

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055858	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/24/2025
NAME OF PROVIDER OR SUPPLIER Rancho Seco Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 144 F Street Galt, CA 95632	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46995</p> <p>Based on observation, interview, and record review, the facility failed to protect the residents ' right to be free from sexual abuse by a staff member for nine of ten sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, and Resident 9) when Certified Nursing Assistant 1 (CNA 1) sexually assaulted (sexual contact upon a person without their consent or on a person who is incapable of providing consent. Includes rape, unwanted sexual touching, oral sex and exposure) Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, and Resident 9.</p> <p>This failure caused the residents fear, anxiety, inability to sleep, to feel ashamed, embarrassed and at risk for long term psychosocial trauma such as social isolation, emotional instability, post-traumatic stress disorder and suicidal risk.</p> <p>On 2/21/25 at 7:25 p.m. an Immediate Jeopardy (IJ, a situation in which the facility ' s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified in the presence of the facility ' s Administrator (ADM) and the Regional Director of Operations (RDO). The IJ began on 12/10/24 when the facility hired CNA 1 with a known criminal history of abuse. The ADM and RDO were informed of the facility ' s failure to have systems in place to ensure all residents were protected from sexual abuse.</p> <p>On 2/24/25 at 3:35 p.m. during an onsite visit, the Department verified and confirmed the IJ was removed after the facility presented an acceptable plan of action (POA, interventions to correct the deficient practice) on 2/21/25 at 9:21 p.m. which included:</p> <ul style="list-style-type: none"> -Immediate suspension of CNA 1 on 1/24/25 -Physician visits to residents subjected to abuse - Activity Director visits to residents subjected to abuse - Psychosocial assessments, and trauma assessment completed for all victims -Every shift monitoring of victims by nursing staff, reviewed by ADM or designee -Audit of all current employee files for history of abuse, adverse actions on background <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>-In-service on preventing abuse and reporting abuse</p> <p>-Physical assessment and interview of all victims</p> <p>Findings:</p> <p>During an interview on 1/30/25 at 1:42 p.m. with the Administrator (ADM) and Director of Nursing (DON), the ADM stated she first learned of the incident with CNA 1 and Resident 1 during the evening of 1/24/25. The ADM stated they suspended CNA 1, and he left the building at 9:15 p.m. on 1/24/25. The ADM stated CNA 1 was hired 12/10/24.</p> <p>During a concurrent interview and record review on 1/30/25 at 2:30 p.m. with the ADM of CNA 1 ' s BACKGROUND SCREENING REPORT [BSR], dated 12/3/24 the BSR indicated, County Criminal History in [name of county] .INFORMATION FOUND .Charge KNOWLINGLY TOUCH WITH INTENTION TO INJURE/INSULT/PROVOKE PERSON .Crime Type MISDEMEANOR .Disposition PLEA OF GUILTY OR RESPONSIBLE; SENTENCE IMPOSED Filing date 10/23/2019 . The ADM confirmed she was aware of the BSR prior to CNA 1 being hired and stated, He did explain to the DSD [Director of Staff Development] that it was a fight between he and his husband .</p> <p>A review of Resident 1 ' s clinical record indicated Resident 1 was admitted to the facility in early 2022 with diagnoses which included muscle weakness, encephalopathy (a medical condition that affects the brain ' s function), and intracranial injury (injury to the brain).</p> <p>During a review of Resident 1 ' s Minimum Data Set (MDS, federally mandated resident assessment tool) dated 11/23/24, the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 4/15, which indicated severe cognitive impairment.</p> <p>During a review of Resident 1 ' s Order Summary Report [OSR], order date 3/28/22, the OSR indicated, Resident is incapable of making health care decisions .</p> <p>During a review of Resident 1 ' s Progress Notes [PN], dated 1/27/25 at 6:56 p.m. the PN indicated, On 1/24/25 at approximately [8:30 p.m.] CNA [CNA 2] notified this nurse that a male CNA [CNA 1] assigned to the resident has no shirt on when doing care to the resident .</p> <p>During a review of the police report (Interview of CNA 1), dated 1/28/25, the report indicated CNA 1 confirmed he had [sexually assaulted] Resident 1.</p> <p>During a review of Resident 1 ' s PN, dated 1/29/25 at 7:15 a.m. the PN indicated, Resident is noted to keep one hand in his brief covering his private area. CNA ' s [Certified Nursing Assistant] are having trouble with ADL [Activities of Daily Living: basic tasks such as bathing, toileting] care. They are able to do care but takes reassurance.</p> <p>During an interview on 2/3/25 at 9:30 a.m. with Police Officer (PO 1) in the police department, PO 1 confirmed CNA 1 admitted to [sexual assault] on Resident 1.