STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235569	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ovid Healthcare Center	9480 E M-21 Ovid, MI 48866

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30337 This citation pertains to intake MI00145732. Based on observations, interviews, and record reviews, the facility failed to protect the residents' right to be free from mental abuse/verbal abuse (Resident #5), sexual abuse (Resident #1 and Resident #2) and deprivation of goods and services (Resident #6 and Resident #7) by staff and protect Resident #6, Resident #3, and Resident #4. Findings Include: Resident #6 (R6) and Resident #2 (R2) Incident and Investigation Report dated 6/27/24 at 2:39 PM indicated R2 and R6 were found in the dining room participating in sexual behaviors; both residents were touching each other in their perineal areas. R6's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS, a cognitive screener) score of 05 (00-07 Severe Cognitive Impairment). R2's MDS dated [DATE] revealed he had a BIMS score of 11 (08-12 Moderate Impairment). Progress Note dated 6/27/24 at 5:02 PM indicated R2 had been sexually inappropriate 3 times during the shift with another resident. The last occurrence was at 4:15 PM, R2 was seen behind the warming station in the dining room, with another male resident, being inappropriate below the waist, same as 2 times prior. R2 was told behavior was not to happen and R2 began yelling and wouldn't leave the dining room. R2's Behavior Monitoring and interventions task, in the electronic medical record, included history of yelling, cursing, making rude comments, throwing things, and verbal threats. Interventions included reapproach at later time or alternate staff, redirect with conversation, snacks, or activity and to guide R2 away from others. The same report revealed on 6/22/24 at 4:44 PM R2 displayed public sexual acts. Activities note dated 6/22/24 at 4:24 PM revealed R2 was asked 3 times to get away from another resident and asked to leave Bingo for being rude to other residents. R2's care plan dated 7/02/24 indicated he had episodes of hypersexuality (sexual addiction, excessive sexual thoughts, desires, urges or behaviors) and R2's guardian did not consent to sexual contact with R6. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	R6's care plan dated 3/21/23 revealed he had neurodevelopmental disorder and history of temporary stroke. R6's Behavior Monitoring task indicated he had behaviors of entering others personal space, sexually touching other consenting resident, reaching out toward others, masturbating with the door open and curtain not pulled. Interventions included to guide R6 away from the area while redirecting to other activity of interest such as watching game shows. The same Behavior Monitoring task indicated to redirect R6 away from R2, do not seat the two next to each other or allow them to be in areas by themselves. The same report revealed R6 was sexually inappropriate on 6/27/24 at 8:55 PM, 7/04/24 at 12:10 PM and 7/21/24 at 5:36 AM. Progress Note dated 6/27/24 at 4:39 PM revealed R6 was sexually inappropriate 3 times during the shift with another resident. The last occurrence was noted at 4:15 PM. The same note indicated when R6 was told touching other residents below the waist in the dining room was not to continue, R6 yelled and refused to leave the dining room. R6 attempted to stop staff from backing him up in his wheelchair to take him to his room. R6 was informed by the nurse that he was to stay in his room for his meal because of his inability to follow directions and for the inappropriate sexual behavior that had taken place 2 times prior. R6 started to get loud and stated he was coming out. R6 was informed that he was to stay in his room to eat because he was unable to keep his hands to himself and follow instructions. There was only one incident report generated on 6/27/24 regarding R2 and R6. Incident and Investigation Report dated 6/27/24 at 2:39 PM indicated R2 and R6's chart documentation and progress notes were reviewed. The same report indicated additional interviews were not performed and was not necessary or feasible. The same report under conclusion indicated guardians of both residents did not consent for residents to participate in sexual behavior. The report instructed to provide a brief description of the plan to avoid this situation in the future; the response was education provided to residents and staff on redirection when sexual behaviors were exhibited. The same report was signed by Interim Director of Nursing (DON) B and Nursing Home Administrator (NHA) A. The same Incident and Investigation Report dated 6/27/24 at 2:39 PM instructed to describe any action taken by the facility to protect the resident during the investigation and in response to the question was education provided to Licensed Practical Nurse (LPN) J on abuse and safety policies. The same form questioned if the incident was reported to State Agency, and the facility staff checked no, it was not reported. The same investigation included an audit, a list of 21 residents, identified by room number only, dated 6/28/24. The list included 20 residents that were located on the 100 wing, and 1 resident on the 200 wing; there were no residents from the 300 or 400 units. Residents were asked two yes or no questions: had they ever been sexually abused (touched or verbal) and have they seen another resident be sexually abused. There were not any yes answers documented on the form. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Psychiatric Note dated 7/09/24 and signed by physician's assistant on 7/19/24, revealed R2 was seen due to increased inappropriate sexual behavior. Since last visit changes to R2's medications included Paxil (antidepressant) was discontinued on 7/05/24, Lexapro (antidepressant) was started on 7/12/24 by the primary care physician; and Estradiol (estrogen, female sex hormone) was started by the primary care physician on 7/06/24. The same note indicated R2 was recently noted by staff with his hands down another residents' pants. It was recommended to monitor R2, as several medication changes had been implemented by his primary care physician. Certified Nurse Assistant (CNA) M was interviewed on 7/23/24 at 2:30 PM and stated on 6/27/24, she observed R2 and R6, sitting side by side next to each other at a table in the middle of the main dining room; and was not behind the warming station. CNA M stated R2 was slouched in his wheelchair and R6 had his hand on R2's pants, over his perineal area. CNA M stated R2 and R6 were separated around 7 times on 6/27/24. LPN J was interviewed on 7/23/24 at 12:29 PM and stated the incident on 6/27/24 with R2 and R6 occurred more than once. LPN J stated she wrote occurrences in residents progress notes and other nurses did not because it occurred frequently. LPN J stated she was directed to chart using the term sexual behavior versus sexually inappropriate. LPN J stated on 6/27/24 following the incident with R2, an activity aide took R6 to his room. LPN J stated she went to R6's doorway and told him he needed to keep his hands to himself and that he should eat his dinner in his room. R6 wanted to go back to the dining room, and LPN J stated she told R6 to go back to his room. LPN J stated R6 was drawn to R2, and it was absolutely ridiculous. Interim DON B was interviewed on 7/19/24 at 1:30 PM and stated had been interim DON since May of 2024. DON B did not know why incident with R2 and R6 were not reported to State Agency. DON B stated LPN J attempted to barricade R6 in his room on 6/27/24. DON B stated R6 was forced to eat dinner in his room on 6/27/24 and stay in his room for approximately 2 hours. DON B stated LPN J was terminated on 7/18/24, LPN J was not removed from the schedule pending investigation. DON B confirmed she did not interview other staff regarding the incidents that occurred on 6/27/24. DON B stated she did not know why incident with R6 and LPN J was not reported to State Agency. Abuse Prohibition Policy revised 9/09/22 defined Involuntary Seclusion as separation of a resident from other residents or from his/her room or confinement to her/his room against the resident's will or the will of the resident's legal representative. Resident #5 (R5) and Resident #4 (R4) R5 filed a grievance on 7/02/24 alleging R4 kept harassing her and kissing her hand. The same grievance indicated R5 did not like it, it was an ongoing problem and she wanted it to stop. R5's MDS dated [DATE] revealed she was admitted to the facility on [DATE] and had a BIMS score of 15 (13-15 Cognitively Intact). The same MDS assessment indicated she had not had any physical, verbal or other behaviors during the look-back period. R5's progress note dated 6/19/24 indicated she had increased anxiety. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Progress note dated 7/02/24 at 1:32 PM indicated they had spoke with R5 regarding the grievance filed about an altercation with a male resident. The male resident was provided with sitter to ensure resident was safe. R5 was agreeable to the plan. R4's MDS dated [DATE] revealed he had a BIMS score of 03 (00-07 Severe Cognitive Impairment). R4's Behavior Monitoring and interventions task report included history of making verbal threats of physical violence, sexual comments and sexual gestures. The same report instructed to redirect R4 from the area or triggering event, make R4 aware his comments feel uncomfortable, guide R4 way from others if he starts making sexual or other inappropriate comments, provide one to one staff supervision as necessary. The same report ran on 7/19/24 did not indicate R4 had any behaviors, including sexually inappropriate or grabbing, noted during the last 30 days. Progress Note dated 4/21/24 at 10:00 PM revealed R4 had to be redirected with his sexually charged language, and had been approaching residents being sexually inappropriate. Progress Note dated 4/21/24 at 10:55 PM revealed R4, over the last month, had become increasingly sexually inappropriate to staff and female residents. Progress Note dated 6/19/24 at 12:10 PM indicated R4 was being followed by resident at risk and his physician had increased his estrogen medication. The same note revealed R4 had an increase in sexually inappropriate comments, entering others personal space and attention seeking. Action taken included staff to redirect R4 away from others, redirect him with activities, and conversation. Progress Note dated 6/30/24 at 5:21 AM revealed R4 had inappropriate behavior the first 5 hours of the shift. R4 had followed and made inappropriate comments to another female resident who told him no multiple times, when redirected resident would laugh and then hit on the nurse. R4 was continually redirected and removed twice from common areas for harassing female residents. Progress Note dated 6/30/24 at 9:01 PM revealed R4 .just came out of room in wheelchair and was witnessed fondeling [sic] the same female resident he has been harassing tonight and last night while this nurse taking care of him. Resident was rubbing up her arm and placing hand on her lower back, while holding her hand with his other hand. Resident reminded that hands are to be kept to himself and that it is not ok to touch other residents, especially females. Resident started laughing and said well, what can I do then, touch you? and winked and laughed and started propelling himself towards this nurse. Resident politely asked to return to his room or another area of facility away from this female resident if he could not follow rules and keep his hands to himself. Resident then returned to his room and is now resting in bed . Registered Nurse H was interviewed on 7/23/24 at 9:25 AM regarding R4's progress note dated 6/30/24 at 9:01 PM and stated fondling was a poor choice of words. R4 was holding another residents hand and rubbing her wrist and forearm. RN H stated R4 was not re-directable at times and there was two weeks where he was really ramped up. RN H stated the female resident R4 was touching on 6/30/24 was not R5, it was with another female resident. NHA A was interviewed on 7/19/24 at 2:45 PM and stated the incident between R4 and R5 wasn't reported to State Agency and that she asked R5 questions and took care of it right away, the day the grievance was filed, on 7/02/24. