STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225466	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highview of Northampton	222 River Road Leeds, MA 01053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 37227 Based on interviews and records reviewed, for five of five sampled residents (Resident #1, Resident #2, Resident #3, Resident #4 and Resident #5) who were alert, oriented and able to make themselves understood by staff, the Facility failed to ensure these residents were free from abuse by a staff member. On 07/28/24, Resident #1 reported that he/she had been touched in a sexually inappropriate and unsolicited manner by one of the Facility's male staff members (later identified as Certified Nurse Aide (CNA) #1). During the course of the Facility's and local law enforcement investigations, Resident #2, Resident #3, Resident #4 and Resident #5, also reported they had been inappropriately touched in a sexual and unwanted manner by CNA #1. All five resident's accountings of the sexually abusive incidents were very similar, their descriptions and recollections of the incidents remained consistent, with all five residents reporting they were touched and/or spoken to by CNA #1 in a sexually inappropriate manner. The Residents' said they did not report the incidents to staff right away due to embarrassment and humiliation, and during their interviews they became emotional, visibly upset and disturbed by having to talk about and relive the trauma of their individual incidents. Findings include: Review of the Facility Policy titled Abuse, Neglect and Exploitation, dated as implemented in February 2023, indicated the following: It is the policy of the 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 of resident property. -Sexual abuse is nonconsensual sexual contact of any type with a resident. -The Facility will assign responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Actual harm Residents Affected - Some	1. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 07/28/24, indicated that Resident #1 reported that at approximately 3:00 A.M., he/she was awakened by a white male CNA, wearing blue scrubs (later identified as CNA #1) who said he needed to bring him/her to the bathroom. The Report indicated that Resident #1 told CNA #1 that he/she was independent and did not need assistance. The Report indicated CNA #1 assisted Resident #1 up from the bed and inappropriately touched his/her breasts while he dragged him/her to the bathroom. The Report indicated that once Resident #1 was in the bathroom, CNA #1 removed his/her brief and touched his/her genital area before he penetrated him/her with a gloved finger. The Report indicated that Resident #1 told CNA #1 to stop, so he pulled up his/her brief, brought him/her back to his/her bed, and he left the room. Resident #1 was admitted to the Facility in October 2018, diagnoses included major depression and anxiety disorder. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 06/13/24, indicated that Resident #1 was cognitively intact, with a score of 15 out of 15 on the Brief Interview for Mental Status (BIMS, scores indicate: 0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, and 13-15 cognitively intact). The Assessment indicated Resident #1 was independent with hygiene and only required supervision or hands on assistance with transfers. Review of Resident #1's Written Witness Statement, dated 07/28/24, indicated a man (later identified as CNA #1) came into his/her room at 3:00 A.M., and told him/her that he/she needed to be changed. The Statement indicated Resident #1 told CNA #1 that he/she was independent, did not need his help, and said he (CNA #1) started taking off his/her clothes anyway and that he groped his/her breasts. The Statement indicated that Resident #1 said he/she was a little groggy and shaky because at 10:00 P.M., he/she was administered a sleeping pill. The Statement indicated that CNA #1 undressed him/her, despite telling him to stop, and despite telling him that his/her brief was not wet. The Statement indicated that while CNA #1 changed Resident #1's brief, he poked [him/her] down there [genital area] twice. The Statement indicated Resident #1 did not immediately report the incident to the overnight nurse because he/she was in shock and instead, returned to bed feeling used. The Statement indicated Resident #1 reported the incident to the day shift nurse because, he/she felt molested, was concerned for his/her roommate (Resident #3), and was concerned for other residents at the facility that were unable to advocate for themselves. The Statement indicated that when Resident #1 told Resident #3 about the incident, and that Resident #3 had said that CNA #1 had done the same thing to him/her. During an interview on 08/08/24 at 11:45 A.M., Resident #1 said on 07/28/24, CNA #1 came into his/her room around 3:00 A.M. and told him/her that he needed to change him/her. Resident #1 said he/she told CNA #1 he/she could do that on his/her own. Resident #1 said he/she could walk, but CNA #1 dragged him/her towards the bathroom while inappropriately touching his/her breasts. Resident #1 said that when CNA #1 pulled down his/her brief, he penetrated him/her with a gloved finger. Resident #1 said he/she reported the incident [to the following shift nurse] because he/she was concerned the same thing might happen to other residents. