STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/16/2024
NAME OF PROVIDER OR SUPPLIER Lafayette Center		STREET ADDRESS, CITY, STATE, ZIP CODE 93 Main Street Franconia, NH 03580	

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 - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 37488 Based on record review and interview it was determined that the facility failed to ensure that a resident was free from abuse for 1 of 3 residents reviewed for abuse (Resident Identifier #5). Findings include: Review on 8/7/24 of Resident #5's medical record revealed the following diagnosises: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. Further review of the medical record that Resident #5 has a Brief Interview for Mental Status (BIMS) of 3. Review on 8/7/24 of a facility reported incident, dated 5/9/24, revealed that on 5/5/24, Resident #2 was observed by a staff member with his/her hand down the pants of Resident #5. Interview on 8/7/24 with Staff A (Activities Director) revealed on 5/5/24, Staff A observed Resident #2 with his/her hand down the pants of Resident #5. Further interview revealed that Staff A was aware of multiple incidents of Resident #2 being sexually inappropriate with residents who have cognitive issues. Interview on 8/7/24 at approximately 11:50 a.m. with Staff H (Licensed Nursing Assistant (LNA)) revealed that on 7/27/24, he/she observed Resident #5 lying in bed and Resident #2 was positioned with his/her right hand on Resident #5's left shoulder and Resident #2's other hand was rubbing back and forth on Resident #5's genital area. Interview on 8/16/24 at approximately 8:30 a.m. with Staff K (LNA) revealed that on 8/13/24 around dinner time, Staff K had witnessed Resident #1 touching Resident #5 at the top of their inner thigh near their genital area. Staff K stated that he/she immediately separated the residents and reported the incident to Staff M (Licensed Practical Nurse (LPN)) because it was inappropriate. Interview on 8/19/24 at approximately 1:20 p.m. with Staff L (LNA) revealed that Staff L witnessed Resident #1 run his/her hand up Resident #5's leg to where [pronoun omitted] leg meets [pronoun omitted] crotch. Staff L further revealed that he/she was not aware of any interventions in place for Resident #1 to prevent inappropriate behaviors. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/16/2024
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review on 8/7/24 of Resident #2's medical record revealed that Resident #2 had a BIMS of 12 with no cognitive or mood related diagnosis. Review on 8/7/24 of Resident #2 care plan revealed a focus for potential to exhibit physical behaviors related to poor impulse control and adjustment disorder with depressed mood, created on 5/29/24, revealed the following interventions: Evaluate need for Psych/Behavioral Health consult, initiated on 5/29/24, Encourage resident/patient to seek staff support for distressed mood, initiated on 5/29/24, and Divert resident/patient by giving alternative objects or activities, created on 5/29/24. Further review Resident #2's care plan revealed a care plan for tendency to exhibit sexually inappropriate behavior related to: lack of disinhibition, created on 4/1/24 and revised on 5/6/24, with the following interventions: Evaluate need for Psych/Behavioral Health consult, initiated on 5/9/24, Provide psychosocial rehabilitation education regarding appropriate sexual behavior through use of Meditelecare, initiated on 5/9/24, When sexually inappropriate behaviors occur, approach [name omitted] in a calm, unhurried manner, reassure as necessary, initiated on 4/1/24 and revised on 5/9/24. Review on 8/7/24 of Resident #1's medical record revealed that Resident #2 had a BIMS of 3 and the following diagnsosises: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. Review on 8/7/24 of Resident #1's care plan revealed a focus for the potential to demonstrate verbal/physical behaviors toward others related to ineffective coping skills, with an intervention to provide 1:1 care when up in wheel chair, created on 8/7/24.

