

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115692	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/31/2024
NAME OF PROVIDER OR SUPPLIER  Medical Management Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1509 Cedar Ave Macon, GA 31204	

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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41196</b></p> <p>Based on observation, staff interviews, record review, and a review of the facility policy titled Abuse, Neglect, and Exploitation, the facility failed to protect two residents' (R) (R2, R3) right to be free from sexual abuse by a resident (R1). Specifically, the facility failed to implement appropriate interventions and separate vulnerable residents from potential perpetrators.</p> <p>Findings include:</p> <p>The facility's Abuse, Neglect and Exploitation policy reviewed on 4/4/2024 documented, Policy: 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, neglect, exploitation, and misappropriation or resident property.</p> <p>R1 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including traumatic subdural hemorrhage without loss of consciousness; altered mental status; unspecified dementia, unspecified severity with other behavioral disturbance, vascular dementia, severe with agitation and psychotic disorder with delusions due to known physiological condition. Review of the 9/20/2024 Quarterly Minimum Data Set (MDS), the resident had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of zero out of 15.</p> <p>R2 was admitted on [DATE] with diagnoses including unspecified dementia, unspecified severity, with other behavioral disturbance; dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance and pain, unspecified. Review of the 10/1/2024 Annual MDS, the resident had severe cognitive impairment with BIMS score of 99, which represented an inability to complete the interview.</p> <p>R3 was admitted on [DATE] with diagnoses including neurocognitive disorder, other extrapyramidal and movement disorders, Alzheimer's disease with early onset, and psychotic disorder with delusions due to a known physiological condition. Review of the 5/23/2024 Significant Change in Condition MDS, the resident had severe cognitive impairment with BIMS score of 99, which indicated an inability to complete the interview.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 115692
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's Resident Incident Report dated 5/21/2024 documented that on 4/11/2024 at approximately 8:30 p.m., Certified Nurse Assistant (CNA) HH found R1 behind the closed door in R3's room. According to the report, R1 pulled down R3's brief, and his brief was pulled down as well. While the report documented the facility implemented 15-minute checks for 72 hours with R1, they failed to protect R3 and other residents from further abuse.</p> <p>A review of the facility's census revealed that during the 4/11/2024 incident, R1 lived in room D12-1 while R3 shared room B4-2 with R2. During visual observation, these rooms were separated by an L shaped hallway with a nurse station facing the D hallway and a large dining room acting as a barrier between R1 and R2, and R3's room. However, after the first incident, the facility moved R1 to Room B92. The room was directly across from Room B4 (the room occupied by R2 and R3) and was out of the line of sight from all nursing stations, and no monitoring mechanisms were in place.</p> <p>The facility's Resident Incident Report, dated 5/14/2024, documented a second incident involving all three residents. According to the report, CNA BB reportedly found R1 in bed with R2, while R3's brief had reportedly been pulled down. The facility's room placement had increased access to vulnerable residents by moving R1 from room D12-1 to room B92, directly across from their known victims' room.</p> <p>During an interview on 10/29/2024 at 12:00 p.m., CNA BB stated they were working the 3:00 p.m. through 11:00 p.m. shift on 5/13/2024 when they found R1 in bed with R2 while R3's brief had been pulled down. CNA BB stated that R1 had just his brief on while the resident lay in bed with R2. CNA BB added that R2 was fully clothed when R1 was observed in bed with her. CNA BB stated they redirected R1 out of the room and notified Charge Nurse DD of her observation.</p> <p>During an interview on 10/29/2024 at 1:48 p.m., Social Worker CC stated she was not made aware of the possible sexual abuse incidents involving R1, R2, and R3. Social Worker CC confirmed she had moved R1 on 5/1/2024 due to roommate conflicts. Social Worker CC stated she would not have made the switch had she known about the sexual abuse allegation involving R1 and R3.</p> <p>During an interview on 10/29/2024 at 3:16 p.m., Charge Nurse DD stated she was the Charge Nurse on duty during the two incidents (referring to the incident dated 4/11/2024 and the incident dated 5/13/2024). Charge Nurse DD stated after CNA HH and CNA BB alerted her to finding R1 in a compromised position relative to R2 and R3.</p> <p>During an interview on 10/30/2024 at 9:10 a.m., the Administrator stated the facility's protocols were not followed on how the inappropriate sexual contact involving R1, R2, and R3 were handled. The Administrator further revealed several opportunities were missed, including but not limited to immediate head-to-toe assessment, obtaining written statements from staff, interviews with cognitive residents, law enforcement notification in the event sexual abuse was confirmed, incident report on all vulnerable residents to rule out sexual abuse as well as having an interdisciplinary meeting to revise the care plans for the affected residents with consideration for room placement. The Administrator stated all the enumerated opportunities did not happen but should have happened.