STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325079	A. Building B. Wing	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mimbres Memorial Nursing Home	900 West Ash Street Deming, NM 88031

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 - Immediate jeopardy to resident health or safety 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** 49313 Based on interview and record review, the facility failed to keep residents free from abuse for 6 (R #21, R #22, R #23, R #25, R #26, and R #27) of 6 (R #21, R #22, R #23, R #25, R #26, and R #27) residents sampled for abuse when staff failed to: 1. Implement interventions to prevent R #24 from touching R #21, R #23, R #25, and R #26 without consent. 2. Ensure R #24 did not enter R #25's room and R #27's personal space without permission while not fully clothed. 3. Ensure R #24 did not use sexually inappropriate comments when speaking to R #22. These deficient practices could likely result in physical harm to residents with inappropriate behaviors, physical harm and/or psychosocial distress (unpleasant emotions associated with a highly stressful situation) or worsening of current mental health conditions for the residents who were subject to this behavior. The findings are: R #24 A. Record review of R #24's medical record revealed R #24 was admitted to the facility on [DATE]. B. Record review of R #24's medical record no date revealed he had the following diagnoses: 1. Vascular Dementia (problems, with reasoning, planning, judgment, memory and other though processes caused by brain damage from impaired blood flow to the brain), unspecified severity, with agitation. 2. Cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it). 3. Other Age-related cataract (cloudy area in the lens of the eye). 4. Dry eye syndrome (tears aren't able to provide adequate lubrication of the eye) of bilateral lacrimal glands (tear-shaped gland that secretes tears). (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	C. Record review of R #24's care plan, dated [DATE], revealed R #24 had a history of making sexually inappropriate comments, gestures and would flash his private areas (added to care plan on [DATE]). On [DATE], this behavior was identified as resolved and removed from R #24's care plan. D. Record review of R #24's current care plan, multiple dates, revealed the following: 1. On [DATE], R #24 had severely impaired cognitive function and becomes restless, agitated, or more confused at times throughout the day. a. On [DATE], staff revised the cognitive status section of R #24's care plan to include an intervention for staff to provide one-to-one observation as practicable (based on staff availability). 2. On [DATE], staff added noncompliance/preferences to R #24's care plan, with the goal to redirect R #24 when he overestimates his abilities (believe his abilities are more than they are), refuses care, and respect his preferences. a. On [DATE], staff revised the noncompliance/preference section of R #24's care plan to include that R #24 attempts to engage in explicit/sexual language. b. On [DATE], staff revised the noncompliance/preference section of R #24's care plan to include that R #24 prefers to be nude and prefers to be naked from the waist down. The intervention is for staff to encourage R #24 to cover himself when in a common area. 3. Staff did not document the behavior that R #24, which included entering other residents rooms without consent or interventions aimed to prevent this behavior. 4. Staff did not document the behavior that R #24 touched residents without consent or interventions aimed to prevent this behavior. E. Record review of R #24's medical record revealed that safety checks were completed every 15 minutes from [DATE] to [DATE] and every 30 minutes from [DATE] to [DATE] (unclear why safety checks stopped). F. Record review of R #24's physician orders, multiple dates, revealed the following orders: 1. Start date [DATE], discontinue date [DATE], Risperidone (antipsychotic medication used to treat schizophrenia, bipolar, or irritability associated with autistic disorder), 1 milligram (mg, unit of measure indicating ,d+[DATE] of a gram), every 12 hours as needed (PRN) for agitation related to vascular dementia. 2. Start date [DATE], discontinue date [DATE], Risperidone 1 mg, two times a day for dementia with behaviors related to restlessness and agitation. 3. Start date [DATE], Remeron (antidepressant used to treat depression) 15 mg at bedtime for depression. 4. Start date [DATE], discontinue date [DATE], Risperidone 0.5 mg at bedtime for vascular dementia with agitation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	5. Start date [DATE], discontinue date [DATE], Risperidone 0.5 mg at bedtime for vascular dementia with agitation. 6. Start date [DATE], discontinue date [DATE]: Depakote (anticonvulsant medication used to treat seizure disorders and certain psychiatric conditions) 125 mg, one tablet, two times a day, for restlessness and agitation. 7. Start date [DATE], Depakote 125 mg, two tablets, two times a day for restlessness and agitation. G. Record review of R #24's [DATE] Medication Administration Record revealed the following: 1. On [DATE], PRN Risperidone administered. 2. On [DATE], PRN Risperidone not administered. 3. On [DATE], PRN Risperidone not administered. 4. On [DATE], PRN Risperidone not administered. 5. On [DATE], PRN Risperidone not administered. 6. On [DATE], PRN Risperidone not administered. 7. From [DATE] through [DATE] all scheduled doses of Risperidone were received. H. Record review of R #24's [DATE] Treatment Administration Record (TAR), revealed that a one-to-one safety observation every hour for Safety monitoring was added to R #24's TAR on [DATE] and discontinued on [DATE]. I. Record review of R #24's [DATE] Activities of Daily Living (ADL) sheet revealed the following: 1. On [DATE], staff documented that R #24 had sexually inappropriate behaviors. 2. On [DATE], staff documented that R #24 had sexually inappropriate behaviors. J. Record review of R #24's medical record revealed that R #24 was on 15-minute safety checks from [DATE] to [DATE]. R #23 K. Record review of R #23's medical record revealed R #23 was admitted on [DATE]. L. Record review of R #23's medical record no date revealed she had the following diagnoses: 1. Post-traumatic stress disorder (PTSD, a disorder in some people who have experienced a shocking, scary, or dangerous event). