STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Utica Rehabilitation & Nursing Center	2535 Genesee Street Utica, NY 13501

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. 37385 Based on record review and interviews during the abbreviated survey (NY00330966), the facility failed to ensure that residents were free from sexual abuse and failed to protect residents from further abuse for 1 of 7 residents (Residents #4) reviewed. Specifically, Resident #5 had intact cognitive function, a history of sexually inappropriate behaviors, and continued to exhibit sexually inappropriate behaviors, including making verbal sexual requests to residents. There were no documented interventions to address the resident's ongoing behaviors or to protect other residents from abuse. Resident #4, a cognitively impaired resident, was found in Resident #5's room engaging in a sexual act. Resident #4 was not assessed timely, notifications to their representative, medical provider, and the police were not made timely, and interventions to protect Resident #4 and other vulnerable residents were not implemented timely. The facility's failure to protect residents from sexual abuse resulted in harm that is Immediate Jeopardy and Substantial Quality of Care for Resident #4 which had the likelihood to affect 114 residents in the facility. Findings include: The facility policy, The Seven Components of a Systematic Approach to Abuse Prohibition, effective 8/2020, documented: - Verbal abuse was defined as the use of oral, written, or gestured language in a derogatory and disparaging manner. - Sexual abuse included, but was not limited to, the use of sexual coercion, sexual harassment, or sexual assault. - Prevention of Abuse included: identify, correct, and intervene in situations in which abuse, neglect, and/or misappropriation of resident property is more likely to occur. This included an analysis of the assessment, care planning, and monitoring of residents with needs and behaviors, which might lead to conflict or neglect, such as residents with a history of aggressive behaviors, entering other residents' rooms, self-injurious behaviors, communication disorders, and those who require heavy nursing care and/or are totally dependent on staff. Resident #4 had diagnoses including dementia and anxiety disorder. The 12/1/2023 Minimum Data Set assessment documented the resident had severe cognitive impairment, exhibited behaviors of wandering, and was independent for transfers and walking. (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	Resident #5: Resident #5 had diagnoses including cerebral infarction (stroke), dementia, and impulse disorder. The 10/11/2023 Minimum Data Set assessment documented the resident had intact cognition, exhibited verbal behaviors toward others which impacted others by significant intrusion of privacy or activity and significant disruption of care or the living environment, was independent with propelling their wheelchair, and required supervision for transfers. The residents Medical Orders for Life Sustaining Treatment documented the resident made their own decision related to resuscitation and preferred medical interventions. Resident #5 signed as the decision-maker on 12/22/2022. Resident #5's admission records included medical and psychiatric provider notes from the long-term care facility from where they were transferred. On 8/21/2023 and 9/11/2023, Nurse Practitioner # 25 (also a provider for the current facility) documented the resident made very explicit inappropriate comments to residents and staff. The resident was redirected and stated they could not help themselves. The 8/30/2023 progress note from Resident #5's prior facility, completed by Psychiatric Nurse Practitioner #24 (also a provider at the current facility) documented the resident had a history of sexually inappropriate behaviors, a history of touching other residents in a sexual manner and remained verbally inappropriate. Staff were advised to ignore the resident's comments and keep the resident away from female residents. The resident appeared to have impulse control disorder and was noted to make very explicit vulgar sexual comments to female staff. The resident was prescribed Depakote (seizure medication sometimes used for psychiatric disorders) and failed a trial of Tagamet (antacid sometimes used to treat hypersexuality) for sexually inappropriate behaviors. The 10/6/2023 at 2:50 PM facility Admission Evaluation completed by Registered Nurse Supervisor #13 documented the resident was alert and oriented to person, place, and time, was able to understand and be understood. The 10/7/2023 Social Worker #23 progress note documented a Brief Interview for Mental Status was completed. The resident's score was 14 (range 0-15, a score of 13-15 indicates intact cognitive function). The 10/9/2023 at 8:04 PM Licensed Practical Nurse #11 progress note documented the resident was very inappropriate to another (unidentified) resident, asking them for sexual favors. The 10/9/2023 at 3:03 PM Social Worker #23 progress note documented they met with the resident after multiple reports of inappropriate comments to staff. On 10/9/2023 Nurse Practitioner #25 (who was also the resident's provider at their prior facility) documented in a progress note the resident was transferred from another facility. Staff reported the resident had been sexually inappropriate with female staff since their admission. The resident continued to do so despite being asked not to. This was an ongoing issue while at the previous facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The 10/10/2023 at 9:51 AM Director of Social Services progress note documented they reviewed reports from the previous facility and determined Resident #5 did not do well with roommates and did not get along with peers. The Director of Social Services offered the resident a private room on the fourth floor (unit designated for residents with dementia). The resident agreed and was moved to the fourth floor. The Comprehensive Care Plan initiated 10/11/2023 documented the resident made sexual comments toward staff and others, related to dementia, ineffective coping skills, mental/emotional illness, and poor impulse control. Interventions included: administer medications as ordered; analyze key times places, circumstances, triggers, what de-escalates behavior and document; assess and anticipate needs, food, thirst, toileting needs, comfort level, body positioning, pain; positive feedback for good behavior; psychiatric/psychology consult as needed; and redirect when inappropriate. On 10/28/2023, Psychiatric Nurse Practitioner #24 documented Resident #5 attempted to touch female residents inappropriately and was noted to make frequent very explicit vulgar sexual comments to female staff. On 11/1/2023 at 12:08 PM, Licensed Practical Nurse #10 documented the resident made sexual comments to two (unidentified) female residents stating, come sit on my mustache. When addressed, the resident stated one of the residents showed them their breasts. There was no documented evidence of an investigation of the 11/1/2023 incident or of the identification of the two residents involved. The 11/2/2023 at 2:12 PM Director of Social Services progress note documented they spoke to the resident about recent reports of speaking inappropriately in a sexual manner. Today, a resident (later identified as Resident #4 in an interview) was reportedly wandering into Resident #5's room and Resident #5 requested Resident #4 disrobe. Staff intervened, and Resident #5 said they could not help themselves. The Director of Social Services suggested they learn to change this behavior as this would lead to someone pressing charges and the resident certainly would not want to deal with that at this age. Resident #5 agreed and assured the Director of Social Services they would change. The Director of Social Services suggested if the resident could not change, the next step would be issuing a discharge notice. There was no documented evidence of steps taken to protect Resident #4 following the report of Resident #5 asking them to undress in their room. There were no documented interventions for Resident #5 to address Resident #4 or any other residents who may wander into Resident #5's private room. The 11/10/2023 at 1:37 PM Licensed Practical Nurse Manager #3 documented Resident #5 was moved to the south end of the Fourth Floor, the male end of the unit. The 11/13/2023 at 8:19 PM Social Worker #23 progress note documented the resident continued to make vulgar comments to staff and to other residents. The social worker told the resident if they continued to make others feel uncomfortable in the dining room, the resident would be asked to eat in their room. When speaking to the resident about their behavior, they often brushed it off. (continued on next page)

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F 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

The 11/14/2023 Nurse Practitioner #20 progress note documented the resident had ongoing sexual inappropriate behaviors at the current and former facility. They were managed with Depakote for impulse control disorder. Nursing staff did not think the Depakote was effective and the resident frequently made sexually inappropriate comments to staff and residents. The resident had been found asking female residents with dementia for sexual favors. The plan was to start Tagamet, monitor behaviors closely, and continue follow-up with psychiatry.