</p> <p>During a concurrent observation and interview on 2/3/25 at 1:12 p.m. with Resident 1 in his bedroom, Resident 1 was sitting in a reclining wheelchair, he was unable to reposition himself or stand. Resident 1 was unable to have any meaningful conversation.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 2/3/25 at 3:19 p.m. with CNA 2, CNA 2 stated, I was doing my rounds [evening shift of 1/24/25] .I saw that Resident 1 ' s door was closed, and I was confused because I was his CNA .the curtain was all the way closed [around Resident 1 ' s bed] .I saw heels of shoes from under the curtain like they were kneeling .I saw [CNA 1] with Resident 1 ' s bed all the way to the floor. [CNA 1 ' s] shirt was off. Resident 1 ' s brief [adult incontinence undergarment] was all the way off. [CNA 1 ' s] hands were on [Resident 1 ' s] [groin area] .</p> <p>During an interview on 2/4/25 at 11:23 a.m. with CNA 3, CNA 3 stated since the incident with CNA 1 she has had difficulty providing care for Resident 1 [Resident 1] would cover his penis with his hands when I am assisting him with his brief. This is new behavior.</p> <p>During an interview on 2/4/25 at 11:43 a.m. with CNA 4, CNA 4 stated Resident 1 ' s appetite has not been the same . [Resident 1] has been constantly trying to hold and cover himself [indicated to groin], even when he is eating.</p> <p>A review of Resident 2 ' s clinical record indicated Resident 2 was admitted to the facility in late 2023 with diagnoses which included cerebral infarction (occurs when blood flow to the brain is interrupted, causing brain cells to die), cerebral edema (brain swelling), and depression.</p> <p>During a review of Resident 2 ' s MDS dated [DATE], the MDS indicated a BIMS score of 13/15, which indicated intact cognition.</p> <p>During a review of Resident 2 ' s OSR, order date 9/9/24, the OSR indicated, Resident is incapable of making his/her own health decisions .</p> <p>During a review of Resident 2 ' s PN dated 1/24/25 at 7:36 p.m. the PN indicated, A CNA informed me that [CNA 1] was sitting on his knee near the resident bed. the curtain was close (sic). when I went in, I asked the CNA 1what he was doing and he said, ' I was giving the resident urinal ' .</p> <p>During a review of Resident 2 ' s PN dated 1/24/25 at 9 p.m. the PN indicated, Resident verbalized that [CNA 1] [sexually assaulted him]. Resident stated the situation happened twice, but he did not mention it. He also said that the (sic) CNA entered his room to change him and [sexually assaulted him] .</p> <p>During a review of untitled facility document dated 1/25/25, the document indicated, [Resident 2] . Do you have any issues you would like to let us know of? Last week it happened twice, one male CNA entered my room to change me and [sexually assaulted him]. I told him [CNA 1] to stop. I had a hard time sleeping last night thinking he will come back in my room .</p> <p>During a review of the police report (Interview with CNA 1) dated 1/28/25, the report indicated CNA 1 confirmed he had [sexually assaulted] Resident 2.</p> <p>During an interview on 2/3/25 at 9:30 a.m. with PO 1 in the police department, PO 1 confirmed CNA 1 admitted to [sexual assault] on Resident 2.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 2/3/25 at 12:45 p.m. with Resident 2 in his bedroom, Resident 2 was sitting in his wheelchair, and provided two instances of [sexual assault] by CNA 1. Resident 2 stated, Sometimes I hear a noise in the night I wake up and wonder if it could be him. After I wake up sometimes, I can ' t go back to sleep .</p> <p>During an interview on 2/3/25 at 1:33 p.m. with Licensed Nurse (LN 1), LN 1 confirmed she was working 1/24/25 and stated, .My CNA came to me and said CNA 1 [was in Resident 2 ' s room] and was kneeling on the floor with the curtain closed. I went to [Resident 2 ' s] room .Resident 2 ' s brief was open, and CNA 1 had a urinal in his hand .</p> <p>During an interview on 2/4/25 at 11:43 a.m. with CNA 4, CNA 4 stated Resident 2 had been upset, crying and told CNA 4 God is never going to forgive me for that .</p> <p>A review of Resident 3 ' s clinical record indicated Resident 3 was admitted to the facility in mid-2024 with diagnoses which included muscle weakness, and need for assistance with personal care.</p> <p>During a review of Resident 3 ' s MDS dated , 1/26/25 the MDS indicated a BIMS score of 9/15, which indicated moderate cognitive impairment.</p> <p>During a review of Resident 3 ' s OSR, the OSR did not indicate Resident 3 ' s capacity to make health care decisions.</p> <p>During a review of Resident 3 ' s PN dated 1/25/25 at 11:15 a.m., the PN indicated, Resident is verbalizing that when male CNA [CNA 1] was giving them (sic) shower yesterday .CNA took his shoes off .Then when the Resident opened his eyes, he said thatthe (sic) CNA was down to his underwear .Resident said he was shocked. Then the resident said the CNA became fully naked and started washing the resident. Resident said that the CNA proceeded to [sexually assault him]. Resident said he was embarrassed and shocked .