

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115503	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2024
NAME OF PROVIDER OR SUPPLIER Jesup Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 Savannah Highway Jesup, GA 31545	

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** 46659</p> <p>Based on interview, record review, document review, and facility policy review, the facility failed to protect a resident's right to be free from sexual, verbal, and physical abuse by a resident. Specifically, the facility failed to protect Resident #7, who was cognitively impaired and wandered in the facility from sexual abuse by Resident #6, who had a history of sexually inappropriate behavior. On 10/18/2024, when staff were unable to locate Resident #7, they initiated a search and found the resident in Resident #6's bathroom seated on the toilet. Resident #6 stood in front of Resident #7 unclothed from the waist down with their genitals in their hand. Furthermore, on 08/09/2024, Resident #6 was found standing over the bed of Resident #8, a cognitively impaired resident, with their genitals in their hand and expressed inappropriate sexual gestures and comments. On 09/03/2024, Resident #6 grabbed the wheelchair of Resident #10 and prevented Resident #10 from moving about in their wheelchair. On 09/18/2024, Resident #6 voiced inappropriate sexual comments to Resident #9 as Resident #9 straightened their shirt. On 10/03/2024, Resident #6 was found masturbating in the doorway of Resident #2's room. These deficient practices affected 5 (Residents #2, #7, #8, #9, and #10) of 15 sampled residents reviewed for abuse.</p> <p>It was determined that the provider's non-compliance with one of more requirements of participation had caused, or was likely to cause serious injury, harm, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.12 Freedom from Abuse, Neglect, and Exploitation, F600, at a scope and severity of K.</p> <p>The IJ began on 08/09/2024, when Resident #6 expressed inappropriate sexual gestures and comments as they were found standing over the bed of Resident #8.</p> <p>On 11/15/2024 at 1:25 PM, the interim Administrator and Director of Nursing (DON) were informed of the IJ situation and provided a completed IJ template. A removal plan was requested. On 11/15/2024 at 1:25 PM, the interim Administrator and Director of Nursing (DON) were informed of the IJ situation and provided a completed IJ template. A removal plan was requested. An approved Credible Allegation of Compliance was received on 11/17/2024. Based on the validation of the Credible Allegation of Compliance, the State Survey Agency determined the deficient practice was corrected on 11/15/2024 and the immediacy of the IJ being removed on 11/16/2024.</p> <p>Findings included:</p> <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>A facility policy titled, F607 Abuse Prevention Program, Prevention of Abuse effective 04/2024, indicated, The community staff will not condone any form of resident abuse, neglect, exploitation, or mistreatment and will continually monitor the facility's policies, procedures, training programs, systems, etc. to assist in preventing resident abuse.</p> <p>A facility policy titled, F607, F943 Abuse Prevention Program, Training, effective 08/2024, indicated h. Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property including: 1. Verbal, mental, sexual and physical abuse.</p> <p>An Admission Record revealed the facility admitted Resident #6 on 07/10/2024. According to the Admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease, type 2 diabetes mellitus, chronic kidney disease, hypertension, and repeated falls.</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/15/2024, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment.</p> <p>Resident #6's care plan, included a focus area initiated 08/13/2024, that indicated the resident sometimes had behaviors which included sexually inappropriate language to staff, grabbed staff, and made sexual comments and sexual gestures. Interventions directed to staff to administer medications as the doctor ordered (initiated 08/13/2024), attempt interventions before the behaviors began (initiated 08/13/2024), provide care in pairs (initiated 08/14/2024), and refer the resident for psychiatric services as needed (initiated 08/13/2024).</p> <p>Resident #6's nursing progress note, dated 08/09/2024 at 12:53 PM, revealed that while a hospice certified nursing assistant (CNA) provided a shower to the resident, the resident grabbed the hospice CNA between her legs and when the hospice CNA jumped back, Resident #6 asked the hospice CNA what she was jumping back for.</p> <p>During a telephone interview on 11/13/2024 at 9:28 AM, the hospice CNA stated as she dried Resident #6's back during the provision of a shower, she gave the resident a towel to dry their genital area and that was when the resident placed their hands between her legs. The hospice CNA stated she reported the incident to the facility and the facility provided another staff member to be present when care was provided to the resident.</p> <p>Resident #6's nursing progress note, dated 08/09/2024 at 4:07 PM, revealed that while a CNA obtained incontinence briefs, Resident #6 approached the CNA and stated, Are you going to put one of those on me, while they grabbed their groin area.</p> <p>Resident #6's nursing progress note, dated 08/09/2024 at 4:08 PM, revealed Resident #6 was found in a resident (Resident #8) of the opposite sex's room. According to the nursing progress note, when the roommate (Resident #3) of the resident (Resident #8) informed Resident #6 that the resident (Resident #8) was deaf, Resident #6 replied that is alright, we can still feel our way around and proceeded to grab their genital area.</p> <p>An Admission Record revealed the facility admitted Resident #3 on 05/16/2023. According to the Admission Record, the resident had a medical history that included diagnoses of heart failure and muscle weakness.</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 quarterly MDS, with an ARD of 07/10/2024, revealed the facility admitted Resident #10 on 03/12/2024. According to the MDS, the resident had a BIMS score of 4, which indicated the resident had severe cognitive impairment. Per the MDS, Resident #10 had active diagnoses to include stroke and hemiplegia or hemiparesis.</p> <p>During an interview on 11/12/2024 at 11:24 AM, Licensed Practical Nurse (LPN) #13 stated on 09/03/2024, Resident #3 hollered for her to come to their room. According to LPN #13, Resident #6 had come into Resident #3 and Resident #8's room. LPN #13 stated when she entered the room, Resident #6 was leaned over Resident #8's bed. LPN #13 stated she did not know how long Resident #6 had been in Resident #8's room. LPN #13 stated also on 09/03/2024, as Resident #6 was in the hallway, the resident grabbed the wheelchair of Resident #10 and prevented Resident #10 from going forward. According to LPN #13, after this incident, Resident #6 was placed on 1:1 until the resident was transferred to a behavioral health facility on 09/04/2024.</p> <p>Resident #6's nursing skilled note dated 09/16/2024 at 10:58 PM, revealed the resident made sexual remarks to other residents and a CNA. Per the skilled note, staff explained to Resident #6 that they could not talk to residents of the opposite sex in that way, but the resident continued with sexual remarks.</p> <p>Resident #6's nursing skilled note dated 09/18/2024 at 12:30 PM, revealed as a resident of the opposite sex (Resident #9) was straightening their shirt, Resident #6 told the resident, let me see it all, lean over so I can see them [breasts], and I can tell by your mouth, you nasty.</p> <p>An Admission Record revealed the facility admitted Resident #9 on 05/31/2019. According to the Admission Record, the resident had a medical history to include diagnoses of type 2 diabetes mellitus, lack of coordination, muscle weakness, dementia, and cognitive communication deficit.