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. Delusional Disorders (a mental illness in which the individual has one or more firmly held false beliefs that persist for at least one month). 3. Visual hallucinations (a false perception of an external visual stimulus where none exists). 4. Major depressive disorder (MDD,a mood disorder that causes a persistent feeling of sadness and loss of interest that can interfere with daily life). M. Record review of R #23's quarterly MDS, dated [DATE], revealed she had a Brief Interview for Mental Status (BIMS) score of 15 (13 to 15 cognitively intact). N. Record review of R #23's nursing progress note, dated [DATE], revealed the following: 1. R #23 reported that R #24 had touched her leg and made her feel unsafe. 2. R #23 sat in her wheelchair, having a conversation in front of R #24's doorway. 3. R #23 was unable to propel herself from R #24's doorway. 4. R #24 tried to assist R #23 in moving and touched her leg. 5. Staff were placed outside R #23 and R #24's rooms to closely observe for any behaviors. 6. R #23 and R #24 were placed on 15-minute safety checks, which included observing the residents every 15 minutes. O. Record review of CNA #21 witness statement, dated [DATE], revealed the following: 1. R #23 was sitting in front of R #24's room having a conversation. 2. CNA #21 heard R #23 tell R #24 to get away from her. 3. CNA #21 observed R #24 trying to help R #23 move because she was stuck between his wheelchair and the wall. 4. R #23 told CNA #21 that R #24 did not hurt her, but he touched her left leg up close to her groin. 5. R #23 told CNA #21 that she didn't feel safe anymore. 6. R #23 said that she was afraid R #24 would try to come into her room. P. Record review of R #23's progress note, dated [DATE], revealed the following: 1. R #23 was up all-night having hallucinations that R #24 was coming into her room (two days after the incident with R #24). 2. R #23 did not feel safe. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. Recommended moving R #23 to another hall. Q. Record review of R #23's social services note, dated [DATE], revealed that R #23 was moved to another room. R. Record review of R #23's progress note, dated [DATE], revealed that R #23 did not feel safe. S. On [DATE] at 1:01 PM, during an interview with R #23, she revealed that the incident happened not too long ago (did not provide date) and stated, The black guy tried to touch me inappropriately (did not describe how). T. Record review of R #23's Resident Safety Survey (survey used by the facility to identify resident safety concerns), dated [DATE], revealed the following: 1. R #23 told staff that she feels uncomfortable with R #24 in the nursing home. 2. States that he touched her thigh. 3. Staff told R #23 that R #24 is nearly blind and asked if she new that, to which she replied that she did not know (unable to determine staff purpose for line of questioning). 4. R #23 stated that she feels safer since her room change. U. Record review of R #23's care plan, dated [DATE], revealed the following: 1. R #23 had a history of hallucinations. 2. R #23 had a history of PTSD due to a history of sexual abuse. 3. R #23 had accused a male peer of being in her room, (did not specify who R #23 accused or the date of the accusation). R #22: V. Record review of R #22's medical record revealed R #22 was admitted on [DATE]. W. Record review of R #22's medical record revealed she had the following diagnoses: 1. Major depressive disorder (MDD). 2. Vascular Dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain) with mood disturbance. 3. Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions) with early onset. X. Record review of R #22's quarterly MDS, dated [DATE], revealed she had a BIMS score of 12 (moderately cognitively impaired). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Y. Record review of CNA #21's witness statement, dated [DATE], revealed the following: 1. CNA #21 overheard R #24 ask R #22 if she likes having sex. 2. R #22 told R #24 she could not hear him. 3. CNA #21 told R #24 to get away from R #22 and that it was inappropriate for him to speak to R #22 that way. Z. On [DATE] at 12:24 PM, during an interview with LPN #21, the following was revealed: 1. She was told by CNA #21 that R #24 told R #22 that he wanted to do something sexual to her but, R #22 didn't hear him. 2. Staff moved R #22 away and kept an eye on R #24. 3. CNA's had told her about R #24 touching female residents (did not provide dates). 4. The facility never indicated that staff were supposed to keep an eye on R #24 due to sexually inappropriate language or touching others without consent. 5. R #24 had said something of a sexual nature to one of the CNAs, and she told the CNA to report it to the administration (she was unsure of the date). R #21 AA. Record review of R #21's medical record revealed R #21 was admitted on [DATE]. BB. Record review of R #21's medical record revealed R #21 had the following diagnoses: 1. Vascular Dementia with other behavioral disturbances. 2. Adjustment disorder (a group of symptoms such as stress, feeling sad or hopeless, and physical symptoms that can occur after stressful life events) with depressed mood. CC. Record review of R #21's quarterly MDS, dated [DATE], revealed she had a BIMS score of 3 (0 to 7 severe cognitive impairment). DD. On [DATE] at 2:01 PM, during an interview with R #21's Power of Attorney (POA, the authority to act for another person in specified or all legal or financial matters), the following was revealed: 1. The ADON called her on [DATE] and notified her that another resident touched R #21's thigh (did not know who the other resident was) on [DATE]. 2. The facility handled the situation internally, and she was not aware of what had been done. 3. She declined counseling for R #21 because R #21 did not remember the event due to her dementia. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	EE. Record review of CNA #22's witness statement, dated [DATE], revealed the following: 1. CNA #22 witnessed R #24 rubbing R #21's thigh and was trying to take her to his room. 2. CNA #22 removed R #21 away from R #24 and notified the nurse. FF. On [DATE] at 1:32 PM, during an interview with CNA #22, the following was revealed: 1. She witnessed R #24 rubbing R #21's thigh, but she was unsure what the date was. 2. She removed R #21 from the situation. 