</p> <p>During a review of the police report interview of Resident 3 dated 1/25/25, the report indicated Resident 3 stated, I was kind of embarrassed .this has been an ongoing thing basically since [CNA 1] got here .Things like exposing himself .[CNA1] [sexually assaulted Resident 3] .I am just embarrassed. I fear for my life in here. I couldn ' t believe how blatant he was .</p> <p>During a review of the police report (Interview of CNA 1) dated 1/28/25, the report indicated CNA 1 confirmed he had [sexually assaulted] Resident 3.</p> <p>During an interview on 2/3/25 at 9:30 a.m. with PO 1 in the police department, PO 1 confirmed CNA 1 admitted to [sexual assault] on Resident 3.</p> <p>During an interview on 2/3/25 at 3:19 p.m. with CNA 2, CNA 2 stated on 1/24/25 Resident 3 had told her CNA 1 had taken him into the shower (evening of 1/24/25), taken his clothes off and [sexually assaulted him].</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 2/24/25 at 1:48 p.m. with Resident 3 in his bedroom, Resident 3 was asked about the incident on 1/24/25 with CNA 1, Resident 3 stated that when CNA 1 took him to the shower the CNA 1 took his own clothes off and was naked. Resident 3 said that CNA 1 put his privates in [Resident 3 's] face and Resident 3 said he kept jerking his head back. Resident 3 further stated that when CNA 1 put him back to bed he sexually assaulted him. Resident 3 stated, I was so upset that night I went to the hospital .</p> <p>A review of Resident 4 ' s clinical record indicated Resident 4 was admitted to the facility in late 2024 with diagnoses which included cognitive communication deficit, phocomelia (a congenital condition that causes malformation of the arms and legs), depression, dementia, schizophrenia (a disorder that affects a person ' s ability to think, feel and behave), anxiety disorder and adult failure to thrive (a syndrome in older adults characterized by a decline in overall health).</p> <p>During a review of Resident 4 ' s MDS dated [DATE], the MDS indicated a BIMS score of 9/15, which indicated moderate cognitive impairment.</p> <p>During a review of Resident 4 ' s OSR, order start date of 12/19/24, the OSR indicated, Resident is Capable Of Understanding Rights .</p> <p>During a review of Resident 4 ' s PN dated 1/29/25 at 4:37 p.m. the PN indicated, While in police, (sic) the abuser confessed that he sexually abused the resident. Staff interviewed the resident, and he states that the abuser [sexually assaulted him].</p> <p>During a review of the police report (Interview of CNA 1) dated 1/28/25, the report indicated CNA 1 confirmed he had [sexually assaulted] Resident 4.</p> <p>During a review of the police report interview of Resident 4, dated 1/29/25, the report indicated Resident 4 stated, .this happened to me three times. [CNA 1] [sexually assaulted Resident 4] .I was scared when the nurse was [sexually assaulting him] .I never said anything to him and he never said anything to me .I did not want him to do this to me . Resident 4 stated in his interview that he felt scared when the nurse [CNA 1] was working at the care center.</p> <p>During an interview on 2/3/25 at 9:30 a.m. with PO 1 in the police department, PO 1 confirmed CNA 1 admitted to [sexual assault] on Resident 4.</p> <p>During a concurrent observation and interview on 2/3/25 at 11:33 a.m. with Resident 4 in his bedroom, Resident 4 was lying in bed. Resident 4 stated, He [CNA 1] came three or four times. The first time he [CNA1] masturbated himself and [sexually assaulted Resident 4]. The second time he [CNA 1] took off all his clothes. He [CNA 1] was masturbating himself and [sexually assaulted Resident 4] .I am afraid he has friends here that will do things to me .I did not tell him to stop because I was afraid and ashamed . Resident 4 stated he did not really feel safe in the facility.</p> <p>During an interview on 2/4/25 at 11:35 a.m. with CNA 6, CNA stated, [Resident 4] does have a change in behavior [since the incident] .As I start to wipe him he gets an erection, when I turn him he started to touch me .its new behavior.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A review of Resident 5 ' s clinical record indicated Resident 5 was admitted to the facility in early 2023 with diagnoses which included need for assistance with personal care, traumatic brain injury (brain dysfunction cause by an outside force, usually a violent blow to the head), cognitive communication deficit, muscle weakness, and paraplegia (loss of motor function in the legs).</p> <p>During a review of Resident 5 ' s MDS dated [DATE], the MDS indicated a BIMS score of 11/15, which indicated moderate cognitive impairment.</p> <p>During a review of Resident 5 ' s OSR, the OSR did not indicate Resident 5 ' s capacity to make health care decisions.</p> <p>During a review of an untitled facility document dated 1/25/25, the document indicated, [Resident 5] . Do you have any issues you would like to let us know of? Yesterday, a male with [description of CNA 1] entered in my room, pulled his pants down and showed me his butt, and started masturbating in front of me. I told him to get out of my face and my room. This incident happened another time with the same male in my room .