</p> <p>A quarterly MDS, with an ARD of 09/23/2024, revealed Resident #9 had a BIMS score of 7, which indicated the resident had severe cognitive impairment. The MDS revealed the resident had moderate difficulty with hearing and usually understood others.</p> <p>During an interview on 11/12/2024 at 11:24 AM, LPN #13 stated as Resident #9 sat on their bed and repositioned their shirt, Resident #6 made some very inappropriate sexual comments to Resident #9. According to LPN #13, Resident #9 was very hard of hearing and did not hear anything Resident #6 stated. LPN #13 stated she reported the incident to the Administrator, as the staff was to report all allegations immediately to the Abuse Coordinator, who was the Administrator or call the Director of Nursing.</p> <p>During an interview on 11/16/2024 at 11:05 AM, LPN #6 stated abuse could be many things such as physical, sexual, and verbal to name a few. LPN #6 stated if a resident said something that was inappropriate or mean, it could be considered verbal abuse.</p> <p>Resident #6's skilled note, dated 10/01/2024 at 11:52 AM, revealed the resident was noted to have inappropriate behaviors towards opposite sex staff and residents. The skilled note indicated Resident #6 told a female staff member to come to their bed and told a resident of the opposite sex (Resident #15) that I got to put it somewhere. Per the skilled note, staff continued to redirect Resident #6 away from residents of the opposite sex and moved residents of the opposite sex from Resident #6.</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>An Admission Record revealed the facility admitted Resident #15 on 01/19/2021. According to the Admission Record, the resident had a medical history to include diagnoses of dementia, altered mental status, and muscle weakness.</p> <p>A quarterly MDS, with an ARD of 07/18/2024, revealed Resident #15 had a BIMS score of 5, which indicated the resident had severe cognitive impairment.</p> <p>Resident #6's SS note, dated 10/03/2024 at 11:00 AM, revealed SS notified nursing staff and the Director of Nursing (DON) that Resident #6 had increased sexual behaviors and inappropriate comments toward staff and other residents.</p> <p>Resident #6's IDT [Interdisciplinary Team]: Behavioral Health Evaluation, dated 10/04/2024, revealed the resident had a history of inappropriate sexual behavior.</p> <p>Resident #6's psychiatry follow-up note, dated 10/08/2024, revealed the resident was seen for a chief complaint of sexually inappropriate behaviors. According to the note, on 08/09/2024, Resident #6 exhibited sexually inappropriate gestures and comments towards a hospice CNA. The note indicated Resident #6 was sent to a behavioral health unit on 09/03/2024 as the resident grabbed the wheelchair of a resident of the opposite sex and would not let the resident go further in their wheelchair. Per the note, a couple of days after 09/11/2024, the resident began to make sexual remarks to CNAs and other residents. According to the note, while Resident #6 was on one-to-one supervision, on 09/18/2024, the resident made inappropriate sexual remarks to another resident of the opposite sex. Per the note, on 10/03/2024, Resident #6 was transferred to a behavioral health unit after they was found masturbating in the doorway of a resident of the opposite sex room (Resident #2). Per the note, Resident #6 returned to the facility on [DATE]. The note revealed that during the visit, the nurse practitioner explained to the resident that their behaviors were inappropriate and would not be tolerated in the facility. Per the note, Resident #6 was very aware of their behaviors, but claimed to forget what happened. Per the note, the resident was able to make decisions regarding their healthcare and living situation and expressed to the Social Services Director (SSD) that they no longer wanted to live in the nursing home and requested to be transferred to an assisted living, group home, or apartment. The note indicated the resident was ambulatory with a walker and able to move around the facility without difficulty. According to the note, Resident #6 should be kept from residents of the opposite sex as they were very aware of their behaviors.</p> <p>During an interview on 11/11/2024 at 10:02 AM, the Nurse Practitioner (NP) acknowledged the information she included in the psychiatry follow-up note dated 10/08/2024, all came from the physician's progress notes. The NP stated she has seen Resident #6 at the request of the social worker four times since the resident admitted to the facility. The NP stated there had no improvements in the resident's behavior and she made no medication changes because the facility sent the resident out for evaluation.</p> <p>A quarterly MDS, with an ARD of 09/22/2024, revealed the facility admitted Resident #2 on 01/06/2023. The MDS revealed Resident #2 had a BIMS score of 14, which indicated the resident had intact cognition.</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>Resident #6's Progress Notes with a date of service 10/16/2024, revealed nursing reported that since Resident #6 returned from the behavioral health unit, the resident had less hypersexual behaviors, but still made inappropriate comments. Per the Progress Note, nursing had to watch Resident #6 closely because the resident kept sitting next to residents of the opposite sex in the common area, particularly those residents who had cognitive impairment and did not rebuke them.</p> <p>An Admission Record revealed the facility admitted Resident #7 on 10/17/2024. According to the Admission Record, the resident had a medical history that included diagnoses of dementia, neurocognitive disorder with Lewy bodies, hallucinations, and anxiety disorder.</p> <p>The facility's five-day report dated 10/25/2024, revealed on 10/18/2024 around 4:45 PM, LPN #9 observed Resident #7 seated on the toilet fully clothed in the bathroom of Resident #6. Per the report, Resident #6 stood in front of Resident #7, with their pants and incontinence brief down around their ankles, while they faced Resident #7 with their genitalia in their right hand. According to the note, LPN #6 and the DON entered the room and observed the same. Per the note, LPN #6 instructed Resident #6 to pull up their pants and incontinence brief and leave the bathroom. The note revealed LPN #6 assisted Resident #7 from the toilet, placed the resident into their wheelchair and removed the resident from the bathroom. The note indicated both residents were placed on one-to-one supervision and the police, the Medical Director, and the families of both residents were called. According to the note, Resident #7 did not have any apparent injuries to their face, their face was dry, and all their clothing was on correctly and not shuffled. The note indicated Resident #7 was not able to give any description of what occurred. The report indicated that upon conclusion of the investigation, while the facility was unable to substantiate sexual contact, it was determined that Resident #6 committed indecent exposure to a vulnerable person, Resident #7.</p> <p>Resident #6's nursing skilled note dated 10/18/2024 at 11:45 PM, revealed the resident was asked by a CNA if they understood what they done wrong and Resident #6 replied, Yes, I wanted [him/her] to suck it.</p> <p>During an interview on 10/28/2024 at 2:00 PM, the SSD stated Resident #7 was at the facility for a five-day respite, and the facility was aware the resident wandered.</p> <p>During an interview on 10/28/2024 at 3:38 PM, LPN #6 stated she heard a CNA say that he could not locate Resident #7. LPN #6 stated she looked in the resident's room and when she could not find the resident, she initiated a code so that staff would stop what they were doing and look for the resident. LPN #6 stated LPN #8 went into Resident #6's room and yelled for her as she walked by. According to LPN #6, Resident #7 was observed sitting on the toilet and she immediately told Resident #6 to pull up their pants up and leave the bathroom. Per LPN #6, she assessed Resident #7 and found the resident's clothing was not disturbed and their face was dry.