The 11/15/2023 Psychologist #26 evaluation documented Resident #5 was referred for making sexually inappropriate comments to staff and residents. Staff were particularly concerned that Resident #5 was inviting female residents with dementia to go to their room, apparently for sexual favors. The resident admitted to making comments, found it funny, and reported they had no interest in changing their behavior. The resident was at moderate risk of sexual offense with concern about them sexually abusing non-consenting demented females. Recommendations included close supervision, refrain from overreaction, as any reaction could reinforce their behavior, keep them busy, encourage them to work on model cars.

There was no documented evidence of steps taken to address Psychologist #26's recommendations and no documented evidence the evaluation was reviewed by the Director of Social Services, nursing staff, or the medical provider. There were no documented care plan updates or interventions.

The 12/2023 Documentation Survey Report documented the resident exhibited sexually inappropriate behaviors on 12/7, 12/16, 12/17, 12/23, 12/26, and 12/29/2023.

The 12/17/2023 at 10:22 PM Licensed Practical Nurse #16 progress note documented the resident asked another (unidentified) resident to go to their room and sleep with them.

The 12/20/2023 at 8:17 PM, Social Worker #23 documented they met with Resident #5 again over their inappropriate language. The resident often agreed they would no longer make these comments but continued with this behavior. The social worker reminded the resident they could be in a lot of trouble if they continued with this behavior.

The 12/30/2023 at 5:30 PM Licensed Practical Nurse #16 progress note documented staff reported a resident was observed in Resident #5's room, acts being performed by the other resident, and they were taken out of the room immediately. The supervisor was made aware.

The untimed 12/30/2023 Resident Accident/Incident Report documented Resident #5 was observed with another resident (Resident #4) in their bed. Certified Nurse Aide #15 was assigned to Resident #5 and Resident Assistant #14 and reported the occurrence. There was no documented statement from Resident #5 and their mental status was noted as oriented, with behaviors present noted as perversion (sexual behaviors that are considered abnormal, repulsive, or obsessive). Registered Nurse Supervisor #12 was notified on 12/30/2023 at 4:59 PM. The report included recommendations for preventative measures, and documented actions taken were a comprehensive psychiatric evaluation, placement in a psychiatric facility, and one-to-one staff monitoring. The care plan and the certified nurse aide accountability were updated, a psychiatric referral was made, and abuse and neglect were not suspected. This section of the report was signed by Registered Nurse Supervisor #12, dated 12/30/2023. The medical provider was notified on 12/31/2023 at 7:50 AM, and Resident #4's relative was notified on 12/31/2023 at 7:15 AM. The form was signed by Registered Nurse Supervisor #12 and dated 12/31/2023 at 7:15 AM.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with Licensed Practical Nurse #10 on 9/11/2024 at 1:00 PM, they stated Resident #5 asked staff and residents for sexual favors almost daily while on the Fourth Floor. The resident appeared to be aware of their inappropriate behaviors, such as looking around for staff when they made inappropriate comments to other residents. The nurse was unaware of the reason Resident #5 was on the unit, which was primarily for residents with dementia. It was common for multiple residents to walk the unit, often going in and out of other resident rooms, including Resident #4. Resident #4 did not seek out attention in an inappropriate manner and did not exhibit sexually inappropriate behaviors. Licensed Practical Nurse #10 observed Resident #4 wandering into Resident #5's room prior to 12/30/2023. Licensed Practical Nurse #10 could not recall the 2 female residents noted in their 11/1/2023 progress note. They recalled the incident and thought they reported it to a supervisor. One of the female residents was moved to the Third Floor to keep them away from Resident #5. The nurse was unaware of any interventions to address Resident #5's behaviors or to address Resident #4 wandering into rooms. It was expected residents who wandered were monitored, but there was nothing specific such as making sure they did not go into Resident #5's room. During an interview on 9/16/2024 at 3:31 PM the Director of Social Services stated when Resident #5 was admitted , they had intact cognitive function and made their own healthcare decisions. The decision to move Resident #5 to the Fourth Floor was based on their potential to have an altercation with a roommate and they were provided with a private room. They were aware of Resident's #5's history, and knew they had to be worried about females on the unit. They determined the resident's behavior toward females could be better managed than a potential physical altercation with roommates. Resident #5 received constant counseling and reminders about their inappropriate behaviors, and they thought the resident understood. The verbal intervention was not effective as the resident continued to exhibit a pattern of sexually inappropriate behaviors. There were no other interventions in place to protect other residents or address Resident #5's behaviors. The Director of Social Services stated their 11/2/2023 progress note about Resident #5 asking a female resident to undress was referring to Resident #4. Resident #4 was known to wander at times. They were unaware of any interventions put in place to protect Resident #4 after the 11/2/2023 incident, aside from redirection. The Director of Social Services was responsible for behavioral care planning and coordination of behavioral health services. The Director of Social Services reviewed Resident #5's 11/15/2023 evaluation completed by Psychologist #26. They did not recall if there were any recommendations and did not recall discussing Resident #5 with the psychologist. When asked if steps should have been taken to address Psychologist #26's note that Resident #5 was at risk of sexually offending on demented, non-consenting females, the Director of Social Services stated they were unaware of how to respond. They were unaware of the reason Resident #5 remained on the Fourth Floor despite the risk to female residents with dementia. During an interview on 9/16/2024 at 4:51 PM, the Administrator stated the residents on the Fourth Floor primarily had dementia. Generally, a resident with intact cognitive function would not be placed on the Fourth Floor. Resident #5 was at risk being on the Fourth Floor due to their history of sexually inappropriate behaviors and intact cognition. The residents on the Fourth Floor were at risk of being abused due to cognitive decline and being more vulnerable. Resident #5 should have been moved from the Fourth Floor following incidents when they were inappropriate or attempted to be sexually inappropriate with female residents. Additionally, following the 11/15/2023 Psychologist #26 evaluation, the resident was not appropriate to remain on the Fourth Floor. The Administrator stated staff should have acted sooner to prevent sexual abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 9/17/2024 at 12:09 PM, Registered Nurse Supervisor #12 stated on 12/30/2023, they were notified of the incident at the time as noted on the incident report and assessed Resident #4 then. They did not