</p> <p>During a review of Resident 5 ' PN dated 1/27/25 at 1:47 p.m. the PN indicated, Resident appeared worried and anxious. Expressed his worries about alleged abuser returning to the building .</p> <p>During a review of Resident 5 ' s PN dated 1/27/25 at 6:38 p.m. the PN indicated, On 1/24/25 at approximately [8 p.m.], According to charge nurse resident was upset that the resident (sic) pants fell down, and he [Resident 5] saw his [CNA1 ' s] butt .</p> <p>During a review of the police report (Interview of CNA 1) dated 1/28/25, the report indicated CNA 1 confirmed he had [sexually assaulted] Resident 5.</p> <p>During an interview on 2/3/25 at 9:30 a.m. with PO 1 in the police department, PO 1 confirmed CNA 1 admitted to [sexual assault] on Resident 5.</p> <p>During a concurrent observation and interview on 2/3/25 at 1:40 p.m. with Resident 5 on the outside patio, Resident 5 stated, [CNA 1] came into my room and [sexually assaulted him]. I hollered and hit the wall and the call button. He did not leave the room . Resident 5 began to cry, visibly shake and stated, I get scared in my room. I ' m afraid he is going to come back and do it again .I don ' t feel safe.</p> <p>During an interview on 2/4/25 at 11:43 a.m. with CNA 4, CNA 4 stated, He [Resident 5] called me in to stay in his room [after the incident] because his roommate had walked out of the bathroom and was walking toward his bed and [Resident 5] was freaking out because he thought ' the guy ' was coming back. I stayed with him .he kept crying .</p> <p>A review of Resident 6 ' s clinical record indicated Resident 6 was originally admitted to the facility in early 2024 with diagnoses which included muscle weakness, dementia, and depression.</p> <p>During a review of Resident 6 ' s MDS, dated [DATE], the MDS indicated a BIMS score of 9/15, which indicated moderate cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 8 ' s OSR, order date 5/14/24, the OSR indicated, Resident is [Capable Of Understanding Rights, Responsibilities, And Informed Consent].</p> <p>During a review of Resident 8 ' s PN dated 2/3/25 at 4:17 p.m. the PN indicated, Resident alleges that last month one male CNA had [sexually assaulted him] in his room in front of himself and his roommate .</p> <p>During an interview on 2/3/25 at 3:02 p.m. with Resident 8 in his bedroom, Resident 8 stated, He [CNA 1] came into the room .he walked over to my bed and lifted his shirt up all the way to his chest, and then pulled his pants down, he was not wearing anything .I did not say anything .I felt shocked, I did not expect that .</p> <p>During an interview on 2/4/25 at 12:31 p.m. with LN 2, LN 2 stated, We have to do STD [sexually transmitted disease] testing on all the residents. It ' s a lot for the residents.</p> <p>During an interview on 2/4/25 at 2:30 p.m. with the ADM and DON, the ADM confirmed she was aware of CNA 1 ' s previous charges and chose to hire him. The ADM stated her expectations were, Residents are treated with dignity and respect. They are not to be abused.</p> <p>A review of Resident 9 ' s clinical record indicated Resident 9 was admitted to the facility late 2020 with diagnoses which included muscle weakness, anxiety disorder, and depression.</p> <p>During a review of Resident 9 ' s MDS, dated [DATE], the MDS indicated a BIMS score of 15/15, which indicated no cognitive impairment.</p> <p>During a review of Resident 9 ' s OSR, order date 9/27/24, the OSR indicated, Resident is Capable Of Understanding Rights, Responsibilities, And Informed Consent.</p> <p>During a review of Resident 9 ' s PN dated 2/18/25 at 12:36 p.m. the PN indicated, .the male CNA [CNA1] had exposed himself inappropriately by Pulled (sic) his pants down in (sic) dining room. [Resident 9] was able to describe she was closed (sic) to piano .I was able to see his blue underwear, then he pulled his pants up and left.</p> <p>During a review of Resident 9 ' s PN dated 2/24/25 at 9:48 p.m. the PN indicated, .[Resident 9] stated, ' I can still see the incident, I am not able to get over it, but I am working on it ' .</p> <p>During an interview on 2/18/25 at 11:08 a.m. with Resident 9 in her bedroom, Resident 9 stated, He [CNA 1] was standing across the room .It was evening time .He [CNA 1] took his pants and pulled them down so I could see his whole blue bikini underwear in the front. He hooked his thumbs into the waistband of his pants and pulled them down . I think it mentally hurt us .</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Rancho Seco Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 144 F Street Galt, CA 95632	