</p> <p>During an interview on 10/28/2024 at 4:05 PM, CNA #8 stated Resident #7 wandered around the facility and went into other residents' rooms. CNA #8 stated he saw Resident #7 when he came on shift; however, when he rounded, he could not locate the resident. CNA #8 stated the facility called a code and staff found Resident #7 in Resident #6's room.</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 10/28/2024 at 4:24 PM, LPN #9 stated as she looked for Resident #7, when she went into Resident #6's room, the bathroom door was closed. LPN #9 stated she found Resident #7 fully clothed and Resident #6 was naked from the waist down. According to LPN #9, staff had Resident #6 pull up their pants and escorted out of the room to a safe location.</p> <p>During an interview on 10/29/2024 at 2:15 PM, the DON stated she assisted when the code was called to look for Resident #7. According to the DON, the nurses handled the situation and she called the police. According to the DON, Resident #6 had behaviors/inappropriate comments, but she did not think the resident was dangerous.</p> <p>During an interview on 11/12/2024 at 2:05 PM, the surveyor reviewed each of the incidents that involved Resident #6 and the interim Administrator stated the only incident that was reported was the incident on 10/18/2024 as she did not think the other incidents were abuse as the other residents involved were hard of hearing or there were no signs that abuse occurred. The interim Administrator stated it was just part of living in the nursing home and since Resident #6 never exposed themselves, she did not consider the incidents as abuse.</p> <p>On 11/18/2024 at 6:47 AM, a removal plan was submitted by the facility and accepted by the state survey agency. It read as follows:</p> <p>Removal Plan</p> <p>F600</p> <p>1. The facility will ensure residents are free from abuse, neglect, and exploitation.</p> <p>The facility will ensure interventions are implemented to prevent abuse involving resident-to-resident interactions and altercations for Resident #2, Resident #3, Resident #7, Resident #8, Resident #15, and Resident #9, and any other allegations of abuse. Residents in the facility are at risk and have the potential to be affected.</p> <p>Resident #6 is currently on 1:1, which began 10/18/2024, and remains on 1:1. Resident #6's care plan was updated to reflect the 1:1, and the facility is working on permanent housing out in the community with assistance from a local social services organization. A thirty-day discharge notice was issued to Resident #6 on 11/01/2024. Behavioral health services are following resident #6. Resident #6 was moved to a private room on 10/08/2024. Residents #7 and Resident #8 are no longer in the facility. Residents #2, #3, #9, and #15 were seen by behavioral health services on 11/16/2024 and visits have been completed, with no adverse outcome noted. Skin checks were performed on all female residents on 11/14/2024, along with all male residents on 11/15/2024, who were non-interviewable with no negative outcomes. Social Services performed psychosocial checks on Residents #2, #3, #9, and #15 on 11/14/2024 with no negative outcome.</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>2. Current staff and contracted staff (all departments) were educated by Administrator, Director of Nursing (DON), and Unit Manager (UM) on 11/13/2024. The members of the governing body (Corporate Regional Director of Clinical Services) educated the DON and the Administrator on 11/13/2024. The DON educated the UMs on 11/13/2024. The UMs educated current and contracted staff 11/13/2024. Current staff and contracted staff who have not been educated will be educated prior to their next scheduled shift. Ninety-nine percent (99%) of staff have been educated for current and contracted staff. The DON, the Administrator, and UM will educate the remaining staff who have not been educated prior to returning to work (all departments). Education was provided on the following: Abuse and Neglect Policy and Procedure, When to Report Policy and Procedure, and Proper Investigation of Occurrences and Allegations of Abuse and Neglect, which include identification of abuse, appropriate interventions in the event of alleged abuse and resident safety. One as needed (PRN) staff member has not been educated on the policies and cannot work until education is provided. New hires will receive the abuse and neglect education upon hire. Education will be provided to employees, contract staff, and any new hires prior to working (all departments).</p> <p>3. The governing body member Regional Director of Clinical Services and the Regional Directors of Operations (via phone) completed the education of abuse and neglect on 11/15/2024 with DON, Interim Administrator, Nurse Practitioner (NP), and Medical Director (MD).</p> <p>4. The Administrator, DON, and/or UM were educated on the 24-hr reports and risk management reports and the Administrator and/or DON to ensure immediate interventions. The Administrator and DON were trained on this process by the Regional Clinical Director on 11/13/2024 and UM were trained by the DON on 11/13/2024.</p> <p>5. The Administrator and/or DON will ensure immediate interventions are implemented with every occurrence and/or allegation of abuse and neglect to ensure resident safety and protection. Allegations of abuse & neglect will be reported timely to the state agencies as applicable (police, Ombudsman, physician, family).</p> <p>6. An AD HOC [a Latin term used as a shorthand phrase for as or when needed] QAPI [quality assurance and performance improvement] meeting was conducted on 11/15/2024 with Administrator, DON, Regional Director of Clinical Services, Medical Director, and Nurse Practitioner.</p> <p>7. The Medical Director and Nurse Practitioner were made aware on 11/15/2024 and agree with the immediate jeopardy removal plan.</p> <p>8. Abuse and Neglect Policy and Procedure, When to Report Policy and Procedure, and Proper Investigation of Occurrences and Allegations of Abuse and Neglect, which include identification of abuse, appropriate interventions in the event of alleged abuse and resident safety were reviewed on 11/13/2024 and no changes were made.</p> <p>9. All corrections were completed on 11/15/2024.</p> <p>10. The immediacy of the IJ was removed on 11/16/2024.</p> <p>On 11/18/2024, the survey team conducted on-site verification to confirm the facility had implemented the above written removal plan, as follows:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115503	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2024
NAME OF PROVIDER OR SUPPLIER Jesup Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 Savannah Highway Jesup, GA 31545	

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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>	<ol style="list-style-type: none"> 1. Observations conducted from 11/12/2024 to 11/18/2024, revealed Resident #6 was on 1:1 supervision. Review of the resident's medical record revealed Resident #6's care plan had been updated and facility staff worked to find alternate placement for the resident. 2. Review of facility documentation revealed facility staff, to include the Administrator, DON, NP, and MD, were educated about abuse on 11/13/2024 and interviews with staff revealed no concerns related to their understanding of abuse. Documentation further indicated the Administrator, DON, NP, and MD were educated on the 24-hour and risk management reports. Interviews with the staff revealed no concerns related to their understanding of the 24-hour and risk managements reports. 3. Review of the facility documentation revealed an AD HOC QAPI meeting was conducted on 11/15/2024. 4. Interview conducted with the MD and NP revealed their understanding of the facility's removal plan and no concerns were identified. 5. Review of the facility's abuse policies and procedures were conducted and revealed no changed had been made to the facility's policies and procedures.

