STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145183	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goldwater Care Danville	620 Warrington Avenue Danville, IL 61832

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to protect the resident's right (R1) to be free from sexual abuse by another resident (R2) by failing to supervise R2, a resident with a known history of behaviors of inappropriate touching towards other residents (R3, R4, R5, R6, R7, R8, R10, R14). R1-R8, R10, and R14 are nine of 14 residents reviewed for abuse in the sample list of 16. These failures resulted in R2 sexually abusing R1 when R2 was left unsupervised. The Immediate Jeopardy began on 5/24/24 when R1 was sexually abused by R2. V1 Administrator was notified of the Immediate Jeopardy on 6/11/24 at 11:21 AM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 6/13/24, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings include: The facility was previously cited F600D on Facility Reported Incident of April 7, 2024/IL171905, survey exit 4/23/24 for resident to resident sexual abuse by R2. The facility's Abuse Prevention and Reporting-Illinois policy dated 10/24/22 documents residents have the right to be free from abuse and the facility prohibits abuse. This policy documents the facility will identify occurrences and patterns of potential mistreatment, investigate abuse allegations and make changes to prevent future occurrences. This policy documents sexual abuse is non-consensual contact with a resident and includes unwanted intimate touching of any kind, including breasts and perineal area. The facility's investigation for R2's/R3's incident on 4/7/24 at 2:58 PM documents V1 was notified that R3 reported that R2 touched R3's breast. This investigation documents V11 Activity Aide was interviewed and V11 stated R3 was brought to activities by V20 Visitor who reported R3 said R3 was afraid of R2, because R2 follows R3 around and won't leave R3 alone. This interview documents V20 told V11 that V20 witnessed R2 grab R3's hand and R3 told V11 that R3 was afraid of R2 because He's (R2) following me around and rubbing my chest on top of my clothes. V11's statement dated 4/8/24 documents after lunch on the same day as R2's/R3's incident, R2 was sitting next to R5 with R2's hand on R5's upper left thigh, R5 pushed R2's wheelchair away, and V11 separated R2 and R5. V41 Certified Nursing Assistant (CNA) interview dated 4/8/24 documents R2 and R14 were sitting at the nurse's desk and R2 rubbed R14's stomach. (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's investigation for R1's/R2's incident of 5/24/24 at 3:18 PM, documents the following: A Registered Nurse (RN V3) reported R2's hand was underneath of R1's shirt. Prior to the incident, V5 CNA brought R2 to the East lounge. Approximately five to ten minutes later, V4 Registered Nurse (RN) looked up to see R2 had wheeled his wheelchair in front of R1, and R2's right hand was underneath the left front side of R1's shirt. V4 asked V3 RN (who had her back to R1/R2) to separate R1 and R2. R1 had no reaction to R2, and neither R1 or R2 remembered the incident. R2 was placed on one to one monitoring during waking hours and has a bed alarm at night. R2 has a history of wandering into other resident rooms looking for R2's spouse, who previously resided in the facility. This investigation documents that during staff and resident interviews, R6 reported R2 wandered into R6's room and asked to hold R6's hand and staff promptly removed R2 from R6's room. V21's (CNA) statement dated 5/24/24 documents prior to today V21 had not witnessed R2 touch other residents, but at supper R2 was sitting with R2's eyes closed and his hand was underneath of the table on R10's leg. This statement documents V21 asked R2 if R2 knew that R2's hand was on a man's leg, and R2 immediately removed R2's hand. V10's (CNA) statement dated 5/28/24 documents two or three weeks ago V10 came from the main dining room, R5 was sitting in a wheelchair in the middle hall and R2 came from the west area and reached towards R5's chest. This statement documents R2 barely touched R5 as V10 separated R2 from R5 and took R2 back to the East wing (where R2 resides). R1's Minimum Data Set (MDS) dated [DATE] documents R1 has severe cognitive impairment. R1's Care Plan revised 5/29/24 documents R1 is at risk for abuse/neglect related to dementia, depression, and behaviors, and there was an incident with another resident on 5/24/24 where R1 was touched inappropriately. R2's MDS dated [DATE] documents R2 has severe cognitive impairment. R2's Care Plan dated 4/8/24 documents R2 has behaviors of physical inappropriate touching towards female residents due to R2's dementia and poor impulse control. The Care Plan includes interventions to analyze the time of day, places, circumstances, triggers, and what de-escalates the behavior (5/24/24), encourage acceptable behaviors (4/8/24), involve physicians and counseling services to detour inappropriate behaviors (4/8/24), maintain communication with R2's family and potentially suggest memory care placement (4/8/24), monitor/document/report inappropriate behaviors (5/24/24), staff should monitor R2 when around female residents and remove R2 if R2 moves too close to female residents or displays inappropriate behaviors (4/8/24), and R2 will be offered one to one monitoring (5/24/24). There is no documentation in R2's medical record of one to one monitoring implementation, besides nursing notes that do not document consistent one to one monitoring daily for each shift. The Daily Nurse Assignment Sheets dated 5/25/25-6/10/24 documents a sitter is assigned for one to one monitoring on days and evening shifts, but does not document one to one monitoring was assigned on evening shift on 6/7/24 and 6/8/24 or any night shifts. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/10/24 at 8:45 AM and 1:56 PM, and on 6/11/24 at 8:50 AM R2 was lying in bed with bed alarm in place, and no staff were in or directly outside of R2's room. On 6/10/24 at 8:45 AM R2 was confused and did not recall incidents involving female residents. On 6/10/24 at 9:16 AM R2 self propelled R2's wheelchair up the East hall towards the nurses' station. There was no staff directly with R2. V1 Administrator came up behind R2 and mentioned R2 was done with therapy, and then V13 Housekeeper pushed R2 to the dining room and sat with R2. On 6/10/24 at 3:27 PM R2 was sitting in the dining room at the end of a table participating in a large group BINGO activity. R7 and R13 (female residents) were on each side of and within R2's reach. There was no staff directly with R2 besides V14 Activity Director who was standing near R2 and leading the activity, occasionally turning V14's back to R2 as V14 called out BINGO numbers. On 6/10/24 at 8:48 AM R1 was lying in bed. R1 was confused and not interviewable. On 6/10/24 at 9:38 AM R3 stated there was only one time that a male resident (identified as R2) touched her inappropriately. R3 stated (R2) put his hand on R3's thigh and went up underneath of R3's shirt, which made R3 feel uneasy. R3 stated when R3 sees (R2) now R3 thinks danger and stays aware from R2. On 6/10/24 at 10:00 AM R6 stated several weeks ago a male resident (identified as R2) came into R6's room while R6 was in bed, and attempted to hold R6's hand. R6 stated R6 pulled her hand away and called for staff who immediately removed R2 from R6's room. At this time R5 (R6's roommate) was confused and not interviewable. On 6/10/24 at 8:55 AM V9 CNA stated V9 heard that R2 has inappropriately touched R1, R3, R5 and R7. On 6/10/24 at 9:00 AM V3 RN stated (in reference to R1's/R2's 5/24/24 incident) at 3:20 PM V3 was talking to an unidentified resident in the East lounge and V4 RN asked V3 to get R2. V3 stated V3 turned around to see R1 and R2 sitting near the patio doors and R2's hand was up underneath of R1's sweatshirt near R1's breast. V3 stated R1 had no expression or response to R2 touching R1. V3 stated R2 was moved to an area away from R1. V3 described R1 as having limited cognition and V3 confirmed R2 had prior similar incidents involving other unidentified female residents. V3 stated staff had been trying to keep R2 in a visual observed area and there was no one specifically assigned to monitor the East lounge at the time of R1's/R2's incident. On 6/10/24 at 9:22 AM V12 Housekeeping Supervisor stated V12 heard that R2 tried to touch R3 again and R4 a couple of weeks ago, and R2 had tried to touch R10. V12 stated R2 gets touchy feely with staff as well and a couple weeks ago R2 rubbed V12's arm and tried to move up V12's arm. On 6/10/24 at 10:17 AM V8 CNA stated a couple months ago R8 was yelling get out of here and V18 receptionist found R2 in R8's room. V8 stated V8 heard R8 yell out he (R2) was rubbing my (R8's) leg, but V8 did not witness R2 touch R8. V8 stated a couple months ago R2 was found on the floor of R7's room after R2 tried to get into bed with R7. V8 stated V8 was not sure what was done at that time to address R2's behaviors other than staff would redirect R2 when R2 wandered to the middle hall. V8 stated R2 has a sitter now, but if there isn't an assigned sitter then R2 sits in an area where staff can watch R2. V8 stated after R2 is gotten up V8 takes R2 to activities where staff are present, since the CNAs are busy giving showers. V8 stated today someone is assigned to be with R2 from 9:00 AM until 3:00 PM, but there isn't always someone assigned for R2's one to one monitoring. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/10/24 at 10:30 AM V4 RN stated (in reference to R1's/R2's incident) V4 had just started V4's shift and was working the East hall. V4 stated R2 had tried to get out of bed and V4 told V5 to bring R2 to the East Lounge where a lot of residents were seated due to a severe thunderstorm. V4 stated V4 was not aware at that time that R2 was not to be by other residents and supervised. V4 stated R2 was sitting between R10 and an unidentified female resident. V4 stated V4 was counting narcotic medications with the oncoming shift nurse and about five to ten minutes after R2 was brought to the lounge, V4 looked up to see R2 in front of R1 with R2's hand underneath of R1's shirt near R1's breast. V4 stated V4 told V3 RN, who had her back to the lounge, to separate R2 from R1. V4 stated R2 was not aware of what was going on, R2 is confused and tries to find R2's wife, which V4 believes to be the root cause of R2's behavior. V4 stated R1 had no response to R2, R1 is confused and does not have the cognitive ability to consent to being touched like that. V4 stated there was no staff directly supervising the lounge at the time of the incident, and if R2 had a sitter or direct supervision it likely would have prevented the incident. V4 stated The hard thing is, he moves very fast. You can be watching him one minute and then the next thing you know he's on the other side of the building. He is very fast when he gets his feet moving. It's very hard to do your stuff (work) and keep an eye on him. V4 stated since the incident R2 has been on one to one monitoring during the day until 8:00 PM, but not at night since R2 has a bed alarm. On 6/10/24 at 11:16 AM V10 CNA stated V10 has only heard of incidents approximately one month ago including R2 touching R8 while R8 was in bed, R2 touching R5's thigh, and R2 falling in R7's room while attempting to get into bed with R7. V10 stated within the last couple weeks, V10 caught R2 just in time as V10 came from the dining room and witnessed R2 reach out towards R7's breast while sitting near the middle hallway. V10 stated R2's fingertip barely brushed across R7's breast as V10 separated R2 from R7. V10 stated R2 now has someone assigned to be with R2, and if we don't due to short staffing then we just keep our eyes on R2. On 6/10/24 at 3:22 PM V5 CNA confirmed V5 was the CNA who brought R2 to the lounge on 5/24/24. V5 stated prior to that day, V5 was not aware that R2 had behaviors of inappropriately touching other residents. On 6/10/24 at 3:46 PM V22 CNA stated V22 worked evening shift on the East wing on 6/7/24 and 6/8/24. V22 confirmed R2 requires one to one monitoring and there was no staff assigned for R2's one to one monitoring on evening shift on 6/8/24. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/10/24 at 1:18 PM V1 Administrator confirmed R2's history of inappropriate touching and attempts to touch other residents. V1 stated we implemented closer monitoring, which was not one to one supervision, for 72 hours after R2's first incident with R3 on 4/7/24, and after the 72 hours staff were just aware to keep an eye out for R2's location and keep R2 away from female residents. V1 stated that same day (4/7/24), R2 had R2's hand on R5's leg. V1 stated R2 returned from the hospital on 5/24/24 and R2's wife had visited at the hospital, which we believe may have been a trigger for R2's behavior causing R2 to think R1 was R2's wife who previously resided in the facility. V1 stated after R2's incident on 5/24/24, we implemented one to one monitoring of R2 while awake since R2 has a bed alarm. V1 stated therapy staff do not always notify the staff when R2 is finished with therapy. V1 stated with staffing we try to assign someone to be with R2 or the department heads/office staff take turns sitting with R2, and the Daily Staffing Sheets document the assigned one to one sitter. V1 stated R2 likes to wander about the facility and talk to residents, R2 is confused and not aware of what R2 is doing. V1 stated V1 did not think R1 has the ability