3. She reported that R #24 touched R #21's thigh to RN #21 after she moved R #21 away from R #24. 4. She completed a witness statement. 5. RN #21 instructed her to keep a close eye on R #24 for the rest of the shift to make sure he didn't try to touch R #21 or any other residents. 6. R #24 had a behavior of coming out of his room naked, and staff were instructed to encourage him to cover himself. 7. There was a time (no date provided), that R #24 came out of his room naked. CNA #22 assisted R #24 back to his room to get dressed, and R #24 tried to touch her in an inappropriate area (area not specified). CNA #22 reported it to the nurse. 8. R #24 had interventions in place regarding behaviors related to aggression, refusing care, and mood. 9. There are no interventions in place for R #24 touching others without consent. 10. She has not been instructed to continue to keep a close eye (monitor) on R #24 after that day. 11. She was not aware of any inappropriate behaviors from R #24 in the last couple months (no date provided). GG. On [DATE] at 3:50 PM, during an interview with RN #21, she revealed the following: 1. She was notified by CNA #22 that R #24 was touching R #21 on the upper thigh. 2. R #21 told her that R #24 touched her leg. 3. She instructed CNA #22 to stay in the common area to keep an eye on R #24 that shift. 4. She was not aware of any time before this incident that R #24 had said or done anything of a sexual nature. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	5. R #24 was not on close observation or 15-minute safety checks at the time he touched R #21's upper thigh. 6. One time (no date provided) R #26 came out of her room and said that R #24 went into her room. 7. R #26 said that she was scared of R #24 because he went into her room. 8. She notified the ADON about R #24 going into R #26's room. 9. RN #21 said that R #23 got moved to another hall because R #23 was scared of R #24. 10. R #24 was placed on frequent checks for a few days after R #23 was moved. 11. The facility did not implement any changes to continue to monitor for this behavior for R #24. 12. R #24's medications were changed, and that seemed to help. R #26 HH. Record review of R #26's medical record no date revealed R #26 was admitted to the facility on [DATE]. II. Record review of R #26's diagnoses, revealed she has the following diagnoses: 1. MDD. 2. Memory Deficit following nontraumatic Intracerebral Hemorrhage. 3. Adjustment Disorder with Mixed Anxiety and Depressed Mood. 4. PTSD. JJ. Record review of R #26's quarterly MDS, dated [DATE], revealed she had a BIMS score of 3. KK. Record review of R #26's social service progress note, dated [DATE], revealed the following: 1. R #26's daughter told staff that R #26 didn't want to take a shower because a black man went in the shower when staff left R #26 alone, and he touched her bottom [Identified in facility initial report as R #24]. 2. R #26 told staff she didn't want to shower because it is cold. 3. R #26 told the social worker that she didn't feel safe because of R #24. She told staff that R #24 asked her how she was doing. She had asked R #24 what he wanted? R #24 responded that he wanted her. 4. R #26 told staff that R #24 didn't touch her (contradicting family members initial statement #1 above). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	LL. Record review of the facility Complaint Narrative Investigation Follow-Up Report (5 day), dated [DATE], revealed the facility identified R #24 as the other resident involved in R #26's allegation. R #27 MM. Record review of R #27's medical record revealed R #27 was admitted to the facility on [DATE]. NN. Record review of R #27's medical diagnoses revealed she had the following diagnoses: 1. MDD. 2. Dementia 3. Hemiplegia (paralysis on one side of the body) and hemiparesis (one sided muscle weakness). OO. Record review of R #27's Resident Safety Survey dated [DATE], revealed the following: 1. R #27 reported that she did not feel safe at the facility because of R #24. 2. R #27 told staff that the man next door [R #24] goes around touching other women and he did that to me the other night and he touched my chair. He was completely naked. PP. Record review of the ADON's interview with R #27, no date, revealed that R #27 told staff that R #24 did not touch her but attempted to take her bag (interview was a follow-up interview after R #27 told staff that R #24 did that to her and was completely naked). QQ. On [DATE] at 3:15 PM, during an interview with R #27, the following was revealed: 1. R #24 had come up behind her in the common area and pulled her wheelchair. 2. When R #27 turned around to see what was happening, R #24 was sitting right next to her, completely naked, so she yelled at him to put some clothes on. 3. R #27 was unsure of the date of this event. 4. R #27 had witnessed R #24 go into other people's rooms. 5. R #23's family told her that R #24 touched R #23 and that is why she was moved to another hall. 6. R #24 touched another lady but she couldn't remember her name. 7. R #24 goes into people's rooms and takes things while they are sleeping. 8. On [DATE] in the evening (two days before this interview), R #24 went into the common area without pants or a covering on his lap while R #27 was sitting in the common area. R #24 looked at her and went back to his room. Staff were not present and there were no other residents present (See finding J, R #24 was supposed to be on Q15 minute checks during this time). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. Some staff members have had sexual things happen to them in their past, so they get uncomfortable with certain situations, which made the staff more sensitive to resident's behaviors. 5. The interim DON and ADON did not think that R #24's behaviors were sexual in nature. 6. The interim DON stated that R #24 did not have the cognitive ability to have sexual behaviors. 7. R #24 had been doing well so they resolved the issue regarding sexual behaviors on his care plan (See finding C, review of R #24's care plan revealed the interventions related to sexual behaviors were discontinued on [DATE], the same day as the incident with R #23). AAA. On [DATE] at 9:50 AM, during an interview with the interim administrator, he revealed the following: 1. He reviewed each of the incidents and determined them unsubstantiated. 