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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** 46659</p> <p>Based on interview, record review, and facility policy review, the facility failed to report allegations of abuse to the state survey agency. On 08/09/2024, Resident #6 was found standing over the bed of Resident #8, a cognitively impaired resident, with their genitals in their hand and expressed inappropriate sexual gestures and comments. On 09/03/2024, Resident #6 grabbed the wheelchair of Resident #10 and prevented Resident #10 from moving about in their wheelchair. On 09/18/2024, Resident #6 voiced inappropriate sexual comments to Resident #9 as Resident #9 straightened their shirt. On 10/03/2024, Resident #6 was found masturbating in the doorway of Resident #2's room. These deficient practices affected 4 (Residents #2, #8, #9, and #10) of 15 sampled residents reviewed for abuse.</p> <p>It was determined that the provider's non-compliance with one of more requirements of participation had caused, or was likely to cause serious injury, harm, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.12 Freedom from Abuse, Neglect, and Exploitation, F609, at a scope and severity of K.</p> <p>The IJ began on 08/09/2024, when the facility failed to report an allegation of abuse to the state survey agency when Resident #6 expressed inappropriate sexual gestures and comments as they were found standing over the bed of Resident #8.</p> <p>On 11/15/2024 at 1:25 PM, the interim Administrator and Director of Nursing (DON) were informed of the IJ situation and provided a completed IJ template. A removal plan was requested. An approved Credible Allegation of Compliance was received on 11/17/2024. Based on the validation of the Credible Allegation of Compliance, the State Survey Agency determined the deficient practice was corrected on 11/15/2024 and the immediacy of the IJ being removed on 11/16/2024.</p> <p>Findings included:</p> <p>A facility policy titled, F607 F609 Abuse Program: Training, Reporting and Response, Covered Individual Responsibilities effective 08/2024, indicated, The facility, through the Administrator or their designee, will report alleged violations related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property the results of all investigations to the proper authorities within prescribed time frames.</p> <p>An Admission Record revealed the facility admitted Resident #6 on 07/10/2024. According to the Admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease, type 2 diabetes mellitus, chronic kidney disease, hypertension, and repeated falls.</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/15/2024, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Resident #6's care plan, included a focus area initiated 08/13/2024, that indicated the resident sometimes had behaviors which included sexually inappropriate language to staff, grabbed staff, and made sexual comments and sexual gestures. Interventions directed to staff to administer medications as the doctor ordered (initiated 08/13/2024), attempt interventions before the behaviors began (initiated 08/13/2024), provide care in pairs (initiated 08/14/2024), and refer the resident for psychiatric services as needed (initiated 08/13/2024).</p> <p>Resident #6's nursing progress note, dated 08/09/2024 at 4:08 PM, revealed Resident #6 was found in a resident (Resident #8) of the opposite sex's room. According to the nursing progress note, when the roommate (Resident #3) of the resident (Resident #8) informed Resident #6 that the resident (Resident #8) was deaf, Resident #6 replied that is alright, we can still feel our way around and proceeded to grab their genital area.</p> <p>An Admission Record revealed the facility admitted Resident #3 on 05/16/2023. According to the Admission Record, the resident had a medical history that included diagnoses of heart failure and muscle weakness.</p> <p>A quarterly MDS, with an ARD of 08/08/2024, revealed Resident #3 had a BIMS score of 12, which indicated the resident had moderate cognitive impairment.</p> <p>An Admission Record revealed the facility admitted Resident #8 on 06/30/2023. According to the Admission Record, the resident had a medical history to include diagnoses of hemiplegia and hemiparesis following cerebral infarction, muscle weakness, cognitive communication deficit, functional quadriplegia, and contracture of the right upper arm and right lower leg.</p> <p>A quarterly MDS, with an ARD of 07/01/2024, revealed Resident #8 had a BIMS score of 6, which indicated the resident had severe cognitive impairment.</p> <p>During an interview on 11/16/2024 at 2:10 PM, Resident #3 stated they recalled when Resident #6 came into their room and stood by Resident #8's bed. According to Resident #3, they yelled for help and asked staff to remove Resident #6 from their room. Resident #3 stated when they informed Resident #6 that Resident #8 was deaf, Resident #6 stated some bad things. Per Resident #3, Resident #6 stated we can feel our way around and then grabbed their private parts.</p> <p>Resident #6's nursing progress note, dated 09/03/2024 at 11:10 AM, revealed Resident #6 grabbed the wheelchair of a resident of the opposite sex (Resident #10) and would not let the resident continue further in their wheelchair. Per the progress note, Resident #6 was assisted back to their room and placed on 1:1 observation.</p> <p>A quarterly MDS, with an ARD of 07/10/2024, revealed the facility admitted Resident #10 on 03/12/2024. According to the MDS, the resident had a BIMS score of 4, which indicated the resident had severe cognitive impairment. Per the MDS, Resident #10 had active diagnoses to include stroke and hemiplegia or hemiparesis.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/12/2024 at 11:24 AM, Licensed Practical Nurse (LPN) #13 stated on 09/03/2024, Resident #3 hollered for her to come to their room. According to LPN #13, Resident #6 had come into Resident #3 and Resident #8's room. LPN #13 stated when she entered the room, Resident #6 was leaned over Resident #8's bed. LPN #13 stated she did not know how long Resident #6 had been in Resident #8's room. LPN #13 stated also on 09/03/2024, as Resident #6 was in the hallway, the resident grabbed the wheelchair of Resident #10 and prevented Resident #10 from going forward. According to LPN #13, after this incident, Resident #6 was placed on 1:1 until the resident was transferred to a behavioral health facility on 09/04/2024.</p> <p>Resident #6's nursing skilled note dated 09/18/2024 at 12:30 PM, revealed as a resident of the opposite sex (Resident #9) was straightening their shirt, Resident #6 told the resident, let me see it all, lean over so I can see them [breasts], and I can tell by your mouth, you nasty.</p> <p>An Admission Record revealed the facility admitted Resident #9 on 05/31/2019. According to the Admission Record, the resident had a medical history to include diagnoses of type 2 diabetes mellitus, lack of coordination, muscle weakness, dementia, and cognitive communication deficit.</p> <p>A quarterly MDS, with an ARD of 09/23/2024, revealed Resident #9 had a BIMS score of 7, which indicated the resident had severe cognitive impairment. The MDS revealed the resident had moderate difficulty with hearing and usually understood others.</p> <p>During an interview on 11/12/2024 at 11:24 AM, LPN #13 stated as Resident #9 sat on their bed and repositioned their shirt, Resident #6 made some very inappropriate sexual comments to Resident #9. According to LPN #13, Resident #9 was very hard of hearing and did not hear anything Resident #6 stated. LPN #13 stated she reported the incident to the Administrator, as the staff was to report all allegations immediately to the Abuse Coordinator, who was the Administrator or call the Director of Nursing.</p> <p>Resident #6's psychiatry follow-up note, dated 10/08/2024, revealed the resident was seen for a chief complaint of sexually inappropriate behaviors. According to the note, on 08/09/2024, Resident #6 exhibited sexually inappropriate gestures and comments towards a hospice CNA. The note indicated Resident #6 was sent to a behavioral health unit on 09/03/2024 as the resident grabbed the wheelchair of a resident of the opposite sex and would not let the resident go further in their wheelchair. Per the note, a couple of days after 09/11/2024, the resident began to make sexual remarks to CNAs and other residents. According to the note, while Resident #6 was on one-to-one supervision, on 09/18/2024, the resident made inappropriate sexual remarks to another resident of the opposite sex. Per the note, on 10/03/2024, Resident #6 was transferred to a behavioral health unit after they was found masturbating in the doorway of a resident of the opposite sex room (Resident #2). Per the note, Resident #6 returned to the facility on [DATE]. The note revealed that during the visit, the nurse practitioner explained to the resident that their behaviors were inappropriate and would not be tolerated in the facility. Per the note, Resident #6 was very aware of their behaviors, but claimed to forget what happened. Per the note, the resident was able to make decisions regarding their healthcare and living situation and expressed to the Social Services Director (SSD) that they no longer wanted to live in the nursing home and requested to be transferred to an assisted living, group home, or apartment. The note indicated the resident was ambulatory with a walker and able to move around the facility without difficulty. According to the note, Resident #6 should be kept from residents of the opposite sex as they were very aware of their behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A quarterly MDS, with an ARD of 09/22/2024, revealed the facility admitted Resident #2 on 01/06/2023. The MDS revealed Resident #2 had a BIMS score of 14, which indicated the resident had intact cognition.