to consent to sexual contact, and V1 interviewed R1 who had no recollection of the incident with R2. On 6/10/24 at 2:24 PM the Daily Staffing Sheets were reviewed and verified with V1, confirming no documented assigned staff to provide R2's one to one monitoring on evening shift on 6/7/24 and 6/8/24. V1 stated the East CNAs would have shared the monitoring on 6/8/24 and V1 did R2's monitoring from 5:00 PM until 7-7:30 PM on 6/7/24. On 6/11/24 at 8:55 AM V1 confirmed there is no documentation of one to one monitoring in R2's medical record, besides the nursing notes. On 6/10/24 at 2:18 PM V6 (R1's Family) stated the facility notified V6 that a male resident put his hand up underneath of R1's shirt. V6 was asked how R1 would have felt or responded if R1 did not have cognitive impairment. V6 stated R1 would have been shocked and would have yelled/screamed. The Immediate Jeopardy that began on 5/24/24 was removed on 6/13/24 when the facility took the following actions to remove the immediacy. 1. V1 Administrator, V37 Minimum Data Set (MDS)/Registered Nurse (RN) and V40 MDS/RN all stated on 6/13/24 that staff in-services on the Abuse Policy were started on 6/11/24 and completed on 6/12/24. V1 Abuse Coordinator stated V1 was inserviced by V47 Regional Clinical Nurse on 6/11/24. V37 and V40 MDS/RN's both stated they had received their abuse policy inservices on 6/11/24 by V1 Administrator. On 6/13/24 V1 Administrator stated the facility's plan to in-service those staff such as PRN (As-Needed) and/or Agency staff is to notify the staff member by email with a link to complete abuse training. V1 Administrator stated the facility has not received the staff member's submitted Abuse Training in-service then the staff schedules will be monitored by V36 Scheduler. V36 will notify V1 Administrator if there are any agency staff scheduled. V1 Administrator stated V1 or the nurse on-call will meet the staff member at the facility and ensure the Abuse Policy training is completed prior to the staff member working. 2. V44 Human Resources Director stated on 6/13/24 that there have not been any new staff member hired since 6/6/24. V44 stated all new hire employees receive the Abuse Policy training through an electronic system which the new employee must complete prior to working in the facility. V44 HR stated the new hire employee also has a face to face meeting in which the Abuse Policy is also discussed verbally. V44 HR stated the employee is encouraged to ask questions. V44 HR stated the Abuse Policy is reviewed in its entirety. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. V32 Social Service Director (SSD) stated on 6/13/24 that R1's Abuse Assessment was completed on 6/11/24 but did not reflect R1's recent history of being abused. V32 SSD stated R1's assessment completed on 6/11/24 was not accurate. V32 SSD completed R1's Abuse Risk Assessment on 6/13/24 that did reflect R1's recent history of being sexually abused. 4. A facility wide audit was started on 6/10/24 for all residents who have been identified via the careplan to show potential behaviors that may impede other resident's safety. This audit was completed daily from 6/10/24-6/13/24 for 'the week ending 6/15/24.' V1 stated the facility wide audit was completed by V1. V1 Administrator stated there were no new residents identified by the audit. V1 stated this audit will continue daily for six weeks in conjunction with the later audit in the abatement plan. 5. V43 [NAME] President of Operations (VPO) stated V43 reviewed the facility abuse policy on 6/11/24 and found that there were no updates to be made. V43 stated the facility abuse policy follows the state and federal guidelines for recognizing and reporting abuse and inappropriate behavior, abuse identification, definitions, reporting and preventing. 6. R2's Care Plan dated 4/23/24 documents R2 has physical inappropriate behaviors of touching towards female residents and was updated with an intervention dated 6/11/24 that R2 was hospitalized for sexual behaviors and psychiatric evaluation. This care plan documents interventions dated 6/12/24 for one to one monitoring 24 hours per day, not to be around female residents, prompt intervention when approaching female residents, remove from setting when displaying inappropriate behaviors, and report these behaviors to the abuse coordinator and supervisor. 