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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245425 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/15/2024 |
| NAME OF PROVIDER OR SUPPLIER Thorne Crest Retirement Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Garfield Avenue Albert Lea, MN 56007 | |

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) |
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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42355</p> <p>Based on observation, interview, and document review the facility failed to immediately implement appropriate interventions to protect residents from sexual abuse from R1 who had sexual behaviors that were inflicted on 6 residents (R2, R3, R4, R6, R7, R9) in the facility which resulted in a potential risk of serious harm identifying immediate jeopardy.</p> <p>The IJ began on 10/6/24, when facility failed to implement protection measures after staff observed R1 inappropriately touching R2's breast/chest area on 10/6/24. The administrator, director (DON) and assistant director of nursing (ADON) were notified of the IJ on 10/11/24 at 4:43 p.m. The immediate jeopardy was removed on 10/13/24 at 9.11 a.m. but noncompliance remained at the lower scope and severity level 2 E - pattern scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings include:</p> <p>Review of facility reported incident dated 10/7/24 at 3:05 p.m., indicated on 10/6/24 around 11:50 a.m., nursing assistant (NA-A) walked out to the day room and saw R1 had his right hand under R2's shirt and appeared to be doing a rubbing/grabbing in a circular motion on R2's chest area. NA-A ran over to R1, grabbed his hand, and said no. NA-A stayed with R1 and R2 and called for licensed practical nurse (LPN-A) to come right away to the day room. LPN-A removed R2 to behind the nurse' station and NA-A took R1 to his room.</p> <p>R1's face sheet included diagnoses of dementia without behavioral disturbance, memory deficit following a cerebrovascular disease, epilepsy (seizure disorder) and hearing loss. R1 was admitted to facility on 6/11/24 from another skilled facility.</p> <p>R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated moderately impaired cognition, poor decisions, required cues and supervision, with signs and symptoms of delirium without inattention, disorganized thinking or altered level of consciousness. R1 used a walker and a wheelchair with maximal assistance from staff for dressing, transfers, and bed mobility. R1 had no delusions or hallucinations, no behaviors, wandering or rejection of cares noted.</p> <p>(continued on next page)</p> |

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

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p> | <p>During an interview on 10/15/24 at 2:32 p.m., family member (FM)-B stated R1's wife would complain about R1 being touchy, towards the end of her life. R1 had problems with inappropriately touching female residents at previous facility and was why R1 was moved to this facility. FM-B was hopeful that the move would resolve the problem.</p> <p>R1's progress note dated 6/10/24 at 2:21 p.m., R1 was admitted to facility. The note did not identify history of behaviors.</p> <p>R1's physician visit note dated 6/13/24, indicated new admit from a previous facility with behavioral issues and was having problems swallowing his medications whole. R1's Depakote (antiseizure medication also used for behaviors) and Paroxetine (antidepressant) were discontinued. The note indicated R1 had normal behavior, mood, and affect.</p> <p>R1's physician visit dated 6/21/24, noted R1 had lots of behavioral problems, specially making sexual advances towards women at previous facility and continued at this facility. This behavior was a source of concern and embarrassment for family, and they asked for a medication to decrease R1's libido. MD-A re-started low dose of paroxetine to help with behaviors. Nurses to continue with respiratory and behavior monitoring. In review of R1's record, there was no documentation of any behaviors that were referenced in the physician note.</p> <p>R1's progress note dated 6/22/24 at 12:59 p.m., indicated staff reported to nurse, with wake up cares R1 was grabby with the staff and attempting to touch staff buttocks. Staff kindly removed R1's hands and reminded R1 to keep to himself. Note further indicated after lunch time another staff reported R1 was sitting at in the dining room with residents that needed staff assistance to eat when R1 went up to the resident from [room x-unidentified resident]. and put both his hands on her shoulders. Staff intervened and reminded R1 to keep his hands to himself.