</p> <p>During an interview on 11/12/2024 at 2:05 PM, the surveyor reviewed each of the incidents that involved Resident #6 and the interim Administrator stated the only incident that was reported was the incident on 10/18/2024 as she did not think the other incidents were abuse as the other residents involved were hard of hearing or there were no signs that abuse occurred. The interim Administrator stated as she looked back on each of the incidents, she could now see how the other incidents should have been reported.</p> <p>During an interview on 11/14/2024 at 11:01 AM, the DON stated the only incident that was reported to the state survey agency was the incident that occurred on 10/18/2024 between Resident #6 and Resident #7.</p> <p>On 11/18/2024 at 6:47 AM, a removal plan was submitted by the facility and accepted by the state survey agency. It read as follows:</p> <p>Removal Plan</p> <p>F609</p> <p>1. The facility will ensure that all alleged violations of abuse, neglect, exploitation, or mistreatment are reported to the state survey agency and all other state agencies that are applicable (police department, Ombudsman, physician, family, guardians) within the required time frame. Reporting to state immediately but no later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. [The residents] had full body skin assessments, and all other [male/female] residents were completed as well, on 11/14/2024. Visits by the social worker for psychosocial wellbeing for [the residents] related to allegations of abuse were completed on 11/14/2024 with no negative outcomes noted. [The residents] have been seen by behavioral health services with no adverse outcomes noted. Resident #8 is no longer residing in the facility. Residents in the facility are at risk and have the potential to be affected. The incidents with [the residents] were reported to the state agency on 11/15/2024 and were investigated.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>2. Current facility staff and contracted facility staff (all departments) were educated by the Unit Managers (UM) on 11/13/2024 on the following: Abuse and Neglect Policy and Procedure, When to Report Policy and Procedure, and Proper Investigation of Occurrences and Allegations of Abuse and Neglect, which include identification of abuse, appropriate interventions in the event of alleged abuse and resident protection. The members of the governing body (Corporate Regional Director of Clinical Services) educated the Director of Nursing (DON) and Administrator on 11/13/2024. The DON educated the Unit Managers on 11/13/2024, and the Unit Managers educated current and contracted staff on 11/13/2024. Current staff and contracted staff who have not been educated will be educated prior to their next scheduled shift. Ninety-nine percent (99%) of staff have been educated for current and contracted staff. The DON, Administrator, and Unit Managers will educate remaining staff who have not been educated prior to returning to work (all departments).</p> <p>3. The Administrator, Interim Administrator, DON, Nurse Practitioner (NP), and Medical Director completed the education on abuse and neglect by the Regional Director of Clinical Services on 11/15/2024.</p> <p>4. The Administrator, DON, and/or Unit Manager will review 24-hr reports and risk management reports Mondays through Fridays. The Registered Nurse (RN) supervisor will review 24-hour reports and incident reports on Saturdays and Sundays and report any unusual occurrences immediately to the Administrator. The Administrator and DON were trained on this process by the Regional Clinical Director on 11/15/2024 and the UMs were trained by the DON on 11/15/2024.</p> <p>5. An AD HOC [a Latin term used as a shorthand phrase for as or when needed] Quality Assurance and Performance Improvement (QAPI) meeting was conducted on 11/15/2024 with the Administrator, DON, Regional Director of Clinical Services, Medical Director, and NP. Discussed were the Abuse and Neglect Policy and Procedure, When to Report Policy and Procedure, and Proper Investigation of Occurrences and Allegations of Abuse and Neglect which include identification of abuse, appropriate interventions in the event of alleged abuse and resident protection. The agenda also included potential IJ removal plan, residents that were affected, and interventions to prevent future occurrences.</p> <p>6. The Medical Director and Nurse Practitioner were made aware on 11/15/2024 and agrees with the immediate jeopardy removal plan.</p> <p>7. Abuse and Neglect Policy and Procedure, When to Report Policy and Procedure, and Proper Investigation of Occurrences and Allegations of Abuse and Neglect were reviewed on 11/15/2024 and no changes were made.</p> <p>8. All corrections were completed on 11/15/2024.</p> <p>9. The immediacy of the IJ was removed on 11/16/2024.</p> <p>On 11/18/2024, the survey team conducted on-site verification to confirm the facility had implemented the above written removal plan, as follows:</p> <p>1. Review of facility documentation revealed the facility notified the state survey agency of the allegations of abuse on 11/15/2024.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>2. Review of facility documentation revealed facility staff were educated about abuse reporting on 11/13/2024 and interviews with staff revealed no concerns related to their understanding of the requirements to report allegations of abuse.</p> <p>3. Review of facility documentation revealed the Administrator, interim Administrator, DON, NP, and MD were educated the requirements to report abuse on 11/15/2024. Interviews with the staff revealed no concerns related to their understanding of the requirements to report allegations of abuse.</p> <p>4. Review of the facility documentation revealed an AD HOC QAPI meeting was conducted on 11/15/2024.</p> <p>5. Interviews conducted with the MD and NP revealed their understanding of the facility's removal plan and no concerns were identified.</p> <p>6. Review of the facility's abuse policies and procedures were conducted and revealed no changed had been made to the facility's policies and procedures.</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46659</p> <p>Based on interview, record review, document review, and facility policy review, the facility failed to thoroughly investigate an allegation of sexual abuse perpetrated by a resident. Specifically, on 10/18/2024, when staff were unable to locate Resident #7, a cognitively impaired resident who wandered in the facility, staff initiated a search and found Resident #7 in Resident #6's bathroom seated on the toilet. Resident #6, who had a history of sexually inappropriate behavior, stood in front of Resident #7 unclothed from the waist down with their genitals in their hand. Furthermore, the facility failed to investigate allegation of verbal, sexual, and physical abuse perpetrated by a resident and implement effective measures to prevent further abuse by a resident, Resident #6, who repeatedly exhibited inappropriate sexual aggressive behaviors. Specifically, on 08/09/2024, Resident #6 was found standing over the bed of Resident #8, a cognitively impaired resident, with their genitals in their hand and expressed inappropriate sexual gestures and comments. On 09/03/2024, Resident #6 grabbed the wheelchair of Resident #10 and prevented Resident #10 from moving about in their wheelchair. On 09/18/2024, Resident #6 voiced inappropriate sexual comments to Resident #9 as Resident #9 straightened their shirt. On 10/03/2024, Resident #6 was found masturbating in the doorway of Resident #2's room. These deficient practices affected 5 (Residents #2, #7, #8, #9, and #10) of 15 sampled residents reviewed for abuse.</p> <p>It was determined that the provider's non-compliance with one of more requirements of participation had caused, or was likely to cause serious injury, harm, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.12 Freedom from Abuse, Neglect, and Exploitation, F609, at a scope and severity of K.</p> <p>The IJ began on 08/09/2024, when the facility failed to investigate an allegation of abuse to the state survey agency when Resident #6 expressed inappropriate sexual gestures and comments as they were found standing over the bed of Resident #8.