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Resident #1 (R1), Resident #3 (R3), Resident #6 (R6) On 7/19/24 at 10:04 AM R1 was observed sitting in her wheelchair in the hallway near the small dining room. MDS dated [DATE] revealed R1 was admitted to the facility on [DATE], had severely impaired cognition, and had diagnoses including depression and Dementia. Receptionist I was interviewed on 7/24/24 at 12:43 PM, and confirmed she was working on 7/04/24, and witnessed R3 standing in the hall by the front dining room, with his penis exposed. Receptionist I stated R1 was in her wheelchair next to him. R3 was reaching for R1's arm, like he wanted her to touch him. Receptionist I stated she separated R3 and R1 and asked activities staff to keep a close eye on R1. Receptionist I stated she reported the incident to NHA A via phone. Activities Aide (AA) O was interviewed on 7/23/24 at 3:40 PM and stated on 7/04/24, around 3:30 PM, she was in the dining room for Bingo with a group of residents, and saw R2 looking down R1 shirt and R6 hand was on top of R2's pants, over his perineal area. AA O stated she wrote a statement and put in under NHA A's door. AA O stated she had witnessed R6 chase after R2. AA O stated she had also witnessed R2 and R6 with their hands down each others pants, behind the steam table, but did not remember the date. Social Services (SS) C was interviewed on 7/19/24 at 2:00 PM and stated she was not aware of any additional details related to the documentation of R3's sexually inappropriateness, in behavior tracking task on 7/04/24 at 12:11 PM, 7/06/24 at 10:22 AM and 3:09 PM; and on 7/07/24 at 12:27 PM. SS C stated R3 had the potential to masturbate in the hallway. SS C stated when behaviors were documented in behavior tracking, she reviewed the care plan, discussed the behavior in the morning meetings and revised the care plan. SS C was unable to provide details of R2's behaviors of public sexual acts documented on 6/22/24 at 4:44 PM or on 7/04/24 at 11:32 AM; in which included cursing. SS C stated R2 and R3 had medication adjustments due to increase masturbation in inappropriate places. SS C stated she had no knowledge of allegations of abuse involving R1. NHA A was interviewed on 7/19/24 at 2:45 PM and stated the facility had an increase in resident sexual behaviors recently. NHA A stated she did not have any knowledge of any incidents that occurred with R1, R3 or R6 on 7/04/24. NHA A stated the facility was looking into getting cameras, as cameras could be useful due to the layout of the building. During an interview on 7/23/24 at 12:29 PM, LPN J stated on 7/04/24 at 11:09 AM, a CNA reported to her R2 was following R1 around and touched R1 breasts with his hands. LPN J stated she did not see R2 touch R1's breasts, but did observe R2 following R1 around that morning. LPN J stated R2 stalked people and acted like he was crazy, but R2 knew what he was doing. LPN J stated she reported the incident to DON B via text message. Interim Director of Nursing (DON) B was interviewed on 7/24/24 at 11:21 AM and stated behaviors were reviewed in the morning meetings by reviewing the dashboard and notes. DON B stated she was not aware behaviors were documented in the tasks section of the medical record and had never run that report. DON B stated there was no morning meeting on 7/05/24, because most of the management team was off on vacation. DON B stated the first time she heard about the incidents that occurred on 7/04/24 with R1, R3, and R6 was on 7/23/24, during the survey. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	A reasonable person (one expect a reasonable person in a similar situation to suffer as a result of the noncompliance), in R1's position would likely suffer recurrent debilitating fear/anxiety that may be manifested as panic, immobilization, screaming, and/or extremely aggressive or agitated behavior(s) (e.g., trembling, cowering) in response to an identifiable situation (e.g., approach of specific residents) Ongoing, persistent expression of dehumanization or humiliation in response to an identifiable situation, that persisted regardless of whether the precipitating event(s) had ceased. Resident #7 (R7) R7's significant change MDS assessment dated [DATE] revealed R7 had a BIMS score of 15 (13-15 Cognitively Intact). The same MDS assessment revealed R7 had the diagnoses of endometrial cancer, schizoaffective-bipolar type disorder, and obesity. An electronic mail (email) from hospice staff was sent to facility staff on 7/15/24 at 12:17 PM and indicated a concern regarding LPN J. The hospice staff stated they had spoken to LPN J many times; LPN J refused to give R7 additional food as requested or has removed food from R7's room. The email indicated LPN J had stated that she forced the nurse assistants to clean R7 up after R7 had refused. Hospice staff stated in the same email they had observed LPN J being very gruff and even rude toward residents, including residents that were not under hospice care. The same email indicated if R7 wished to eat chocolate pudding for every meal, then so be it. Interim DON B was interviewed on 7/19/24 at 1:30 PM and stated it was reported LPN J was rude and gruff to R7. DON B stated LPN J told R7 she did not need any more pudding because she weighed 500 pounds. DON B stated the incident with LPN J and R7 was first verbally reported on 7/12/24, and LPN J was terminated on 7/18/24. R7 was observed lying in bed 7/24/24 at 1:25 PM and stated staff were still denying her food. R7 stated she had requested a second serving at lunch and she did not receive any more food. R7 began crying during the interview and stated when denied food it made her feel less than a human. R7 stated the facility staff thinks she should be on a diet. Certified Nurse Assistant (CNA) K was interviewed on 7/24/24 at 1:30 PM and stated she had requested R7 receive more food and a kitchen staff member stated R7 already received double portions with her lunch meal. Interim Director of Nursing (DON) B was interviewed on 7/24/24 at 11:21 AM and stated she did not investigate allegations of abuse regarding R7. NHA A was interviewed on 7/24/24 at 12:09 PM and stated she did not investigate the allegation of abuse reported by hospice staff because she did not receive the email. NHA A stated she has had 6 DON's since December 2023, and the DON B did not know everything she was supposed to be doing. NHA A stated staff should not deny R7's requests for food. Dietary Manager (DM) N was interviewed on 7/24/24 at 1:45 PM and stated the kitchen had run out of bratwurst during lunch, and stated she did not know if R7 was offered a different item; but would go ask her if she would like something else to eat. Abuse Prohibition Policy revised 9/09/22, revealed the Administrator or designee would notify any State or Federal agencies of allegations per state guideline (2 hours if abuse allegation or serious injury; all others not later than 24 hours).

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30337 This citation pertains to intake MI00145732. Based on interview and record review, the facility failed to prevent involuntary seclusion in one of 10 residents reviewed for abuse (Resident #6), resulting in verbal behaviors and frustration. Findings include: Resident #6 (R6) Incident and Investigation Report dated 6/27/24 at 2:39 PM indicated R6 was found in the dining room participating in sexual behaviors. R6's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS, a cognitive screener) score of 05 (00-07 Severe Cognitive Impairment). R6's care plan dated 3/21/23 revealed he had neurodevelopmental disorder and history of temporary stroke. R6's Behavior Monitoring task indicated he had behaviors of entering others personal space, sexually touching other consenting resident, reaching out toward others, masturbating with the door open and curtain not pulled. Interventions included to guide R6 away from the area while redirecting to other activity of interest such as watching game shows. Progress Note dated 6/27/24 at 4:39 PM revealed R6 was sexually inappropriate 3 times during the shift with another resident. The last occurrence was noted at 4:15 PM. The same note indicated when R6 was told touching other residents below the waist in the dining room was not to continue, R6 yelled and refused to leave the dining room. R6 attempted to stop staff from backing him up in his wheelchair to take him to his room. R6 was informed by the nurse that he was to stay in his room for his meal because of his inability to follow directions and for the inappropriate sexual behavior that had taken place 2 times prior. R6 started to get loud and stated he was coming out. R6 was informed that he was to stay in his room to eat because he was unable to keep his hands to himself and follow instructions. There was no mention R6's guardian was contacted or agreeable to R6 being confined to his room. Incident and Investigation Report dated 6/27/24 at 2:39 PM indicated R6's chart documentation and progress notes were reviewed. The same report indicated additional interviews were not performed and was not necessary or feasible. The same report under conclusion indicated R6's guardian did not consent for residents to participate in sexual behaviors with other residents. The report instructed to provide a brief description of the plan to avoid this situation in the future; the response was education provided to residents and staff on redirection when sexual behaviors were exhibited. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The same Incident and Investigation Report dated 6/27/24 at 2:39 PM instructed to describe any action taken by the facility to protect the resident during the investigation and in response to the question was education provided to Licensed Practical Nurse (LPN) J on abuse and safety policies. The same form questioned if the incident was reported to State Agency, and the facility staff checked no, it was not reported. The same report was signed by Interim Director of Nursing (DON) B and Nursing Home Administrator (NHA) A. LPN J was interviewed on 7/23/24 at 12:29 PM and stated on 6/27/24 following the incident with another resident in the dining room, an activity aide took R6 to his room. LPN J stated she went to R6's doorway and told him he needed to keep his hands to himself and that he should eat his dinner in his room. R6 wanted to go back to the dining room, and LPN J stated she told R6 to go back to his room. Interim DON B was interviewed on 7/19/24 at 1:30 PM and stated had been interim DON since May of 2024. DON B stated LPN J attempted to barricade R6 in his room on 6/27/24. DON B stated R6 was forced to eat dinner in his room on 6/27/24 and stay in his room for approximately 2 hours. DON B stated LPN J was terminated on 7/18/24, LPN J was not removed from the schedule pending investigation. DON B confirmed she did not interview other staff regarding the incidents that occurred on 6/27/24. DON B stated she did not know why incident with R6 and LPN J was not reported to State Agency. NHA A was interviewed on 7/19/24 at 2:45 PM, and stated she could see why she should have reported the incident with R6 and LPN J to State Agency. Abuse Prohibition Policy revised 9/09/22 defined Involuntary Seclusion as separation of a resident from other residents or from his/her room or confinement to her/his room against the resident's will or the will of the resident's legal representative.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30337 This citation pertains to intake MI00145732. Based on observation, interview and record review, the facility failed to implement their abuse policy and procedures in 7 of 10 residents reviewed for abuse (Resident #1, #2, #3, #4, #5, #6, and Resident #7), resulting in continued allegations of abuse. Findings include: Resident #6 (R6) and Resident #2 (R2) Incident and Investigation Report dated 6/27/24 at 2:39 PM indicated R2 and R6 were found in the dining room participating in sexual behaviors; both residents were touching each other in their perineal areas. R6's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS, a cognitive screener) score of 05 (00-07 Severe Cognitive Impairment). R2's MDS dated [DATE] revealed he had a BIMS score of 11 (08-12 Moderate Impairment). Progress Note dated 6/27/24 at 5:02 PM indicated R2 had been sexually inappropriate 3 times during the shift with another resident. The last occurrence was at 4:15 PM, R2 was seen behind the warming station in the dining room, with another male resident, being inappropriate below the waist, same as 2 times prior. R2 was told behavior was not to happen and R2 began yelling and wouldn't leave the dining room. The same note indicated the progress note would be included in the shift report, 24 hour report and a communications report. R2's Behavior Monitoring and interventions task, in the electronic medical record, included history of yelling, cursing, making rude comments, throwing things, and verbal threats. Interventions included reapproach at later time or alternate staff, redirect with conversation, snacks, or activity and to guide R2 away from others. The same report revealed on 6/22/24 at 4:44 PM R2 displayed public sexual acts. Activities note dated 6/22/24 at 4:24 PM revealed R2 was asked 3 times to get away from another resident and asked to leave Bingo for being rude to other residents. R2's care plan dated 7/02/24 indicated he had episodes of hypersexuality (sexual addiction, excessive sexual thoughts, desires, urges or behaviors) and R2's guardian did not consent to sexual contact with R6. R6's care plan dated 3/21/23 revealed he had neurodevelopmental disorder and history of temporary stroke. R6's Behavior Monitoring task indicated he had behaviors of entering others personal space, sexually touching other consenting resident, reaching out toward others, masturbating with the door open and curtain not pulled. Interventions included to guide R6 away from the area while redirecting to other activity of interest such as watching game shows. The same task indicated to redirect R6 away from R2, do not seat the two next to each other or allow them to be in areas by themselves. The same task report revealed R6 was sexually inappropriate on 6/27/24 at 8:55 PM, 7/04/24 at 12:10 PM and 7/21/24 at 5:36 AM. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Progress Note dated 6/27/24 at 4:39 PM revealed R6 was sexually inappropriate 3 times during the shift with another resident. The last occurrence was noted at 4:15 PM. The same note indicated when R6 was told touching other residents below the waist in the dining room was not to continue, R6 yelled and refused to leave the dining room. R6 attempted to stop staff from backing him up in his wheelchair to take him to his room. R6 was informed by the nurse that he was to stay in his room for his meal because of his inability to follow directions and for the inappropriate sexual behavior that had taken place 2 times prior. R6 started to get loud and stated he was coming out. R6 was informed that he was to stay in his room to eat because he was unable to keep his hands to himself and follow instructions. There was only one incident report generated on 6/27/24 regarding R2 and R6. Incident and Investigation Report dated 6/27/24 at 2:39 PM indicated R2 and R6's chart documentation and progress notes were reviewed. The same report indicated additional interviews were not performed and was not necessary or feasible. Under conclusion it was documented guardians of both residents did not consent for residents to participate in sexual behavior. The report instructed to provide a brief description of the plan to avoid this situation in the future; the response was education provided to residents and staff on redirection when sexual behaviors were exhibited. The same Incident and Investigation Report dated 6/27/24 at 2:39 PM instructed to describe any action taken by the facility to protect the resident during the investigation and in response to the question was education provided to Licensed Practical Nurse (LPN) J on abuse and safety policies. The same form questioned if the incident was reported to State Agency, and the facility staff checked no, it was not reported. The same report was signed by Interim Director of Nursing (DON) B and Nursing Home Administrator (NHA) A. The same investigation included an audit, a list of 21 residents, identified by room number only, dated 6/28/24. The list included 20 residents that were located on the 100 wing, and 1 resident on the 200 wing; there were no residents from the 300 or 400 units. Residents were asked two yes or no questions: had they ever been sexually abused (touched or verbal) and have they seen another resident be sexually abused. Psychiatric Note dated 7/09/24 and signed by physician's assistant on 7/19/24, revealed R2 was seen due to increased inappropriate sexual behavior. Since last visit changes to R2's medications included Paxil (antidepressant) was discontinued on 7/05/24, Lexapro (antidepressant) was started on 7/12/24 by the primary care physician; and Estradiol (estrogen, female sex hormone) was started by the primary care physician on 7/06/24. The same note indicated R2 was recently noted by staff with his hands down another residents' pants. It was recommended to monitor R2, as several medication changes had been implemented by his primary care physician. Certified Nurse Assistant (CNA) M was interviewed on 7/23/24 at 2:30 PM and stated on 6/27/24, she observed R2 and R6, sitting side by side next to each other at a table in the middle of the main dining room; and was not behind the warming station. CNA M stated R2 was slouched in his wheelchair and R6 had his hand on R2's pants, over his perineal area. CNA M stated R2 and R6 were separated around 7 times on 6/27/24. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN J was interviewed on 7/23/24 at 12:29 PM and stated the incident on 6/27/24 with R2 and R6 occurred more than once. LPN J stated she wrote occurrences in residents progress notes and other nurses did not because it occurred frequently. LPN J stated she was directed to chart using the term sexual behavior versus sexually inappropriate. LPN J stated on 6/27/24 following the incident with R2, an activity aide took R6 to his room. LPN J stated she went to R6 doorway and told him he needed to keep his hands to himself and that he should eat his dinner in his room. R6 wanted to go back to the dining room, and LPN J stated she told R6 to go back to his room. LPN J stated R6 was drawn to R2, and it was absolutely ridiculous. Interim DON B was interviewed on 7/19/24 at 1:30 PM and stated had been interim DON since May of 2024. DON B did not know why incident with R2 and R6 were not reported to State Agency. DON B stated LPN J attempted to barricade R6 in his room on 6/27/24. DON B stated R6 was forced to eat dinner in his room on 6/27/24 and stay in his room for approximately 2 hours. DON B stated LPN J was terminated on 7/18/24, LPN J was not removed from the schedule pending investigation. DON B confirmed she did not interview other staff regarding the incidents that occurred on 6/27/24. DON B stated she did not know why incident with R6 and LPN J was not reported to State Agency. Resident #5 (R5) and Resident #4 (R4) R5 filed a grievance on 7/02/24 alleging R4 kept harassing her and kissing her hand. The same grievance indicated R5 did not like it, it was an ongoing problem and she wanted it to stop. R5's MDS dated [DATE] revealed she was admitted to the facility on [DATE] and had a BIMS score of 15 (13-15 Cognitively Intact). The same MDS assessment indicated she had not had any physical, verbal or other behaviors during the look-back period. R5's progress note dated 6/19/24 indicated she had increased anxiety. Progress note dated 7/02/24 at 1:32 PM indicated they had spoke with R5 regarding the grievance filed about an altercation with a male resident. The male resident was provided with a sitter to ensure resident was safe. R5 was agreeable to the plan. R4's MDS dated [DATE] revealed he had a BIMS score of 03 (00-07 Severe Cognitive Impairment). R4's Behavior Monitoring and interventions task report included history of making verbal threats of physical violence, sexual comments and sexual gestures. The same report instructed to redirect R4 from the area or triggering event, make R4 aware his comments feel uncomfortable, guide R4 way from others if he starts making sexual or other inappropriate comments, provide one to one staff supervision as necessary. The same report ran on 7/19/24 did not indicate R4 had any behaviors, including sexually inappropriate or grabbing, noted during the last 30 days. Progress Note dated 6/19/24 at 12:10 PM indicated R4 was being followed by resident at risk and his physician had increased his estrogen medication. The same note revealed R4 had an increase in sexually inappropriate comments, entering others personal space and attention seeking. Action taken included staff to redirect R4 away from others, redirect him with activities, and conversation. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Progress Note dated 6/30/24 at 5:21 AM revealed R4 had inappropriate behavior the first 5 hours of the shift. R4 had followed and made inappropriate comments to another female resident who told him no multiple times, when redirected resident would laugh and then hit on the nurse. R4 was continually redirected and removed twice from common areas for harassing female residents. NHA A was interviewed on 7/19/24 at 2:45 PM and stated the incident between R4 and R5 wasn't documented on an incident report or reported to State Agency. Resident #1 (R1), Resident #3 (R3), Resident #6 (R6) On 7/19/24 at 10:04 AM R1 was observed sitting in her wheelchair in the hallway near the small dining room. MDS dated [DATE] revealed R1 was admitted to the facility on [DATE], had severely impaired cognition, and had diagnoses including depression and Dementia. Receptionist I was interviewed on 7/24/24 at 12:43 PM, and confirmed she was working on 7/04/24, and witnessed R3 standing in the hall by the front dining room, with his penis exposed. Receptionist I stated R1 was in her wheelchair next to him. R3 was reaching for R1's arm, like he wanted her to touch him. Receptionist I stated she separated R3 and R1 and asked activities staff to keep a close eye on R1. Receptionist I stated she reported the incident to NHA A via phone. Activities Aide (AA) O was interviewed on 7/23/24 at 3:40 PM and stated on 7/04/24, around 3:30 PM, she was in the dining room for Bingo with a group of residents, and saw R2 looking down R1 shirt and R6 hand was on top of R2's pants, over his perineal area. AA O stated she wrote a statement and put in under NHA A's door. AA O stated she had witnessed R6 chase after R2. AA O stated she had also witnessed R2 and R6 with their hands down each others pants, behind the steam table, but did not remember the date. Social Services (SS) C was interviewed on 7/19/24 at 2:00 PM and stated she was not aware of any additional details related to documentation of R3 checked for sexually inappropriateness, in behavior tracking task on 7/04/24 at 12:11 PM, 7/06/24 at 10:22 AM and 3:09 PM; and on 7/07/24 at 12:27 PM. SS C stated R3 had the potential to masturbate in the hallway. SS C stated when behaviors were documented in behavior tracking, she reviewed the care plan, discussed the behavior in the morning meetings and revised the care plan. SS C was unable to provide details of R2's behaviors of public sexual acts documented on 6/22/24 at 4:44 PM or on 7/04/24 at 11:32 AM; in which included cursing. SS C stated R2 and R3 had medication adjustments due to increase masturbation in inappropriate places. SS C stated she had no knowledge of allegations of abuse that involved R1. NHA A was interviewed on 7/19/24 at 2:45 PM and stated the facility had an increase in resident sexual behaviors recently. NHA A stated she did not have any knowledge of any incidents that occurred with R1, R3 or R6 on 7/04/24. NHA A stated the facility did not have cameras, but cameras could be useful because of the layout of the building. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/23/24 at 12:29 PM, LPN J stated on 7/04/24 at 11:09 AM, a CNA reported to her R2 was following R1 around and touched R1 breasts with his hands. LPN J stated she did not see R2 touch R1's breasts, but did observe R2 following R1 around that morning. LPN J stated R2 stalked people and acted like he was crazy, but R2 knew what he was doing. LPN J stated she reported the incident to DON B via text message. Resident #7 (R7) R7's significant change MDS assessment dated [DATE] revealed R7 had a BIMS score of 15 (13-15 Cognitively Intact). The same MDS assessment revealed R7 had the diagnoses of endometrial cancer, schizoaffective-bipolar type disorder, and obesity. An electronic mail (email) from hospice staff was sent to facility staff on 7/15/24 at 12:17 PM and indicated a concern regarding LPN J. The hospice staff stated they had spoken to LPN J many times; LPN J refused to give R7 additional food as requested or has removed food from R7's room. The email indicated LPN J had stated that she forced the nurse assistants to clean R7 up after R7 had refused. Hospice staff stated in the same email they had observed LPN J being very gruff and even rude toward residents, including residents that were not under hospice care. The same email indicated if R7 wished to eat chocolate pudding for every meal, then so be it. Interim DON B was interviewed on 7/19/24 at 1:30 PM and stated it was reported LPN J was rude and gruff to R7. DON B stated LPN J told R7 she did not need any more pudding because she weighed 500 pounds. DON B stated the incident with LPN J and R7 was first verbally reported on 7/12/24, and LPN J was terminated on 7/18/24. LPN J was not removed from the schedule pending investigation. There was no incident report and no other residents or other staff, with the exception of LPN J that were interviewed. Interim Director of Nursing (DON) B was interviewed on 7/24/24 at 11:21 AM and stated behaviors were reviewed in the morning meetings by reviewing the dashboard and notes. DON B stated she was not aware behaviors were documented in the tasks section of the