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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335457	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fiddlers Green Manor Rehab and Nursing Center	168 West Main Street Springville, NY 14141

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39086 Based on observation, interview, and record review conducted during a Complaint investigation (Complaint #NY00307069) during the Standard survey completed on 4/16/24, the facility did not protect the resident's right to be free from sexual abuse for two (Resident's #22 &53) of three residents reviewed. Specifically, Resident #53 was observed by staff engaged in non-consensual sexual contact with Resident #22. The finding is: The policy and procedure titled Abuse Prevention Program revised 12/16 documented our residents have the right to be free from abuse. This includes but was not limited sexual abuse. As part of the resident abuse prevention, the administration will: protect our residents from abuse from facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. The policy and procedure titled Abuse and Neglect-Clinical Protocol revised 3/18 documented that sexual abuse was defined as non-consensual sexual contact of any type with a resident. Resident #53 had diagnoses that included Parkinson's Disease (brain disorder that cause unintended and uncontrollable movements), sleep disorder, and mood disorder. The Minimum Data Set, dated dated dated [DATE], documented Resident #53 was understood, understands, and was cognitively intact. The comprehensive care plan revised 8/22/22 (current at the time of alleged abuse) documented Resident #53 ambulated independently with a rollator walker, and was independent for meeting their emotional, physical, and social needs. Interventions included supervision during activity programs due to prior legal convictions; staff to monitor for any behavior problems related to history of prior convictions and no unsupervised outside appointments. The Kardex (guide used by staff to provide care) with an as of date of 12/16/22 documented Resident #53 was independent with transfers and ambulation using a rolling walker. Resident #22 had diagnoses that included schizophrenia, bipolar, and dementia. The Minimum Data Set (MDS- a resident assessment tool) dated 10/10/22, documented Resident #1 was understood, usually understands, and had severe cognitive impairment. (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 - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan dated 8/21/18 documented Resident #22 had impaired thought processes due to dementia. Resident #22 was dependent on staff for meeting emotional, intellectual, physical, and social needs. Review of the nursing progress notes dated 12/15/22 at 5:00 PM, Licensed Practical Nurse #1 documented that Certified Nurse Aide #1 observed Resident #53 with their hands under Resident #22's gown near their chest area. Residents #22 and #53 were immediately separated. Resident #53 denied that they had their hands in Resident #22's gown to Licensed Practical Nurse #1. Review of the investigation summary dated 12/15/22 documented Resident #53 was witnessed by Certified Nurse Aide #1 with their hands under Resident #22's shirt. Resident #22 stated Resident #53 was playing with my breasts. Resident #53 denied touching Resident #22 at the time of the incident and later stated they did touch Resident #22 inappropriately. Review of the Police Report Sex Offense Investigation dated 12/15/22 documented at 6:03 PM a forcible touching incident occurred between Resident's #22 and #53. Certified Nurse Aide #1 witnessed the incident. Resident #22 was moved from the 2nd floor to the 1st floor to keep them away from Resident #53. Certified Nurse Aide #1 stated they went to a common room on the 2nd floor where they saw Resident #53 behind Resident #22 (who was in a wheelchair), reaching into Resident #22's hospital gown up to Resident #53's shoulders with their hands over Resident #22's breast area. Resident #22 was interviewed and had to be brought back continually to the subject matter and relayed they were sexually abused throughout their childhood. Resident #22 stated they did not ask Resident #53 to touch them. Resident #53 squeezed Resident #22's breasts. Resident #53 stated they were giving Resident #22 a massage and may have touched the breast by accident. During an observation and interview on 4/9/24 at 10:22 AM, Resident #22 self-propelled their wheelchair to their room. Resident #22 had no recall of the incident and stated they had no inappropriate contact with other residents at the facility. During observation and interview on 4/10/24 at 11:45 AM, Resident #53 was sitting at the bedside and stated they were never involved with inappropriate contact with other residents. Resident #53 was also observed walking with staff. During a telephone interview on 4/12/24 at 9:37 AM, Licensed Practical Nurse #1 stated Certified Nurse Aide #1 reported they had witnessed Resident #53's hands under Resident #22's hospital gown at 5:00 PM in the resident dining room. There were no other residents in the dining room at the time of the incident. Supper was delivered to resident rooms which left the dining room unattended by staff. Licensed Practical Nurse #1 reported the incident to the Director of Nursing. During a telephone interview on 4/15/24 at 11:23 AM, (the former) Social Worker #2 stated at the time of the incident (12/15/22) Resident #53 ambulated independently with a rollator walker and was cognitively intact. Resident #22 lacked capacity and did not know right from wrong. Resident #22 couldn't consent. Social worker #2 stated, Resident #53 was witnessed to touch Resident #22's breasts and that was considered sexual abuse. During a telephone interview on 4/15/24 at 10:48 AM, Certified Nurse Aide #2 stated Resident #53 was out of their room on 12/15/22 more than usual, however, they did not think much of it at that time. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 4/15/24 at 12:20 PM, Certified Nurse Aide #1 stated on 12/15/22 between the hours of 2:00 PM - 5:00 PM they noticed Resident #53 was acting strange and was seeking out Resident #22. Certified Nurse Aide #1 stated Resident #53 was out of their room more than usual that day. Certified Nurse Aide #1 stated they came out of another resident's room and noticed Resident #53 pacing back and forth with a smirk on their face. Certified Nurse Aide #1 didn't think anything of it. Certified Nurse Aide #1 stated they saw Resident #53 walk into the dining room. A few minutes later they went to check and that was when they saw Resident #53 standing behind Resident #22 who was seated in wheelchair at the table with their hands through arm holes of Resident #22's gown. Resident #53 was touching Resident #22's chest area. Resident #53 had a weird look on their face as if they knew I saw something that I shouldn't have seen. Certified Nurse Aide #1 intervened and informed Licensed Practical Nurse #1. Certified Nurse Aide #1 stated something was odd and they should have provided more supervision and deterred Resident #53 from entering the dining room sooner but did not. Resident #22 had dementia, could not consent to being touched, therefore was sexual abuse. During an interview on 4/15/24 at 1:44 PM, Certified Nurse Aide #3 stated Resident #53 spent time in their room and attended activities. Increased supervision was provided during activities. When Resident #53 was not attending activities, staff just kept eyes on them. Certified Nurse Aide #3 stated there was no specific monitoring system in place for certified nurse aides to document Resident #53's location. Resident #53 ambulated independently with a rollator walker and could enter other resident rooms on the unit. During an interview on 4/16/24 at 8:53 AM, the (current) Social Worker #1 stated they knew of Resident #53's past legal convictions and would have expected to have been made aware of the sexual abuse history that had occurred between Resident #53 and Resident #22. Social Worker #1 stated Licensed Practical Nurse #4 kept an eye on Resident #53 during the day. In the absence of Licensed Practical Nurse #4, nursing staff monitored Resident #53's where abouts. Social Worker #1 stated they would have expected a more person-centered plan and specific interventions to monitor Resident #53's interactions with other residents more closely. During an interview on 4/16/24 at 9:13 AM, the Director of Nursing stated staff were educated and empowered with awareness on Resident #53's behaviors. The facility had vulnerable residents and was incapable for providing direct supervision for Resident #53. If there was a situation on the unit and staff were attending other residents there was the potential Resident #53, could get into another resident's room without staff's knowledge. The process for monitoring was not good, Resident #22 was moved to another unit. There was no system in place which prevented other vulnerable residents from being at risk. The Director of Nursing stated the facilities investigation into the 12/15/22 incident on between Resident #53 and #22 had concluded sexual abuse occurred. During an interview on 4/16/24 at 10:22 AM, Licensed Practical Nurse #2 stated they redirected Resident #53 when they ambulated in the wrong direction and entered other resident rooms. Staff on the unit were responsible to monitor Resident #53's location. There was no specific system in place for accountability or place to documented Resident 53's whereabouts on a consistent basis. During an interview on 4/16/24 at 10:24 AM, Licensed Practical Nurse #4 Unit Manager stated Resident #53 could potentially enter other resident's rooms, on the unit. Licensed Practical Nurse #4, Unit Manager stated there were no other means of providing increased supervision towards preventing further occurrence other than redirection and there was no documented evidence of ongoing monitoring to prevent reoccurrence. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/16/24 at 10:59 AM, the Administrator stated there was no video surveillance from the incident on 12/15/22. The incident that occurred between Resident #53 and Resident #22 was determined to be sexual abuse. During a telephone interview on 4/16/24 at 12:05 PM, the Medical Director stated Resident # 22 lacked capacity, was unable to consent, therefore the incident on 12/15/22 was sexual abuse. 10 NYCRR 415.3(d)(1)(vii)