2. He determined that each event was not sexual in nature (did not elaborate). BBB. On [DATE] at 1:08 PM, during an interview with R #24's physician, the following was revealed: 1. He did not recall being notified that R #24 asked a female resident if she liked having sex or that he touched other residents without their consent. 2. R #24 used to be very aggressive with staff and would isolate himself in his room. 3. They changed R #24's medications and he became more mellow. 4. The medication changes were intended to improve R #24's behaviors with, refusing showers, isolation, and aggression with staff. 5. He was unsure which medications were adjusted. 6. R #24 has made improvements and started coming out of his room and having conversations with other residents about ,d+[DATE] months ago. CCC. On [DATE] at 1:02 PM, during a joint interview with the interim DON and the interim Administrator, they revealed the following: 1. They watched video footage and determined that R #24 did not touch R #21's leg. 2. They watched video footage and determined that R #24 did not go into the shower with R #26. 3. R #24 did not have sexual intentions with R #27; he was just trying to grab her bag. 4. R #24 did not have sexual intentions when he went into R #25's room naked in the middle of the night. R #25 thought he was only trying to wake her up. Since she or her family didn't think it was abuse, it wasn't abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	DDD. On [DATE] at 2:58 PM, during an interview with R #24's physician, the following was revealed: 1. Around [DATE], R #24 started becoming vulgar and having sexual behaviors like touching others and making sexual comments. 2. The facility contacted mental health services and together they decided to adjust R #24's medications. 3. They started R #24 on Risperidone, but he became lethargic (a state of weariness that involves diminished energy, mental capacity, and motivation) so they adjusted his Risperidone and started R #24 on Depakote. 4. R #24 started having appropriate interactions with residents and staff after the medication changes. 5. They have not seen any issues since the medication changes. EEE. On [DATE] at 3:35 PM, during an interview with the interim DON, the following was revealed: 1. R #24 was placed on one-to-one monitoring as practicable (as staffing allows). 2. The facility is not staffed to be able to have a staff member monitoring a resident around the clock. 3. One-to-one monitoring means more frequent rounding and checks, no specific timing of rounding. 3. Staff do not document one-to-one monitoring. 4. Staff only document if something occurs. The above findings resulted in an Immediate Jeopardy that was called on [DATE] at 3:37 PM. The facility was verified to have fully implemented this approved plan on [DATE] at 4:39 PM. Upon implementation of the Plan of Removal the Immediate Jeopardy was lifted on [DATE]. Plan of Removal A. How facility will ensure harm will not occur or recur: The attending physician, medical director, and Ombudsman were notified of the Immediate Jeopardy issued to the facility on [DATE]. The facility implemented the immediate actions and implemented the following to ensure harm will not occur or recur. There have been no events of sexual inappropriate comments and/or gestures from Resident #24 in over 70 days. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. The current care plan was revised to observe/monitor behaviors of touching. Resident #24 was immediately placed on 15-minute observations. The 15-minute observations will remain in effect for seventy-two (72) hours and will end on [DATE]. Then, every shift thereafter, when behavior resolves 15-minute safety check will resolve. Date Completed: On-going process 2. Safety Surveys were conducted to ask all residents and nursing staff employees if they felt unsafe around Resident # 24. Date Completed: [DATE] 3. Education has been provided to staff: a. To increase staff awareness of when an event occurs related to inappropriate sexual comments and /or behavior; the staff will communicate during daily huddles. b. Additional education provided include: i. Abuse and Neglect; ii. 15-minute Safety Checks for 72 hours during a new event; then every shift for residents identified to have a pattern of inappropriate behaviors until resolved. iii. Know your Resident - which includes the process for reviewing the pattern of current and past behaviors, and interventions in the Care Plan with all staff and new employees iv. Shift huddle handoff will include not only medical report but also behavior changes and or concerns Date Completed: On-going 4. On-Going Monitoring: a. New events will require 15-minute checks for inappropriate behaviors b. After 15 minutes checks have concluded, checks will be every shift for those residents that have a pattern of inappropriate behavior or show signs of behavioral escalation. 5. CNA's making the 15-minute observation checks will immediately report to the charge nurse any changes in behavior or inappropriate sexual remarks or actions. This will remain in effect for seventy-two (72) hours and will end on [DATE]. For residents that have a history of behavioral issues, after the 15 minute checks have expired, the behavioral monitoring will occur every shift. Any changes and or escalation in behavioral will be reported. Date Completed: on-going (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	6. Attempts are made to provide education on care plan and current interventions to Resident #24. However, due to BIMS score of 3.0, the resident does not comprehend the education. Date Completed: [DATE] 7. The Charge nurse is to verify every shift (12 hours) with the CNA assigned of the 15-minute observations. This will remain in effect for seventy-two (72) hours and will end on [DATE], then every shift thereafter. Date Completed: [DATE] 8. All resident care plans have been updated to address observation and monitoring of the encouraging all residents on the reporting of any unwanted pilfering/physical contact, including verbalizations that maybe offensive from any other resident. Date Completed: On-going process 9. If an event occurs going forward that involves inappropriate sexual comments and/or gestures, the resident will immediately be placed on 15-minute observation checks for seventy -two (72) hours and the observation checks are documented for the established timeframe. The care plan will be updated to reflect the interventions put in place. Date completed: On-going process.