recall the incident occurring at 10:45 AM, as they responded at 4:59 PM. The Registered Nurse Supervisor was unaware of the reason the notifications and interventions were all documented on 12/31/2023 and stated they addressed everything on 12/30/2023. During a telephone interview on 9/19/2024 at 9:57 AM, Licensed Practical Nurse #16 stated on 12/30/2023, they were alerted by Resident Assistant #14 that Resident #4 was in Resident #5's room engaging in a sexual act. Certified Nurse Aide #15 walked Resident #4 out of the room and the nurse called Registered Nurse Supervisor #12. The supervisor arrived and spoke to Resident #5 and assessed Resident #4. The nurse could not recall the time the supervisor arrived. They could not recall if the police were notified, if Resident #5 was moved to another floor, or if one-to-one supervision was implemented on 12/30/2023 or 12/31/2023. Resident #4 often walked about the unit halls and went in and out of other resident rooms. Resident #5 appeared to have intact cognitive function and Licensed Practical Nurse #16 was unaware of the reason they were moved to a unit with residents with dementia. Resident #5 required ongoing redirection for their inappropriate comments to residents. The nurse was unaware of any other interventions in place to address residents who wandered into other rooms or to monitor Resident #5 when near female residents. During an interview on 9/20/2024 at 12:27 PM, Licensed Practical Nurse Manager #3 stated they covered the Fourth Floor from 10/2023 through 12/2023. They were aware of Resident #5's sexually inappropriate behaviors when the resident was moved to the Fourth Floor. Resident #5 frequently asked female residents for sexual favors and asked them to go into Resident #5's room. Licensed Practical Nurse Manager #3 was aware of Psychologist #26's evaluation on 11/15/2023 as they read it in the resident's record. The psychologist did not speak to nursing staff related to their evaluations and there was no process for evaluations to be communicated to medical or social services staff. The Nurse Manager attempted to address the concerns noted in the evaluation with the Director of Social Services who stated Resident #5 was not going to change. The Nurse Manager was concerned that Resident #5 was at risk to abuse females with dementia on the Fourth Floor and discussed their concerns with the Director of Social Services multiple times. The Nurse Manager also addressed their concerns at morning meetings when multiple department managers were in attendance. The resident remained on the Fourth Floor despite the Nurse Manager's concerns. There were no specific steps taken to protect the residents on the Fourth Floor, as the social services staff responded by going and speaking to Resident #5. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with Certified Nurse Aide #15 on 9/20/2024 at 4:13 PM, they stated Resident #5 exhibited sexually inappropriate behaviors since they were moved to the Fourth Floor in 10/2023. Resident #5 asked female residents for sexual favors, attempted to, or did touch them, and asked female residents with dementia to go in their room. They constantly redirected Resident #5 and reported their concerns multiple times. The resident remained on the unit and the aide was unaware of any interventions in place, aside from monitoring and redirection. On 12/30/2023, Resident Assistant #14 approached Certified Nurse Aide #15 at the nurse's desk and stated Resident #4 was in Resident #5's room. Certified Nurse Aide #15 went to Resident #5's room, which was toward the far end of the hall. The nurse aide observed Resident #4 sitting on the edge of the bed, Resident #5 was lying on the bed with their pants down and Resident #4 was touching Resident #5's penis. The aide immediately brought Resident #4 out of the room and reported to Licensed Practical Nurse #16. Certified Nurse Aide #15 was certain this occurred prior to lunch, as they noted the time in their statement of 10:45 AM. They did not work past 2:00 PM, and it could not have occurred later in the afternoon. The aide did not recall seeing a supervisor come to the unit following the incident. The following day, on 12/31/2023, Resident #5 remained on the unit and there was no one-to-one supervision for Resident #5. 10NYCRR 415.4(b)(1)(i) ____ Immediate Jeopardy was identified, and the Administrator was notified on 9/16/2024 at 7:08 PM. Immediate Jeopardy was removed on 9/20/2024 at 5:17 PM prior to survey exit based on the following corrective actions taken: 1. A comprehensive review of the past 90 days of all current residents' records (progress notes, incidents) was completed on 9/20/2024, by the Corporate RN. The review included direct care staff interviews by the Corporate RN to identify any potential unidentified behavioral concerns. 2. A review of all behavioral consults the past 30 days was completed by 9/20/2024 to ensure any recommendations were for addressed. 3. A Regional Administrator/Licensed Master Social Worker and telehealth psychology services were identified for availability for consultation as needed. 4. As of 9/20/2024, 100% of all staff currently working have been educated on abuse, sexual abuse prevention, responding to abuse, signs of abuse, steps to take to protect residents, and reporting abuse. 5. As of 9/20/2024, 86% of the total staff population have received education, with education planned to continue until 100% is reached. 6. As of 9/20/2024, 100 % of all supervisors were educated on response to abuse allegations, including documentation and protection of residents. 7. The remaining staff will be educated prior to the start of their next shift or upon return from their leave. (continued on next page)

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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. 37385 Based on record review and interviews during abbreviated surveys (NY00330966, NY00344094, and NY00344130), the facility did not ensure allegations of abuse and neglect were thoroughly investigated for 4 of 6 residents (Residents #4, #5, #6, and #9) reviewed, and an additional 6 unidentified residents. Specifically, facility investigations did not identify concerns related to: - Resident #4, a cognitively impaired resident, was found in Resident #5's room engaging in a sexual act and was not assessed by a qualified professional timely, protective interventions were not implemented timely, police, family, and the medical provider were not notified timely, and a staff member left the residents after discovering them engaged in a sexual act. Cross referenced in F 600 Free from Abuse and Neglect and F 684 Quality of Care. - Resident #5 was involved in a physical altercation with Resident #6, they were not assessed by a qualified professional timely and a staff member documented they notified a supervisor who declined to assess the resident at the time. Cross referenced in F 684 Quality of Care. - Resident #9 was given vaccinations by an unqualified staff member who was not suspended pending the investigation. - Resident #5 had sexually inappropriate behaviors toward other residents documented in their medical record on 6 instances. The 6 residents involved were not identified and there were no corresponding investigations related to the incidents. Cross referenced in F 600 Free from Abuse and Neglect. Findings include: The facility policy, Seven Components of a Systematic Approach to Abuse Prohibition, effective 8/2020 documented: - Verbal abuse was defined as the use of oral, written, or gestured language in a derogatory and disparaging manner. - Sexual abuse included, but was not limited to, the use of sexual coercion, sexual harassment, or sexual assault. - The facility requires reporting of any potential violation to administration, will take immediate action to address actual occurrences. - The facility will immediately initiate, and conduct a thorough investigation, that includes appropriately managing the investigation to ensure a factual and objective accounting of the events to determine if potential abuse, neglect, mistreatment has occurred. - Protect residents during abuse investigations. Employees accused of participating in the alleged abuse will be immediately reassigned to duties that do not involve resident contact or will be suspended until the findings of the investigation have been reviewed by the Administrator. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1) Resident #4 had diagnoses including dementia and anxiety disorder. The 12/1/2023 Minimum Data Set assessment documented the resident had severe cognitive impairment and exhibited behaviors of wandering. The resident was independent for transfers and walking. Resident #5 had diagnoses including cerebral infarction, dementia, and impulse disorder. The 10/11/2023 Minimum Data Set assessment documented the resident had intact cognition and exhibited verbal behaviors toward others. The resident's behaviors impacted others by significant intrusion of privacy or activity and significant disruption of care or the living environment. The 12/30/2023 untimed Resident Accident/Incident Report documented Resident #5 was observed with another resident (Resident #4) in Resident #5's bed. Certified Nurse Aide #15 was assigned to Resident #5 and Resident Assistant #14 reported the occurrence. There was no documented statement from Resident #5, their mental status was noted as oriented, with behaviors present noted as perversion. Registered Nurse Supervisor #12 was notified on 12/30/2023 at 4:59 PM. The medical provider was notified on 12/31/2023 at 7:50 AM, and Resident #4's relative was notified on 12/31/2023 at 7:15 AM. The form was signed by Registered Nurse Supervisor #12 and dated 12/31/2023 at 7:15 AM. The 12/30/2023 at 5:30 PM Licensed Practical Nurse #16 progress note documented staff reported a resident was observed in Resident #5's room, acts being performed by the other resident, and they were taken out of the room immediately. The Supervisor was made aware. There was no documented evidence Resident #4 was assessed immediately following the incident. There was no documented evidence Resident #4's family and medical provider were notified on 12/30/2023, or that the police were notified on 12/30/2023. There was no documented evidence Resident #5 was placed on one-to-one supervision or moved to another unit on 12/30/2023. There was no documented evidence of steps taken to protect Resident #4 and other residents on 12/30/2023. Resident Assistant #14's statement dated 12/31/2023 documented they found Resident #4 on Resident #5's bed and Resident #4 had their hand on Resident #5's penis. Resident Assistant #14 asked Resident #4 to go with them and had to go get another staff member due to Resident #5 having their hand on Resident #4's hand and said [Resident #4] does it so good. Certified Nurse Aide #15's written statement dated 12/31/2023 documented on 12/30/2023 at 10:45 AM, they were notified by Resident Assistant #14 that Resident #4 was in Resident #5's room. Certified Nurse Aide #15 went to Resident #5's room and observed Resident #4 playing with [Resident #5's] private parts. Certified Nurse Aide #15 took Resident #4 out of the room and reported to the nurse. When the aide went to work the following morning, the night shift staff were not aware of the incident, and it was not reported to them and was not charted until 12/31/2023. The 12/31/2023 at 7:18 AM Registered Nurse Supervisor #12 progress note documented Resident #4's representative was notified of the incident. The 12/31/2023 at 7:52 AM Registered Nurse Supervisor #12 progress note documented Nurse Practitioner #27 was notified of the new incident involving Resident #5. The Nurse Practitioner was informed that administration was currently deliberating a plan of action, and the resident was on one-to-one supervision. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview with Registered Nurse Supervisor #12 on 9/17/2024 at 12:09 PM, they stated on 12/30/2023, they were notified of the incident at the time as noted on the incident report and assessed the resident at that time. They did not recall the incident occurring at 10:45 AM, as they responded at 4:59 PM. The Registered Nurse Supervisor was unaware of the reason the notifications and interventions were all documented on 12/31/2023 and stated they addressed everything on 12/30/2023. During an interview with Certified Nurse Aide #15 on 9/20/2024 at 4:13 PM they stated on 12/30/2023, Resident Assistant #14 approached Certified Nurse Aide #15 at the nurse's desk and stated Resident #4 was in Resident #5's room. Certified Nurse Aide #15 went to Resident #5's room, which was toward the far end of the hall. The nurse aide observed Resident #4 sitting on the edge of the bed, Resident #5 was lying on the bed with their pants down and Resident #4 was touching Resident #5's penis. The aide immediately brought Resident #4 out of the room and reported to the nurse. Certified Nurse Aide #15 was certain this occurred prior to lunch, as they noted the time in their statement of 10:45 AM. They did not work past 2:00 PM, and it could not have occurred later in the afternoon. The aide did not recall seeing a supervisor come to the unit following the incident. The aide stated they noted in their written statement that staff on the 12/30-12/31/2023 night shift were not aware of the incident when they went to work on 12/31/2023 in the morning. Resident #5 remained on the unit and there was no one-to-one supervision for Resident #5. Certified Nurse Aide #15's 12/30/2024 time sheet documented they clocked out at 2:09 PM. During a telephone interview on 9/19/2024 at 9:57 AM, Licensed Practical Nurse #16 stated on 12/30/2023, they were alerted by Resident Assistant #14 that Resident #4 was in Resident #5's room engaging in a sexual act. Certified Nurse Aide #15 walked Resident #4 out of the room and the nurse called Registered Nurse Supervisor #12. They could not recall the time of day and thought it was near the end of the day shift. They stated they notified the supervisor right after the incident was reported to them. The nurse did not recall if there was a delay in the supervisor responding to the unit, or if Resident #5 was moved to another floor and if 1:1 supervision was implemented. During a telephone interview with the Director of Nursing and the Administrator on 10/4/2024 at 12:38 PM, they stated investigations were utilized to rule abuse and systemic issues that may have contributed. On 12/30/2023, Resident #4 should have been assessed immediately following the incident. In the absence of the Director of Nursing and Administrator following the incident on 12/30/2023, Registered Nurse Supervisor #12 was responsible to ensure timely notifications, assessment, and interventions. They did not address the discrepancies in the times and days of the notification to family, medical, and police. The notifications should have been made the day of the incident and the protective interventions should have been put in place immediately. 