</p> <p>R1's progress note dated 7/3/24 at 9:50 a.m., care conference held and indicated the Paxil started on 6/21/24 had been helpful with R1's behaviors.</p> <p>R1's behavior care plan initiated on 7/18/24, included Problematic manner in which resident acts characterized by inappropriate sexual behavior (verbal and physical) related to R1 makes inappropriate remarks, resident touches other female residents and/or staff inappropriately The care plan directed the following:</p> <ul style="list-style-type: none"> -Avoid type of conversation that could encourage or initiate inappropriate behavior, dated, 7/18/24; -Constant supervision in recreation programs, dated 7/18/24; -distract R1 if possible, dated 7/18/24; -document a summary of each episode, dated 7/18/24; -Remove R1 from the public area when behavior was disruptive/unacceptable. Talk with R1 in low pitch, calm voice to decrease/eliminate undesired behavior and provide diversional activity, date 7/18/24. <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p> | <p>R1's progress note dated 7/23/24 at 10:49 p.m., indicated R1 went into other resident's rooms, especially [room x-unidentified resident]. R1 was removed and easily redirected. No further occurrences from R1.</p> <p>R1's progress note dated 7/24/24 at 5:25 p.m., indicated R1 was noted to enter other residents' rooms on 7/23/24, no physical contact was made. R1 has history of inappropriate behaviors. Care conference scheduled for 8/2/24 with FM-B and MD-A to review plan of care and current medications to see what else can be done to manage R1's behaviors. R1 put on 15-minute checks to ensure R1 has no behaviors towards other residents.</p> <p>R1's behavioral care plan was revised on 7/24/24, included 15-minute checks to protect other residents from R1's behavior and entering other residents' rooms, dated 7/24/24.</p> <p>During an interview on 10/10/24 at 4:39 p.m., social worker (SW-A), indicated R1 had inappropriate sexual behaviors at previous facility when he was admitted to Thorncrest. SW-A stated no preventative or protection interventions were put into place until 15-minute checks were implemented on 7/24/24, when R1 had inappropriate interactions with R3.</p> <p>R1's progress note dated 7/30/24 at 10:44 p.m., staff member mentioned they overheard R1 in living room state to visitors I'd like to borrow your keys to take R3 out on a date. After super R1 was noted to be moving self-closer to R3. R1 was redirected and moved away female residents. No further concerns noted or reported, will continue to monitor.</p> <p>R1's progress note dated 8/1/24 4:43 p.m., writer noted R1 sitting right in front of R3, who R1 has bothered in the past. R3 looked uncomfortable as R1 was directly in front of R3's wheelchair. Writer took female resident aside. R3 informed writer R1 was not doing or saying anything but would prefer R1 not sitting by her. Writer informed nurse and nurse aide working to monitor. R3's record included a progress note dated 8/1/24, that identified the aforementioned encounter.</p> <p>R3's quarterly MDS dated [DATE], indicated R3 did not have cognitive impairment. R3 had diagnoses of end stage renal disease and diabetes. R3 required moderate assistance with ADLs, wheelchair use and did not walk.</p> <p>R3's progress note dated 6/15/24, identified staff reported R3 initiated hand holding with R1 and R3 told staff she was old friends with R1, R1's record did not identify this encounter.</p> <p>R3's record included a progress note dated 7/19/24, identified activity aide (AA)-A overheard R1 asking R3 for a kiss in the dayroom but R3 denied R1 and R1 moved to a different area of the dayroom, R1 record did not identify this encounter.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p> | <p>During an interview on 10/11/24 at 9:44 a.m., R3 was sitting in her wheelchair in her room watching TV. R3 stated she knew R1 from the past. R1 on several occasions would roll up to her in his wheelchair, reach over and hold her hand. R3 was okay with this until R1 rolled into her room and told her You and me and pointed to her bed. R3 put on call light and staff came to remove R1 from R3's room. R3 recalled another incident where R1 was holding her hand and tried to move her had to his private area (penis). R3 stated that made her very uncomfortable. Staff saw what R1 was doing so they removed him from her personal space. Staff have told both R1 and R3 they needed to stay 4 feet away from each other. R3 was not able to remember the dates of either incidents. R3 did not want to ever be close to R1 as she felt he was inappropriate with his actions. In review of R1's and R3's records it did not address these encounters as R3 described and/or could not be ascertained if these incidents were accounted for in the record as they were not specified.