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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 - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 43408 Based on interview and record review, it was determined that the facility failed to ensure that alleged violations of abuse were reported immediately to the State Survey Agency (SSA) for 3 of 4 allegations of abuse reviewed (Resident Identifiers are #1, #2 and #3). Findings include: Review on 8/7/24 of the facility policy titled, Abuse, Neglect and Exploitation, revised on 01/2024, revealed: . VII Reporting/Response .1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframe's: a. Immediately, but not later than 2 hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury . Resident #2 Review on 8/7/24 of a facility reported incident, reported to the State Agency on 7/28/24 at 6:02 a.m., revealed that Resident #2 was observed by Staff H (Licensed Nursing Assistant (LNA)) with his/her right hand on Resident #5's left shoulder and his/her other hand placed on the genital area of Resident #5 on 7/27/24 at 8:30 a.m Interview on 8/7/24 at approximately 11:50 a.m. with Staff H (LNA) revealed that on 7/27/24, Staff H observed Resident #2 with his/her hands on the outside of Resident #5's clothing rubbing and squeezing his/her genital area. Staff H stated they immediately notified Staff I (Nurse). Interview on 8/7/24 at approximately 11:40 a.m. with Staff I revealed that on 7/27/24, Staff H reported to Staff I that Resident #2 was in Resident #5's room and was rubbing Resident #5's genital area. Staff I also revealed that he/she wrote a note for Staff J (Assistant Director of Nursing) about the incident and left it in their mailbox because Staff J was not in the facility. Interview on 8/7/24 at approximately 1:00 p.m. with Staff F (Director of Nursing) confirmed that the incident with Resident #2 and Resident #5 occurred on 7/27/24 and was reported to the SSA on 7/28/24, more than 2 hours after the incident. Resident #3 Review on 8/7/24 of a facility reported incident, reported to the State Agency on 8/6/24 at 1:38 p.m., revealed that Resident #4 had fallen, possibly due to an altercation with Resident #3. Interview on 8/7/24 at approximately 12:40 p.m. with Staff G (Social Services) revealed that on the morning of 8/1/24, Resident #4 had told Staff G that they were attacked by another resident the night before. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lafayette Center	93 Main Street Franconia, NH 03580

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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 - Few	Interview on 8/8/24 at approximately 7:25 a.m. with Staff C (Registered Nurse) revealed that on the evening of 7/31/24, Staff C had heard a commotion coming from Resident #4 room. Staff C had responded to the commotion and had seen Resident #3 exiting Resident #4's room. Resident #4 was on the floor inside the doorway when staff arrived. Resident #4 had stated that Resident #3 had hit them and caused them to fall. Interview on 8/7/24 at approximately 9:00 a.m. with Staff F confirmed that the incident with Resident #3 and Resident #4 had occurred on 7/31/24 was reported to the SSA on 8/6/24, more than 2 hours after the allegation was made. Resident #1 Interview on 8/16/24 at approximately 8:30 a.m. with Staff K (LNA) revealed that Staff K had witnessed an interaction between Resident #1 and Resident # 5 on 8/13/24 around dinner time. Interview further revealed that Resident #1 was seen touching Resident #5 on [pronoun omitted] inner thigh almost to [pronoun omitted [genital area]. Staff K stated that Resident #5 was visibly upset. Staff K stated that he/she immediately separated the residents and reported the incident to Staff M (Licensed Practical Nurse). Interview on 8/16/24 at approximately 10:00 a.m. with Staff E (Administrator) confirmed that the incident with Resident #1 and Resident #5 had occurred on 8/13/24 and had not been reported to the SSA.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 43408 Based on observation, interview, and record review, it was determined that the facility failed to revise care plans for 2 of 3 residents reviewed for abuse (Resident Identifiers are #1 and #3). Findings include: Resident #1 Review on 8/7/24 of a facility reported incident revealed that Resident #1 was observed by Staff B (Licensed Nursing Assistant) with his/her hand placed on the genital area of Resident #6 on 7/28/24 at 4:40 p.m. Review on 8/7/24 of Resident #1's medical record revealed a provider progress note, dated 7/30/24, that stated Resident #1 had been seen for increased sexual behaviors towards others and also indicated staff reported increased wandering behaviors with difficulty to redirect. Review on 8/7/24 of Resident #1's care plan revealed a care plan for the potential to demonstrate verbal/physical behaviors towards others related to ineffective coping skills, created on 7/1/24 and revised on 7/15/24. Resident #1's behavior care plan revealed the following interventions: Evaluate need/provide for Psych/Behavioral Health consultation, created on 7/15/24. Further review of Resident #1's care plan revealed no other interventions were added for behaviors. Resident #3 Interview on 8/7/24 at approximately 12:40 p.m. with Staff G (Social Services) revealed that on the morning of 8/1/24 that Resident #4 had informed Staff G that they were attacked by another resident the night before. Interview on 8/8/24 at approximately 7:25 a.m. with Staff C (Registered Nurse) revealed that on the evening of 7/31/24 Staff C had heard a commotion coming from Resident #4's room. Staff C had responded to the commotion and had seen Resident #3 exiting Resident #4's room. Resident #4 was on the floor inside the doorway of their room when staff arrived. Resident #4 had stated that Resident #3 had hit them and caused them to fall. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review on 8/7/24 of Resident #3's care plan revealed a care plan for potential to demonstrate verbal behaviors related to: Cognitive loss/ Dementia; and shaves head at times initiated on 8/23/23. Resident #3's behavior care plan identified the following interventions: If resident requests/attempts to shave head attempt to discourage from activity using calm, gentle approach and if unable to redirect, assure safety during activity, created on 8/23/23, Evaluate need/provide Psych/Behavioral Health consultation, created on 8/23/23, Explain all care, including procedures (one step at a time), and the reason for performing the care before initiating, created on 8/23/23, Provide consistent, trusted caregiver and structured daily routine, when possible, created 8/23/23, Remove resident/patient from environment, if needed. Gently guide the resident from the environment while speaking in a calm, reassuring voice, created on 8/23/23, Provide environment that is conducive to the patients ability to get adequate sleep and maintain preferred sleep/wake schedule, created 8/23/23, Allow time for expression of feelings, provide empathy, encourage, and reassurance, created 8/23/23. Further review of Resident #3's care plan revealed no other behavior care plans. Interview on 8/8/24 at approximately 1:10 p.m. with Staff F (Director of Nursing) revealed that Resident #1 and Resident #3 both had a room change in response to allegations and medication review requested in response to the above incidents.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 37488 Based on observation, interview and record review it was determined that the facility failed to ensure that residents who are trauma survivors were free from re-traumatization for 1 of 1 residents reviewed for trauma (Resident Identifier #4). Findings include: Review on 8/7/24 of a facility reported incident revealed Resident #4 yelled out for help. Staff observed Resident #3 exiting Resident #4's room. Resident #4 was found lying on the floor with a hematoma to the top right side of his/her head, a skin tear to the right elbow and complaints of rib pain. Interview on 8/7/24 at approximately 12:40 p.m. with Staff G (Social Services) revealed that Resident #4 had told Staff G that he/she had a past history of trauma. Staff G further revealed that Resident #4's daughter had revealed to Staff G that Resident #4 had a past history of trauma. Interview on 8/7/24 at approximately 1:15 p.m. with Resident #4 revealed that he/she remembered Resident #3 coming to his/her room and hitting him/her. Resident #4 stated that he/she had a traumatic past and was upset with Resident #3 trying to get into the room. Resident #4 further revealed that the lanyard that was worn around his/her neck with a whistle at the end is in case Resident #3 comes close to him/her. Review on 8/7/24 of Resident #4's medical record revealed a nurses note written by Staff C (Registered Nurse) that documented that Resident #3 entered Resident #4's room without consent and that Resident #4 told Resident #3 to get the hell out. Further review of the nurses note revealed that Resident #3 then hit Resident #4 and knocked him/her to the ground. Further review of Resident #4 medical record revealed no evidence of care plan interventions for history of trauma.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 48515 Based on interview and record review it was determined that the facility failed to ensure an accurately documented medical record for 1 of 4 allegations of abuse (Resident Identifier is #1). Interview on 8/16/24 at approximately 8:30 a.m. with Staff K (Licensed Nursing Assistant) revealed that Staff K had witnessed an interaction between Resident #1 and Resident # 5 on 8/13/24 around dinner time. Interview further revealed that Resident #1 was seen touching Resident #5 on [pronoun omitted] inner thigh almost to [pronoun omitted] [genital area]. Staff K stated that he/she immediately separated the residents and reported the incident to Staff M (Licensed Practical Nurse). Interview on 8/16/24 at approximately 9:00 a.m. with Staff M revealed that he/she was the nurse on duty when the above incident occurred. Staff M also revealed that he/she wrote a nurse's note, on 8/13/24, giving an accurate account of the above incident. Staff M further revealed that their nurse's note detailing the incident had been struck out, not by Staff M. Staff M was told by Staff F (Director of Nursing) that it was put in the wrong part of the medical record and it needed to be moved to another section. Review on 8/16/24 of Resident # 1's medical record confirmed that a nurse's note written by Staff M on 8/13/24 at 11:02 p.m. had been struck out. Further review of the medical recorded revealed no evidence of the incident that occurred on 8/13/24. Interview on 8/16/24 at approximately 10:20 a.m. with Staff F confirmed the above finding and revealed the incident had been struck out of the medical record and a note about the incident had been added to the Risk Management System, which is not part of the medical record.