7. R2's Nursing Note dated 6/11/2024 at 2:58 PM documents R2 was transferred to the local hospital for evaluation of sexual behaviors and a request for psychiatric evaluation was requested through the hospital's electronic communication system by R2's physician. R2 remained at the hospital as of 6/13/24. On 6/12/24 at 1:35 PM V23, Medical Director, stated R2 was transferred to the hospital on 6/11/24 for requested psychiatric evaluation of R2's behaviors, R2 was admitted to the hospital, and R2's medications have been adjusted. 8. On 6/11/24 the facility held an Emergency Quality Assurance Performance Improvement (QAPI) meeting with V23 and the interdisciplinary team to discuss the deficiency and the facility's action plan. The QAPI Meeting Minutes dated 6/11/24 document a meeting was held to review the deficiency and develop action plan, and attendees included V1 Administrator, V23, and nurse management staff. On 6/12/24 at 1:35 PM V23 confirmed V23 attended the QAPI meeting, the deficiency and action plan were reviewed. 9. The facility has identified residents at risk for sexual abuse by completing the Abuse/Neglect Screening assessment. The Abuse/Neglect Screening assessment report documents the facility completed this assessment for all residents on 6/11/24 which identified residents at risk for abuse. R1's, R3's, and R7's Abuse/Neglect Screening assessments dated 6/11/24 are not accurate to include a history of abuse from R2's inappropriate touching. R2's Abuse/Neglect Screening assessment dated [DATE] is not accurate to include R2's inappropriate sexual behaviors towards others. On 6/13/24 at 9:29 AM V32 Social Services Director confirmed all resident Abuse/Neglect Screenings were completed on 6/11/24. On 6/13/24 at 9:50 AM V32 confirmed R1's, R2's, R3's, and R7's Abuse/Neglect Screenings are not accurate. V32 stated V32 will update their assessments. On 6/13/24 at 11:37 AM V32 provided R1's, R2's, R3's, and R7's revised Abuse/Neglect Screenings dated 6/13/24. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10. V1 Administrator stated on 6/13/24 that R2's continual supervision was on-going prior to the approval of the Abatement plan. V1 Administrator stated R2 left the facility en route to the emergency room for evaluation on 6/11/24. R2 remains out of the facility during remainder of survey timeframe. V37 MDS/RN stated V37 and V40 MDS/RN will review the hospital documentation and update R2's Electronic Medical Record (EMR)/Careplan upon R2's return from the hospital. V1 Administrator stated R2 will remain on continual supervision upon return from the hospital. V36 Scheduler stated V36 schedules the staff who are supposed to provide continual observations of R2. V36 stated if there is a problem finding staff or if a scheduled staff member calls in then the manager on duty is responsible for filling the position or providing continual observations of R2. V1 Administrator stated on 6/13/24 that the Quality Assurance (QA) tool designed and being completed will continue daily for six weeks. V1 Administrator stated V1 is responsible for completing the audits and has no further issues. 11. V37 Minimum Data Set (MDS)/Registered Nurse (RN) stated V37 MDS/RN and V40 MDS/RN both reviewed and updated R1, R2, R15, R16's Care plans on 6/11/24.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to report an allegation of resident to resident physical abuse to the state survey agency for two (R8, R9) of 14 residents reviewed for abuse in the sample list of 16. Findings include: The facility's Abuse Prevention and Reporting-Illinois policy dated 10/24/22 documents physical abuse includes hitting and resident to resident altercations should be reviewed as potential abuse. This policy documents that resident to resident altercations involving willful action that results in physical injury, mental anguish or pain will be reported as required by regulation. This policy documents the facility will notify the Department of Public Health of abuse allegations initially and the results of the investigation within five working days. The facility's 2024 Abuse Tracking Log documents a physical abuse allegation/altercation involving R8 and R9 on 5/8/24. The facility's investigation to R8's/R9's 5/8/24 incident dated 5/12/24, documents the following: V18 Receptionist heard R9 yell out quit hitting me. V18 immediately went into R8's/R9's room along with V14 Activity Director. R9 was seated in the wheelchair between the two beds and R8 was lying in bed facing R9. Staff did not witness R9 hit R8, and residents were separated. This incident was immediately reported to V1 Administrator. R9 reported R8 hit R9's left arm several times. R9 was assessed and