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During a review of the facility ' s policy and procedure (P&P) titled, Abuse, Neglect and Exploitation, dated 2023, the P&P indicated, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse .[Criminal sexual abuse] . serious bodily also includes sexual intercourse with a resident who is incapable of declining to participate in the sexual act or lacks the ability to understand the nature of the sexual act .[Sexual abuse] is non-consensual sexual contact of any type with a resident .Possible indicators of abuse include, but are not limited to: sudden unexplained changes in behavior and/or activities such as fear of a person or place, or feelings of guilt and shame .</p> <p>During a review of the facility ' s P&P titled, Resident Rights, dated 2/21, the P&P indicated, Employees shall treat all residents with kindness, respect, and dignity .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident ' s right to .a dignified existence .be free from abuse .</p>		

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<p>F 0606</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Not hire anyone with a finding of abuse, neglect, exploitation, or theft.</p> <p>46995</p> <p>Based on interview and record review, the facility failed to protect nine out of 97 residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8 and Resident 9) from sexual abuse and the potential to affect all residents in the facility when the facility knowingly employed Certified Nursing Assistant 1 (CNA 1) with a history of a criminal misdemeanor (an offense punishable under criminal law).</p> <p>This failure led to nine residents ' (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8 and Resident 9) being sexually assaulted (sexual contact upon a person without their consent or on a person who is incapable of providing consent. Includes rape, unwanted sexual touching, oral sex and exposure) by CNA 1, with the potential to affect all residents in the facility who received care.</p> <p>On 2/21/25 at 7:25 p.m. an Immediate Jeopardy (IJ, a situation in which the facility ' s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified in the presence of the facility ' s Administrator (ADM) and the Regional Director of Operations (RDO). The IJ began on 12/10/24 when the facility hired CNA 1 with a known criminal history of abuse. The ADM and RDO were informed of the facility ' s failure to have systems in place to ensure all residents were protected from sexual abuse when the facility hired CNA 1 with a history of assault/intent to harm to care for a vulnerable population. This caused residents to have fear, anxiety, inability to sleep, to feel ashamed, embarrassed and at risk for long term psychosocial trauma such as social isolation, emotional instability, post-traumatic stress disorder and suicidal risk.</p> <p>On 2/24/25 at 3:35 p.m. during an onsite visit, the Department verified and confirmed through observation, interview and record review the IJ was removed after the facility presented an acceptable plan of action (POA, interventions to correct the deficient practice) on 2/21/25 at 9:21 p.m. which included the following:</p> <ul style="list-style-type: none"> -Immediate suspension of CNA 1 on 1/24/25 -Audit of all current employee files to review background investigations - RDO in-serviced ADM to not hire employees with background/history of abuse. -ADM and/or designee to review applicant backgrounds -Director of Staff Development (DSD) and/or designee will contact listed references for new hires. <p>Findings:</p> <p>(continued on next page)</p>		

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<p>F 0606</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>During an interview on 1/30/25 at 1:42 p.m. with the ADM and Director of Nursing (DON), the ADM stated on 1/24/24 at 9:15 p.m. CNA 1 was suspended and removed from the building after allegations of sexual abuse toward Resident 1 were brought forward by CNA 2. The ADM stated CNA 1 was hired 12/10/24. The ADM stated, We do an initial interview, we check references and do a background check. The ADM stated CNA 1 ' s background check was completed, and she believed the DSD (Director of Staff Development) checked references.</p> <p>During a concurrent interview and record review on 1/30/25 at 2:30 p.m. with the ADM of CNA 1 ' s BACKGROUND SCREENING REPORT [BSR], dated 12/3/24 the BSR indicated, County Criminal History in [name of county] .INFORMATION FOUND .Charge KNOWLINGLY TOUCH WITH INTENTION TO INJURE/INSULT/PROVOKE PERSON .Crime Type MISDEMEANOR .Disposition PLEA OF GUILTY OR RESPONSIBLE; SENTENCE IMPOSED Filing date 10/23/2019 . The ADM confirmed she was aware of the BSR prior to CNA 1 being hired and stated, He did explain to the DSD [Director of Staff Development] that it was a fight between he and his husband .</p> <p>During an interview on 1/30/25 at 3:08 p.m. with the ADM, the ADM was asked if the staff had voiced any concerns regarding CNA 1 and stated, .he came in to work one day with a black eye .</p> <p>During an interview on 1/30/25 at 3:18 p.m. with the DSD, the DSD stated, .On Friday the 24th he had been late to his shift .He did have two blackened eyes and a small cut on his cheek . When asked about CNA 1 ' s BSR misdemeanor, the DSD stated, [CNA 1] came forward on 12/3/24 about the information on his BSR incident dated 2019. He mentioned that he had several job opportunities and had no problem getting them after he explained what happened .