medical record and had never run that report. DON B stated there was no morning meeting on 7/05/24, because most of the management team was off on vacation. DON B stated the first time she heard about the incidents that occurred on 7/04/24 with R1, R3, and R6 was on 7/23/24 during the survey. Abuse Prohibition Policy revised 9/09/22, revealed each resident would be free from verbal, mental, sexual, physical abuse, corporal punishment, involuntary seclusion and any physical or chemical restraint imposed for purposes of discipline or convenience that were not required to treat the resident's medical symptoms. The same policy defined sexual abuse as non-consensual sexual contact of any type with a resident and included but not limited to: unwanted intimate touching of any kind especially of breasts or perineal area; all types of sexual assault or batter, such as rape, sodomy, fondling and/or intercourse or coerced nudity; forced observation of masturbation and/or pornography. If at anytime the facility had reason to suspect the resident did not have the capacity to consent to sexual activity the facility should evaluate whether the resident had the capacity to consent. Verbal abuse was use of verbal or nonverbal conduct, gestured communication or sounds to residents within hearing distance, regardless of age, ability to comprehend, or disability; which caused or had the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The same policy defined Involuntary Seclusion as separation of a resident from other residents or from his/her room or confinement to her/his room against the resident's will or the will of the resident's legal representative. The Director of Nursing or designee would complete an assessment of the resident(s) and document findings in the medical record. The same policy indicated if the accused was an employee of the facility, he/she would be suspended until the investigation was completed. The facility Quality Assurance Performance Improvement Committee would investigate occurrences, patterns, and trends that may indicate presence of abuse, neglect or misappropriation of resident property to determine the direction of the investigation/intervention, through analysis of systems, audits, and reports. Identification through the safety program begins with the Incident Report. The Administrator or designee would notify any State or Federal agencies of allegations per state guideline (2 hours if abuse allegation or serious injury; all other not later than 24 hours). Substantiated complaints against nurses would be reported to the State Board of Nursing.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 30337 This citation pertains to intake MI00145732. Based on observation, interview and record review, the facility failed to immediately report allegations of abuse in 7 of 10 residents reviewed for abuse (Resident #1, #2, #3, #4, #5, #6, and Resident #7), resulting in likelihood of continued abuse. Findings include: Resident #6 (R6) and Resident #2 (R2) Incident and Investigation Report dated 6/27/24 at 2:39 PM indicated R2 and R6 were found in the dining room participating in sexual behaviors; both residents were touching each other in their perineal areas. R6's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS, a cognitive screener) score of 05 (00-07 Severe Cognitive Impairment). R2's MDS dated [DATE] revealed he had a BIMS score of 11 (08-12 Moderate Impairment). Progress Note dated 6/27/24 at 5:02 PM indicated R2 had been sexually inappropriate 3 times during the shift with another resident. The last occurrence was at 4:15 PM, R2 was seen behind the warming station in the dining room, with another male resident, being inappropriate below the waist, same as 2 times prior. R2 was told behavior was not to happen and R2 began yelling and wouldn't leave the dining room. The same note indicated the progress note would be included in the shift report, 24 hour report and a communications report. R2's Behavior Monitoring and interventions task revealed on 6/22/24 at 4:44 PM R2 displayed public sexual acts. Activities note dated 6/22/24 at 4:24 PM revealed R2 was asked 3 times to get away from another resident and asked to leave Bingo for being rude to other residents. R2's care plan dated 7/02/24 indicated he had episodes of hypersexuality (sexual addiction, excessive sexual thoughts, desires, urges or behaviors) and R2's guardian did not consent to sexual contact with R6. R6's care plan dated 3/21/23 revealed he had neurodevelopmental disorder and history of temporary stroke. R6's Behavior Monitoring task indicated he was sexually inappropriate on 6/27/24 at 8:55 PM, 7/04/24 at 12:10 PM and 7/21/24 at 5:36 AM. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Progress Note dated 6/27/24 at 4:39 PM revealed R6 was sexually inappropriate 3 times during the shift with another resident. The last occurrence was noted at 4:15 PM. The same note indicated when R6 was told touching other residents below the waist in the dining room was not to continue, R6 yelled and refused to leave the dining room. R6 attempted to stop staff from backing him up in his wheelchair to take him to his room. R6 was informed by the nurse that he was to stay in his room for his meal because of his inability to follow directions and for the inappropriate sexual behavior that had taken place 2 times prior. R6 started to get loud and stated he was coming out. R6 was informed that he was to stay in his room to eat because he was unable to keep his hands to himself and follow instructions. There was only one incident report generated on 6/27/24 regarding R2 and R6. Incident and Investigation Report dated 6/27/24 at 2:39 PM indicated R2 and R6's chart documentation and progress notes were reviewed. The same report indicated additional interviews were not performed and was not necessary or feasible. The same report under conclusion indicated guardians of both residents did not consent for residents to participate in sexual behavior. The report instructed to provide a brief description of the plan to avoid this situation in the future; the response was education provided to residents and staff on redirection when sexual behaviors were exhibited. The same form questioned if the incident was reported to State Agency, and the facility staff checked no, it was not reported. The same report was signed by Interim Director of Nursing (DON) B and Nursing Home Administrator (NHA) A. Psychiatric Note dated 7/09/24 and signed by physician's assistant on 7/19/24, revealed R2 was seen due to increased inappropriate sexual behavior. The same note indicated R2 was recently noted by staff with his hands down another residents' pants. Certified Nurse Assistant (CNA) M was interviewed on 7/23/24 at 2:30 PM and stated on 6/27/24, she observed R2 and R6, sitting side by side next to each other at a table in the middle of the main dining room; and was not behind the warming station. CNA M stated R2 was slouched in his wheelchair and R6 had his hand on R2's pants, over his perineal area. CNA M stated R2 and R6 were separated around 7 times on 6/27/24. LPN J was interviewed on 7/23/24 at 12:29 PM and stated the incident on 6/27/24 with R2 and R6 occurred more than once. LPN J stated she wrote occurrences in residents progress notes and other nurses did not because it occurred frequently. LPN J stated she was directed to chart using the term sexual behavior versus sexually inappropriate. LPN J stated on 6/27/24 following the incident with R2, an activity aide took R6 to his room. LPN J stated she went to R6 doorway and told him he needed to keep his hands to himself and that he should eat his dinner in his room. R6 wanted to go back to the dining room, and LPN J stated she told R6 to go back to his room. LPN J stated R6 was drawn to R2, and it was absolutely ridiculous. Interim DON B was interviewed on 7/19/24 at 1:30 PM and stated had been interim DON since May of 2024. DON B did not know why incident with R2 and R6 were not reported to State Agency. DON B stated LPN J attempted to barricade R6 in his room on 6/27/24. DON B stated R6 was forced to eat dinner in his room on 6/27/24 and stay in his room for approximately 2 hours. DON B stated LPN J was terminated on 7/18/24, LPN J was not removed from the schedule pending investigation. DON B stated she did not know why incident with R6 and LPN J was not reported to State Agency. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #5 (R5) and Resident #4 (R4) R5 filed a grievance on 7/02/24 alleging R4 kept harassing her and kissing her hand. The same grievance indicated R5 did not like it, it was an ongoing problem and she wanted it to stop. R5's MDS dated [DATE] revealed she was admitted to the facility on [DATE] and had a BIMS score of 15 (13-15 Cognitively Intact). The same MDS assessment indicated she had not had any physical, verbal or other behaviors during the look-back period. Progress note dated 7/02/24 at 1:32 PM indicated they had spoke with R5 regarding the grievance filed about an altercation with a male resident. The male resident was provided with a sitter to ensure resident was safe. R5 was agreeable to the plan. R4's MDS dated [DATE] revealed he had a BIMS score of 03 (00-07 Severe Cognitive Impairment). R4's Behavior Monitoring and interventions task report included history of making verbal threats of physical violence, sexual comments and sexual gestures. Progress Note dated 6/19/24 at 12:10 PM indicated R4 was being followed by resident at risk and his physician had increased his estrogen medication. The same note revealed R4 had an increase in sexually inappropriate comments, entering others personal space and attention seeking. Progress Note dated 6/30/24 at 5:21 AM revealed R4 had inappropriate behavior the first 5 hours of the shift. R4 had followed and made inappropriate comments to another female resident who told him no multiple times, when redirected resident would laugh and then hit on the nurse. R4 was continually redirected and removed twice from common areas for harassing female residents. Progress Note dated 6/30/24 at 9:01 PM revealed R4 .just came out of room in wheelchair and was witnessed fondeling [sic] the same female resident he has been harassing tonight and last night while this nurse taking care of him. Resident was rubbing up her arm and placing hand on her lower back, while holding her hand with his other hand. Resident reminded that hands are to be kept to himself and that it is not ok to touch other residents, especially females. Resident started laughing and said well, what can I do then, touch you? and winked and laughed and started propelling himself towards this nurse. Resident politely asked to return to his room or another area of facility away from this female resident if he could not follow rules and keep his hands to himself. Resident then returned to his room and is now resting in bed . Registered Nurse H was interviewed on 7/23/24 at 9:25 AM regarding R4's progress note dated 6/30/24 at 9:01 PM and stated fondling was a poor choice of words. R4 was holding another resident's hand and rubbing her wrist and forearm. RN H stated R4 was not re-directable at times and there was two weeks where he was really ramped up. RN H stated the female resident R4 was touching on 6/30/24 was not R5, it was with another female resident. NHA A was interviewed on 7/19/24 at 2:45 PM and stated the incident between R4 and R5 wasn't documented on an incident report or reported to State Agency. Resident #1 (R1), Resident #3 (R3), Resident #6 (R6) (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/19/24 at 10:04 AM R1 was observed sitting in her wheelchair in the hallway near the small dining room. MDS dated [DATE] revealed R1 was admitted to the facility on [DATE], had severely impaired cognition, and had diagnoses including depression and Dementia. Receptionist I was interviewed on 7/24/24 at 12:43 PM, and confirmed she was working on 7/04/24, and witnessed R3 standing in the hall by the front dining room, with his penis exposed. Receptionist I stated R1 was in her wheelchair next to him. R3 was reaching for R1's arm, like he wanted her to touch him. Receptionist I stated she separated R3 and R1 and asked activities staff to keep a close eye on R1. Receptionist I stated she reported the incident to NHA A via phone. Activities Aide (AA) O was interviewed on 7/23/24 at 3:40 PM and stated on 7/04/24, around 3:30 PM, she was in the dining room for Bingo with a group of residents, and saw R2 looking down R1 shirt and R6 hand was on top of R2's pants, over his perineal area. AA O stated she wrote a statement and put in under NHA A's door. AA O stated she had witnessed R6 chase after R2. AA O stated she had also witnessed R2 and R6 with their hands down each others pants, behind the steam table, but did not remember the date. Social Services (SS) C was interviewed on 7/19/24 at 2:00 PM and stated she was not aware of any additional details related to documentation of R3 checked for sexually inappropriateness, in behavior tracking task on 7/04/24 at 12:11 PM, 7/06/24 at 10:22 AM and 3:09 PM; and on 7/07/24 at 12:27 PM. SS C stated R3 had the potential to masturbate in the hallway. SS C stated when behaviors were documented in behavior tracking, she reviewed the care plan, discussed the behavior in the morning meetings and revised the care plan. SS C was unable to provide details of R2's behaviors of public sexual acts documented on 6/22/24 at 4:44 PM or on 7/04/24 at 11:32 AM; in which included cursing. SS C stated R2 and R3 had medication adjustments due to increase masturbation in inappropriate places. SS C stated she had no knowledge of any abuse allegations that involved R1. NHA A was interviewed on 7/19/24 at 2:45 PM and stated the facility had an increase in resident sexual behaviors recently. NHA A stated she did not have any knowledge of any incidents that occurred with R1, R3 or R6 on 7/04/24. During an interview on 7/23/24 at 12:29 PM, LPN J stated on 7/04/24 at 11:09 AM, a CNA reported to her R2 was following R1 around and touched R1 breasts with his hands. LPN J stated she did not see R2 touch R1's breasts, but did observe R2 following R1 around that morning. LPN J stated R2 stalked people and acted like he was crazy, but R2 knew what he was doing. LPN J stated she reported the incident to DON B via text message. Resident #7 (R7) R7's significant change MDS assessment dated [DATE] revealed R7 had a BIMS score of 15 (13-15 Cognitively Intact). The same MDS assessment revealed R7 had the diagnoses of endometrial cancer, schizoaffective-bipolar type disorder, and obesity. (continued on next page)