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	During an interview on 08/08/24 at 2:24 P.M., the Director of Social Services said that she met with Resident #1 on the morning of 07/29/24 as a follow up to the alleged incident with CNA #1. The Director of Social Services said that Resident #1 told her that he/she was too scared to report the incident to the overnight nurse. The Director of Social Services said that during her visit with Resident #1, he/she told her that he/she was disgusted with CNA #1, and said he/she did not want him working at the Facility anymore. The Social Worker said Resident #1 did not have a history of being accusatory toward staff. Review of the Police Report, dated 07/28/24, indicated that Resident #1 reported to Nurse #2 that a CNA had inappropriately touched him/her. The Report indicated the accused CNA was described as a tall, white male who was wearing blue scrubs. The Report indicated that Nurse #2 told the officer that the only CNA that fit the description, and that had provided care to Resident #1 on the overnight shift was CNA #1. The Police Report indicated that Resident #1 appeared distraught and in disbelief about what he/she had to relay to the Officer. The Report indicated Resident #1 told the Officer he/she had be given Trazodone (antidepressant) at approximately 10:00 P.M. to help with sleeping. The Report indicated that Resident #1 told the Officer that Certified Nurse Aide (CNA) #1 approached him/her in bed and asked why he/she was wearing a sweater because it was too hot. The Report indicated CNA #1 helped Resident #1 remove his/her sweater and he began to grope his/her body and rubbed his hands over his/her breasts. The Police Report indicated that Resident #1 said that CNA #1 told him/her (Resident #1) that he needed to change his/her incontinence brief, and that Resident #1 told him that he/she did not require assistance to go to the bathroom, or with changing his/her brief. The Report indicated that once Resident #1 was in the bathroom, CNA #1 pulled down his/her brief, rubbed his/her genitals and inserted a finger inside him/her. The Report indicated that Resident #1 said he/she told CNA #1 to stop and asked what he was doing, and that CNA #1 had replied, I am checking to see how wet you are. The Police Report indicated Resident #1 had told his/her roommate (Resident #3), about the incident and Resident #3 alleged that CNA #1 had done the same thing to him/her. The Report indicated that Resident #1 was concerned that similar incidents may have happened to other residents who were unable to come forward and report sexual abuse. Review of Resident #1's Nurse Progress Note, dated 07/29/24 at 11:07 P.M., (as a late entry for 07/28/24), indicated that CNA #1 told Nurse #1 that he did not get Resident #1 out of bed, and said that he/she needed continual supervision because he/she was unsteady walking to the bathroom. The Note indicated CNA #1 told Nurse #1 that he observed Resident #1 had his/her eyes closed while he/she sat on the toilet. The Note indicated Nurse #1 made a note in the physician communication book, to request a medication review. The Note indicated that when Nurse #1 went to Resident #1's room, he/she was in bed with his/her eyes closed. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	During a telephone interview on 08/13/24 at 2:00 P.M., Nurse #1 said that during the overnight shift on 07/28/24, CNA #1 told her that Resident #1 was asking for Klonopin. Nurse #1 said that CNA #1 told her that he saw that Resident #1 was unsteady while standing in his/her room and said he made sure that he/she got to the bathroom safely. Nurse #1 said she works overnight shifts primarily and had not personally observed Resident #1 to be unsteady on his/her feet. Nurse #1 said Resident #1 was independent with activities of daily living (ADL), was continent of bowel and bladder, but chose to wear pull up briefs as a precautionary measure. Review of Certified Nurse Aide #1's payroll records indicated he worked on the South (Resident #1's) Unit as follows: -7/27/24 from 6:33 P.M. into 7/28/24 until 6:48 A.M. During a telephone interview on 08/08/24 at 4:03 P.M., Certified Nurse Aide (CNA) #1 (which also included a review of his Written Witness Statement dated 07/28/24) said that he had worked at the Facility for over a year, primarily on the South Unit, and said that his main shift was 11:00 P.M. to 7:00 A.M., but that he sometimes came in on the 3:00 P.M. to 11:00 P.M. shift to help out. CNA #1 said that on 07/28/24, sometime around 3:00 A.M., he provided care to Resident #1's roommate (Resident #3). CNA #1 said that while he was in the room, he noticed that Resident #1 was unsteady when he/she walked toward the bathroom, so he intervened and placed a hand on his/her shoulder to steady him/her. CNA #1 said he left Resident #1 alone in the bathroom and said that when he/she exited the bathroom, he assisted him/her back to bed. CNA #1 said that after he left Resident #1's room, he told Nurse #1 that he/she appeared unsteady, and that Resident #1 had requested Klonopin (anti-anxiety medication). 