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/30/2024 at 9:45 a.m., the Director of Nursing (DON) stated she was not employed at the facility at the time of the incidents. The DON stated her expectation after sexual abuse was suspected or observed was that a head-to-toe assessment would be done immediately and results documented to rule out sexual abuse. The DON added that written statements would be obtained from staff immediately versus the following day, and 15-minute safety checks would be started immediately versus the following day. The DON further stated that law enforcement would be notified if sexual abuse was suspected.</p> <p>During an interview on 10/30/2024 at 10:30 a.m., the Medical Director stated he was not notified of the incidents until the next day and was not available to examine the residents personally. The Medical Director emphasized the importance of evaluating residents to rule out sexual abuse, given the compromised positions they were found in. The Medical Director added that the facility's decision to move R1 closer to the victims demonstrated poor judgment.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41196</p> <p>Based on record review, family and staff interviews, and a review of the facility's policy titled Abuse, Neglect and Exploitation, the facility failed to report allegations of sexual abuse to the State Survey Agency within the required timeframes and failed to notify the residents' Responsible Parties of the incidents. This deficient practice affected two of three residents (R) (R2 and R3), who were reviewed for abuse reporting.</p> <p>Findings include:</p> <p>The facility's Abuse, Neglect and Exploitation policy reviewed on 4/4/2024 documented under the Reporting and Response Portion of the policy . 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 timeframes: (a) Immediately, but not later than two (2) hours after allegation is made, if the event that cause the allegation involve abuse or result in serious bodily injury, or (b) Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.</p> <p>R #1 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses that included traumatic subdural hemorrhage without loss of consciousness; altered mental status; unspecified dementia with behavioral disturbance, vascular dementia, severe with agitation and psychotic disorder with delusions due to known physiological condition. According to the 9/20/2024 Quarterly Minimum Data Set (MDS), the resident had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of zero out of 15.</p> <p>R #2 was admitted on [DATE] with diagnoses that included unspecified dementia, unspecified severity, with other behavioral disturbance; dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance and pain, unspecified. According to the 10/1/2024 Annual MDS, the resident had severe cognitive impairment with BIMS score of 99 due to inability to complete the interview.</p> <p>R #3 was admitted on [DATE] with diagnoses including neurocognitive disorder with Lewy bodies; other extrapyramidal and movement disorders; Alzheimer's disease with early onset, and psychotic disorder with delusions due to known physiological condition. According to the 5/23/2024 Significant Change in Condition MDS, the resident had severe cognitive impairment with BIMS Score of 99 due to inability to complete the interview.</p> <p>A review of the facility's incident reports revealed:</p> <p>1. The facility failed to report the 4/11/2024 incident involving R#1 and R#3 to the State Survey Agency until 5/21/2024 (41 days after the incident occurred).</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 - Few</p>	<p>During an interview on 10/29/2024 at 10:00 a.m., R3's family member, listed as the Power of Attorney, stated they were never called nor made aware of any alleged sexual abuse that involved the resident.</p> <p>During an interview on 10/29/2024 at 10:11 a.m., R2's listed responsible party/guardian denied being made aware of any alleged sexual abuse involving the resident.</p> <p>During an interview on 10/29/2024 at 12:00 p.m., Certified Nurse Assistant (CNA) BB stated they reported their observations immediately to the charge nurse on duty when they discovered R1 undressed in bed with R2.</p> <p>During an interview on 10/29/2024 at 1:48 p.m., Social Worker CC stated her duty as a Social Worker serving nursing home residents who have allegedly experienced sexual abuse was to focus first on ensuring immediate safety and mandatory reporting to authorities. Social Worker CC stated she was not notified of either incident when it occurred, which affected her ability to intervene adequately.</p> <p>During an interview on 10/29/2024 at 3:16 p.m., Charge Nurse DD stated she was told of the incident; however, she did not observe the residents firsthand. Charge Nurse DD stated she had completed an incident report and contacted the relevant family members and the resident's attending physician. When advised of the residents' family member's denial of being notified of the incidents, Charge Nurse DD stated she had to cover their oversight.</p> <p>During an interview on 10/30/2024 at 9:10 a.m., the Administrator stated the facility's protocols were not followed. The Administrator revealed that for the first inappropriate sexual contact made by R#1 towards R#3 on 4/11/2024 at 8:30 p.m., Charge Nurse DD did not notify the Director of Nursing, the Assistant Director of Nursing, or the Administrator until the following day.</p> <p>During an interview on 10/30/2024 at 9:45 a.m., the Director of Nursing stated the facility's expectation was immediate notification of administration, physician, and responsible parties following any allegation of abuse. The DON added that law enforcement should have been notified if sexual abuse was suspected.</p> <p>During an interview on 10/30/2024 at 10:30 a.m., the Medical Director stated they were not notified of the incidents until the next day after they had happened and were not available to examine the residents personally. The Medical Director emphasized that delayed notification impacted their ability to evaluate the residents and direct appropriate medical interventions properly.