</p> <p>During an interview on 10/11/24 at 10:19 a.m., NA-C stated she thought R1 behaviors started a couple of months ago, not sure on date but was able to remember when R1 was admitted , it was mentioned that he had sexual inappropriate touching at previous facility. NA-C stated R1 and R3 needed to be kept separated and R1 was on 15-minute checks since his behaviors had started. NA-C did not think the 15 minute checks were adequate; R1 was independent with wheelchair mobility.</p> <p>During an interview on 10/11/24 at 9:22 a.m., LPN-B stated she did the admission for R1 when he first came to facility in June of 2024. R1's record from the previous facility included notes about R1 sexually touching female residents inappropriately. After R1 was admitted here he started holding hands with R3 and going into R3's room. R3 did not like this, so staff were to try to keep an eye on him and do 15-minute checks. LPN-B did not think the 15- minute checks were adequate because R1 was independent in his wheelchair and he was quick.</p> <p>During and interview on 10/11/24 at 12:41 p.m. R5 who was a male resident reported he was familiar with R1. One day he witnessed R1 rolling up behind a female resident and put his hands right up her shirt. R5 could not recall if there had been staff in the vicinity at the time nor remember if he had reported the incident to staff. R5 could not recall the female residents name she had discharged and could not remember the date but That is something you will never forget! R5's quarterly MDS dated [DATE], identified R5 had moderate cognitive impairment.</p> <p>R1's progress note dated 9/26/24 at 2:09 p.m., indicated R1 followed a resident into their room. R1 was removed and redirected. The note did not identify if R1 had been directly observed going into the room.</p> <p>R1's progress note dated 10/4/24 at 11:17 a.m., indicated R1 was attempting to hold a female resident's hand while she was sleeping. Nurse intervened and separated residents. The note did not identify which female resident, location of this interaction nor the duration.</p> <p>R1's progress note dated 10/5/24 at 11:32 a.m., R1 wandered into a resident's room. Was easily redirected. The note did not identify if R1 was directly observed going into resident's room and what R1 was doing or where R1 was in the room when he was redirected.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p> | <p>An undated and untimed facility video recording that was approximately two minutes long was reviewed. At the start of the video a total of 14 residents sat in a semi-circle facing the same direction in front of the nursing station. R1 sat in his wheelchair next to R2's left side. R1 was holding onto R2's right lower arm while R2 had her head resting on her left hand with her eyes closed. Housekeeper (HSK-A) can be seen riding a floor cleaning machine directly behind the residents; he made several passes and did not look towards R1 and R2. At 42 seconds, R1 looked toward R2 and moved his hand up her arm towards R2's chest. HSK-A came back into the picture and did not look toward R1 or R2. At 54 seconds, R1 moved his right hand around R2's chest area and held R2's right hand with his left hand. At one minute marker, R1's right hand went under R2's shirt. At 1 minute 15 seconds, a staff member walked directly behind R1 and R2, she did not turn her head to see R1's hand was up R2's shirt; the staff continued to walk by without intervention. At one minute 18 seconds, licensed practical nurse (LPN)-A brought a resident into the commons area by the medication cart and left without looking toward R1 and R2. R1 continued to move his right hand around under R2 shirt while holding R2's right lower arm with his left hand. At one minute 30 seconds, R1 placed R2's right hand on his right thigh as he continued to move his right hand under R2's shirt as HSK-A went by again in the floor cleaning machine. At 1 minute 35 seconds, R2 leaned back in her wheelchair and lifted her head up. At one minute 45 seconds, a female staff person in blue and white returns and as she went by looked at R1 and R2 and stopped, turned around and told R1 No in a stern voice and removed his hand from under R2's shirt. Staff person pulled down R2's shirt and called out for LPN-A to come right away at one minute 54 seconds. The video concludes when LPN-A entered the room.