</p> <p>During an interview on 2/3/25 at 10:28 a.m. with the DSD, the DSD stated she did not contact CNA1 ' s previous employer [skilled nursing facility] she was not able to reach them .called and left messages, but they did not return the call.</p> <p>During a concurrent interview and record review on 2/4/25 at 10:45 a.m. with the DSD of text message between the DSD and CNA 1, the DSD was asked what reference she called and stated, There are no specifics of who I call .I will do personal and professional . The DSD provided a document which contained CNA 1 ' s text message on 12/3/24 to the DSD which indicated, .I [CNA 1] received an email for the background check .It ' s a long story, to shorten it down called the cops on myself. Due to the nature of the situation, I was arrested and later charged. It was involving me and my husband . The DSD stated she brought the information to the ADM on 12/3/24 and the ADM and DSD called CNA 1 on 12/3/24 who gave further details of the charges.</p> <p>During an interview on 2/4/25 at 2:30 p.m. with the ADM and DON, the ADM confirmed she was aware of CNA 1 ' s previous charges and chose to hire him and stated, . [CNA 1] explained it as a domestic abuse. The ADM stated her expectations, Residents are treated with dignity and respect. They are not to be abused.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Abuse, Neglect and Exploitation, dated 2023, the P&P indicated, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse . ' Abuse ' means the willful infliction of injury . ' Physical Abuse ' includes, but is not limited to hitting, slapping .Potential employees will be screened for a history of abuse .Background, reference, and credentials ' checks shall be conducted on potential employees .</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46995</p> <p>Based on interview and record review, the facility failed to report immediately to the Department three allegations of sexual abuse for three of ten sampled residents (Resident 1, Resident 2, and Resident 5), when the Department received the facility ' s reports of alleged sexual abuse after two hours of occurrence.</p> <p>This failure decreased the facility ' s potential to protect vulnerable residents and provide a safe environment.</p> <p>Findings:</p> <p>A review of Resident 1 ' s admission record indicated Resident 1 was admitted to the facility in early 2022.</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS; federally mandated resident assessment tool), dated 11/23/24, indicated a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of four out of 15 with severe cognitive impairment.</p> <p>A review of the facility ' s document titled, Report of Suspected Dependent Adult/Elder Abuse, indicated the report was faxed to the Department on 1/25/25 at 12:21 a.m. The report further indicated the alleged abuse occurred on 1/24/25 around 8:30 p.m. and Resident 1 acknowledged that Certified Nursing Assistant 1 (CNA 1) was shirtless in his room.</p> <p>A review of Resident 2 ' s admission record indicated Resident 2 was admitted to the facility in late 2023.</p> <p>A review of Resident 2 ' s MDS, dated [DATE], indicated a BIMS score of 13 out of 15 with intact cognition.</p> <p>A review of the facility ' s document titled, Report of Suspected Dependent Adult/Elder Abuse, indicated the report was faxed to the Department on 1/25/25 at 12:31 a.m. The report further indicated the alleged abuse occurred on 1/24/25 around 8:30 p.m. and Resident 2 alleged that CNA 1 sexually assaulted him.</p> <p>A review of Resident 5 ' s admission record indicated Resident 5 was admitted to the facility in early 2023.</p> <p>A review of Resident 5 ' s MDS, dated [DATE], indicated a BIMS score of 11 out of 15 with moderate cognitive impairment.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility ' s document titled, Report of Suspected Dependent Adult/Elder Abuse, indicated the report was faxed to the Department on 1/27/25 at 1:49 p.m. The report further indicated the Interdisciplinary Team (IDT; a group of healthcare professionals from different disciplines who work together to provide care) arrived to Resident 5 ' s room on 1/27/25 at 6:30 a.m. and were notified by Resident 2 that CNA 1 was standing next to Resident 5 ' s room with his pants down and tried to open Resident 5 ' s brief.</p> <p>During a concurrent interview and record review on 2/21/25 at 12 p.m. with the Administrator (ADM), the facility ' s reports were reviewed. ADM confirmed reports were sent to the Department more than two hours after facility was made aware of the alleged abuse incidents and stated it should have been reported within two hours to ensure residents ' safety and to meet the requirements of abuse reporting.</p> <p>A review of the facility ' s policy and procedure titled, Abuse, Neglect and Exploitation, dated 2023, indicated, . Reporting/Response .The facility will have written procedures that include: Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies [e.g. , law enforcement when applicable] within specified time frames . 