</p> <p>(Cross reference F600)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41196</p> <p>Based on staff interviews, record review, and a review of the facility's policy titled Care Plans - Comprehensive, the facility failed to develop and implement comprehensive care plans that addressed sexual abuse incidents, prevention measures, and safety interventions. This deficient practice affected three of three residents (R) (R1, R2, R3) reviewed for abuse.</p> <p>Findings include:</p> <p>The facility policy titled, Care Plans - Comprehensive revised October 2010 documented Policy Interpretation and Implementation 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. The Revisions portion of the policy further documented 8. Assessments of residents are ongoing, and care plans are revised as information about the resident and the resident's condition change.</p> <p>R#1 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including traumatic subdural hemorrhage without loss of consciousness; altered mental status; unspecified dementia with behavioral disturbance, vascular dementia, severe with agitation and psychotic disorder with delusions due to known physiological condition. According to the 9/20/2024 Quarterly Minimum Data Set (MDS), the resident had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of zero out of 15.</p> <p>Review of R1's care plan revealed:</p> <ol style="list-style-type: none"> <li>1. No updates addressed the inappropriate sexual behaviors directed at R2 and R3.</li> <li>2. No interventions for increased supervision needs.</li> <li>3. No behavioral management strategies.</li> <li>4. No room placement considerations.</li> </ol> <p>R 2 was admitted on [DATE] with diagnoses including unspecified dementia, unspecified severity, with other behavioral disturbance; dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance and pain, unspecified. According to the 10/1/2024 Annual MDS, the resident had severe cognitive impairment with BIMS score of 99 due to the inability to complete the interview.</p> <p>Review of R2's care plan revealed:</p> <ol style="list-style-type: none"> <li>1. No modifications were made after the 5/13/2024 incident.</li> <li>2. No interventions that addressed safety related to room placement.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. No psychological support measures.</p> <p>4. No enhanced monitoring requirements.</p> <p>R3 was admitted on [DATE] with diagnoses including neurocognitive disorder with lewy bodies; other extrapyramidal and movement disorders; Alzheimer's disease with early onset, and psychotic disorder with delusions due to known physiological condition. According to the 5/23/2024 Significant Change in Condition MDS, the resident had severe cognitive impairment with BIMS score of 99 due to inability to complete the interview. A review of R3's medical record revealed a care plan dated 7/12/2022 which documented the resident was considered bedfast all or most of the time related to preference of condition (Hospice) status. Additionally, the care plan dated 5/1/2024 documented that R3 was at risk for increased anxiety and restlessness from having individuals come into her room and being unable to speak loud enough to alert others of concerns.</p> <p>Review of R3's care plan revealed:</p> <ol style="list-style-type: none"> <li>1. No updates following the alleged sexual abuse incidents of 4/11/2024 and 5/13/2024.</li> <li>2. No interventions that addressed increased vulnerability to abuse.</li> <li>3. No modifications to address the psychological impact related to the incidents.</li> <li>4. No enhanced monitoring measures despite the documented risk of anxiety and inability to call for help.</li> </ol> <p>During an interview on 10/29/2024 at 12:00 p.m., Certified Nurse Assistant (CNA) BB stated she discovered R1 undressed in bed with R2, while R3's brief was pulled down.</p> <p>During an interview on 10/29/2024 at 1:48 p.m., Social Worker CC stated her duty included helping modify care plans to enhance safety and monitor resident adjustment over time. Social Worker CC stated she was not made aware of the situation (referring to the inappropriate sexual behavior directed at Residents R2 and R3) and, therefore, could not update care plans appropriately. Social Worker CC stated she moved R1 on 5/1/2024 to the room opposite R3's room due to roommate conflicts but would not have made the switch had she known about the sexual abuse incidents involving R1 and R3.</p> <p>During an interview on 10/29/2024 at 3:16 p.m., Charge Nurse DD stated she did not complete an assessment on R2 or R3, which prevented appropriate care plan updates based on assessment findings.</p> <p>During an interview on 10/30/2024 at 9:10 a.m., the Administrator stated the facility's protocols were not followed, including the requirement to update care plans following incidents of abuse. The Administrator acknowledged that failures to update the care plans left residents without proper protective interventions.</p> <p>During an interview on 10/30/2024 at 9:45 a.m., the Director of Nursing stated that a facility-wide assessment of all vulnerable residents should have been completed, with care plan updates to reflect assessment findings and necessary interventions.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/30/2024 at 10:30 a.m., the Medical Director stated that coordination with psychiatry services was limited because the facility did not inform him of the full scope of what occurred with the residents at the time. The Medical Director emphasized that the course of action after any potential abuse should include updating care plans to address room placement and prevent contact between the involved residents. The Medical Director stated that the facility's decision to move R1 to a room directly opposite R2 and R3's room lacked reasonable judgment and should have been addressed in the process of updating care plans.</p> <p>Cross reference F600</p>		