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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. 49313 Based on record review and interview, the facility failed to report allegations of abuse or neglect within two hours to the State Agency (SA) for 6 (R #21, R #22, R #23, R #25, R #26, and R #27) of 6 (R #21, R #22, R #23, R #25, R #26, and R #27) residents sampled for abuse. If the facility fails to report allegations of abuse or neglect to the SA within two hours, then residents could likely continue to be abused, suffer serious bodily injury, and/or experience in psychosocial distress (unpleasant emotions associated with a highly stressful situation) or worsening of current mental health conditions. The findings are: R #21 A. Record review of CNA #22's witness statement, dated 05/05/24, revealed CNA #22 witnessed R #24 rubbing R #21's thigh and was trying to take her to his room. B. Record review of the Health Facility Incident Report, dated 05/06/24, revealed the following: 1. The facility identified the type of alleged incident as abuse. 2. R #24 was the consumer identified in the allegation. 3. R #24 was touching a female resident's thigh. 4. The facility did not report the incident between R #21 and R #24 to the SA within 2 hours. C. Record review of the Facility's Complaint Narrative Investigation Follow-Up Report (5-Day), dated 05/09/24, revealed the following: 1. R #24 was identified as the main resident that was involved in the 05/04/24 incident. 2. R #21 was not identified as the other resident involved as the potential victim in the incident. 3. The summary of incident revealed the following: a. The incident occurred on 05/04/24 (initial report listed the date of incident as 05/05/24). b. Two CNA's observed R #24 touch a female resident's leg c. One CNA heard R #24 ask if she (R #21) wanted to have sex. R #22 D. Record review of CNA #21's witness statement, dated 05/04/24, revealed the following: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. CNA #21 overheard R #24 ask R #22 if she likes having sex. 2. R #22 told R #24 that she could not hear him. R #23 E. Record review of R #23's nursing progress note, dated 04/27/24, revealed that R #23 reported to staff that a male resident touched her leg and made her feel unsafe. F. Record review of the Health Facility Incident Report, dated 04/30/24, revealed the following: 1. The facility identified the type of alleged incident as abuse. 2. The facility did not report the incident to the SA within 2 hours. R #25 G. Record review of R #24's progress note, dated 05/10/24, revealed the following: 1. R #24 went into R #25's room wearing no pants or covering and proceeded to touch R #25's leg (R #24 was on hourly one-to-one observations between 05/05/24 to 05/28/24 according to R #24's care plan). 2. R #25 told the staff member that R #24 put his hands on her leg. 3. R #25 thought R #24 was only trying to wake her up and didn't think he meant any harm. R #26 H. Record review of R #26's social service progress note, dated 05/09/24 at 12:00 PM, revealed that R #26's daughter told staff that R #26 didn't want to take a shower because a black man went in the shower when staff left R #26 alone and he touched her bottom. I. Record review of the Health Facility Incident Report, dated 05/09/24, revealed the following: 1. The facility identified the type of alleged incident as abuse. 2. The report was submitted with R #24 identified as the consumer. 3. The report was completed and submitted to the State Agency at 6:10 PM, not within two hours of becoming aware of the alleged incident. R #27 J. Record review of R #27's Resident Safety Survey, dated 05/09/24, revealed the following: 1. R #27 did not feel safe at the facility because of R #24. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. She told staff that he goes around touching other women and R #24 did that to her 'the other day' (R #24 was on hourly one-to-one observations between 05/05/24 to 05/28/24 according to R #24's care plan). 3. R #24 was completely naked. K. On 7/23/24 at 1:02 PM, during an interview with the interim Administrator, he confirmed the following: 1. The facility did not report the incident with R #22 to the SA. a. The Complaint Narrative Investigation Follow-Up Report, dated 05/09/24, had information pertaining to two different incidents with R #24. i. On 05/04/24, R #24 asked R #22 if she liked sex. ii. On 05/05/24, R #24 allegedly touched R #21's leg. b. They didn't consider the incident between R #24 and R #22 abuse, because R #22 didn't hear the comment. 2. The facility did not report the incident between R #24 and R #25 to the SA. a. The facility administration did not feel like it was abuse because R #25 the facility administration did not think it was abuse and R #25 or her family did not think it was abuse. 3. The facility did not report the incident between R #24 and R #27 to the SA. a. The facility administration did not feel like it was abuse. During their follow-up questions with R #27, they determined that R #24 was trying to grab R #27's bag, so administration didn't think it was abuse.