</p> <p>On 11/15/2024 at 1:25 PM, the interim Administrator and Director of Nursing (DON) were informed of the IJ situation and provided a completed IJ template. A removal plan was requested. An approved Credible Allegation of Compliance was received on 11/17/2024. Based on the validation of the Credible Allegation of Compliance, the State Survey Agency determined the deficient practice was corrected on 11/15/2024 and the immediacy of the IJ being removed on 11/16/2024.</p> <p>Findings included:</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A facility policy titled, F607 Abuse Prevention Program, Investigation F600, F602, F603, F610 last revised 08/2022, indicated, Reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management. The policy specified, Guidelines 1. Should an incident or suspected incident of resident abuse, mistreatment, misappropriation, neglect or injury of unknown source be reported, the Administrator, or his/her designee, will appoint a member of management to investigate the alleged incident. 2. The individual conducting the investigation will, as a minimum: a. Review the completed documentation forms; b. Review the resident's medical record to determine events leading up to the incident; c. Interview the person(s) reporting the incident; d. Interview any witnesses to the incident; e. Interview the resident (as medically appropriate); f. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; g. Interview the resident's roommate, family members, and visitors, as able or as appropriate to the situation; h. Review all events leading up to the alleged incident. Per the policy, 15. Inquires concerning abuse reporting and investigation should be referred to the Administrator or to the Director of Nursing Services.</p> <p>An Admission Record revealed the facility admitted Resident #6 on 07/10/2024. According to the Admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease, type 2 diabetes mellitus, chronic kidney disease, hypertension, and repeated falls.</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/15/2024, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment.</p> <p>Resident #6's care plan, included a focus area initiated 08/13/2024, that indicated the resident sometimes had behaviors which included sexually inappropriate language to staff, grabbed staff, and made sexual comments and sexual gestures. Interventions directed to staff to administer medications as the doctor ordered (initiated 08/13/2024), attempt interventions before the behaviors began (initiated 08/13/2024), provide care in pairs (initiated 08/14/2024), and refer the resident for psychiatric services as needed (initiated 08/13/2024).</p> <p>Resident #6's nursing progress note, dated 08/09/2024 at 4:08 PM, revealed Resident #6 was found in a resident (Resident #8) of the opposite sex's room. According to the nursing progress note, when the roommate (Resident #3) of the resident (Resident #8) informed Resident #6 that the resident (Resident #8) was deaf, Resident #6 replied that is alright, we can still feel our way around and proceeded to grab their genital area.</p> <p>An Admission Record revealed the facility admitted Resident #3 on 05/16/2023. According to the Admission Record, the resident had a medical history that included diagnoses of heart failure and muscle weakness.</p> <p>A quarterly MDS, with an ARD of 08/08/2024, revealed Resident #3 had a BIMS score of 12, which indicated the resident had moderate cognitive impairment.</p> <p>An Admission Record revealed the facility admitted Resident #8 on 06/30/2023. According to the Admission Record, the resident had a medical history to include diagnoses of hemiplegia and hemiparesis following cerebral infarction, muscle weakness, cognitive communication deficit, functional quadriplegia, and contracture of the right upper arm and right lower leg.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Jesup Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 Savannah Highway Jesup, GA 31545	
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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A quarterly MDS, with an ARD of 07/01/2024, revealed Resident #8 had a BIMS score of 6, which indicated the resident had severe cognitive impairment.</p> <p>During an interview on 11/16/2024 at 2:10 PM, Resident #3 stated they recalled when Resident #6 came into their room and stood by Resident #8's bed. According to Resident #3, they yelled for help and asked staff to remove Resident #6 from their room. Resident #3 stated when they informed Resident #6 that Resident #8 was deaf, Resident #6 stated some bad things. Per Resident #3, Resident #6 stated we can feel our way around and then grabbed their private parts.</p> <p>Resident #6's nursing progress note, dated 09/03/2024 at 11:10 AM, revealed Resident #6 grabbed the wheelchair of a resident of the opposite sex (Resident #10) and would not let the resident continue further in their wheelchair. Per the progress note, Resident #6 was assisted back to their room and placed on 1:1 observation.</p> <p>A quarterly MDS, with an ARD of 07/10/2024, revealed the facility admitted Resident #10 on 03/12/2024. According to the MDS, the resident had a BIMS score of 4, which indicated the resident had severe cognitive impairment. Per the MDS, Resident #10 had active diagnoses to include stroke and hemiparesis or hemiparesis.</p> <p>During an interview on 11/12/2024 at 11:24 AM, Licensed Practical Nurse (LPN) #13 stated on 09/03/2024, Resident #3 hollered for her to come to their room. According to LPN #13, Resident #6 had come into Resident #3 and Resident #8's room. LPN #13 stated when she entered the room, Resident #6 was leaned over Resident #8's bed. LPN #13 stated she did not know how long Resident #6 had been in Resident #8's room. LPN #13 stated also on 09/03/2024, as Resident #6 was in the hallway, the resident grabbed the wheelchair of Resident #10 and prevented Resident #10 from going forward. According to LPN #13, after this incident, Resident #6 was placed on 1:1 until the resident was transferred to a behavioral health facility on 09/04/2024.</p> <p>Resident #6's nursing skilled note dated 09/18/2024 at 12:30 PM, revealed as a resident of the opposite sex (Resident #9) was straightening their shirt, Resident #6 told the resident, let me see it all, lean over so I can see them [breasts], and I can tell by your mouth, you nasty.</p> <p>An Admission Record revealed the facility admitted Resident #9 on 05/31/2019. According to the Admission Record, the resident had a medical history to include diagnoses of type 2 diabetes mellitus, lack of coordination, muscle weakness, dementia, and cognitive communication deficit.</p> <p>A quarterly MDS, with an ARD of 09/23/2024, revealed Resident #9 had a BIMS score of 7, which indicated the resident had severe cognitive impairment. The MDS revealed the resident had moderate difficulty with hearing and usually understood others.</p> <p>During an interview on 11/12/2024 at 11:24 AM, LPN #13 stated as Resident #9 sat on their bed and repositioned their shirt, Resident #6 made some very inappropriate sexual comments to Resident #9. According to LPN #13, Resident #9 was very hard of hearing and did not hear anything Resident #6 stated. LPN #13 stated she reported the incident to the Administrator, as the staff was to report all allegations immediately to the Abuse Coordinator, who was the Administrator or call the Director of Nursing.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/16/2024 at 11:05 AM, LPN #6 stated abuse could be many things such as physical, sexual, and verbal to name a few. LPN #6 stated if a resident said something that was inappropriate or mean, it could be considered verbal abuse.</p> <p>Resident #6's skilled note, dated 10/01/2024 at 11:52 AM, revealed the resident was noted to have inappropriate behaviors towards opposite sex staff and residents. The skilled note indicated Resident #6 told a female staff member to come to their bed and told a resident of the opposite sex (Resident #15) that I got to put it somewhere. Per the skilled note, staff continued to redirect Resident #6 away from residents of the opposite sex and moved residents of the opposite sex from Resident #6.</p> <p>An Admission Record revealed the facility admitted Resident #15 on 01/19/2021. According to the Admission Record, the resident had a medical history to include diagnoses of dementia, altered mental status, and muscle weakness.</p> <p>A quarterly MDS, with an ARD of 07/18/2024, revealed Resident #15 had a BIMS score of 5, which indicated the resident had severe cognitive impairment.