</p> <p>R1's progress note dated 10/7/24 at 11:39 a.m., indicated R1 was caught with his hands up a female resident (R2) shirt in the day room on 10/6/24 at 11:50 a.m. It was reported R1's right hand was under R2's shirt and R1 was rubbing, grabbing, and making circular motions on R2 chest area. Staff immediately intervened by removing R1 back to his room. R1 was not allowed to sit next to other female residents in the day room or dining room, this will continue to prevent another inappropriate interaction. NP-A was consulted on medications and order received to increase Paxil to 20 mg daily and to follow up with physician assistant (PA) on 10/17/24 for effectiveness.</p> <p>R1's care plan was not revised to identify the intervention for R1 to not allowed to sit next to female residents in the dining room and the day room. Additionally, R1's record did not identify a comprehensive assessment that would identify the level of supervision R1 required, no changes were made to duration in which R1 was checked on.</p> <p>R2's quarterly MDS dated [DATE], indicated R2 had severe cognitive impairment, required moderate assistance with her activities of daily living (ADLs). R2's diagnoses included cancer, heart failure, and depression.</p> <p>R2's care plan dated 10/10/24 did not address her vulnerabilities.</p> <p>Review of R2's progress note dated 10/7/24 at 12:01 p.m., addressed the incident in which R1 inappropriately touched R2 on 10/6/24 at 11:50 a.m. LPN-A was notified and took R2 behind the nurses' station for observation. R2 did not appear to be disturbed or upset by this happening. No marks noted on skin.</p> <p>During an interview on 10/10/24 at 2:29 p.m., R2 was not able to articulate the correct date or year, however was aware she was in [NAME] Lea, Minnesota. R2 denied anyone touched her inappropriately.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p> | <p>During an interview on 10/15/24 at 2:49 p.m., NA-L stated she would feel embarrassed, feel very violated and affect her dignity if someone were to come up to her and start feeling their chest area.</p> <p>During an interview on 10/15/24 at 3:05 p.m., ADON stated would feel violated if someone were to come up to her and start feeling their chest area.</p> <p>During an interview on 10/15/24 at 3:08 p.m. NA-C stated she would feel very upset, violated, and fearful if someone were to come up to her and start feeling their chest area.</p> <p>During an interview on 10/11/24 at 9:15 a.m., a white board was used to communicate with R1. R1 articulated the month, the year, and the town he lived in. R1 denied inappropriately touching female residents, stating bullshit, when asked. R1 denied any problems with the staff or other residents.</p> <p>During an interview on 10/11/24 at 9:01 a.m., HSK-A stated his job was to take care of the floors. He had not been told to monitor or keep an eye on any specific resident.</p> <p>During an interviews on 10/10/24 at 4:15 p.m. and 10/11/24 at 10:03 a.m., NA-A stated when R1 was first admitted to the facility she was not informed R1 had sexually inappropriate behaviors prior to admission to the facility, she was told to just watch if he tried to touch female residents but not why. She later became aware NA-A explained R1 went into other resident's rooms about three times per week, usually happened around mealtimes when staff were not available to make sure he would go back to his room after he ate. NA-A stated she had witnessed the incident between R1 and R2 on 10/6/24 around 11:50 a.m. NA-A was walking back to her unit by the dayroom, when she saw R1's right hand under R2's shirt and seemed to be grabbing and rubbing at R2's chest area. NA-A ran over to the residents and removed R1's hand from under R2's shirt and told R1 No and then yelled for LPN-A to come to day room. LPN-A removed R2, and NA-A took R1 to his room. NA-A did not know how long R1's hand had been under R2's shirt as was not working that unit. NA-A stated she was aware R1 had history of sexually inappropriate behaviors