2. Review of the Report submitted by the Facility via HCFRS, dated 07/29/24, indicated that on an unspecified date, a male CNA (later identified as CNA #1) went into Resident #3's room in the middle of the night to perform incontinence care. The Report indicated that Resident #3 said CNA #1 was rough when providing the care and inserted a gloved finger into his/her genital area. The Report indicated Resident #3 told CNA #1 to stop, so he finished his/her care and left the room. Resident #3 was admitted to the Facility in June 2021, diagnoses included major depressive disorder and autistic disorder (neurological and developmental disorder that affects how people interact with others, communicate, learn, and behave). Review of Resident #3's Quarterly MDS Assessment, dated 05/01/24, indicated that Resident #3 was alert, had the ability to express his/her needs and wants, and was moderately cognitively impaired, with a score of 9 out of 15 on the BIMS. The Assessment indicated Resident #3 was always incontinent of bladder and bowel and required maximum assistance from staff with toileting hygiene. Review of Resident #3's Witness Statement (as told to and documented by the Director of Social Services), dated 7/29/24, indicated Resident #3 said he/she knew that CNA #1's behavior was inappropriate, because the female CNAs did not touch him/her in that same manner. The Statement indicated that Resident #3 never told staff about the incident but, he/she reported the incident when the police came to interview his/her roommate (Resident #1). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	During an interview on 08/08/24 at 11:50 A.M. Resident #3 said that CNA #1 touched his/her breasts and genitals in an inappropriate manner and said CNA #1 rubbed his/her genitals in a circular motion and inserted a naked finger inside him/her. Resident #3 said he/she told CNA #1 that he/she did not like what he was doing and said he/she did not report the incident at the time it happened. Resident #3 said he/she was fearful at the time of the incident, but said he/she feels safe now that CNA #1 is gone. The Director of Social Services said that Resident #3 tended to be very literal when communicating and it was not in his/her nature to fabricate stories. The Director of Social Services said that Resident #3 told her that CNA #1 did not provide him/her with incontinent care on the night of the alleged incident with Resident #1 (contrary to what CNA #1 reported). Review of Resident #3's Medical Record, including his/her CNA ADL flowsheets, indicated there was no documentation to support that CNA #1 provided him/her with care on the overnight shift on 07/27/24 into 07/28/24. 3. Review of the Report submitted by the Facility via HCFRS, dated 07/29/24, indicated that during random resident interviews, performed as part of the Facility's internal investigation (related to Resident #1's sexual abuse allegation against CNA #1 from 7/28/24), Resident #2 reported an allegation of sexual abuse by CNA #1. The Report indicated that a few weeks prior to the interview (sometime around mid July 2024, exact date unknown), that CNA #1 was rough with Resident #2's genital area while performing incontinence care and CNA #1 penetrated him/her with a gloved finger. The Report indicated Resident #2 told CNA #1 to stop, so he finished his/her care and left the room. The Report indicated Resident #2 has not seen CNA #1 since the night of the incident. Resident #2 was admitted to the Facility in February 2022, diagnoses included major depressive disorder and chronic respiratory failure. Review of Resident #2's Quarterly MDS Assessment, dated 05/01/24, indicated that Resident #2 was cognitively intact, with a score of 15 out of 15 on the BIMS. The Assessment indicated Resident #1 was incontinent of bladder and bowel and required moderate assistance from staff with hygiene. Review of Resident #2's Witness Statement (as told to and documented by the Director of Social Services), dated 7/29/24, indicated that during random interviews (as part of an internal abuse investigation) Resident #2 told the Director of Social Services that during the nightshift a few weeks ago, CNA #1 was rough with him/her during care. The Statement indicated Resident #2 pointed to his/her private area and said CNA #1 touched him/her there and said he was rough when he changed his/her incontinence brief. The Statement indicated that Resident #2 said that CNA #1 penetrated him/her with a finger and it made him/her uncomfortable. During an interview on 08/08/24 at 11:35 A.M., Resident #2 said that he/she usually had his/her brief changed in the early morning and said there were usually two or three CNAs that did rounds together. Resident #2 said that one morning, approximately one month ago (exact date unknown), CNA #1 came into his/her room alone, to provide incontinence care. Resident #2 said that CNA #1 put his finger inside his/her incontinence brief and said, do you know what this is? and said he/she responded back, I don't know, I am stupid. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Resident #2 said that while CNA #1's hand was in his/her brief, CNA #1 penetrated him/her with a finger. Resident #2 said she told CNA #1 don't touch me and told him to leave and not come back. Resident #2 said he/she was very upset and taken aback by the incident. Resident #2 said there also was another incident when (exact date unknown) CNA #1 flipped his/her hospital gown up during care, and exposed his/her breasts, unnecessarily. The Director of Social Services said that Resident #2 self-isolated in his/her room and did not interact with his/her peers. The Director of Social Services said Resident #2 was a reliable historian. 4. Review of the Report submitted by the Facility via HCFRS and Resident #4's Witness Statement, both dated 08/12/24, indicated that Resident #4 reported an allegation of sexual abuse involving a staff member during a routine psychotherapy visit with his/her mental health provider. The Report indicated that Resident #4 alleged that CNA #1 had been sexually inappropriate during the provision of his/her incontinence care on two occasions (exact dates unknown). The Report indicated that during the first incident, CNA #1 made inappropriate remarks about Resident #4's breasts while providing care and CNA #1 had asked if he/she had a boyfriend/girlfriend that visited. The Report indicated that during the second incident, CNA #1 touched Resident #4's genitals, causing him/her to jump, and that CNA #1 asked him/her if she liked it. The Report indicated that when CNA #1 finished Resident #4's care, he came around to the left side of the bed, and Resident #4 noticed that his (CNA #1's) penis was erect. The Report indicated that CNA #1 offered to show Resident #4 his erect penis, and then exposed himself to him/her. The Report indicated that CNA #1 told Resident #4, before he left the room, that the incident would be their little secret and that Resident #4 had said he/she would not tell anyone. Resident #4 was admitted to the Facility in December 2017, diagnoses included major depressive disorder and poly-osteoarthritis (arthritis affecting four or more joints in the body). Review of Resident #4's Quarterly MDS Assessment, dated 07/18/24, indicated that Resident #4 was cognitively intact, with a score of 15 out of 15 on the BIMS. The Assessment indicated Resident #4 was frequently incontinent of bladder and bowel and was dependent on staff for toileting hygiene. During an interview on 08/15/24 at 1:31 P.M., with Resident #4, due to the sensitive nature of the interview, the surveyor and Resident #4 were joined by Social Worker #1 at Resident #4's request. Resident #4 said that CNA #1 usually worked the overnight shift, from 11:00 P.M. to 7:00 A.M., but sometimes came in early, on the evening shift. Resident #4 said that approximately six weeks ago (around the first week of July 2024, but exact date unknown), sometime after the evening meal, he/she had a bowel movement and rang the call light to request assistance. Resident #4 said that CNA #1 answered the call light and provided him/her with incontinence care. Resident #4 said that CNA #1 removed his/her hospital gown during care and made an inappropriate sexual comment about his/her breasts. Resident #4 said he/she did not report it to anyone because he/she thought no one would believe him/her. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	When the surveyor asked Resident #4 when the second incident occurred, he/she reviewed the calendar on his/her phone for several minutes and said the second incident happened on the overnight shift, approximately four weeks after the initial incident, on or around 7/28/24 (exact date unknown). Resident #4 said that CNA #1 was in his/her room around 3:30 A.M., providing care to his/her roommate when he/she woke up to the sound of water running in the sink. Resident #4 said he/she asked CNA #1 if he could change his/her incontinence brief, since he was already in the room. Resident #4 said that CNA #1 closed the privacy curtain and came to the window side of his/her bed to provide incontinence care. Resident #4 said that while CNA #1 cleaned his/her backside, he asked if he/she had a boyfriend/girlfriend, and that he/she told him they had broken up. Resident #4 said that while CNA #1 cleaned his/her genital area he/she initially jumped because he was rough, and in response to his/her reaction, CNA #1 asked if what he was doing to him/her felt good. Resident #4 said that when CNA #1 came around to the front of his/her bed, after he had finished his/her incontinence care, he/she noticed that his genital area (penis) was aroused, under his blue scrubs. Resident #4 said he/she told CNA #1 that he/she had a couple pictures of male genitalia on his/her phone, and CNA #1 responded by pulling his penis out of his scrub pants, and he said, do you want another one? Resident #4 said CNA #1 played with his penis in front of him/her. Resident #4 said he/she was disturbed and disgusted by the incident. Resident #4 said he/she did not report either of the incidents when they occurred, because he/she felt the staff would not believe him/her and said staff had previously labeled him/her as accusatory. Resident #4 said he/she had decided to report the