</p> <p>Resident #6's psychiatry follow-up note, dated 10/08/2024, revealed the resident was seen for a chief complaint of sexually inappropriate behaviors. According to the note, on 08/09/2024, Resident #6 exhibited sexually inappropriate gestures and comments towards a hospice CNA. The note indicated Resident #6 was sent to a behavioral health unit on 09/03/2024 as the resident grabbed the wheelchair of a resident of the opposite sex and would not let the resident go further in their wheelchair. Per the note, a couple of days after 09/11/2024, the resident began to make sexual remarks to CNAs and other residents. According to the note, while Resident #6 was on one-to-one supervision, on 09/18/2024, the resident made inappropriate sexual remarks to another resident of the opposite sex. Per the note, on 10/03/2024, Resident #6 was transferred to a behavioral health unit after they was found masturbating in the doorway of a resident of the opposite sex room (Resident #2). Per the note, Resident #6 returned to the facility on [DATE]. The note revealed that during the visit, the nurse practitioner explained to the resident that their behaviors were inappropriate and would not be tolerated in the facility. Per the note, Resident #6 was very aware of their behaviors, but claimed to forget what happened. Per the note, the resident was able to make decisions regarding their healthcare and living situation and expressed to the Social Services Director (SSD) that they no longer wanted to live in the nursing home and requested to be transferred to an assisted living, group home, or apartment. The note indicated the resident was ambulatory with a walker and able to move around the facility without difficulty. According to the note, Resident #6 should be kept from residents of the opposite sex as they were very aware of their behaviors.</p> <p>A quarterly MDS, with an ARD of 09/22/2024, revealed the facility admitted Resident #2 on 01/06/2023. The MDS revealed Resident #2 had a BIMS score of 14, which indicated the resident had intact cognition.</p> <p>An Admission Record revealed the facility admitted Resident #7 on 10/17/2024. According to the Admission Record, the resident had a medical history that included diagnoses of dementia, neurocognitive disorder with Lewy bodies, hallucinations, and anxiety disorder.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The facility's five-day report dated 10/25/2024, revealed on 10/18/2024 around 4:45 PM, LPN #9 observed Resident #7 seated on the toilet fully clothed in the bathroom of Resident #6. Per the report, Resident #6 stood in front of Resident #7, with their pants and incontinence brief down around their ankles, while they faced Resident #7 with their genitalia in their right hand. According to the note, LPN #6 and the DON entered the room and observed the same. Per the note, LPN #6 instructed Resident #6 to pull up their pants and incontinence brief and leave the bathroom. The note revealed LPN #6 assisted Resident #7 from the toilet, placed the resident into their wheelchair and removed the resident from the bathroom. The note indicated both residents were placed on one-to-one supervision and the police, the Medical Director, and the families of both residents were called. According to the note, Resident #7 did not have any apparent injuries to their face, their face was dry, and all their clothing was on correctly and not shuffled. The note indicated Resident #7 was not able to give any description of what occurred. The report indicated that upon conclusion of the investigation, while the facility was unable to substantiate sexual contact, it was determined that Resident #6 committed indecent exposure to a vulnerable person, Resident #7. The facility five-day report failed to show the incidents the events that lead to Resident #7 being found in Resident #6's bathroom and/or interviews with staff from all shifts.</p> <p>Resident #6's nursing skilled note dated 10/18/2024 at 11:45 PM, revealed the resident was asked by a CNA if they understood what they done wrong and Resident #6 replied, Yes, I wanted [him/her] to suck it.</p> <p>During an interview on 11/12/2024 at 2:05 PM, the surveyor reviewed each of the incidents that involved Resident #6. The interim Administrator stated the only incident that was reported was the incident on 10/18/2024 as she did not think the other incidents were abuse as the other residents involved were hard of hearing or there were no signs that abuse occurred. The interim Administrator stated as she looked back on each of the incidents, she could now see how the other incidents should have been reported and investigated.</p> <p>On 11/18/2024 at 6:47 AM, a removal plan was submitted by the facility and accepted by the state survey agency. It read as follows:</p> <p>Removal Plan</p> <p>F610</p> <p>1. The facility will ensure that all alleged violations of abuse, neglect, exploitation, and mistreatment are appropriately investigated and reported to state agencies. All residents have the potential to be affected. On 11/15/2024 incidents involving [the residents] have been reported to the state and investigations started, skin assessments, and incident reports made.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>2. Current facility staff and contracted staff (all departments) were educated by the nursing administration staff on the Abuse and Neglect Policy and Procedure, When to Report Policy and Procedure, education on behaviors and on documentation of behaviors and interventions in the electronic medical records, and Proper Investigation of Occurrences and Allegations of Abuse and Neglect, which include identification of abuse, appropriate interventions in the event of alleged abuse and resident protection from abuse. New hires will receive the abuse and neglect education, and procedure and protocol upon hire. Education will be provided to employees, contract staff, and any new hires prior to working. Completion date 11/13/2024. A member of the governing body (Regional Director of Clinical Services) educated the Director of Nursing (DON), and Interim Administrator on 11/13/2024. A member of the governing body (Regional Director of Clinical Services) educated the DON, Interim Administrator, Medical Director, Nurse Practitioner (NP) and Administrator on 11/15/2024 for Abuse and Neglect Policy and Procedure, When to Report Policy and Procedure, education on behaviors and on documentation of behaviors and interventions in the electronic medical records, and Proper Investigation of Occurrences and Allegations of Abuse and Neglect, which include identification of abuse, appropriate interventions in the event of alleged abuse and resident protection from abuse .The DON educated the Unit Managers, and the Unit Managers educated current and contracted staff. Current staff and contracted staff who have not been educated will be educated prior to their next scheduled shift. Ninety- nine percent 99% of staff have been educated for current and contracted staff. The DON, Administrator, and Unit Manager will educate remaining staff who have not been educated prior to returning to work (all departments).</p> <p>3. The Interim Administrator, Administrator, DON, NP, and the Medical Director completed the education on abuse and neglect and reporting of abuse and resident protection by the Regional Director of Clinical Services on 11/15/2024. Completion date 11/15/2024</p> <p>4. An AD HOC [a Latin term used as a shorthand phrase for as or when needed] QAPI [Quality Assurance and Performance Improvement] meeting was conducted on 11/15/2024 with the Administrator, DON, Regional Director of Clinical Services, Medical Director, and Nurse Practitioner to discuss the IJ and Removal Plan.</p> <p>5. The Medical Director and Nurse Practitioner were made aware on 11/15/2024 and agree with the immediate jeopardy removal plan.</p> <p>6. All corrections were completed on 11/15/2024.</p> <p>7. The immediacy of the IJ was removed on 11/16/2024.</p> <p>On 11/18/2024, the survey team conducted on-site verification to confirm the facility had implemented the above written removal plan, as follows:</p> <p>1. Review of facility documentation revealed the facility notified the state survey agency of the allegations of abuse on 11/15/2024 and began to conduct their investigations.</p> <p>2. Review of facility documentation revealed facility staff were educated about abuse on 11/13/2024 and interviews with staff revealed no concerns related to their understanding of abuse prohibition.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>3. Review of facility documentation revealed the Administrator, interim Administrator, DON, NP, and MD were educated the requirements to complete an investigation for all allegations of abuse on 11/15/2024. Interviews with the staff revealed no concerns related to their understanding of the requirements to conduct abuse investigations.</p> <p>4. Review of the facility documentation revealed an AD HOC QAPI meeting was conducted on 11/15/2024.</p> <p>5. Interviews conducted with the MD and NP revealed their understanding of the facility's removal plan and no concerns were identified.