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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** 49313 Based on record review and interview, the facility failed to have evidence that a thorough investigation of an allegation of abuse was conducted and preventive measures to keep residents safe were implemented for 6 (R #21, R #22, R #23, R #25, R #26, and R #27) of 6 (R #21, R #22, R #23, R #25, R #26, and R #27) residents sampled for abuse. These deficient practices could likely result in residents being at risk of continued abuse if allegations are not thoroughly investigated and preventative measures are not implemented. The findings are: R #21 A. Record review of R #21's medical record revealed R #21 was admitted on [DATE]. B. On 07/18/24 at 2:01 PM, during an interview with R #21's Power of Attorney (POA, the authority to act for another person in specified or all legal or financial matters), the following was revealed: 1. The ADON notified her that R #21 was trying to leave, and another resident tried to move her from going by the door. 2. That the other resident touched R #21's thigh. 3. The facility handled the situation internally, and she was not aware of what was done. 4. She declined counseling for R #21 because R #21 did not remember the event due to her dementia. C. Record review of the facility's complaint investigation file, no date, revealed the following: 1. The facility's Initial Incident Report, dated 05/06/24, revealed: a. On 05/05/24, R #24 was witnessed touching a female resident's thigh. b. Both residents were separated and redirected. c. R #24 was placed on increased safety checks. 2. CNA #21's witness statement, dated 05/04/24, revealed: a. CNA #21 overheard R #24 ask a female resident if she likes having sex. b. The female resident told R #24 that she could not hear him. 3. LPN #21's witness statement, dated 05/04/24, revealed: a. CNA #21 told her that R #24 asked a female resident if she likes having sex. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. LPN #21 notified the house supervisor of the incident. c. LPN #21 notified the DON and the female's POA. d. The house supervisor spoke to R #24 about the appropriateness of these types of conversations with the female residnets. 4. CNA #22's witness statement, dated 05/05/24, revealed: a. CNA #22 witnessed R #24 rubbing a female resident's thigh and was trying to take her to his room. b. CNA #22 removed the female resident away from R #24 and notified the nurse. 5. The facility Complaint Narrative Investigation Report, dated 05/09/24, revealed: a. R #24 was the only resident identified in the incident. b. The summary of incident revealed the following: i. The incident occurred on 05/04/24 (initial report listed the date of incident as 05/05/24). ii. Two CNA's observed R #24 touch a female resident's leg. iii. One CNA heard R #24 ask the female resident if she wanted to have sex. c. The future preventative/corrective action revealed: i. Residents were separated with increased visual observations (did not include specifics regarding frequency or duration of these observations). ii. Medications were reviewed for R #24 (did not include specifics for if medications were adjusted). iii. Labs were ordered and R #24 had abnormal urinalysis (a test of the urine) results, but the physician did not treat the resident for the abnormal results. d. The conclusion revealed: i. The facility determined that the incident did not occur. ii. The facility's video did not include findings to substantiate abuse. e. Staff did not document any other witness statements of the events surrounding either of the incidents on 05/04/24 and 05/05/24. f. Staff did not document R #24's statement at the time of the incident on 05/04/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. R #24 had done that to a couple of female residents. 4. R #23 got moved to another hall because R #24 touched her. 5. R #24 would approach female residents that were not cognitively intact or able to understand what he was saying or doing. 6. The facility never indicated that the staff were supposed to keep an eye on R #24. H. On 7/23/24 at 1:02 PM, during an interview with the interim Administrator, he confirmed the following: 1. The facility did not report the incident with R #22 to the SA. a. The Complaint Narrative Investigation Follow-Up Report, dated 05/09/24, had information pertaining to two different incidents with R #24: i. On 05/04/24, R #24 asked R #22 if she liked sex. ii. On 05/05/24, R #24 allegedly touched R #21's leg. 2. The facility did not consider the incident between R #24 and R #22 was abuse, because R #22 did not hear the comment. R #23 I. Record review of R #23's medical record revealed R #23 was admitted on [DATE]. J. Record review of R #23's nursing progress note, dated 04/27/24, revealed the following: 1. R #23 reported that a male resident touched her leg and made her feel unsafe. 2. R #23 was sitting in her wheelchair having a conversation in front of male resident's doorway. 3. R #23 was unable to propel herself from the male resident's doorway. 4. Male resident tried to assist R #23 to move and touched her leg. 5. Staff was placed outside of R #23's room and outside male resident's room. 6. R #23 and male resident were placed on 15-minute safety checks for 48 hours. K. Record review of the facility's complaint investigation file, no date, revealed the following: 1. The facility Initial Incident Report, dated 04/30/24, revealed: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. The report was a faxed copy and the text about the incident does not indicate the reason for the report only that the resident was safe in bed with call light and was placed on 15 minute safety checks for 48 hours. 