incident to staff, on Monday, because he/she feared it might happen to other residents, including his/her roommate, or residents at a different facility, if CNA #1 took a job elsewhere. Resident #4 said that he/she knew that CNA #1 had formerly worked in group homes, and said he/she feared the possibility of him returning to that setting because his/her (Resident #4's) goal was to be discharged to a group home. During the interview, Resident #4 was observed continuously wringing his/her hands and frequently cried while he/she talked to the surveyors about the incidents. Resident #4 was visibly upset and appeared to be genuinely afraid of CNA #1, as he/she talked about how he had interacted with and treated him/her. During an interview on 08/15/24 at 2:13 P.M., Social Worker #1 said that she had never observed Resident #4 wringing his/her hands, as he/she did while talking to the surveyors about the incidents involving CNA #1. Social Worker #1 also said that Resident #4 was embarrassed about what happened and had been hesitant to report the incident because his/her care plan indicated the need for two staff with care due to his/her history of accusatory behavior. Social Worker #1 said that Resident #4's past accusations, involved splitting staff and said that Resident #4 had never made any other accusations alleging sexual abuse by staff and had never reported any issues out of fear for the safety of his/her roommate and/or other residents. Review of Certified Nurse Aide #1's payroll records indicated he worked the following hours on the South Unit during the first week of July 2024: -07/01/24 from 10:44 P.M. into 07/02/24 until 7:02 A.M. -07/02/24 from 10:56 P.M. into 07/03/24 until 7:03 A.M. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	-07/04/24 from 10:51 P.M. into 07/05/24 until 7:11 A.M. -07/05/24 from 5:34 P.M. into 07/06/24 until 7:25 A.M. -07/06/24 from 10:57 P.M. into 07/07/24 until 7:05 A.M. Further review of CNA #1's payroll records indicated he worked the following hours on the South Unit during the last full week of July 2024: -07/22/24 from 11:23 P.M. into 07/23/24 until 7:00 A.M. -07/23/24 from 11:10 P.M. into 07/24/24 until 7:10 A.M. -07/24/24 from 10:51 P.M. into 07/25/24 until 7:12 A.M. -07/25/24 from 6:41 P.M. into 07/26/24 until 7:11 A.M. -07/27/24 from 6:33 P.M. into 07/28/24 until 6:48 A.M. 5. Review of the Report submitted by the Facility via HCFRS, dated 08/19/24, indicated that Resident #5 reported an allegation of abuse to the Department of Public Health (DPH) surveyors, while they were investigating allegations of abuse by CNA #1, and that Resident #5 had reported that he/she was inappropriately touched on five different occasions by CNA #1 during care. The Report indicated that when CNA #1 provided incontinence hygiene, he wiped him/her and then used his gloved finger to slide against his/her genitalia. The Report indicated that Resident #5 had not reported the incidents to staff, but had eventually started refusing care from CNA #1. Resident #5 was admitted to the Facility in October 2022, diagnoses included cerebral palsy and paranoid schizophrenia. Review of Resident #5's Quarterly MDS Assessment, dated 07/03/24, indicated that Resident #5 was cognitively intact, with a score of 15 out of 15 on the BIMS. The Assessment indicated Resident #5 was always incontinent of bladder and bowel and required moderate assistance from staff for toileting hygiene. During an interview on 08/15/24 at 4:10 P.M., Resident #5 said he/she had been inappropriately touched by a male CNA on several occasions and he/she identified CNA #1 by name. Resident #5 said he/she did not report the incidents to staff because he/she was afraid that someone would get back (retaliate) at him/her. When the surveyor asked if Resident #5 could recall any of the dates when the incidents occurred, he/she looked at his/her notes and said incidents had occurred with CNA #1 on 04/25/24 and 05/03/24. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Resident #5 said the incidents usually occurred between 5:00 A.M. and 5:30 A.M., during early morning incontinence care. Resident #5 said CNA #1 covered a washcloth with his hands to wipe his/her genitals, and used one finger outside the cloth to rub along his/her genital area each time he cleaned him/her. Resident #5 said he/she understood the difference between incontinence care and sexually inappropriate behavior. Resident #5 said that when he/she told CNA #1 he was being inappropriate, that he claimed he was just cleaning him/her. Resident #5 said he/she was tired when the incidents occurred because it was early in the morning but said that he/she felt shocked and upset, and said I just wanted him to stop. Review of Certified Nurse Aide #1's payroll schedule indicated he worked on the South Unit on: -04/25/24 from 11:00 P.M. into 04/26/24 until 7:00 A.M. -05/02/24 from 11:00 P.M. into 05/03/24 until 7:00 A.M. During an interview on 08/08/24 at 5:05 P.M., the Administrator said he was notified of the initial allegation of sexual abuse, involving CNA #1 and Resident #1, on the morning of 07/28/24. The Administrator said that CNA #1 was no longer in the facility when the allegation was reported