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 .</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Respond appropriately to all alleged violations.</p> <p>46995</p> <p>Based on interview and record review, the facility failed to thoroughly investigate staff to resident allegations of sexual abuse (sexual contact upon a person without their consent or on a person who is incapable of providing consent. Includes rape, unwanted sexual touching, oral sex and exposure) for nine of ten residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8 and Resident 9) by Certified Nursing Assistant (CNA 1) when additional victims were identified (Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, and Resident 10) after the facility ' s initial investigation.</p> <p>This failure resulted in the facility not identifying all victims of abuse in a timely manner which delayed counseling, monitoring and increased the risk for unmet emotional trauma.</p> <p>Findings:</p> <p>A review of Resident 1's clinical record indicated Resident 1 was admitted to the facility in early 2022 with diagnoses which included muscle weakness, encephalopathy (a medical condition that affects the brain ' s function), and intracranial injury (injury to the brain).</p> <p>During a review of the facility's document titled, Report of Suspected Dependent Adult/Elder Abuse, faxed to the Department on 1/25/25 at 12:21 a.m. the report indicated Resident 1 was a victim of sexual abuse which occurred on 1/24/25 by CNA 1.</p> <p>A review of Resident 2's clinical record indicated Resident 2 was admitted to the facility in late 2023 with diagnoses which included cerebral infarction (occurs when blood flow to the brain is interrupted, causing brain cells to die), cerebral edema (brain swelling), and depression.</p> <p>During a review of the facility ' s document titled, Report of Suspected Dependent Adult/Elder Abuse, faxed to the Department on 1/25/25 at 12:31 a.m. the report indicated Resident 2 was a victim of sexual abuse which occurred on 1/24/25 by CNA 1.</p> <p>A review of Resident 3's clinical record indicated Resident 3 was admitted to the facility in mid-2024 with diagnoses which included muscle weakness and need for assistance with personal care.</p> <p>During a review of the facility's document titled, Report of Suspected Dependent Adult/Elder Abuse, faxed to the Department on 1/25/25 at 4:12 p.m. the report indicated Resident 3 was a victim of sexual abuse by CNA 1 and staff was not notified until the next day around lunchtime.</p> <p>A review of Resident 5's clinical record indicated Resident 5 was admitted to the facility in early 2023 with diagnoses which included need for assistance with personal care, traumatic brain injury (brain dysfunction cause by an outside force, usually a violent blow to the head), cognitive communication deficit, muscle weakness, and paraplegia (loss of motor function in the legs).</p> <p>During a review of the facility's document titled, Report of Suspected Dependent Adult/Elder Abuse, faxed to the Department on 1/27/25 at 1:49 p.m. the report indicated Resident 5 was a victim of sexual abuse by CNA 1.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of the Police Report, dated 1/28/25, the report indicated CNA 1 confirmed he had sexually assaulted Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, and Resident 6.</p> <p>A review of Resident 6's clinical record indicated Resident 6 was originally admitted to the facility in early 2024 with diagnoses which included muscle weakness, dementia, and depression.</p> <p>During a review of the facility's document titled, Report of Suspected Dependent Adult/Elder Abuse, faxed to the Department on 1/29/25 at 6:19 p.m. the report indicated Resident 6 was a victim of sexual abuse by CNA 1.</p> <p>A review of Resident 4's clinical record indicated Resident 4 was admitted to the facility in late 2024 with diagnoses which included cognitive communication deficit, phocomelia (a congenital condition that causes malformation of the arms and legs), depression, dementia, schizophrenia (a disorder that affects a person 's ability to think, feel and behave), anxiety disorder and adult failure to thrive (a syndrome in older adults characterized by a decline in overall health).</p> <p>During a review of the facility's document titled, Report of Suspected Dependent Adult/Elder Abuse, faxed to the Department on 1/29/25 at 6:28 p.m. the report indicated Resident 4 was a victim of sexual abuse by CNA 1.</p> <p>A review of Resident 7's clinical record indicated Resident 7 was admitted to the facility mid-2023 with diagnoses which included need for assistance with personal care, depression, and anxiety.</p> <p>During a review of the department's On-Line Health Facility Complaint form, anonymously submitted, dated 1/31/25, the form indicated, Patient [Resident 7] confined (sic) in me and told me he has been a victim of sexual abuse by a CNA .CNA name is [CNA 1] .