had no injury. V1 interviewed R8 who stated she (R9) keeps going back and forth and it's driving me nuts. What else was I suppose to do? There is no documentation in the facility's investigation file of this incident, that this incident was reported to the Illinois Department of Public Health (IDPH). R8's Minimum Data Set (MDS) dated [DATE] documents R8 has severe cognitive impairment. R9's MDS dated [DATE] documents R9 has severe cognitive impairment. On 6/10/24 at 11:49 AM V18 stated (referring to R8's/R9's 5/8/24 incident) between 3:15 PM and 4:00 PM V18 was sitting at the desk and heard R9 say stop hitting me. V18 did not see R8 hit R9, but R9 was holding R8's arm. V18 stated R9 was sitting between the beds and R8 was in bed within R9's reach. V18 stated R8 said R9 kept moving back and forth and wouldn't stop. On 6/10/24 at 12:40 PM V1 Administrator stated resident to resident altercations have to be reported to corporate and V1 was told because there was no injury, R8's/R9's 5/8/24 incident did not need to be reported to IDPH. V1 confirmed R9 alleged that R8 hit R9, which would be considered an allegation of physical abuse, and confirmed this incident was not reported to IDPH.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to have an agreement for outside services for behavioral health needs. This failure affects one (R2) of 14 residents reviewed for abuse in the sample list of Findings include: The facility's Facility assessment dated [DATE] documents behavioral and mental health providers, behavioral aides, Psychologist, and Psychiatrist are part of the staff/health care professionals/medical practitioners that are needed to provide support and care for the residents. R2's Care Plan dated 5/24/24 documents R2 has diagnoses of Dementia, Psychotic Disturbance, Mood Disturbance, and Anxiety. This Care Plan documents R2 has behaviors of physical inappropriate touching towards female residents due to R2's dementia and poor impulse control and includes interventions to analyze the time of day, places, circumstances, triggers, and what de-escalates the behavior; encourage acceptable behaviors; involve physicians and counseling services to deter inappropriate behaviors; maintain communication with R2's family and potentially suggest memory care placement; monitor/document/report inappropriate behaviors; staff should monitor R2 when around female residents and remove R2 if R2 moves too close to female residents or displays inappropriate behaviors; and R2 will be offered one to one monitoring. There is no documentation in R2's medical record that R2 receives psychiatric behavioral services. R2's Nursing Note dated 6/11/2024 at 2:58 PM documents R2 was transferred to the local hospital for evaluation of sexual behaviors and for psychiatric evaluation. On 6/13/24 at 12:25 PM V1 Administrator confirmed the facility does not have a provider for behavioral health and does not have an agreement with outside services to provide behavioral health services. V1 stated the facility contacted (behavioral health service), who will be coming to the facility on [DATE].

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	145183	A. Building B. Wing	06/13/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to maintain residents' complete and accurate medical records. This failure affects five (R1, R2, R3, R6, R7) of five residents reviewed for physician visits in the sample list of 16. Findings include: The facility's undated Medical Record Policy documents complete medical records will be maintained for each resident to ensure each resident's medical record is accessible and organized to facilitate compilation of information and communication between health care professionals. This policy documents physician progress notes shall be recorded in the resident's record at the time of each visit, and including at least every 30 days for the first 90 days and then at least every 60 days. 1. On 6/11/24 R1's electronic medical record (EMR) did not contain physician progress notes after 12/22/23. 2. R2's Care Plan revised 5/24/24 documents R2 admitted to the facility on [DATE] and V23 is R2's primary physician. On 6/11/24 R2's EMR did not contain physician progress notes by V23, V24 or V25. 3. On 6/11/24 R3's EMR did not contain physician progress notes after 11/15/23. 