2. CNA #21 witness statement, dated 04/27/24, revealed the following: a. R #23 was sitting in front of R #24's room having a conversation. b. CNA # 21 heard R #23 tell R #24 to get away from her. c. CNA #21 observed R #24 trying to help R #23 move because she was stuck between his wheelchair and the wall. d. R #23 told CNA #21 that R #24 did not hurt her, but he touched her left leg up close to her groin. e. R #23 told CNA #21 that she didn't feel safe anymore. f. R #23 said that she was afraid R #24 would try to come into her room. 3. The facility Complaint Narrative Investigation Report, dated 05/05/24, revealed: a. R #23 was the only resident identified in the incident. b. Facility Actions after the incident: i. CNA removed R #23 and took her to her room. ii. R #23's physician, POA, DON, and ADON were notified. iii. Video was reviewed. c. Future Preventative/Corrective Action: i. R #23 was assessed by charge nurse. ii. R #23 was asked if she felt safe and she responded that she did not feel safe anymore. iii. Both residents were placed on 15-minute safety checks for 48 hours. iv. Trauma screening was completed on R #23. v. A mental health consult was requested for R #23. d. The conclusion revealed: i. It was determined that R #24 did touch R #23's left leg. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ii. R #23 was stuck behind the male resident's wheelchair. iii. CNA's were placed outside of R #23's room (did not indicate duration of intervention). iv. The allegation of abuse was unsubstantiated. e. Staff did not document any other witness statements of the events surrounding the incident. f. Staff did not document R #24's statement at the time of the incident. g. Staff did not document the dates or times of the video footage that was reviewed for either incident. h. Staff did not document what was observed during the review of the video footage. R #25 L. Record review of R #25's medical record revealed R #25 was admitted to the facility on [DATE]. M. Record review of R #24's progress note, dated 05/10/24, revealed the following: 1. R #24 went into R #25's room wearing no pants or covering and proceeded to touch R #25's leg (R #24 was on hourly one-to-one observations between 05/05/24 to 05/28/24). 2. R #25 told a staff member that R #24 put his hands on her leg. 3. R #25 thought R #24 was only trying to wake her up and didn't think he meant any harm. 4. The nurse asked the CNA's to keep their eyes on R #24 for the rest of the shift. 5. The nurse notified management and the doctor about the incident. N. On 7/23/24 at 1:02 PM, during an interview with the interim Administrator, he confirmed that the facility did not complete an investigation into the incident between R #24 and R #25 because facility administration did not feel like it was abuse because R #25 and her family did not think it was abuse. R #26 O. Record review of R #26's medical record revealed R #26 was admitted to the facility on [DATE]. P. Record review of R #26's social service progress note, dated 05/09/24, revealed the following: 1. R #26's daughter told staff that R #26 didn't want to take a shower because a black man (did not specify who) went in the shower when staff left R #26 alone and he touched her bottom. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R #26 told the social worker that she didn't feel safe because of the man. She told staff that the man asked her how she was doing and that she had asked the man what he wanted and the man responded that he wanted her. 3. R #26 told staff that the other resident didn't touch her. Q. Record review of the facility complaint investigation file, no date, revealed the following: 1. The facility Initial Incident Report, dated 05/09/24, revealed: a. Identified R #24 as the consumer. b. Indicates that a family member reported that the resident had touched her mother on nightshift during a shower. c. The family member did not know the date or time of the incident. 2. Staff witness statement, dated 05/09/24, revealed that R #26 did not want to take a shower because she was cold. 3. Resident safety surveys, dated 05/09/24, revealed: a. The survey had three questions that were asked to the residents: i. How are you doing? ii. Do you feel safe? ii. Do you have any concerns with your care? iv. Staff did not document any specific questions about concerns with other residents or questions related to sexual abuse. 4. The facility Complaint Narrative Investigation Report, dated 05/14/24, revealed: a. Resident's involved: i. R #26. ii. R #24. b. Summary of incident: i. R #26's daughter reported that R #26 was crying when offered a shower. ii. R #26 indicated that during a previous shower (no date given) a male resident touched her. iii. A CNA left R #26 alone in the shower area. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. She told staff that he goes around touching other women and R #24 did that to her 'the other day'. 3. R #27 was completely naked. T. Record review of the facility interview with R #27, no date, revealed that R #27 told staff that R #24 did not touch her but attempted to take her bag. U. On 07/22/24 at 3:15 PM, during an interview with R #27, the following was revealed: 1. R #24 had come up behind her in the common area and pulled her wheelchair. 2. When R #27 turned around to see what was happening, R #24 was sitting right next to her completely naked, so she yelled at him to go put some clothes on. 3. R #27 was unsure of the date of this event. 4. She was scared that R #24 would come into her room. V. On 7/23/24 at 1:02 PM, during an interview with the interim Administrator, he confirmed that the facility did not complete an investigation into the incident with R #24 and R #27 because during their follow-up questions with R #27, they determined that R #24 was trying to grab R #27's bag, so administration didn't think it was abuse.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 50497 Based on record review and interview, the facility failed to ensure care plan revision occurred for 2 (R #24 and R #31) of 3 (R #24, R #31, and R #32) residents when the staff failed to: 1. Revise R #24's care plan to include behavior of touching other residents without consent. 