</p> <p>A review of Resident 8's clinical record indicated Resident 8 was admitted to the facility mid-2024 with diagnoses which included depression, schizophrenia, bipolar disorder (a disorder associated with episodes of mood swing), and anxiety.</p> <p>During a review of the facility's document titled, Report of Suspected Dependent Adult/Elder Abuse, faxed to the Department on 2/3/25 at 7:16 p.m. the report indicated Resident 8 was a victim of sexual abuse by CNA 1.</p> <p>A review of Resident 9's clinical record indicated Resident 9 was admitted to the facility late 2020 with diagnoses which included muscle weakness, anxiety disorder, and depression.</p> <p>During a review of the facility's document titled, Report of Suspected Dependent Adult/Elder Abuse, faxed to the Department on 2/18/25 at 5:07 p.m. the report indicated Resident 9 was a victim of sexual abuse by CNA 1.</p> <p>During an interview on 1/30/25 at 1:42 p.m. with the Administrator (ADM) and Director of Nursing (DON), the ADM stated she first learned of the incident of alleged sexual abuse with CNA 1 and Resident 1 during the evening of 1/24/25. The ADM stated they suspended CNA 1, and CNA 1 left the building at 9:15 p.m. on 1/24/25.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During review of the facility's five day follow up for Resident 1 dated 1/29/25, Resident 2 dated 1/29/25, Resident 3 dated 1/31/25, Resident 4 dated 2/4/25, Resident 5 dated 1/31/25, Resident 6 dated 2/4/25, Resident 7 dated 2/7/25, and Resident 8 dated 2/7/2. The facility unsubstantiated the allegations of abuse.</p> <p>During an interview on 2/24/25 at 3:25 p.m. with the ADM and Regional Director of Operations, when asked why they unsubstantiated the five day follow up reports the ADM stated, that they made the decision based on what they knew at the time and because the incidents were not witnessed.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect and Exploitation, dated 2023, the P&P indicated, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse .Investigation of Alleged Abuse .An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur .Identifying and interviewing all involved persons .Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause .</p>		

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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)		
<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>46995</p> <p>Based on interview and record review, the facility failed to ensure the Administrator (ADM) managed the facility effectively to meet the need of all residents when a Certified Nursing Assistant (CNA)1, was hired after the ADM and Director of Staff Development (DSD) had knowledge of CNA1 ' s history of abuse.</p> <p>This failure put all resident at risk of abuse and resulted in sexual abuse of nine residents.</p> <p>Findings:</p> <p>During an interview on 1/30/25 at 1:42 a.m. with the Administrator (ADM) and Director of Nursing (DON), the ADM stated CNA 1 ' s background check was completed, and she believed the DSD (Director of Staff Development) checked references.</p> <p>During a concurrent interview and record review on 1/30/25 at 2:30 p.m. with the ADM of CNA 1 ' s BACKGROUND SCREENING REPORT [BSR], the BSR indicated, County Criminal History in [name of county] .INFORMATION FOUND .Charge KNOWLINGLY TOUCH WITH INTENTION TO INJURE/INSULT/PROVOKE PERSON .Crime Type MISDEMEANOR .Disposition PLEA OF GUILTY OR RESPONSIBLE; SENTENCE IMPOSED Filing date 10/23/2019 . The ADM confirmed she was aware of the BSR and stated, He did explain to the DSD [Director of Staff Development] that it was a fight between he and his husband .</p> <p>During an interview on 2/3/25 at 10:28 a.m. with the DSD, the DSD stated she did not contact CNA1 ' s previous employer [skilled nursing facility], but had called and left messages, but the facility did not return the calls.</p> <p>During a concurrent interview and record review on 2/4/25 a 10:45 a.m. with the DSD of text message between the DSD and CNA 1, the DSD provided a document which contained CNA 1 ' s text message on 12/3/24 to the DSD which indicated, .I [CNA1] received an email for the background check .It ' s a long story, to shorten it down called the cops on myself. Due to the nature of the situation I was arrested and later charged. It was involving me and my husband . The DSD stated she brought the information to the ADM, they called CNA 1 who gave further details of the charges.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Abuse, Neglect and Exploitation, dated 2024, the P&P indicated, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that inhibit and prevent abuse .The facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse .the facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written .Potential employees will be screened for a history of abuse .Background, reference, and credentials shall be conducted on potential employees .</p> <p>During a review of the facility ' s P&P titled, Hiring, dated 1/08, the P&P indicated, .The Administrator will determine which, if any applicants are qualified for consideration for the position(s) in question .</p>		