including inappropriately touching female residents. NA-A was aware R1 had demonstrated sexually inappropriate behaviors toward three other female residents R3, R4, and R6. NA-A explained she went into R3 and R6's room, R6 was in the bathroom on the toilet with the door open, R1 was sitting in his wheelchair watching R6 while she was in the bathroom. NA-A recalled another time where she had seen R1 holding R4's hand in the day room, however could not remember the date. NA-A stated the 15 minute check intervention had been in place for a couple of months, additional interventions were to redirect R1 back to his room and make sure he was not at a table with female residents. NA-A stated she did report the incidents with R3, R4, R6 to her nurse but because she worked with multiple nurses she could not recall which nurse she had reported to. In review of R1's, R4's, and R6's records it did not address these encounters as NA-A described and/or could not be ascertained if these incidents were accounted for in the record as they were not specified.</p> <p>R4's significant change MDS dated [DATE], indicated R4 had moderate cognitive impairment and had diagnoses of dementia and anxiety. R4 required moderate to maximal assist with ADL's.</p> <p>R6's quarterly MDS dated [DATE], indicated R6 did not have cognitive impairment with diagnoses of cancer, end stage renal disease, stroke, traumatic brain injury and depression. R6 required moderate to maximal assist with ADLs.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p> | <p>During an interview on 10/10/24 at 2:45 p.m., NA-K stated R1 was on 15-minute checks because R1 self-transferred and R1 liked to grope female residents in inappropriate ways. R1 had touched another female resident (R3) inappropriately in the past and that was when the 15-minute checks started. NA-K stated staff were supposed to keep R1 away from female residents and redirect him. NA-K did not think the 15 minute checks were adequate.</p> <p>During an interview on 10/10/24 at 3:08 p.m., RN-E stated when R1 was admitted from another facility where he had been handsy with female residents and was asked to move out. When he was admitted here staff found out R1 knew R3. R1 would go up to R3 and put his hand on her thigh, that's when the 15-minute checks were implemented. RN-E indicated the incident happened in either June or July, but could not recall the exact date. RN-E stated R1 liked to go into other resident rooms, mainly female's rooms but was easily redirected out. In a subsequent interview on 10/15/24 at 3:57 p.m., RN-E was not able to articulate any protective/preventative measure put into place to protect female residents in facility aside from the 15-minute checks. RN-E did not think the 15-minute checks were adequate.</p> <p>During an interview on 10/11/24 at 10:16 a.m., HSK-B stated has not been told to keep watch on any certain residents or certain residents should not be together.</p> <p>During an interview on 10/11/24 at 12:34, MD-A stated he was both R1's and R2's primary care physician. MD-A was not made aware of the incident regarding R1 and R2. MD-A remembered starting the low dose paroxetine for R1's libido but had not heard of any incidents since the start of the medication in June and thought it was helping. It was his expectation the facility notify the physician and the protocol for abuse be followed to keep the residents free from abuse.</p> <p>During an interview on 10/15/24 at 12:51 p.m., DON stated when she had first been notified of the incident between R1 and R2 on 10/6/24 via text message, she did not think too much of it because she was not aware of R1's sexual behaviors or his history until the incident with R2. Had she known the history she would have come into the facility after the incident to start the investigation and to ensure resident protections were implemented. DON stated she had not been aware of the incident in which R5 reported pertaining to R8. DON reviewed R1's record and indicated the documentation of R1's behaviors were not thorough, the documentation for 15-minute checks was not always completed and did not identify specific information on R1's whereabouts or what he was doing, and did not identify incidents as reported to surveyor by nursing staff and residents. DON would have expected more documentation on R1's behaviors and report all incidents or allegations of inappropriate sexual behaviors. DON further stated bringing in a resident with sexual behaviors is like bringing in a resident with new medical condition. It takes training to learn how to prevent the incident from happening. DON did not think that the 15 minute checks were adequate and implemented that R1 not sit next to female residents in activities or the dining room after the incident occurred on 10/6/24.