2) Resident #5 had diagnoses including cerebral infarction, dementia, and impulse control disorder. The 5/16/2024 Minimum Data Set assessment documented the resident had moderate cognitive impairment and exhibited behaviors of rejection of care 1 to 3 days of the assessment period. The resident required partial/moderate assistance for walking and was independent with wheelchair mobility. Resident #6 had diagnoses including dementia, impulse disorder, and expressive language disorder. The 5/2/2024 Minimum Data Set assessment documented the resident had severe cognitive impairment and did not exhibit behavioral symptoms. The resident utilized a manual wheelchair and was independent with wheelchair mobility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 6/3/2024 Resident Accident/Incident Reports for Residents #5 and #6 documented: - on 6/2/2024 at 6:15 PM, Resident #5 was speaking loudly to another resident. When Resident #5 left the dining room, Resident #6 took Resident #5's hand, they were pulling back and forth, as Licensed Practical Nurse #9 separated them, Resident #5 slid from their wheelchair. - Registered Nurse Supervisor #33 was notified on 6/2/2024 at 6:15 PM. The Director of Nursing was noted as having completed the assessment with no injuries noted. Physician #32 was notified on 6/2/2024 at 7:00 PM, with no new orders. - The residents' representatives were notified on 6/3/2024 at 10:00 AM. - The Nurse Manager/Nurse Supervisor signature line was signed by the Director of Nursing on 6/3/2024. - Licensed Practical Nurse #9's written statement documented on 6/2/2024 at 5:45 PM, in the common area (area outside the dining room), Resident #5 was arguing with another resident. The nurse asked them to stop, and Resident #6 wheeled out of the dining room and grabbed Resident #5's hand. The residents were tugging, and the nurse grabbed both residents, and Resident #5 slipped out of the chair to the floor. The supervisor (later identified as Registered Nurse Supervisor #33) was notified by Licensed Practical Nurse #9 and the supervisor stated they were leaving, and the next supervisor was arriving at 7:00 PM. Resident #5 stated they were all right and staff helped them to the chair. There were no documented progress notes for Residents #5 or #6 on 6/2/2024. There was no documented evidence Residents #5 was assessed by a qualified professional prior to or after being assisted off the floor following the incident on 6/2/2024. There was no documented evidence Residents #6 was assessed by a qualified professional following the incident on 6/2/2024. The 6/2/2024 Nursing Schedule documented Registered Nurse Supervisor #33 was the supervisor until 5:00 PM. There was no supervisor included on the schedule for the 2:00 PM to 10:00 PM shift. Registered Nurse Supervisor #33's 6/2/2024 time sheet documented they clocked out at 6:21 PM. The 6/3/2024 at 2:59 PM Registered Nurse Supervisor #13's progress note in Resident #6's record, documented they physically assessed the resident. No injuries were noted. The 6/3/2024 at 3:02 PM Registered Nurse Supervisor #13's progress note in Resident #5's record, documented they physically assessed the resident. No injuries were noted. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The unsigned, undated Investigative Summary documented on 6/2/2024 at 6:15 AM, Resident #6 took Resident #5's hand and pulled them out of their wheelchair. The residents were immediately separated and assessed with no negative findings. The investigation summary did not address the delay in assessment or notification of the residents' representatives. It did not address the statement from Licensed Practical Nurse #9 that the supervisor on duty declined to respond to the unit to assess the residents. During an interview on 9/10/2024 at 4:10 PM Licensed Practical Nurse #9 stated on 6/2/2024, they witnessed the altercation between Residents #5 and #6. Resident #5 was heard yelling in the dining room with another resident and then exited the dining room to the common area where the nurse was located. As Resident #5 exited the dining room, Resident #6 came out after them, yelled something and grabbed Resident #5's arm, and Resident #5 fell out of their wheelchair. They called Registered Nurse Supervisor #33, who stated they were leaving and told the licensed practical nurse to call the supervisor who was coming on the next shift. The licensed practical nurse was upset by this, and this was the reason they included it on their statement. The nurse stated another Registered Nurse whose name they could recall arrived and assessed Resident #5 prior to getting them back into the wheelchair. During an interview on 9/20/2024 at 3:43 PM Registered Nurse Supervisor #3 stated on 6/2/2024, they did not assess Residents #5 or #6 following the resident-to-resident altercation. When Registered Nurse Supervisor #33 was asked about it (by facility management), they looked in their calendar, as they kept notes about their activities while on duty to ensure they had a record. They stated there were no notes related to being called to assess any residents following an altercation or a fall. They were not notified of an incident on 6/2/2024 at 6:15 PM and would not tell a nurse to call the next supervisor. They were unaware of the reason their name was on the incident reports. If they had been notified near the time they were leaving, they would have stayed and responded to the resident or if they notified another supervisor, they would document it to ensure someone else could assess the residents. During a telephone interview with the Director of Nursing and the Administrator on 10/4/2024 at 12:38 PM, they stated Residents #5 and #6 should have been assessed immediately following the incident. There was no documented assessment on 6/2/2024 and that the was the reason the Director of Nursing completed the assessments on 6/3/2024. If there was no Registered Nurse Supervisor available in the building, the nurse should have called the medical provider before assisting the resident from the floor and this should be documented. They were unaware if Licensed Practical Nurse #9 notified a medical provider. They addressed Registered Nurse Supervisor #33 for reportedly not responding prior to the end of their shift. The medical provider and family/resident representatives should have been notified on 6/2/2024 after the incident. The investigation was not thoroughly completed and should have addressed the delays in notification and assessment. 3) Resident #9 had diagnoses including acute pulmonary edema and type 2 diabetes. The 5/1/2024 Minimum Data Set assessment documented the resident had intact cognition. The resident was up to date on their pneumococcal vaccination and received their influenza vaccination on 4/29/2024. The Investigation Summary completed by the Administrator documented: - on 4/30/2024, Certified Occupational Therapy Assistant #34 observed Certified Nurse Aide #1 giving an injection to Resident #9. The occupational therapy assistant immediately reported to their supervisor, who then reported it to the Director of Nursing. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The Director of Nursing identified that Licensed Practical Nurse #2 was assigned to the resident. The nurse admitted they had given Certified Nurse Aide #1 the instruction to administer the injection. - Licensed Practical Nurse #2's written statement, dated 5/6/2024 at 1:00 PM, documented they instructed the certified nurse aide to give the injection. - Certified Nurse Aide #1 was questioned and admitted to giving the injection at the direction of Licensed Practical Nurse #1. - The resident was assessed and found to have no negative result. - Both employees were suspended immediately, and the incident was reported to the Office of Professions on 5/14/2024. - Certified Occupational Therapy Assistant #34's written statement, dated 4/30/2024 documented they observed Certified Nurse Aide #1 giving Resident #9 an injection in their left arm. The facility investigation did not address: - the type of vaccination the certified nurse aide administered; - the discrepancies in the Medication Administration Records (showing the influenza and pneumonia vaccinations given 4/29/2024 and not signed on 4/30/2024, the date it was noted they were given per the Director of Nursing's 4/30/2024 progress note, or that the COVID-19 vaccination was given 5/1/2024) and the Immunization Report (showing influenza and pneumonia vaccinations given 4/29/2024 and COVID-19 immunization given 4/30/2024); - the 5/1/2024 struck out progress note entered by the Assistant Director of Nursing related to the administration of the COVID-19 vaccine; - the medication error, duplication of vaccine administration; - the lack of medical provider notification related to the medication error; - the lack of disclosure to the resident related to the medication error and the unqualified staff who administered the vaccination; and - the delayed suspension of Certified Nurse Aide #1 following an allegation. Certified Nurse Aide #1's timecard documented: - on 4/30/2024, they clocked in at 6:20 AM, and clocked out at 7:39 PM, - on 5/1/2024, the clocked in at 6:07 AM, and clocked out at 2:04 PM. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 4/30/2024 Daily Nursing Schedule documented Certified Nurse Aide #1 was scheduled for the 6:00 AM to 2:00 PM and the 2:00 PM to 10:00 PM shifts on the second floor. There was a check by their name for both shifts, indicating they were present for the shift. The 5/1/2024 Daily Nursing Schedule documented Certified Nurse Aide #1 was scheduled for the 6:00 AM to 2:00 PM, on the second floor. There was a check by their name, indicating they were present for the shift. During a telephone interview on 9/25/2024 at 3:08 PM, Resident #9 stated they received the flu and pneumonia vaccine, one in each arm. They remembered the staff who administered the vaccinations but was unsure if they were a nurse or an aide. There was no one with the staff member when they administered the vaccines. During a telephone interview on 9/26/2024 at 9:15 AM, Certified Occupational Therapy Assistant #34 stated on 4/30/2024, they entered Resident #9's room at some time before lunch and observed Certified Nurse Aide #1 administer an injection in Resident #9's left arm. The aide was alone in the room with the resident and the therapy assistant did not observe a nurse in the area. They immediately reported to their supervisor, who was directly across the hall, and they (both the Certified Occupational Therapy Assistant and their supervisor) immediately went to the Director of Nursing to report the incident. The therapy aide did not overhear Certified Nurse Aide #1 or Resident #9 say anything and did not address either one at that time. They were certain this occurred on 4/30/2024, as there was no delay in reporting or giving their statement. During a telephone interview on 10/2/2024 at 9:09 AM Certified Nurse Aide #1 stated they administered one vaccination to Resident #9 on 4/30/2024 under the direction of Licensed Practical Nurse #2. They administered one vaccination and could not recall the type of vaccination they administered. They stated they were called to the Administrator's office shortly after giving the immunization and took responsibility for their actions. They completed their shift that day, returned the following day and worked their shift, and was then suspended pending outcome of the investigation. During a telephone interview with the Director of Nursing and the Administrator on 10/4/2024 at 12:38 PM, they stated on 4/30/2024, the incident was immediately reported, and the investigation began immediately. The Director of Nursing and the Administrator spoke to Licensed Practical Nurse #2 and Certified Nurse Aide #1 as soon as it was reported. The employees refrained from commenting about the incident at that time. They were both suspended pending the investigation. The Administrator and Director of Nursing were unaware of the reason Certified Nurse Aide #1's timecards showed they worked until 7:39 PM on 4/30/2024, as they were suspended near the end of the first shift (approximately 2:00 PM). They were unaware of the reason Certified Nurse Aide #1's timecard showed they worked on 5/1/2024, as they were still under suspension and should not have worked. 10NYCRR 415.4(b)(3)

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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. 37385 Based on record review and interviews during the abbreviated survey (NY00330966) the facility did not ensure that Comprehensive Care Plans were reviewed and revised to meet the needs of each resident for 3 of 12 residents (Residents #4, #5, and #13) reviewed. Specifically, Resident #5 exhibited sexually inappropriate behaviors and did not have an individualized care plan to address their behaviors. When their behaviors continued, the care plan was not updated to ensure protection of other residents. Residents #4 and #13 were at risk of being sexually abused and their care plans were not updated to prevent abuse. Findings include: The facility policy, Comprehensive Care Planning, revised 5/2023, documented: - the comprehensive care plan would be prepared by an Interdisciplinary Team that included: the resident/representative, social services, nursing, activities, dietary, rehabilitation, and medical. - The Interdisciplinary Team would review and revise the care plan quarterly, with significant change, annually, and as needed. - A licensed practical nurse may gather data for the care plan and make entries related to episodic short-term care plans. - The care plan must be individualized. - The care plan would be kept current buy all disciplines on an ongoing basis. Disciplines were responsible for updating their respective care plan on a continual basis. 1) Resident #5 had diagnoses including cerebral infarction (stroke), dementia, and impulse disorder. The 10/11/2023 Minimum Data Set assessment documented the resident had intact cognition, exhibited verbal behaviors toward others that impacted others by significant intrusion of privacy or activity and significant disruption of care or the living environment. Resident #5's admission records included medical and psychiatric provider notes from the long-term care facility from where they were transferred. On 8/21/2023 and 9/11/2023, Nurse Practitioner # 25 (also a provider for the current facility) documented the resident made very explicit inappropriate comments to residents and staff. The resident was redirected and stated they could not help themself. On 8/30/2023, Psychiatric Nurse Practitioner #24 from the resident's prior facility (also a provider for the current facility) documented the resident had a history of sexually inappropriate behaviors, a history of touching other residents in a sexual manner and remained verbally inappropriate. Staff were advised to ignore their comments and keep the resident away from female residents. The resident appeared to have impulse control disorder and was noted to make very explicit vulgar sexual comments to female staff. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 10/9/2023 at 8:04 PM Licensed Practical Nurse #11 progress note documented the resident was very inappropriate to another (unidentified) resident, asking them for sexual favors. The 10/9/2023 Social Worker #23 progress note documented they met with the resident after multiple reports of inappropriate comments to staff. The Comprehensive Care Plan initiated 10/11/2023 documented the resident would make sexual comments toward staff and others related to dementia, ineffective coping skills, mental/emotional illness, and poor impulse control. Interventions included: administer medications as ordered; analyze key times places, circumstances, triggers, what de-escalates behavior and document; assess and anticipate needs, food, thirst, toileting needs, comfort level, body positioning, pain; positive feedback for good behavior; psychiatric/psychology consult as needed; and redirect when inappropriate. The care plan did not address the resident's specific behaviors of asking other residents for sexual favors or their history of touching residents in a sexual manner. On 10/28/2023, Psychiatric Nurse Practitioner #24 documented Resident #5 attempted to touch female residents inappropriately and was noted to make frequent very explicit vulgar sexual comments to female staff. On 11/1/2023 at 12:08 PM, Licensed Practical Nurse #10 documented the resident made sexual comments to two (unidentified) female residents stating, come sit on my mustache. When addressed, the resident stated one of the residents showed them her breasts. The 11/2/2023 at 2:12 PM Director of Social Services progress note documented they spoke to the resident about recent reports of speaking in an inappropriately in a sexual manner, Today, a resident (later identified as Resident #4 in an interview) was reportedly wandering into Resident #5's room and Resident #5 requested they (Resident #4) disrobe. The Director of Social Services suggested if the resident could not change, the next step would be issuing a discharge notice. There were no documented interventions for Resident #5 to address Resident #4 or any other residents who may wander into Resident #5's private room. The 11/10/2023 at 1:37 PM Licensed Practical Nurse Manager #3 documented Resident #5 was moved to the south end of the fourth floor, the male end of the unit. The 11/13/2023 at 8:19 PM progress note entered by Social Worker #23 documented the resident continued to make vulgar comments to staff and other residents. The 11/14/2023 Nurse Practitioner #20 progress note documented the resident had ongoing sexual inappropriate behaviors at the current facility and former. They had been found asking female residents with dementia for sexual favors. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 11/15/2023 Psychologist #26 evaluation documented Resident #5 was referred for making sexually inappropriate comments to staff and residents. Staff were particularly concerned that Resident #5 was inviting female residents with dementia to go to their room, apparently for sexual favors. The resident admitted to making comments, found it funny, and reported they had no interest in changing their behavior. The resident was at moderate risk of sexual offending with concern about them sexually abusing non-consenting demented females. Recommendations included close supervision, refrain from overreaction, as any reaction could reinforce their behavior, keep them busy, encourage them to work on model cars. There was no documented evidence of steps taken to address Psychologist #26's recommendations. The 12/17/2023 at 10:22 PM Licensed Practical Nurse #16 progress note documented the resident asked another (unidentified) resident to go to their room and sleep with them. The 12/20/2023 at 8:17 PM, Social Worker #23 documented they met with Resident #5 again over their inappropriate language. The social worker reminded the resident they could be in a lot of trouble if they continued with this behavior. The 12/30/2023 at 5:30 PM Licensed Practical Nurse #16 progress note documented staff reported a resident was observed in Resident #5's room, acts being performed by the other resident, and they were taken out of the room immediately. The comprehensive care plan initiated 1/1/2024 documented: - The resident was abusive toward others, acted out impulsively, attempted to extort or manipulate others for personal gain, demonstrated inappropriate sexual behaviors, was abusive to caregivers. The resident often made sexual advances toward staff and other residents. On 12/30/2023, they had sexually inappropriate behaviors with another resident. Interventions included involve family and notify of incident, medication per physician order and monitor effectiveness, psychiatry consult and follow up as needed, room change/floor change, and 1:1 supervision. The care plan was updated on 1/22/2024 to remove 1:1 supervision and added 15-minute checks. -The resident's room was changed from the fourth floor to the third floor on due to sexually inappropriate behaviors with another resident. Nursing progress notes on 2/19/2024, 3/23/2024, 4/12/2024, and 4/22/2024 documented the resident continued to make sexually inappropriate comments to staff. The 4/24/2024 Social Worker #23 progress note documented they spoke to the resident about their inappropriate comments to staff. The 5/12/2024 at 9:21 PM Licensed Practical Nurse #17 progress note documented the resident was verbally abusive to residents and staff in the dining room. The Comprehensive Care Plan was last updated on 6/7/2024 to address physical and verbal resident-to-resident altercations. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Utica Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2535 Genesee Street Utica, NY 13501	

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 7/15/2024 at 2:46 PM Registered Nurse Supervisor #13 progress note documented Resident #5 was overheard asking a peer in the dining room for a kiss. Before leaving the dining room, the resident (Resident #13) leaned over and kissed Resident #5 on the lips. The residents were counseled individually on appropriate behaviors. The 7/15/2024 at 3:18 PM Director of Social Services note documented Resident #5 was a recipient of a sign of affection from a peer (Resident #13). They reminded Resident #5 they had been spoken to many times about encouraging such behavior from peers. Resident #5 denied their instigation. The Director of Social Services emphasized the brevity of the situation including the possibility of family making charges against Resident #5. There was no documented evidence of review of Resident #5's care plan, or of person-centered interventions to address their ongoing behaviors toward other residents. 