</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>46659</p> <p>Based on interview, record review, and facility policy review, the facility Administrator, who was responsible for the day-to-day operations of the facility, failed to provide oversight to ensure the abuse policy was implemented when a resident, with a history of sexually inappropriate behaviors, repeatedly exhibited verbal, sexual, and physical abuse towards other residents. Specifically, on 10/18/2024, when staff were unable to locate Resident #7, a cognitively impaired resident who wandered in the facility, staff initiated a search and found Resident #7 in Resident #6's bathroom seated on the toilet. Resident #6, who had a history of sexually inappropriate behavior, stood in front of Resident #7 unclothed from the waist down with their genitals in their hand. Furthermore, the facility failed to investigate allegation of verbal, sexual, and physical abuse perpetrated by a resident and implement effective measures to prevent further abuse by a resident, Resident #6, who repeatedly exhibited inappropriate sexual aggressive behaviors. Specifically, on 08/09/2024, Resident #6 was found standing over the bed of Resident #8, a cognitively impaired resident, with their genitals in their hand and expressed inappropriate sexual gestures and comments. On 09/03/2024, Resident #6 grabbed the wheelchair of Resident #10 and prevented Resident #10 from moving about in their wheelchair. On 09/18/2024, Resident #6 voiced inappropriate sexual comments to Resident #9 as Resident #9 straightened their shirt. On 10/03/2024, Resident #6 was found masturbating in the doorway of Resident #2's room. These deficient practices affected 5 (Residents #2, #7, #8, #9, and #10) of 15 sampled residents reviewed for abuse.</p> <p>It was determined that the provider's non-compliance with one of more requirements of participation had caused, or was likely to cause serious injury, harm, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.70 Administration, F835, at a scope and severity of K.</p> <p>The IJ began on 08/09/2024, when the Administrator failed to report an allegation of abuse to the state survey agency and conduct an investigation when Resident #6 expressed inappropriate sexual gestures and comments as they were found standing over the bed of Resident #8.</p> <p>On 11/15/2024 at 1:25 PM, the interim Administrator and Director of Nursing (DON) were informed of the IJ situation and provided a completed IJ template. A removal plan was requested. An approved Credible Allegation of Compliance was received on 11/17/2024. Based on the validation of the Credible Allegation of Compliance, the State Survey Agency determined the deficient practice was corrected on 11/15/2024 and the immediacy of the IJ being removed on 11/16/2024.</p> <p>Findings included:</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A facility policy titled, Administrator F837, last revised 08/2011, revealed Policy Statement A licensed Administrator is responsible for the day-to-day functions of the facility. Policy Interpretation and Implementation 1. The governing board of this facility has appointed an Administrator who is duly licensed in accordance with current federal and state requirements. The Administrator is responsible for, but not limited to: a. Managing the day-to-day functions of the facility; and d. Implementing established resident care policies, personnel policies, safety and security policies, and other operational policies and procedures necessary to remain in compliance with current laws, regulations, and guidelines governing long-term care facilities.</p> <p>Resident record review indicated on 10/18/2024, when staff were unable to located Resident #7, a cognitively impaired resident who wandered in the facility, staff initiated a search and found Resident #7 in Resident #6's bathroom seated on the toilet. Resident #6, who had a history of sexually inappropriate behavior, stood in front of Resident #7 unclothed from the waist down with their genitals in their hand. Furthermore, on 08/09/2024, Resident #6 was found standing over the bed of Resident #8, a cognitively impaired resident, with their genitals in their hand and expressed inappropriate sexual gestures and comments. On 09/03/2024, Resident #6 grabbed the wheelchair of Resident #10 and prevented Resident #10 from moving about in their wheelchair. On 09/18/2024, Resident #6 voiced inappropriate sexual comments to Resident #9 as Resident #9 straightened their shirt. On 10/03/2024, Resident #6 was found masturbating in the doorway of Resident #2's room. (Refer to F600, F607, and F610).</p> <p>During an interview on 11/12/2024 at 2:05 PM, the surveyor reviewed each of the incidents that involved Resident #6. The interim Administrator stated the only incident that was reported was the incident on 10/18/2024 as she did not think the other incidents were abuse as the other residents involved were hard of hearing or there were no signs that abuse occurred. The interim Administrator stated it was just part of living in the nursing home and since Resident #6 never exposed themselves, she did not consider the incidents as abuse. The interim Administrator stated as she looked back on each of the incidents, she could now see how the other incidents should have been reported and investigated.</p> <p>On 11/18/2024 at 6:47 AM, a removal plan was submitted by the facility and accepted by the state survey agency. It read as follows:</p> <p>Removal Plan</p> <p>F835</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>1. The Governing Body will ensure facility administrative staff and facility staff receive education and can demonstrate knowledge of facility systems and competency of procedures for the prevention of abuse and neglect, abuse investigations and resident protection and safety of all residents. The Regional Director of Clinical Services provided education for Director of Administrator and Interim Administrator 11/13/2024 on the Abuse and Neglect Policy and Procedure, When to Report Policy and Procedure, and Proper Investigation of Occurrences and Allegations of Abuse and Neglect. The Regional Director of Clinical Services provided education for Abuse and Neglect Policy and Procedure, When to Report Policy and Procedure, and Proper Investigation of Occurrences and Allegations of Abuse and Neglect to the Administrator, Interim Administrator, Director of Nursing (DON), Nurse Practitioner (NP), and Medical Director (MD) on 11/15/2024. A member of the governing body (Regional Director of Clinical Services) educated the DON and the Administrator. The governing body member, Administrator, DON, Regional Director of Operations (via phone), Regional Director of Clinical Services reviewed the following policies, Behavior Assessment and Monitoring, Abuse and Neglect Policy and Procedure, When to Report Policy and Procedure, and Proper Investigation of Occurrences and Allegations of Abuse and Neglect. The Administrator's and DON's job descriptions and education was reviewed on 11/15/2024 by the Regional Directions of Operations via phone. The DON educated the Unit Managers (UM), and the Unit Managers educated current and contracted staff. Current staff and contracted staff who have not been educated will be educated prior to their next scheduled shift. Ninety-nine percent (99%) of staff have been educated for current and contracted staff. The DON, the Administrator, and UM will educate remaining staff who have not been educated prior to returning to work (all departments).</p> <p>2. The DON, UM, and the Administrator will review the 24-hr report and risk management report Mondays through Fridays found in the electronic medical records. The Registered Nurse (RN) supervisor will review the 24-hr report and risk management report found in the electronic medical records on Saturdays and Sundays and will report any unusual occurrence immediately to the Administrator. The Administrator and DON were trained on this process by the Regional Clinical Director on 11/15/2024 and the UMs were trained by the DON on 11/15/2024.</p> <p>3. An AD HOC [a Latin term used as a shorthand phrase for as or when needed] QAPI [Quality Assurance and Performance Improvement] meeting was conducted on 11/15/2024 with the Administrator, DON, Regional Director of Clinical Services, Medical Director, and Nurse Practitioner.</p> <p>4. The Medical Director was made aware on 11/15/2024 and agrees with the immediate jeopardy removal plan. The governing body member arrived 11/12/2024 and currently remains in facility.</p> <p>5. Abuse and Neglect Policy and Procedure, When to Report Policy and Procedure, and Proper Investigation of Occurrences and Allegations of Abuse and Neglect were reviewed on 11/15/2024 and no changes were made.</p> <p>6. All corrections were completed on 11/15/2024.</p> <p>7. The immediacy of the IJ was removed on 11/16/2024.</p> <p>On 11/18/2024, the survey team conducted on-site verification to confirm the facility had implemented the above written removal plan, as follows:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Jesup Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 Savannah Highway Jesup, GA 31545	
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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<ol style="list-style-type: none"> 1. Review of facility documentation revealed the interim Administrator, Administrator, DON, NP, and MD were educated the requirements related to the prohibition of abuse on 11/15/2024. Interviews with the staff revealed no concerns related to their understanding of the requirements to conduct abuse investigations. 2. Review of the facility documentation revealed an AD HOC QAPI meeting was conducted on 11/15/2024. 3. Interviews conducted with the MD revealed his understanding of the facility's removal plan and no concerns were identified. 4. Review of the facility's abuse policies and procedures were conducted and revealed no changed had been made to the facility's policies and procedures. 		