</p> <p>Review of facility ' s abuse policy titled Preventing Resident Abuse dated 12/19, did not address the protection of residents from abuse. The policy indicated: policy statement: Our facility will not condone any form of resident abuse and will continually monitor our facility ' s policies, procedures, training program, systems, ect., to assist in preventing resident abuse.</p> <p>j. assessing, care planning, and monitoring residents with needs and behaviors that may lead to conflict, or neglect.</p> <p>(continued on next page)</p> | | |

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| NAME OF PROVIDER OR SUPPLIER Thorne Crest Retirement Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Garfield Avenue Albert Lea, MN 56007 | |
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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p> | <p>k. assessing with resident and symptoms of behavior problems and developing and implementing individualized care plans to address behavioral issues.</p> <p>The IJ was removed on 10/13/24 at 9:11 a.m., when it was verified, the facility completed the following actions:</p> <ul style="list-style-type: none"> -The facility reviewed and updated their abuse policy and procedure pertaining to resident-to-resident sexual abuse - R1 ' s care plan was updated with 1:1 while awake to prevent him from having contact with vulnerable females related to his sexual inappropriate touching. -R1 will have a video monitor on while sleeping. -R1 is not to be left by any female residents at any time. -The facility provided education to all facility staff on the policy and on immediate implementation of individualized care plan and protection measures. -The facility completed trauma informed care assessments and care plan updated, on the residents affected by R1 ' s behaviors. | | |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>42355</p> <p>Based on interview and document review the facility failed to timely report actual inappropriate unwanted touching and/or allegations of sexual abuse to the facility administrator/designee and to the State Agency (SA) for 6 of 6 residents (R2, R3, R4, R6, R7, R9) reviewed for abuse.</p> <p>Finding include:</p> <p>Review of facility reported incident #358192 dated 10/7/24 at 3:05 p.m., submitted by social worker (SW-A) indicated on 10/6/24 around 11:50 a.m., NA-A walked out to the day room and saw R1 had his right hand under R2's shirt and seemed to be doing a rubbing/grabbing in a circular motion on R2's chest area. NA-A ran over to R1, grabbed his hand, and said no. NA-A stayed with R1 and R2 and called for LPN-A to come right away to the day room. LPN-A removed R2 to behind the nurse' station and NA-A took R1 to his room.</p> <p>R1's progress note dated 10/7/24 at 11:39 a.m., indicated R1 was caught with his hands up a female resident (R2) shirt in the day room on 10/6/24 at 11:50 a.m. It was reported R1's right hand was under R2's shirt and R1 was rubbing, grabbing, and making circular motions on R2 chest area. Staff immediately intervened by removing R1 back to his room.</p> <p>During an interview on 10/10/24 at 3:17 p.m., licensed practical nurse (LPN-A), called assistant director of nursing (ADON) to report the incident above around 11:50 a.m. on 10/6/24. LPN-A received a phone call back from ADON before she left her shift at 1:30 p.m. ADON stated she had called the DON and needed to have NA-A write a statement before she left for the day and the DON would be in later to do the report.</p> <p>During an interview on 10/10/24 at 4:25 p.m., ADON stated she was made aware of the incident around lunch time on 10/6/24. ADON then made DON aware and was told by DON that she was going to speak to R1 about the incident. ADON was able to articulate this was a reportable incident but not able to state the time frame in which the abuse needed to be reported to the SA. ADON further stated she did not have reporting privileges to the SA, only Administrator, DON, and SW-A.