [DATE] with diagnoses of dementia without behavioral/psychotic and mood disturbance and anxiety. The quarterly MDS assessment dated [DATE] included a BIMS score 7 indicating the resident had severe cognitive impairment. The care plan with revision date of July 4, 2024 included the resident had behavior problems such as intrusive with peers, had sexually inappropriate behaviors such as alluring men to her room and wandered at night into other resident rooms. The goal was that the resident will have fewer episodes of behavior. Interventions included 1:1, to monitor behavior episodes and attempt to determine underlying cause. A late entry health status note dated July 14, 2024 included that on July 13, 2024 there was physical touching between two residents. The documentation did not include description of the incident. A health status note dated July 15, 2024 included that on July 13, 2024 physical touching between two residents were noted. However, the documentation did not include description of the incident The physician order dated July 15, 2024 revealed that the resident was on alert charting two times a day for 3 days for sexually inappropriate behaviors. The orders-administration note dated July 16, 2024 revealed that the resident had a room change and was on alert charting to include any concerns, issues and interventions for sexually inappropriate behaviors. The alert note dated July 16, 2024 included that the resident was on 1:1 due to sexually inappropriate behaviors. -Resident #9 was admitted on [DATE] with diagnosis of mild vascular dementia with other behavioral disturbance. The admission MDS assessment dated [DATE] revealed a BIMS score of 7 indicating the resident had severe cognitive impairment. The MDS also coded for hallucinations, delusion, physical and verbal behaviors towards others. The orders-administration note dated July 9, 2024 included that the resident had verbal behaviors towards others such as threatening comments, screaming, yelling, cursing, name calling, racial slurs/comments and sexually inappropriate comments. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The order-administration notes dated July 11, 2024 included that the resident had behaviors directed at others such as public sexual acts, disrobing in public and throwing or smearing bodily waste. The documentation also included that the resident had been intrusive with a female peer (resident #45), and had been separated 10 times; and, the resident believed that resident #45 was his girlfriend. A late entry health status note dated July 14, 2024 included that on July 13, 2024, physical touching between two residents were noted. The documentation did not include description of the details of the incident. The behavior note dated July 14, 2024 included that the resident was found in the room of resident #45 and he was laying in the bed of resident #45 by a CNA. Per the documentation, the resident did not answer when the CNA asked him what he was doing in the room and bed of resident #45. Despite documentation of the incident between resident #45 and #9, there was no evidence found that this incident was reported to appropriate local agencies such as the SA, police, Adult Protective Services (APS), Ombudsman and the police. There was also no evidence that this allegation was thoroughly investigated to include the following: -Review of documentation and evidence, interviews of the person reporting the incident, any witnesses, the affected resident or the resident's representative (if appropriate); -Interview of the alleged perpetrator (resident #9); and, -Review of all the events leading up to the alleged incident. In an interview with the psychiatric provider conducted on July 31, 2024 at 10:38 a.m., the psychiatric provider said that both residents (#45 and #9) had no cognitive capacity to make a medical decision including a sexual or intimate relationship decision. An interview with Licensed Practical Nurse (LPN/staff #10) was conducted on July 31, 2024 at 10:52 a.m. The LPN stated that if she saw any two residents engaged in sexual intercourse she would immediately separate two residents ensure both residents were safe and then report the incident immediately to the Director of Nursing (DON) and family if applicable. She stated staff may start 15-minute checks on the involved residents; and, she would consider this incident as an abuse allegation until she got more information or completed an investigation on the incident. An interview was conducted on July 31, 2024 at 1:02 p.m. with resident #9 who stated that he had a consensual relationship and had sexual intercourse one or two times with resident #45. He stated there had been no conversation about the relationship with the doctor before or after the relationship. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON (staff #90) conducted on July 31, 2024, the DON stated that if two residents were found engaging in sexual intercourse, it would not be initially assumed to as sexual abuse. The DON said that there would be an investigation and that was how the facility would make sure both residents were safe; and, it would not be reported to the State Agency (SA) or police. Regarding the incident between resident #45 and #9, the DON stated that she recalled an incident between both residents (#45 and #9) but she cannot recall if the incident was about the sexual intercourse. She stated that a CNA reported to her on the night of July 13, 2024 that when the CNA went into room of resident #45, she found resident #45 performing oral sex on resident #9. The DON said that both residents were assessed at that time regarding whether both residents could consent. However, the DON said that both residents were not assessed prior to this incident. She stated the assessment for the ability of both residents to consent should be found in the progress note in the clinical record. During the interview, a review of the clinical record for both residents was conducted with the DON who stated that there was no documentation found in the clinical record of both resident #45 and #9 of the assessment to consent to consensual sexual relationship. The facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, with revision date of April 2021, it stated that residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The policy also included that they will establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems; will implement measures to address factors that may lead to abusive situations, for example: instruct staff regarding appropriate ways to address interpersonal conflicts; and help staff understand how cultural, religious and ethnic differences can lead to misunderstanding and conflicts; will investigate and report any allegations within timeframes required by federal requirements; and, protect residents from any further harm during investigations. The policy included that all allegations are thoroughly investigated and the administrator initiates investigation. It also included that the individual conducting the investigation as a minimum: -Reviews the documentation and evidence; -Reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; -Observes the alleged victim, including his or her interactions with staff and other residents; -Interviews the person reporting the incident; -Interviews any witnesses to the incident; -Interviews the resident (as medically appropriate) or the resident's representative; -Interviews the resident's attending physician as needed to determine the resident's condition; -Interviews staff members on all shift who had contact with he resident during the period of the alleged incident; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Interviews other residents to whom the accused employee provides care or services; -Reviews all events leading up to the alleged incident; and, -Documents the investigation completely and thoroughly. Further review of the policy it revealed that within five (5) business days of the incident, the administrator will provide a follow-up investigation report that will provide sufficient information to describe the results of the investigation, and indicate any corrective actions taken if the allegation was verified.