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	235569	A. Building B. Wing	07/24/2024

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Ovid Healthcare Center	9480 E M-21 Ovid, MI 48866

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An electronic mail (email) from hospice staff was sent to facility staff on 7/15/24 at 12:17 PM and indicated a concern regarding LPN J. The hospice staff stated they had spoken to LPN J many times; LPN J refused to give R7 additional food as requested or has removed food from R7's room. The email indicated LPN J had stated that she forced the nurse assistants to clean R7 up after R7 had refused. Hospice staff stated in the same email they had observed LPN J being very gruff and even rude toward residents, including residents that were not under hospice care. The same email indicated if R7 wished to eat chocolate pudding for every meal, then so be it. Interim DON B was interviewed on 7/19/24 at 1:30 PM and stated it was reported LPN J was rude and gruff to R7. DON B stated LPN J told R7 she did not need any more pudding because she weighed 500 pounds. DON B stated the incident with LPN J and R7 was first verbally reported on 7/12/24, and LPN J was terminated on 7/18/24. LPN J was not removed from the schedule pending investigation. There was no incident report and no other residents or other staff, with the exception of LPN J that were interviewed. Interim Director of Nursing (DON) B was interviewed on 7/24/24 at 11:21 AM and stated behaviors were reviewed in the morning meetings by reviewing the dashboard and notes. DON B stated she was not aware behaviors were documented in the tasks section of the medical record and had never run that report. DON B stated there was no morning meeting on 7/05/24, because most of the management team was off on vacation. DON B stated the first time she heard about the incidents that occurred on 7/04/24 with R1, R3, and R6 was on 7/23/24 during the survey. NHA A was interviewed on 7/24/24 at 12:09 PM and stated she did not investigate the allegation of abuse reported by hospice staff because she did not receive the email. NHA A stated she has had 6 DON's since December 2023, and the DON B did not know everything she was supposed to be doing. Abuse Prohibition Policy revised 9/09/22, revealed the Administrator or designee would notify any State or Federal agencies of allegations per state guideline (2 hours if abuse allegation or serious injury; all others not later than 24 hours) and substantiated complaints against nurses would be reported to the State Board of Nursing.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30337 This citation pertains to intake MI00145732. Based on observation, interview and record review, the facility failed to thoroughly investigate allegations of abuse, in 7 of 10 residents reviewed for abuse (Resident #1, #2, #3, #4, #5, #6, and #7), resulting in the likelihood of continued abuse. Findings include: Resident #6 (R6) and Resident #2 (R2) Incident and Investigation Report dated 6/27/24 at 2:39 PM indicated R2 and R6 were found in the dining room participating in sexual behaviors; both residents were touching each other in their perineal areas. R6's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS, a cognitive screener) score of 05 (00-07 Severe Cognitive Impairment). R2's MDS dated [DATE] revealed he had a BIMS score of 11 (08-12 Moderate Impairment). Progress Note dated 6/27/24 at 5:02 PM indicated R2 had been sexually inappropriate 3 times during the shift with another resident. The last occurrence was at 4:15 PM, R2 was seen behind the warming station in the dining room, with another male resident, being inappropriate below the waist, same as 2 times prior. R2 was told behavior was not to happen and R2 began yelling and wouldn't leave the dining room. R2's Behavior Monitoring and interventions task, in the electronic medical record, included history of yelling, cursing, making rude comments, throwing things, and verbal threats. The same report revealed on 6/22/24 at 4:44 PM R2 displayed public sexual acts. Activities note dated 6/22/24 at 4:24 PM revealed R2 was asked 3 times to get away from another resident and asked to leave Bingo for being rude to other residents. R2's care plan dated 7/02/24 indicated he had episodes of hypersexuality (sexual addiction, excessive sexual thoughts, desires, urges or behaviors) and R2's guardian did not consent to sexual contact with R6. R6's care plan dated 3/21/23 revealed he had neurodevelopmental disorder and history of temporary stroke. R6's Behavior Monitoring task indicated he had behaviors of entering others personal space, sexually touching other consenting resident, reaching out toward others, masturbating with the door open and curtain not pulled. The same Behavior Monitoring task indicated to redirect R6 away from R2, do not seat the two next to each other or allow them to be in areas by themselves. The same report revealed R6 was sexually inappropriate on 6/27/24 at 8:55 PM, 7/04/24 at 12:10 PM and 7/21/24 at 5:36 AM. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Progress Note dated 6/27/24 at 4:39 PM revealed R6 was sexually inappropriate 3 times during the shift with another resident. The last occurrence was noted at 4:15 PM. The same note indicated when R6 was told touching other residents below the waist in the dining room was not to continue, R6 yelled and refused to leave the dining room. R6 attempted to stop staff from backing him up in his wheelchair to take him to his room. R6 was informed by the nurse that he was to stay in his room for his meal because of his inability to follow directions and for the inappropriate sexual behavior that had taken place 2 times prior. R6 started to get loud and stated he was coming out. R6 was informed that he was to stay in his room to eat because he was unable to keep his hands to himself and follow instructions. There was only one incident report generated on 6/27/24 regarding R2 and R6. Incident and Investigation Report dated 6/27/24 at 2:39 PM indicated R2 and R6's chart documentation and progress notes were reviewed. The same report indicated additional interviews were not performed and was not necessary or feasible. The same report under conclusion indicated guardians of both residents did not consent for residents to participate in sexual behavior. The report instructed to provide a brief description of the plan to avoid this situation in the future; the response was education provided to residents and staff on redirection when sexual behaviors were exhibited. The same report instructed to describe any action taken by the facility to protect the resident during the investigation, and in response to the question, education was provided to Licensed Practical Nurse (LPN) J on abuse and safety policies. The same form questioned if the incident was reported to State Agency, and the facility staff checked no, it was not reported. The same investigation included an audit, a list of 21 residents, identified by room number only, dated 6/28/24. The list included 20 residents that were located on the 100 wing, and 1 resident on the 200 wing; there were no residents from the 300 or 400 units. Residents were asked two yes or no questions: had they ever been sexually abused (touched or verbal) and have they seen another resident be sexually abused. The same report was signed by Interim Director of Nursing (DON) B and Nursing Home Administrator (NHA) A. Psychiatric Note dated 7/09/24 and signed by physician's assistant on 7/19/24, revealed R2 was seen due to increased inappropriate sexual behavior. Since last visit changes to R2's medications included Paxil (antidepressant) was discontinued on 7/05/24, Lexapro (antidepressant) was started on 7/12/24 by the primary care physician; and Estradiol (estrogen, female sex hormone) was started by the primary care physician on 7/06/24. The same note indicated R2 was recently noted by staff with his hands down another residents' pants. It was recommended to monitor R2, as several medication changes had been implemented by his primary care physician. Certified Nurse Assistant (CNA) M was interviewed on 7/23/24 at 2:30 PM and stated on 6/27/24, she observed R2 and R6, sitting side by side next to each other at a table in the middle of the main dining room; and was not behind the warming station. CNA M stated R2 was slouched in his wheelchair and R6 had his hand on R2's pants, over his perineal area. CNA M stated R2 and R6 were separated around 7 times on 6/27/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN J was interviewed on 7/23/24 at 12:29 PM and stated the incident on 6/27/24 with R2 and R6 occurred more than once. LPN J stated she wrote occurrences in residents progress notes and other nurses did not because it occurred frequently. LPN J stated she was directed to chart using the term sexual behavior versus sexually inappropriate. LPN J stated on 6/27/24 following the incident with R2, an activity aide took R6 to his room. LPN J stated she went to R6 doorway and told him he needed to keep his hands to himself and that he should eat his dinner in his room. R6 wanted to go back to the dining room, and LPN J stated she told R6 to go back to his room. LPN J stated R6 was drawn to R2, and it was absolutely ridiculous. Interim DON B was interviewed on 7/19/24 at 1:30 PM and stated had been interim DON since May of 2024. DON B did not know why incident with R2 and R6 were not reported to State Agency. DON B stated LPN J attempted to barricade R6 in his room on 6/27/24. DON B stated R6 was forced to eat dinner in his room on 6/27/24 and stay in his room for approximately 2 hours. DON B stated LPN J was terminated on 7/18/24, LPN J was not removed from the schedule pending investigation. DON B confirmed she did not interview other staff regarding the incidents that occurred on 6/27/24. DON B stated she did not know why incident with R6 and LPN J was not reported to State Agency. Resident #5 (R5) and Resident #4 (R4) R5 filed a grievance on 7/02/24 alleging R4 kept harassing her and kissing her hand. The same grievance indicated R5 did not like it, it was an ongoing problem and she wanted it to stop. R5's MDS dated [DATE] revealed she was admitted to the facility on [DATE] and had a BIMS score of 15 (13-15 Cognitively Intact). The same MDS assessment indicated she had not had any physical, verbal or other behaviors during the look-back period. R5's progress note dated 6/19/24 indicated she had increased anxiety. Progress note dated 7/02/24 at 1:32 PM indicated they had spoke with R5 regarding the grievance filed about an altercation with a male resident. The male resident was provided with a sitter to ensure resident was safe. R5 was agreeable to the plan. R4's MDS dated [DATE] revealed he had a BIMS score of 03 (00-07 Severe Cognitive Impairment). R4's Behavior Monitoring and interventions task report included history of making verbal threats of physical violence, sexual comments and sexual gestures. The same report instructed to redirect R4 from the area or triggering event, make R4 aware his comments feel uncomfortable, guide R4 way from others if he starts making sexual or other inappropriate comments, provide one to one staff supervision as necessary. Progress Note dated 4/21/24 at 10:00 PM revealed R4 had to be redirected with his sexually charged language, and had been approaching residents being sexually inappropriate. Progress Note dated 4/21/24 at 10:55 PM revealed R4, over the last month, had become increasingly sexually inappropriate to staff and female residents. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Progress Note dated 6/19/24 at 12:10 PM indicated R4 was being followed by resident at risk and his physician had increased his estrogen medication. The same note revealed R4 had an increase in sexually inappropriate comments, entering others personal space and attention seeking. Action taken included staff to redirect R4 away from others, redirect him with activities, and conversation. Progress Note dated 6/30/24 at 5:21 AM revealed R4 had inappropriate behavior the first 5 hours of the shift. R4 had followed and made inappropriate comments to another female resident who told him no multiple times, when redirected resident would laugh and then hit on the nurse. R4 was continually redirected and removed twice from common areas for harassing female residents. Progress Note dated 6/30/24 at 9:01 PM revealed R4 .just came out of room in wheelchair and was witnessed fondeling [sic] the same female resident he has been harassing tonight and last night while this nurse taking care of him. Resident was rubbing up her arm and placing hand on her lower back, while holding her hand with his other hand. Resident reminded that hands are to be kept to himself and that it is not ok to touch other residents, especially females. Resident started laughing and said well, what can I do then, touch you? and winked and laughed and started propelling himself towards this nurse. Resident politely asked to return to his room or another area of facility away from this female resident if he could not follow rules and keep his hands to himself. Resident then returned to his room and is now resting in bed . Registered Nurse H was interviewed on 7/23/24 at 9:25 AM regarding R4's progress note dated 6/30/24 at 9:01 PM and stated fondling was a poor choice of words. R4 was holding another resident's hand and rubbing her wrist and forearm. RN H stated R4 was not re-directable at times and there was two weeks where he was really ramped up. RN H stated the female resident R4 was touching on 6/30/24 was not R5, it was with another female resident. NHA A was interviewed on 7/19/24 at 2:45 PM and stated the incident between R4 and R5 wasn't reported to State Agency and that she asked R5 questions and took care of it right away, the day the grievance was filed. Resident #1 (R1), Resident #3 (R3), Resident #6 (R6) 7/19/24 at 10:04 AM R1 was observed sitting in her wheelchair in the hallway near the small dining room. MDS dated [DATE] revealed R1 was admitted to the facility on [DATE], had severely impaired cognition, and had diagnoses including depression and Dementia. Receptionist I was interviewed on 7/24/24 at 12:43 PM, and confirmed she was working on 7/04/24, and witnessed R3 standing in the hall by the front dining room, with his penis exposed. Receptionist I stated R1 was in her wheelchair next to him. R3 was reaching for R1's arm, like he wanted her to touch him. Receptionist I stated she separated R3 and R1 and asked activities staff to keep a close eye on R1. Receptionist I stated she reported the incident to NHA A via phone. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Activities Aide (AA) O was interviewed on 7/23/24 at 3:40 PM and stated on 7/04/24, around 3:30 PM, she was in the dining room for Bingo with a group of residents, and saw R2 looking down R1 shirt and R6 hand was on top of R2's pants, over his perineal area. AA O stated she wrote a statement and put in under NHA A's door. AA O stated she had witnessed R6 chase after R2. AA O stated she had also witnessed R2 and R6 with their hands down each others pants, behind the steam table, but did not remember the date. Social Services (SS) C was interviewed on 7/19/24 at 2:00 PM and stated she was not aware of any additional details related to documentation of R3 checked for sexually inappropriateness, in behavior tracking task on 7/04/24 at 12:11 PM, 7/06/24 at 10:22 AM and 3:09 PM; and on 7/07/24 at 12:27 PM. SS C stated R3 had the potential to masturbate in the hallway. SS C stated when behaviors were documented in behavior tracking, she reviewed the care plan, discussed the behavior in the morning meetings and revised the care plan. SS C was unable to provide details of R2's behaviors of public sexual acts documented on 6/22/24 at 4:44 PM or on 7/04/24 at 11:32 AM; in which included cursing. SS C stated R2 and R3 had medication adjustments due to increase masturbation in inappropriate places. SS C stated she had no knowledge of any abuse allegations regarding R1. NHA A was interviewed on 7/19/24 at 2:45 PM and stated the facility had an increase in resident sexual behaviors recently. NHA A stated she did not have any knowledge of any incidents that occurred with R1, R3 or R6 on 7/04/24. NHA A stated the facility did not have cameras and recently received a quote, but cameras could be useful due to the layout of the building. During an interview on 7/23/24 at 12:29 PM, LPN J stated on 7/04/24 at 11:09 AM, a CNA reported to her R2 was following R1 around and touched R1 breasts with his hands. LPN J stated she did not see R2 touch R1's breasts, but did observe R2 following R1 around that morning. LPN J stated R2 stalked people and acted like he was crazy, but R2 knew what he was doing. LPN J stated she reported the incident to DON B via text message. Interim Director of Nursing (DON) B was interviewed on 7/24/24 at 11:21 AM and stated behaviors were reviewed in the morning meetings by reviewing the dashboard and notes. DON B stated she was not aware behaviors were documented in the tasks section of the medical record and had never run that report. DON B stated there was no morning meeting on 7/05/24, because most of the management team was off on vacation. DON B stated the first time she heard about the incidents that occurred on 7/04/24 with R1, R3, and R6 was on 7/23/24, during the survey. A reasonable person (one expect a reasonable person in a similar situation to suffer as a result of the noncompliance), in R1's position would likely suffer recurrent debilitating fear/anxiety that may be manifested as panic, immobilization, screaming, and/or extremely aggressive or agitated behavior(s) (e.g., trembling, cowering) in response to an identifiable situation (e.g., approach of specific residents) Ongoing, persistent expression of dehumanization or humiliation in response to an identifiable situation, that persisted regardless of whether the precipitating event(s) had ceased. Resident #7 (R7) R7's significant change MDS assessment dated [DATE] revealed R7 had a BIMS score of 15 (13-15 Cognitively Intact). The same MDS assessment revealed R7 had the diagnoses of endometrial cancer, schizoaffective-bipolar type disorder, and obesity. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An electronic mail (email) from hospice staff was sent to facility staff on 7/15/24 at 12:17 PM and indicated a concern regarding LPN J. The hospice staff stated they had spoken to LPN J many times; LPN J refused to give R7 additional food as requested or has removed food from R7's room. The email indicated LPN J had stated that she forced the nurse assistants to clean R7 up after R7 had refused. Hospice staff stated in the same email they had observed LPN J being very gruff and even rude toward residents, including residents that were not under hospice care. The same email indicated if R7 wished to eat chocolate pudding for every meal, then so be it. Interim DON B was interviewed on 7/19/24 at 1:30 PM and stated it was reported LPN J was rude and gruff to R7. DON B stated LPN J told R7 she did not need any more pudding because she weighed 500 pounds. DON B stated the incident with LPN J and R7 was first verbally reported on 7/12/24, and LPN J was terminated on 7/18/24. R7 was observed lying in bed 7/24/24 at 1:25 PM and stated staff were still denying her food. R7 stated she had requested a second serving at lunch and she did not receive any more food. R7 began crying during the interview and stated when denied food it made her feel less than a human. R7 stated the facility staff thinks she should be on a diet. Certified Nurse Assistant (CNA) K was interviewed on 7/24/24 at 1:30 PM and stated she had requested R7 receive more food and a kitchen staff member stated R7 already received double portions with her lunch meal. Interim Director of Nursing (DON) B was interviewed on 7/24/24 at 11:21 AM and stated she did not investigate allegations of abuse regarding R7. NHA A was interviewed on 7/24/24 at 12:09 PM and stated she did not investigate the allegation of abuse reported by hospice staff because she did not receive the email. NHA A stated she has had 6 DON's since December 2023, and the DON B did not know everything she was supposed to be doing. NHA A stated staff should not deny R7's requests for food. Dietary Manager (DM) N was interviewed on 7/24/24 at 1:45 PM and stated the kitchen had run out of bratwurst's during lunch, and stated she did not know if R7 was offered a different item; but would go ask her if she would like something else to eat. Abuse Prohibition Policy revised 9/09/22, revealed the Administrator or designee would notify any State or Federal agencies of allegations per state guideline (2 hours if abuse allegation or serious injury; all others not later than 24 hours).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30337 Based on interview and record review, the facility failed to ensure residents received appropriate assessment and treatment for a change of condition in one of 10 residents reviewed for abuse (Resident #8), resulting in delayed treatment and a medication error. Findings include: Resident #8 (R8) During an interview with Interim Director of Nursing (DON) B on 7/19/24 at 1:30 PM, DON B stated on 7/14/24, Licensed Practical Nurse (LPN) J administered Narcan/naloxone (medication that rapidly reversed an opioid [heroin, fentanyl, oxycodone, Vicodin, codeine, morphine] overdose, medication attaches to opioid receptors and reversed/blocked effects of other opioids; Narcan could restore normal breathing to a person if breathing had slowed or stopped due to an opioid overdose). DON B stated there was no indication to administer Narcan, R8's vital signs were stable, Narcan was not prescribed, opioids were not prescribed, and R8 did not have a history of opioid abuse. DON B stated LPN J administered another residents Narcan to R8 without a physician's order. DON B stated LPN J called emergency services after the Narcan failed to wake R8. Physicians Progress Note dated 7/12/24 at 12:00 AM, revealed R8 was [AGE] years old, had a history of bladder cancer, multiple urinary tract infections (UTI); and was in need of medical clearance for further bladder due to a tumor and possible urethral stent placement. Nurses note dated 7/14/24 at 8:48 PM revealed at 12:00 PM, she overheard Physical Therapy reporting to the Certified Nurse Assistant that they had attempted to wake R8 and he did not arouse when they attempted to set him up on the edge of the bed. The same note indicated nurse was unable to arouse R8, and his breathing was shallow, respirations were 10 (normal respiration rate was 12-18 breaths per minute), his blood pressure was 187/89 (normal blood pressure 120/80), pulse was 73 (normal 60 to 100 beats per minute). There was no temperature included in the note. The same note indicated at 12:12 PM Narcan 4 milligrams (mg) was administered. R8 showed no changes in response to the medication. Emergency Medical Services were notified and R8 was transferred to the hospital. In review of R8's July 2024's Medication Administration Record (MAR), R8 was admitted to the facility on [DATE], and there was no documentation Narcan was ordered to administer. Medication and Treatment Incident Report dated 7/14/24 indicated R8 received Narcan without a physician order and the Narcan used was ordered for a different resident. The same report indicated R8's physician was notified on 7/14/24 at 1:05 PM. LPN J was interviewed on 7/23/24 at 12:29 PM and stated she administered another residents Narcan to R8 on 7/14/24, because he took Gabapentin (anticonvulsant) medication and there was not any Narcan in the back-up box. LPN J stated Gabapentin had the ability to be abused, and she used her own judgement when she administered Narcan to R8. LPN J stated she understood Gabapentin was not an opioid. R8's Progress Note dated 7/17/24 at 4:40 PM revealed he was readmitted to the facility and was diagnosed with a UTI.