</p> <p>During an interview on 10/10/24 at 4:39 p.m., SW-A stated she was made aware of incident on 10/7/24 around 9:00 a.m., during morning meeting. SW-A found out around 10:00 a.m., the incident had not been reported and was told by DON the incident was not a reportable incident. SW-A then contacted corporate who she reviewed incident with, they directed her to make the report to the SA and to report it to local law enforcement. SW-A reported to law enforcement and to SA.</p> <p>(continued on next page)</p> | | |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interviews on 10/10/24 at 4:15 p.m. and 10/11/24 at 10:03 a.m., NA-A stated she had witnessed the incident between R1 and R2 on 10/6/24 around 11:50 a.m. NA-A ran over to the residents and removed R1's hand from under R2's shirt and told R1 No and then yelled for LPN-A to come to day room. LPN-A removed R2, and NA-A took R1 to his room. NA-A was aware R1 had demonstrated sexually inappropriate behaviors toward three other female residents R3, R4, and R6. NA-A explained she went into R3 and R6's room, R6 was in the bathroom on the toilet with the door open, R1 was sitting in his wheelchair watching R6 while she was in the bathroom. NA-A recalled another time where she had seen R1 holding R4's hand in the day room, however could not remember the date. NA-A stated she did report the incidents with R3, R4, R6 to her nurse but because she worked with multiple nurses she could not recall which nurse she had reported to.</p> <p>In review of R1's, R3's, R4's, and R6's records it did not address these encounters as NA-A described and/or could not be ascertained if these incidents were accounted for in the record as they were not specified.</p> <p>During an interview on 10/11/24 at 9:44 a.m., R3 was sitting in her wheelchair in her room watching TV. R3 stated she knew R1 from the past. R1 on several occasions would roll up to her in his wheelchair, reach over and hold her hand. R3 was okay with this until R1 rolled into her room and told her You and me and pointed to her bed. R3 put on call light and staff came to remove R1 from R3's room. R3 recalled another incident where R1 was holding her hand and tried to move her had to his private area (penis). R3 stated that made her very uncomfortable. Staff saw what R1 was doing so they removed him from her personal space. Staff have told both R1 and R3 they needed to stay 4 feet away from each other. R3 was not able to remember the dates of either incidents. R3 did not want to ever be close to R1 as she felt he was inappropriate with his actions.</p> <p>During an interview on 10/10/24 at 3:08 p.m., registered nurse (RN)-E stated R1 would go up to R3 and put his hand on her thigh. RN-E indicated the incident happened in either June or July, but could not recall the exact date.</p> <p>In review of R1's and R3's records it did not address these encounters as R3 described and/or could not be ascertained if these incidents were accounted for in the record as they were not specified.</p> <p>During an interview on 10/11/24 at 12:40 p.m., RN-A stated she had witnessed R1 wheel over to R4 when she slept in her wheelchair in the day room. R1 reached over, held her hand and rubbed it. RN-A took R1 to his room. RN-A explained in another incident R9 had told her R1 was trying to hold her hand while R9 was waiting at the medication cart but R9 was able to move herself away. RN-A reviewed R1's record and reported the incidents were not documented. During a subsequent interview on 10/15/24 at 12:11 p.m. RN-A stated she did not report these incidents to her supervisors because she thought it was harmless hand holding and did not know of R1's history of inappropriate sexual behaviors. RN-A could not remember specific dates of either incident but recalled they both had been within the last month.</p> <p>During an interview on 10/15/24 at 12:51 p.m., DON stated she did not know of R1's background, otherwise would have come in on 10/16/24 and made report and started investigation. DON stated all abuse needs to be reported with in two-hour timeframe from time of incident.</p> <p>Review of facility policy Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, dated 9/2022; indicated the following:</p> <p>(continued on next page)</p> | | |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>1.If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law.</p> <p>3.Immediately is defined as:</p> <p>a: within two hours of an allegation involving abuse or result in serious bodily harm; or</p> <p>b: within 24 hours of an allegation that does not involve abuse or result in serious bodily harm.</p> | | |