4. R6's Census documents R6 admitted to the facility on [DATE] and V23 is R6's physician. On 6/11/24 R6's EMR did not contain physician progress notes by V23. R6's Progress Note recorded by V23 and dated 3/25/24 documents it was printed on 6/11/24 at 2:05 PM. 5. On 6/11/24 R7's EMR did not contain physician progress notes after May 2023. On 6/11/24 at 12:29 PM V1 Administrator stated V23 (physician), Physician is in the facility weekly and V24 and V25 (Nurse Practitioners) are here four to five days per week. V1 stated these providers were documenting their notes that went directly into the resident's Electronic Medical Record (EMR), but that recently changed and now the facility has to print and upload their visit notes. V1 stated not all of the visit notes have been uploaded into the residents' EMRs and V1 will have to obtain the physician visit notes requested for R1-R3, R5 and R6. V1 confirmed these notes are uploaded into the miscellaneous section of the resident's EMR.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to ensure staff were trained in the areas identified in its facility assessment. This failure has the potential to affect all 67 residents residing in the facility. Findings include: The facility's Facility assessment dated [DATE] includes, but is not limited to, the following staff training topics: effective communication, resident rights, the facility's infection control program, antibiotic stewardship, 12 hours annual in-service training for Certified Nursing Assistants (CNAs) that includes Dementia training, identifying changes in condition, and Quality Assurance Performance Improvement (QAPI) program. The facility's in-services (requested for the past year) provided by V1,was reviewed. There is no documentation that training was conducted for all staff within the last year on the training topics listed in the Facility Assessment. On 6/11/24 at 3:45 PM a list of training documentation for QAPI, Infection Control, Resident Rights, and Communication was provided to V1 Administrator. On 6/12/24 at 10:15 AM V1 was requested to provide the previously requested training documentation as well as training on Dementia, antibiotic stewardship, and change in condition. On 6/12/24 at 3:25 PM V1 stated V1 had no additional staff training documentation to provide. V1 confirmed The facility's resident roster dated 6/10/24 documents 67 residents reside in the facility.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to conduct ongoing training in effective resident care communications for all staff. This failure has the potential to affect all 67 residents residing in the facility. Findings include: The facility's Facility assessment dated [DATE] includes effective communication as a staff training topic. The facility's in-services (requested for the past year) provided by V1 Administrator,was reviewed. There is no documentation that effective communication training was conducted within the last year. On 6/11/24 at 3:45 PM and 6/12/24 at 10:15 AM V1 Administrator was requested to provide documentation of staff training, including effective communication, that was conducted within the last year. On 6/12/24 at 3:25 PM V1 stated V1 had no additional staff training documentation to provide. The facility's resident roster dated 6/10/24 documents 67 residents reside in the facility.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to conduct ongoing training in Resident Rights for all staff. This failure has the potential to affect all 67 residents residing in the facility. Findings include: The facility's Facility assessment dated [DATE] includes Resident Rights as a staff training topic. The facility's in-services (requested for the past year) provided by V1 Administrator,was reviewed, and there is no documentation that an all staff training was conducted on Resident Rights. On 6/11/24 at 3:45 PM and 6/12/24 at 10:15 AM V1 Administrator was requested to provide documentation of staff training, including Resident Rights, that was conducted within the last year. On 6/12/24 at 3:25 PM V1 stated V1 had no additional staff training documentation to provide. The facility's resident roster dated 6/10/24 documents 67 residents reside in the facility.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to conduct ongoing staff training on the facility's Quality Assurance Performance Improvement (QAPI). This failure has the potential to affect all 67 residents residing in the facility. Findings include: The facility's Facility assessment dated [DATE] includes QAPI as a staff training topic. The facility's in-services (requested for the past year) provided by V1 Administrator, and there is no documentation that an all staff training was conducted on QAPI. On 6/11/24 at 3:45 PM and 6/12/24 at 10:15 AM V1was requested to provide documentation of staff training, including QAPI, that was conducted within the last year. On 6/12/24 at 3:25 PM V1 stated V1 had no additional staff training documentation to provide. The facility's resident roster dated 6/10/24 documents 67 residents reside in the facility.