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30337 This citation pertains to intake MI00145732. Based on interview and record review, the facility failed to ensure adequate staff were scheduled to supervise and report residents with sexual behaviors and protect vulnerable residents in a census of 61 residents, resulting in the likelihood of allegations of abuse not identified, reported or documented. Findings include: Facility assessment dated [DATE] indicated the facility was approximately 3200 square feet and the average daily census over the past 12 months was 62 residents. 26 residents had a diagnosis of dementia. 54 out of 62 residents were dependent or required staff assistance for dressing. 59 out of 62 residents were dependent or required staff assist for bathing. 49 out of 62 residents were dependent or required staff assist for transfers. 36 residents were dependent or required staff assist for eating. 52 out of 62 residents were dependent or required staff assist in toileting. Staff Schedule dated 6/27/24 indicated a census of 59 residents. 5 Certified Nurse Assistants (CNA's) were scheduled during the 6:00 AM to 6:00 PM shift. One CNA was scheduled to work from 6:00 AM to 10:00 AM and then go home. The same schedule indicated one restorative CNA was scheduled from 7:00 AM to 3:30 PM. There were multiple resident to resident sexual occurrences documented on 6/27/24, that indicated additional staff to supervise resident behavior may have prevented abuse. Staff Schedule dated 7/04/24 revealed a census of 59 residents. There were 5 Certified Nurse Assistants (CNA's) and 2 Nurses on the schedule to work day shift (6:00 AM to 6:00 PM). One CNA was assigned to be one to one with a resident that resided on 100 hall for the entire shift. There was one other CNA assigned to 100 hall. One CNA was noted as no call no show; and was scheduled to work from 8:00 AM through 6:00 PM on 200 hall. There were no CNA's assigned to 200 hall residents from 8:00 AM to 4:00 PM. 2 CNA's were on 300 hall. One CNA was scheduled on 400 hall from 6:00 AM to 3:30 PM. There were no CNA's scheduled on 400 hall from 3:30 PM to 6:00 PM. From 8:00 AM to 4:00 PM, there were 4 CNA's to care for 58 residents, 14 to 15 residents each. There was no restorative CNA scheduled on 7/04/24. During the survey from 7/19/24 through 7/23/24, Staff IP was interviewed and stated they recalled they had a call off on 7/04/24 and they had complained to management about the lack of enough staff. Staff D was interviewed during the survey from 7/19/24 through 7/23/24 and stated staffing on 7/04/24 was not adequate. During the survey from 7/19/24 through 7/23/24, Staff Q stated they was not enough staff on 7/04/24 and the Director of Nursing was notified. Staff Q stated they did not witness any abuse on 7/04/24, and stated they were too busy taking care of their residents to notice anything. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the survey from 7/19/24 through 7/23/24 staff E stated staffing was really difficult on 7/04/24. One resident followed the ladies around with his hand down his pants and was hard to re-direct. During the survey from 7/19/24 through 7/23/24, staff F stated on 7/04/24, there was not enough staff to meet residents needs and they did not get a break or take a lunch. During the survey from 7/19/24 through 7/23/24, staff G stated staffing on 7/04/24 was rough. One CNA was pulled to work on another hall; but the nurse kept pulling them back to work on the hall they were pulled from. There was a fall, on 7/04/24; staff G stated they had just finished assisting another resident, when he heard another resident scream. The resident bumped his head when he fell , and was attempting to use the bathroom. Staff G stated they ended their employment at the facility due to low staffing and poor resident care. Scheduler/CNA R was interviewed on 7/23/24 at 3:36 PM and stated they have budgeted hours and divide by census to determine staffing. Scheduler/CNA stated when the census drops they send staff home. Scheduler/CNA R stated 6 CNA's run a lot smoother during the day. Scheduler/CNA R stated on 7/04/24, had a craziness going on, and did not like to see that. On 6/27/24 they had 5 CNA's that day due to the census. Interim Director of Nursing (DON) B was interviewed on 7/24/24 at 11:21 AM and stated there was no morning meeting on 7/05/24, because most of the management team was off on vacation.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30337 This citation pertains to intake MI00145732. Based on interview and record review, the facility administration failed to operationalize its policy and procedures to manintain effective use its resources and ensure identification, investigation, and protection of residents from mental abuse, verbal abuse, sexual abuse and deprivation of goods and services in 7 of 10 residents reviewed for abuse (Resident #1, #2, #3, #4, #5, #6, and Resident #7), and failed to ensure sufficient nursing staff to meet residents needs and the likelihood for continued abuse and unmet resident needs in a current facility census of 61 residents. Findings include: Resident #6 (R6) and Resident #2 (R2) Incident and Investigation Report dated 6/27/24 at 2:39 PM indicated R2 and R6 were found in the dining room participating in sexual behaviors; both residents were touching each other in their perineal areas. R6's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS, a cognitive screener) score of 05 (00-07 Severe Cognitive Impairment). R2's MDS dated [DATE] revealed he had a BIMS score of 11 (08-12 Moderate Impairment). Progress Note dated 6/27/24 at 5:02 PM indicated R2 had been sexually inappropriate 3 times during the shift with another resident. The last occurrence was at 4:15 PM, R2 was seen behind the warming station in the dining room, with another male resident, being inappropriate below the waist, same as 2 times prior. Activities note dated 6/22/24 at 4:24 PM revealed R2 was asked 3 times to get away from another resident. R2's Behavior Monitoring and interventions task, in the electronic medical record, revealed on 6/22/24 at 4:44 PM R2 displayed public sexual acts. There were no resident at risk notes or other notes indicating the circumstances of R2's behavior on 6/22/24 at 4:44 PM was investigated or that no other residents were affected. R2's care plan dated 7/02/24 indicated he had episodes of hypersexuality (sexual addiction, excessive sexual thoughts, desires, urges or behaviors) and R2's guardian did not consent to sexual contact with R6. R6's Behavior Monitoring task indicated he had behaviors of entering others personal space, sexually touching other consenting resident, reaching out toward others, masturbating with the door open and curtain not pulled. The same report revealed R6 was sexually inappropriate on 6/27/24 at 8:55 PM, 7/04/24 at 12:10 PM and 7/21/24 at 5:36 AM. There were no investigations of documented behaviors on 7/04/24 or 7/21/24. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Progress Note dated 6/27/24 at 4:39 PM revealed R6 was sexually inappropriate 3 times during the shift with another resident. The last occurrence was noted at 4:15 PM. The same note indicated when R6 was told touching other residents below the waist in the dining room was not to continue, R6 yelled and refused to leave the dining room. R6 attempted to stop staff from backing him up in his wheelchair to take him to his room. R6 was informed by the nurse that he was to stay in his room for his meal because of his inability to follow directions and for the inappropriate sexual behavior that had taken place 2 times prior. R6 started to get loud and stated he was coming out. R6 was informed that he was to stay in his room to eat because he was unable to keep his hands to himself and follow instructions. There was only one incident report generated on 6/27/24 regarding R2 and R6. Incident and Investigation Report dated 6/27/24 at 2:39 PM indicated R2 and R6's chart documentation and progress notes were reviewed. The same report indicated additional interviews were not performed and was not necessary or feasible. The same report under conclusion indicated guardians of both residents did not consent for residents to participate in sexual behavior. The report instructed to provide a brief description of the plan to avoid this situation in the future; the response was education provided to residents and staff on redirection when sexual behaviors were exhibited. The same report was signed by Interim Director of Nursing (DON) B and Nursing Home Administrator (NHA) A. The same Incident and Investigation Report dated 6/27/24 at 2:39 PM instructed to describe any action taken by the facility to protect the resident during the investigation and in response to the question was education provided to Licensed Practical Nurse (LPN) J on abuse and safety policies. The same form questioned if the incident was reported to State Agency, and the facility staff checked no, it was not reported. The same investigation included an audit, a list of 21 residents, identified by room number only, dated 6/28/24. The list included 20 residents that were located on the 100 wing, and 1 resident on the 200 wing; there were no residents from the 300 or 400 units. Residents were asked two yes or no questions: had they ever been sexually abused (touched or verbal) and have they seen another resident be sexually abused. There were not any yes answers documented from the facility. Psychiatric Note dated 7/09/24 and signed by physician's assistant on 7/19/24, revealed R2 was seen due to increased inappropriate sexual behavior. Since last visit changes to R2's medications included Paxil (antidepressant) was discontinued on 7/05/24, Lexapro (antidepressant) was started on 7/12/24 by the primary care physician; and Estradiol (estrogen, female sex hormone) was started by the primary care physician on 7/06/24. The same note indicated R2 was recently noted by staff with his hands down another residents' pants. It was recommended to monitor R2, as several medication changes had been implemented by his primary care physician. Certified Nurse Assistant (CNA) M was interviewed on 7/23/24 at 2:30 PM and stated on 6/27/24, she observed R2 and R6, sitting side by side next to each other at a table in the middle of the main dining room, not behind the warming station. CNA M stated R2 was slouched in his wheelchair and R6 had his hand on R2's pants, over his perineal area. CNA M stated R2 and R6 were separated around 7 times on 6/27/24. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	LPN J was interviewed on 7/23/24 at 12:29 PM and stated the incident on 6/27/24 with R2 and R6 occurred more than once. LPN J stated she wrote occurrences in residents progress notes and other nurses did not because it occurred frequently. LPN J stated she was directed to chart using the term sexual behavior versus sexually inappropriate. LPN J stated on 6/27/24 following the incident with R2, an activity aide took R6 to his room. LPN J stated she went to R6 doorway and told him he needed to keep his hands to himself and that he should eat his dinner in his room. R6 wanted to go back to the dining room, and LPN J stated she told R6 to go back to his room. LPN J stated R6 was drawn to R2, and it was absolutely ridiculous. Interim DON B was interviewed on 7/19/24 at 1:30 PM and stated had been interim DON since May of 2024. DON B did not know why incident with R2 and R6 were not reported to State Agency. DON B stated LPN J attempted to barricade R6 in his room on 6/27/24. DON B stated R6 was forced to eat dinner in his room on 6/27/24 and stay in his room for approximately 2 hours. DON B stated LPN J was terminated on 7/18/24, LPN J was not removed from the schedule pending investigation. DON B confirmed she did not interview other staff regarding the incidents that occurred on 6/27/24. DON B stated she did not know why incident with R6 and LPN J was not reported to State Agency. Resident #5 (R5) and Resident #4 (R4) R5 filed a grievance on 7/02/24 alleging R4 kept harassing her and kissing her hand. The same grievance indicated R5 did not like it, it was an ongoing problem and she wanted it to stop. R5's MDS dated [DATE] revealed she was admitted to the facility on [DATE] and had a BIMS score of 15 (13-15 Cognitively Intact). The same MDS assessment indicated she had not had any physical, verbal or other behaviors during the look-back period. R5's progress note dated 6/19/24 indicated she had increased anxiety. Progress note dated 7/02/24 at 1:32 PM indicated they had spoke with R5 regarding the grievance filed about an altercation with a male resident. The male resident was provided with sitter to ensure resident was safe. R5 was agreeable to the plan. R4's MDS dated [DATE] revealed he had a BIMS score of 03 (00-07 Severe Cognitive Impairment). R4's Behavior Monitoring and interventions task report included history of making verbal threats of physical violence, sexual comments and sexual gestures. Progress Note dated 4/21/24 at 10:00 PM revealed R4 had to be redirected with his sexually charged language, and had been approaching residents being sexually inappropriate. Progress Note dated 4/21/24 at 10:55 PM revealed R4, over the last month, had become increasingly sexually inappropriate to staff and female residents. Progress Note dated 6/19/24 at 12:10 PM indicated R4 was being followed by resident at risk and his physician had increased his estrogen medication. The same note revealed R4 had an increase in sexually inappropriate comments, entering others personal space and attention seeking. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Progress Note dated 6/30/24 at 5:21 AM revealed R4 had inappropriate behavior the first 5 hours of the shift. R4 had followed and made inappropriate comments to another female resident who told him no multiple times, when redirected resident would laugh and then hit on the nurse. R4 was continually redirected and removed twice from common areas for harassing female residents. There were no incident reports generated. Progress Note dated 6/30/24 at 9:01 PM revealed R4 .just came out of room in wheelchair and was witnessed fondeling [sic] the same female resident he has been harassing tonight and last night while this nurse [sic] taking care of him. Resident was rubbing up her arm and placing hand on her lower back, while holding her hand with his other hand. Resident reminded that hands are to be kept to himself and that it is not ok to touch other residents, especially females. Resident started laughing and said well, what can I do then, touch you? and winked and laughed and started propelling himself towards this nurse. Resident politely asked to return to his room or another area of facility away from this female resident if he could not follow rules and keep his hands to himself. Resident then returned to his room and is now resting in bed . NHA A was interviewed on 7/19/24 at 2:45 PM and stated the incident between R4 and R5 wasn't reported to State Agency; and stated that she took care of the grievance right away, the day the grievance was filed. It was not clear how many times R5 felt she was harassed or received unwanted touching by R4 or if there was a pattern regarding the time of day. Resident #1 (R1), Resident #3 (R3), Resident #6 (R6) MDS dated [DATE] revealed R1 was admitted to the facility on [DATE], had severely impaired cognition, and had diagnoses including depression and Dementia. Receptionist I was interviewed on 7/24/24 at 12:43 PM, and confirmed she was working on 7/04/24, and witnessed R3 standing in the hall by the front dining room, with his penis exposed. Receptionist I stated R1 was in her wheelchair next to him. R3 was reaching for R1's arm, like he wanted her to touch him. Receptionist I stated she separated R3 and R1 and asked activities staff to keep a close eye on R1. Receptionist I stated she reported the incident to NHA A via phone. Activities Aide (AA) O was interviewed on 7/23/24 at 3:40 PM and stated on 7/04/24, around 3:30 PM, she was in the dining room for Bingo with a group of residents, and saw R2 looking down R1 shirt and R6 hand was on top of R2's pants, over his perineal area. AA O stated she wrote a statement and put it under NHA A's door. AA O stated she had witnessed R6 chase after R2. AA O stated she had also witnessed R2 and R6 with their hands down each others pants, behind the steam table, but did not remember the date. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Social Services (SS) C was interviewed on 7/19/24 at 2:00 PM and stated she was not aware of any additional details related to documentation of R3 checked for sexually inappropriateness, in behavior tracking task on 7/04/24 at 12:11 PM, 7/06/24 at 10:22 AM and 3:09 PM; and on 7/07/24 at 12:27 PM. SS C stated R3 had the potential to masturbate in the hallway. SS C stated when behaviors were documented in behavior tracking, she reviewed the care plan, discussed the behavior in the morning meetings and revised the care plan. SS C was unable to provide details of R2's behaviors of public sexual acts documented on 6/22/24 at 4:44 PM or on 7/04/24 at 11:32 AM; in which included cursing. SS C stated R2 and R3 had medication adjustments due to increase masturbation in inappropriate places. SS C stated she had no knowledge of an abuse allegation that involved R1 and other residents. NHA A was interviewed on 7/19/24 at 2:45 PM and stated the facility had an increase in resident sexual behaviors recently. NHA A stated she did not have any knowledge of any incidents that occurred with R1, R3 or R6 on 7/04/24. NHA A stated the facility did not have cameras, but cameras could be useful because of the layout of the building, and had recently received a quote. During an interview on 7/23/24 at 12:29 PM, LPN J stated on 7/04/24 at 11:09 AM, a CNA reported to her R2 was following R1 around and touched R1 breasts with his hands. LPN J stated she did not see R2 touch R1's breasts, but did observe R2 following R1 around that morning. LPN J stated R2 stalked people and acted like he was crazy, but R2 knew what he was doing. LPN J stated she reported the incident to DON B via text message on 7/04/24. Interim Director of Nursing (DON) B was interviewed on 7/24/24 at 11:21 AM and stated behaviors were reviewed in the morning meetings by reviewing the dashboard and notes. DON B stated she was not aware behaviors were documented in the tasks section of the medical record and had never run that report. DON B stated there was no morning meeting on 7/05/24, because most of the management team was off on vacation. DON B stated the first time she heard about the incidents that occurred on 7/04/24 with R1, R3, and R6 was on 7/23/24, during the survey. Resident #7 (R7) R7's significant change MDS assessment dated [DATE] revealed R7 had a BIMS score of 15 (13-15 Cognitively Intact). The same MDS assessment revealed R7 had the diagnoses of endometrial cancer, schizoaffective-bipolar type disorder, and obesity. An electronic mail (email) from hospice staff was sent to facility staff on 7/15/24 at 12:17 PM and indicated a concern regarding LPN J. The hospice staff stated they had spoken to LPN J many times; LPN J refused to give R7 additional food as requested or has removed food from R7's room. The email indicated LPN J had stated that she forced the nurse assistants to clean R7 up after R7 had refused. Hospice staff stated in the same email they had observed LPN J being very gruff and even rude toward residents, including residents that were not under hospice care. The same email indicated if R7 wished to eat chocolate pudding for every meal, then so be it. Interim DON B was interviewed on 7/19/24 at 1:30 PM and stated it was reported LPN J was rude and gruff to R7. DON B stated LPN J told R7 she did not need any more pudding because she weighed 500 pounds. DON B stated the incident with LPN J and R7 was first verbally reported on 7/12/24, and LPN J was terminated on 7/18/24. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	DON B was interviewed on 7/24/24 at 11:21 AM and stated she did not investigate allegations of abuse regarding R7. NHA A was interviewed on 7/24/24 at 12:09 PM and stated she did not investigate the allegation of abuse reported by hospice staff because she did not receive the email. NHA A stated she has had 6 DON's since December 2023, and the DON B did not know everything she was supposed to be doing. Abuse Prohibition Policy revised 9/09/22, revealed the Administrator or designee would notify any State or Federal agencies of allegations per state guideline (2 hours if abuse allegation or serious injury; all others not later than 24 hours). Facility assessment dated [DATE] indicated the facility was approximately 3200 square feet and the average daily census over the past 12 months was 62 residents. 26 residents had a diagnosis of dementia. 54 out of 62 residents were dependent or required staff assistance for dressing. 59 out of 62 residents were dependent or required staff assist for bathing. 49 out of 62 residents were dependent or required staff assist for transfers. 36 residents were dependent or required staff assist for eating. 52 out of 62 residents were dependent or required staff assist in toileting. Staff Schedule dated 6/27/24 indicated a census of 59 residents. 5 Certified Nurse Assistants (CNA's) were scheduled during the 6:00 AM to 6:00 PM shift. One CNA was scheduled to work from 6:00 AM to 10:00 AM and then go home. The same schedule indicated one restorative CNA was scheduled from 7:00 AM to 3:30 PM. There were multiple resident to resident sexual occurrences documented on 6/27/24, that indicated additional staff to supervise resident behavior may have prevented abuse. Staff Schedule dated 7/04/24 revealed a census of 59 residents. There were 5 Certified Nurse Assistants (CNA's) and 2 Nurses on the schedule to work day shift (6:00 AM to 6:00 PM). One CNA was assigned to be one to one with a resident that resided on 100 hall for the entire shift. There was one other CNA assigned to 100 hall. One CNA was noted as no call no show; and was scheduled to work from 8:00 AM through 6:00 PM on 200 hall. There were no CNA's assigned to 200 hall residents from 8:00 AM to 4:00 PM. 2 CNA's were on 300 hall. One CNA was scheduled on 400 hall from 6:00 AM to 3:30 PM. There were no CNA's scheduled on 400 hall from 3:30 PM to 6:00 PM. From 8:00 AM to 4:00 PM, there were 4 CNA's to care for 58 residents, 14 to 15 residents each. There was no restorative CNA scheduled on 7/04/24. During the survey from 7/19/24 through 7/23/24, Staff IP was interviewed and stated they recalled they had a call off on 7/04/24 and they had complained to management about the lack of enough staff. Staff D was interviewed during the survey from 7/19/24 through 7/23/24 and stated staffing on 7/04/24 was not adequate. During the survey from 7/19/24 through 7/23/24, Staff Q stated they was not enough staff on 7/04/24 and the Director of Nursing was notified. Staff Q stated they did not witness any abuse on 7/04/24, and stated they were too busy taking care of their residents to notice anything. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235569	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ovid Healthcare Center	9480 E M-21 Ovid, MI 48866

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the survey from 7/19/24 through 7/23/24 staff E stated staffing was really difficult on 7/04/24. One resident followed the ladies around with his hand down his pants and was hard to re-direct. During the survey from 7/19/24 through 7/23/24, staff F stated on 7/04/24, there was not enough staff to meet residents needs and they did not get a break or take a lunch. During the survey from 7/19/24 through 7/23/24, staff G stated staffing on 7/04/24 was rough. One CNA was pulled to work on another hall; but the nurse kept pulling them back to work on the hall they were pulled from. There was a fall, on 7/04/24; staff G stated they had just finished assisting another resident, when he heard another resident scream. The resident bumped his head when he fell , and was attempting to use the bathroom. Staff G stated they ended their employment at the facility due to low staffing and poor resident care. Scheduler/CNA R was interviewed on 7/23/24 at 3:36 PM and stated they have budgeted hours and divide by census to determine staffing. Scheduler/CNA stated when the census drops they send staff home. Scheduler/CNA R stated 6 CNA's run a lot smoother during the day. Scheduler/CNA R stated on 7/04/24, had a craziness going on, and did not like to see that. On 6/27/24 they had 5 CNA's that day due to the census. Interim Director of Nursing (DON) B was interviewed on 7/24/24 at 11:21 AM and stated there was no morning meeting on 7/05/24, because most of the management team was off on vacation.