and said CNA #1 was immediately placed on administrative leave pending the outcome of their investigation. The Administrator said the police were notified and statements were obtained from staff and residents. The Administrator said that during the course of their investigation and during interviews with a random sample of six alert and oriented residents that resided on the South Unit, where the accused CNA (#1) worked, sexual abuse allegations, involving CNA #1, were reported by Resident #2 and Resident #3. The Administrator said that the conclusion of the Facility's investigation that they substantiated the allegations of sexual abuse, based on multiple allegations from alert and oriented residents with similar stories occurring over several days, and therefore CNA #1 was terminated from the facility on 07/30/24. During a second in-person interview on 08/15/24 at 4:23 P.M., the Administrator said that on 08/12/24, when a fourth allegation of sexual abuse, involving CNA #1, was reported (by Resident #4), the Director of Social Services expanded the investigation to interview additional alert and oriented residents, but said the sample did not include Resident #5 (who reported an allegation of abuse related to CNA #1 to the DPH surveyors on 08/15/24).

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 37227 Based on interviews and records reviewed, for one of five sampled residents (Resident #4), the Facility failed to ensure staff implemented and followed their Abuse, Neglect and Exploitation policy when, on Friday 08/09/24 during a routine visit with a Behavioral Health Clinician, Resident #4 alleged that Certified Nurse Aide (CNA) #1 was sexually inappropriate during care on two different occasions, however the Behavioral Health Clinician did not immediately report the incident per facility policy, left only voicemail's, one of which was for the Social Worker, which was not reviewed until the following Monday morning, and was when Administration became aware. Findings include: Review of the Facility Policy titled Abuse, Neglect and Exploitation, dated as implemented in February 2023, including abuse education slides, indicated the following: -Staff includes employees, the medical director, consultants, contractors, volunteers, caregivers who provide care and services to residents on behalf of the facility, students in the facility's nurse aide training program, and students from affiliated academic institutions, including therapy, social and activity programs. -The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written. -An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. -All Employees are expected to report any potential or actual occurrence of abuse immediately to their supervisor. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 08/12/24, indicated that Resident #4 had a routine visit with a Behavioral Health Clinician, during which he/she reported two allegations of sexual abuse by a facility staff member. The Report indicated Resident #4 alleged that on one occasion CNA #1 made inappropriate comments about his/her body during care. The Report indicated that Resident #4 alleged that on another occasion, CNA #1 touched him/her inappropriately during care and exposed himself to him/her. The Report indicated the Behavioral Health Clinician reported Resident #4's allegation to the in-house Social Worker by phone (by leaving a voice message). Review of Resident #4's Behavioral Health Note, dated 08/09/24, indicated Resident #4 had a routine telehealth psychotherapy session with the Behavioral Health Clinician. The Note indicated Resident #4 reported a concern about an interaction with a Facility staff member. The Note indicated the Behavioral Health Clinician left a voicemail for both the Facility Social Worker and the Director of Nurses regarding Resident #4's specific concerns. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/15/24 at 2:13 P.M., Social Worker #1 said that on Monday morning (8/12/24) she reviewed a voicemail message, left by the Behavioral Health Clinician on Friday afternoon (08/09/24), that reported Resident #4 reported an allegation of sexual abuse by CNA #1. Social Worker #1 said that the Behavioral Health Clinician should not have left a voicemail message and should have notified administration directly. During an interview on 08/15/24 at 4:36 P.M., the Administrator said the Behavioral Health Clinician should have reported Resident #4's abuse allegation directly, so they could have initiated an investigation immediately, and reported the allegation to the state agency within the required timeframe. The Administrator said that leaving a voicemail message was not an acceptable form of notification for an allegation of abuse, and said the Behavioral Health Clinician should have reported the allegation to someone directly. The Administrator said the Director of Nurses was out on leave and he was not notified of the abuse allegation until the morning of 08/12/24.