2. Revise R #24's care plan to include behavior of entering other residents rooms without consent. 3. Revise the care plan with the most current resident information for R #31. These deficient practices could likely result in the care plan not being updated with the most current resident conditions and appropriate interventions, staff being unaware of changes in care provided, and residents not receiving the care related to changes in their health status or healthcare decisions. The findings are: R #24 A. Record review of R #23's nursing progress note, dated 04/27/24, revealed the following: 1. R #23 reported that a male resident (R #24) touched her leg and made her feel unsafe. 2. R #23 sat in her wheelchair having a conversation in front of male resident's (R #24) doorway. 3. R #23 was unable to propel herself from the male resident's (R #24) doorway. 4. Male resident tried to assist R #23 to move and touched her leg. 5. Staff was placed outside R #23 and male resident's room. 6. R #23 and male resident (R #24) placed on 15-minute safety checks for 48 hours. B. Record review of CNA #21's witness statement, dated 04/27/24, revealed the following: 1. R #23 was sitting in front of R #24's room having a conversation. 2. CNA #21 heard R #23 tell R #24 to get away from her. 3. CNA #21 observed R #24 trying to help R #23 move because she was stuck between his wheelchair and the wall. 4. R #23 told CNA #21 that R #24 did not hurt her but he touched her left leg up close to her groin. 5. R #23 told CNA #21 that she didn't feel safe anymore. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. R #23 said that she was afraid R #24 would try to come into her room. C. On 07/19/24 at 12:24 PM, during an interview with LPN #21, the following was revealed: 1. R #24 told R #22 that he wanted to do something sexual to her but R #22 didn't hear him (as reported by the CNA). 2. Staff moved R #22 away form R #24 and kept an eye on R #24. 3. R #24 had this behavior with a couple of female residents (LPN #21 did not give specific dates). 4. R #23 got moved to another hall because R #24 touched her. 5. R #24 would approach female residents with sexual behaviors that were not cognitively intact or able to understand what he was saying or doing. 6. The facility never indicated that the staff were supposed to keep an eye on R #24 for sexual behaviors towards female residents. 7. R #24 had said something of a sexual nature to one of the CNA's and she told the CNA to report it to administration (LPN #21 did not give specific dates). D. Record review of CNA #22's witness statement, dated 05/05/24, revealed the following: 1. CNA #22 witnessed R #24 rubbing R #21's thigh and was trying to take her to his room. 2. CNA #22 removed R #21 away from R #24 and notified the nurse. E. On 07/19/24 at 1:32 PM, during an interview with CNA #22, the following was revealed: 1. She witnessed R #24 rubbing R #21's thigh but she was unsure what the date was. 2. She removed R #21 from the situation. 3. She reported the situation between R #21 and R #24 to RN #21. 4. She completed a witness statement. 5. RN #21 instructed her to keep a close eye on R #24 for the rest of the shift. 6. R #24 comes out of his room naked and staff are instructed to encourage him to cover himself. 7. There was a time, no date provided, that R #24 came out of his room naked. CNA #22 assisted R #24 back to his room to get dressed and R #24 tried to touch her in an inappropriate area (area not specified). CNA #22 reported it to the nurse. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The pych-service started R #24 on Risperidone (antipsychotic medication used to treat schizophrenia, bipolar, or irritability associated with autistic disorder), but he became lethargic (A state of weariness that involves diminished energy) so pych-services tapered (the practice of gradually reducing the dosage of a medication) his Risperidone and started R #24 on Depakote (anticonvulsant medication used to treat seizure disorders and certain psychiatric conditions). 4. R #24 started having appropriate interactions with residents and staff after the medication changes. 5. The facility have not seen any issues since the medication changes . K. Record review of R #24's care plan, no date, revealed the following: 1. It did not include the behavior of touching other residents without consent. 2. It did not include the behavior of entering other residents rooms without consent. 3. It did not contain interventions to prevent R #24 from touching other residents without consent. 4. It did not contain interventions to prevent R #24 from entering other residents rooms without consent. 5. Indicated that R #24 has severely impaired cognitive function related to history of stroke and he becomes agitated or confused at times throughout the day. a. On 05/05/24, Staff updated the interventions to include One-to-one observation as practicable (based on staff availability). L. On 07/19/24 at 10:45 AM, during an interview with RN #23, the following was revealed: 1. She had worked at the facility since the end of May 2024. 2. She was not aware of any male residents talking to or touching female residents without consent. 3. Said that staff were supposed to watch R #24 closely for behaviors of agitation and yelling out. 4. Confirmed that the Treatment Administration Record or the Care plan did not indicate that R #24 was to be monitored for touching residents without consent. 5. She had never been told to keep a close eye on R #24 regarding touching residents without consent. M. On 07/23/24 at 3:35 PM, during an interview with the interim DON, the following was revealed: 1. R #24 was placed on one-to-one monitoring as practicable. (continued on next page)

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