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to conduct ongoing staff training on the facility's Infection Control Program. This failure has the potential to affect all 67 residents residing in the facility. Findings include: The facility's Facility assessment dated [DATE] includes staff training on infection control program, standards, policies, and procedures. The facility's in-services (requested for the past year) provided by V1 Administrator, was reviewed, and there is no documentation that an all staff training was conducted on the facility's Infection Control Program. On 6/11/24 at 3:45 PM and 6/12/24 at 10:15 AM V1 Administrator was requested to provide documentation of staff training, including the facility's infection control program, that was conducted within the last year. On 6/12/24 at 3:25 PM V1 stated V1 had no additional staff training documentation to provide. The facility's resident roster dated 6/10/24 documents 67 residents reside in the facility.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to ensure Certified Nursing Assistants (CNAs), providing care to residents, received 12 hours of annual in-service training . This failure has the potential to affect all 67 residents residing in the facility. Findings include: The facility's Facility assessment dated [DATE] documents CNAs will have 12 hours of annual in-service training which includes training on Dementia. This assessment documents Dementia as one of the common diagnoses of residents that reside in the facility. The facility's in-services (requested for the past year) provided by V1 Administrator, was reviewed, and there is no documentation that training was conducted on Dementia. On 6/12/24 at 8:45 AM V1 Administrator provided a stack of staff in-services and training. V1 stated V2 Director of Nursing does the monthly in-services with the CNAs, but do not have a log to track each CNAs attendance or receipt of training for the annual 12 hours of in-service training. V1 stated the facility used to use (electronic training software), but that ended in June 2023 when the facility changed corporations. Documentation for 12 hours of annual training was requested for V5, V8, V9, V10, V21 CNAs. On 6/12/24 at 12:45 PM V1 provided a hand written list of trainings for V5, V8, V9, V10, and V21 that does not document these CNAs were trained on Dementia or received 12 hours of in-service training. V1 stated V1 went through the in-service sign in sheets to compile the listed CNAs trainings. V1 confirmed V5 did not complete 12 hours of annual in-service training. V1 stated V5 typically works on the East hallway. V1 confirmed the CNAs assist on other halls as needed having the potential to work on all halls of the facility. On 6/12/24 at 3:25 PM V1 confirmed the training list for V5, V8, V9, V10 and V21 does not document Dementia training was completed. V1 stated V1 had no additional documentation of staff training to provide. The facility's resident roster dated 6/10/24 documents 67 residents reside in the facility.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to conduct ongoing behavioral health training for staff providing resident care. This failure has the potential to affect all 67 residents residing in the facility. Findings include: The facility's Facility assessment dated [DATE] documents to consider staff competencies including caring for residents with mental or psychosocial disorders, history of trauma/Post Traumatic Stress Disorder, and implementing nonpharmacological interventions. This assessment lists psychiatric and mood disorders as some of the common diagnoses of residents that are cared for in the facility. The facility's in-services (requested for the past year) provided by V1 Administrator,were reviewed, and there is no documentation that a training was conducted on behavioral health. On 6/11/24 at 3:45 PM and 6/12/24 at 10:15 AM V1 Administrator was requested to provide documentation of staff training, including behavioral training, that was conducted within the last year. At 3:25 PM V1 stated V1 had no additional staff training documentation to provide. The facility's resident roster dated 6/10/24 documents 67 residents reside in the facility.