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 37227 Based on interviews and records reviewed, for one of five sampled residents (Resident #4) who's comprehensive care plan indicated he/she required two staff members present during caregiving related to accusatory behaviors, the Facility failed to ensure staff consistently implemented and followed interventions on the care plan when on two occasions (exact dates unknown) Certified Nurse Aide (CNA) #1 provided care to Resident #4 without another staff member present. Findings include: Review of the Facility's policy titled Comprehensive Care Plan, dated as revised November 2017, indicated the facility is committed to providing residents with all necessary care and services to enable them to achieve the highest quality of life. Recognizing each resident as an individual, we identify and meet those needs in a resident-centered environment. Care plans are oriented toward preventing avoidable decline in clinical and functional levels, maintaining a specific level of functioning and reflect resident preferences and right to refuse certain services or treatment. Resident #4 was admitted to the Facility in December 2017, diagnoses included major depressive disorder and poly-osteoarthritis (arthritis affecting four or more joints in the body). Review of Resident #4's Quarterly Minimum Data Set (MDS) Assessment, dated 07/18/24, indicated that Resident #4 was cognitively intact, with a score of 15 out of 15 on the BIMS. The Assessment indicated Resident #4 was frequently incontinent of bladder and bowel and was dependent on staff for toileting hygiene. Review of Resident #4's Behavior Care Plan, revised on 03/13/24, and reviewed and renewed with Quarterly MDS completed 07/18/24, indicated he/she required two staff members for caregiving related to accusatory behaviors and physical care needs. Review of Resident #4's Care Card (used by CNAs to determine individual care needs), (undated) indicated he/she always required two staff members for care. During an interview on 08/15/24 at 1:31 P.M., with Resident #4,due tothe nature of the interview, he/she requested that Social Worker #1 be present, while speaking to the surveyor. Resident #4 said that CNA #1 usually worked the overnight shift, from 11:00 P.M. to 7:00 A.M., but sometimes came in early, on the evening shift. Resident #4 said that approximately six weeks ago (around the first week of July 2024), sometime after the evening meal, he/she had a bowel movement and rang the call light to request assistance. Resident #4 said that CNA #1 answered the call light and provided him/her with incontinence care without another staff member present. Resident #4 said that CNA #1 touched him/her inappropriately during care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4 said a second incident happened on the overnight shift, approximately four weeks after the initial incident, on or around 7/28/24 (exact date unknown). Resident #4 said that CNA #1 was in his/her room around 3:30 A.M., and he/she asked if he would change his/her incontinence brief. Resident #4 said that CNA #1 closed the privacy curtain and provided incontinence care, without another staff member present. Resident #4 said that while CNA #1 cleaned his/her backside, that CNA #1 touched him/her inappropriately and said he exposed his genitalia (penis) to him/her. During an interview on 08/15/24 at 2:13 P.M., Social Worker #1 said that Resident #4 was care planned to require two staff members to be present during care, due to a history of accusatory behaviors related to splitting staff against each other. Social Worker #1 said Resident #4 had never made any allegations before this about being sexually abused by a staff member. Social Worker #1 said CNA #1 should not have provided care for Resident #4 without another staff member present.

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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. 44129 Based on records reviewed and interviews for three of three sampled residents (Resident #1, #2, and #3), the facility failed to ensure they maintained complete and accurate medical records related to Certified Nurse Aide (CNA) Activities of Daily Living (ADL) Flow Sheets, when documentation for all three shifts on their CNA ADL Flow Sheets, for May, June and July 2024 were incomplete. Findings include: 1) Resident #1 was admitted to the facility in June 2022, diagnoses included Sedative, Hypnotic or Anxiolytic Dependence (dependence on medications that aid in sleep and reduce anxiety) and Major Depressive Disorder. Review of Resident #1's Annual Minimum Data Set (MDS) Assessment, dated 06/13/24 indicated he/she required various levels of assistance with his/her Activities of Daily Living (ADLs) including but not limited to bathing, dressing, grooming, transfers, toileting and personal hygiene. Review of Resident #1's Care Plan, titled ADL-Deficit, revised on 12/12/23 indicated the Resident's ADL status varied from independent (with ambulation, eating and oral care) to continual supervision. Review of Resident #1's ADL Flow Sheets (CNA documentation) dated 05/01/24 through 05/31/24 indicated that for the following shifts, documentation on the flowsheets was incomplete: -7:00 A.M. to 3:00 P.M. 16 days (out of 31) all ADL care areas were left blank. -3:00 P.M. to 11:00 P.M. 12 days (out of 31) all ADL care areas were left blank. -11:00 P.M. to 7:00 A.M. 17 days (out of 31) all ADL care areas were left blank. Review of Resident #1's ADL Flow Sheets dated 06/01/24 through 06/30/24 indicated that for the following shifts, documentation on the flowsheets was incomplete: -7:00 A.M. to 3:00 P.M. 9 days (out of 30) all ADL care areas were left blank. -3:00 P.M. to 11:00 P.M. 8 days (out of 30) all ADL care areas were left blank. -11:00 P.M. to 7:00 A.M. 18 days (out of 30) all ADL care areas were left blank. Review of Resident #1's ADL Flow Sheets dated 07/01/24 thorough 07/31/24 indicated that for the following shifts, documentation on the flowsheets was incomplete: -7:00 A.M. to 3:00 P.M. 9 days (out of 31) all ADL care areas were left blank. -3:00 P.M. to 11:00 P.M. 8 days (out of 31) all ADL care areas were left blank. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-11:00 P.M. to 7:00 A.M. 19 days (out of 31) all ADL care areas were left blank. 2) Resident #2 was admitted to the facility in February 2022, diagnoses included Alcohol Abuse, Chronic Respiratory Failure, and Major Depressive Disorder. Review of Resident #2's Quarterly MDS Assessment, dated 05/01/24 indicated he/she required various levels of assistance with his/her ADLs including but not limited to bathing, dressing, grooming, transfers, bed mobility, toileting and positioning. Review of Resident #2's Care Plan, titled ADL-Deficit, revised on 08/13/23 indicated he/she required various levels of physical assistance with his/her care needs. Review of Resident #2's ADL Flow Sheets dated 05/01/24 through 05/31/24 indicated that for the following shifts, documentation on the flow sheets was incomplete: -7:00 A.M. to 3:00 P.M. 11 days (out of 31) all ADL care areas were left blank. -3:00 P.M. to 11:00 P.M. 23 days (out of 31) all ADL care areas were left blank. -11:00 P.M. to 7:00 A.M. 17 days (out of 31) all ADL care areas were left blank. Review of Resident #2's ADL Flow Sheets dated 06/01/24 through 06/30/24 indicated that for the following shifts, documentation on the flow sheets was incomplete: -7:00 A.M. - 3:00 P.M. 9 days (out of 30) all ADL care areas were left blank. -3:00 P.M. - 11:00 P.M. 9 days (out of 30) all ADL care areas were left blank. -11:00 P.M. - 7:00 P.M. 17 days (out of 30) all ADL care areas were left blank. Review of Resident #2's ADL Flow Sheets dated 07/01/24 through 07/31/24 indicated that for the following shifts, documentation on the flow sheets was incomplete: -7:00 A.M. - 3:00 P.M. 12 days (out of 31) all ADL care areas were left blank. -3:00 P.M. - 11:00 P.M. 11 days (out of 31) all ADL care areas were left blank. -11:00 P.M. - 7:00 A.M. 16 days (out of 31) all ADL care areas were left blank. 3) Resident #3 was admitted to the facility in June 2021, diagnoses included Peripheral Vascular Disease, Major Depressive Disorder, and Autistic Disorder. Review of Resident #3's Quarterly MDS Assessment, dated 05/01/24 indicated he/she required various levels of assistance with his/her ADLs including but not limited to bathing, dressing, grooming, transfers, bed mobility, toileting and positioning. Review of Resident #3's Care Plan, titled ADL Deficit, revised on 05/24/24 indicated he/she required various levels of physical assistance with his/her care needs. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #3's ADL Flow Sheets dated 05/01/24 through 05/31/24 indicated that for the following shifts, documentation on the flow sheets was incomplete: -7:00 A.M. to 3:00 P.M. 10 days (out of 31) all ADL care areas were left blank. -3:00 P.M. to 11:00 P.M. 10 days (out of 31) all ADL care areas were left blank. -11:00 P.M. to 7:00 A.M. 16 days (out of 31) all ADL care areas were left blank. Review of Resident #3's ADL Flow Sheets dated 06/01/24 through 06/30/24 indicated that for the following shifts, documentation on the flow sheets was incomplete: -7:00 A.M. to 3:00 P.M. 6 days (out of 30) all ADL care areas were left blank. -3:00 P.M. to 11:00 P.M. 5 days (out of 30) all ADL care areas were left blank. -11:00 P.M. to 7:00 A.M. 19 days (out of 30) all ADL care areas were left blank. Review of Resident #3's ADL Flow Sheets dated 07/01/24 through 07/31/24 indicated that for the following shifts, documentation on the flow sheets was incomplete: -7:00 A.M. to 3:00 P.M. 5 days (out of 31) all ADL care areas were left blank. -3:00 P.M. to 11:00 P.M. 7 days (out of 31) all ADL care areas were left blank. -11:00 P.M. to 7:00 A.M. 18 days (out of 31) all ADL care areas were left blank. During an interview on 8/13/24 at 3:45 P.M., the Special Project Nurse said CNAs should be completing all their ADL Flow Sheet documentation by the end of their shift. The Special Project Nurse further said he reviewed the ADL Flow Sheets when he provided them to the surveyor and said there were numerous blank spaces which had indicated the CNAs failed to document the residents' ADL status, as required. During an interview on 8/15/24 at 11:25 P.M., Unit Manager #1 said the CNAs were responsible for completing all their documentation by the end of their shift. Unit Manager #1 reviewed the ADL Flow Sheets with the Surveyor and said that every blank space on the ADL Flow Sheets indicated the CNA had failed to document, as required.