2) Resident #4 had diagnoses including dementia and anxiety disorder. The 12/1/2023 Minimum Data Set assessment documented the resident had severe cognitive impairment, exhibited behaviors of wandering, and was independent with transfers and walking. Resident #4's comprehensive care plan initiated 10/6/2022 documented: - the resident was at risk of wandering related to a diagnosis of dementia, was disoriented to place, had impaired safety awareness, and wandered without regard of a specific destination. Interventions included: distract from wandering by offering pleasant diversions, structured activities, food, conversation, television, books, walking outside, reorientation, toileting. The resident preferred visits with family and reminiscent therapy. - The resident had the potential to be abused by others and was a victim of resident abuse previously. The resident was vulnerable due to cognitive disabilities, touched other residents when passing, bumped into other residents, liked to push other residents in their wheelchairs, was unable to perceive harmful situations, and unable to communicate needs effectively. On 5/23/2023, there was a resident-to-resident incident. Interventions included: attempt to respect resident's personal space, invite to activities/remove to room when bothersome to others, and remove to quiet environment when showing sign of potential of abuse. The 11/2/2023 at 2:12 PM Director of Social Services progress note (documented in Resident #5's record) included a resident (later identified as Resident #4 during an interview) was reportedly wandering into Resident #5's room and Resident #5 requested they (Resident #4) disrobe. There was no documented Comprehensive Care Plan updates or interventions related to Resident #4 being at risk of sexual abuse by another resident on the unit who made an inappropriate sexual request. The Resident Accident/Incident Report documented on 12/30/2023, Resident #4 was observed in Resident #5's bed, engaging in a sexual act. 3) Resident #13 had diagnoses including Alzheimer's Disease. The 4/23/2024 Minimum Data Set assessment documented the resident had severe cognitive impairment and did not exhibit behavioral symptoms. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 7/15/2024 at 2:39 PM Registered Nurse Supervisor #13 progress note documented the resident was eating lunch when a peer (Resident #5) asked the resident for a kiss, before leaving the room, Resident #13 leaned over and kissed Resident #5 on the lips. Both residents were counseled individually by staff regarding appropriate behaviors. Seating changes were made to prevent recurrence. Resident #13 was slightly standoffish with staff but accepting of the information. The 7/15/2024 at 3:10 PM Director of Social Services progress note documented Resident #13 gave a peer (Resident #5) a kiss during the lunch meal. The Director of Social Services noted Resident #13 grinned and was blushing like a schoolgirl when they spoke to the resident, and it was a positive seeing them smile. The Director of Social Services added that they suspected the peer (Resident #5) was giving Resident #13 some positive attention, and they were aware of Resident #5's reputation. The Director of Social Services noted their fear was Resident #13 would feel like they were being punished for expressing affection. The situation would bear some monitoring. The comprehensive care plan last updated 8/31/2024 did not include any documented updates or interventions related to Resident #13 being at risk of abuse by another resident on the unit who made an inappropriate sexual request. During an interview on 9/20/2024 at 12:27 PM Licensed Practical Nurse Manager #3 stated they were aware of Resident #5's sexually inappropriate behaviors when the resident was moved to the fourth floor. Resident #5 frequently exhibited behaviors of asking female residents for sexual favors and asking them to go into Resident #5's room. There were no specific steps taken to protect the residents on the fourth floor, as the social services staff responded by speaking to Resident #5. When Resident #5 moved to the third floor, they exhibited the same behaviors. The Nurse Manager was unaware of any new interventions aside from monitoring and seat assignments in the dining room. Resident #13 was cognitively impaired, described as a people pleaser, and would often do anything asked of them. On 7/15/2024, when Resident #5 asked Resident #13 for a kiss, it appeared innocent, and their seats were changed. There were no care plan updates for either resident, although there should have been. It was a potential trigger for Resident #5, due to their history, and could be interpreted as a signal to continue to try and engage Resident #13 in sexual favors. During a telephone interview on 9/19/2024 at 9:57 AM Licensed Practical Nurse #16 stated on 12/30/2023, they were alerted by Resident Assistant #14 that Resident #4 was in Resident #5's room engaging in a sexual act. Resident #4 often walked about the unit halls and went in and out of other resident rooms. Resident #5 required ongoing redirection for their inappropriate comments to residents. The nurse was unaware of any other interventions in place to address residents who wandered into other rooms or to monitor Resident #5 when near female residents. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/16/2024 at 3:31 PM the Director of Social Services stated they were responsible for behavioral care planning. When asked if behavioral care plans were discussed at the interdisciplinary team meetings, they stated if that meant hey [name, Director of Social Services] make a behavioral care plan for this, then yes. The Director of Social Services was aware of Resident's #5's history, stating they knew they had to be worried about females on the unit. Resident #5 received constant counseling and reminders about their inappropriate behaviors and the Director of Social Services thought the resident understood. The verbal intervention was not effective as the resident continued to exhibit a pattern of sexually inappropriately behaviors. There were no other interventions in place to protect other residents or address Resident #5's behaviors. The Director of Social Services stated their 11/2/2023 progress note about Resident #5 asking a female resident to undress was referring to Resident #4. Resident #4 was known to wander at times. They were unaware of any interventions put in place to protect Resident #4 after the 11/2/2023 incident, aside from redirection. If a resident made sexual comments or sexual requests to other residents, this was indicative of a potential for abuse. Resident #5 received ongoing reminders about their inappropriate behaviors and the resident did not care to acknowledge it. The Director of Social Services stated in Resident #5's defense, sometimes it was innocent, and Resident #5 was labeled. They stated when Resident #5 kissed another resident (later identified as Resident #13), they were showing affection and the other resident felt wonderful because they got some attention. During an interview on 9/16/2024 at 4:51 PM the Administrator stated Social Services was responsible for maintaining behavioral care plans, and nurses could update or add interventions. If interventions were not effective, it should be addressed in morning meetings, at care plan meetings, or discussed with the team as soon as possible. A resident who made sexually inappropriate verbal requests to other residents had the potential for abuse. A care plan should be implemented to address the resident making the request as well as the resident who was asked. Residents who had cognitive impairments were vulnerable to abuse. Resident #4 should have had a specific care plan to address the potential to be victimized due to wandering into other rooms. The intervention of the Director of Social Services speaking to Resident #5 repeatedly was not sufficient to address their behaviors. The care plan was not individualized to address Resident #5's behaviors. 415.11(c)(2)(ii-iii)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34465 Based on record review and interview during the abbreviated survey (NY00340854, NY00335730, NY00340963, NY00330996, and NY00344094), the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 6 of 12 residents reviewed (Residents #1, #2, #3, #4, #5, and #6). -Resident #3, had episodes of vaginal/rectal bleeding, was not assessed by a qualified professional, and the medical provider was not notified timely of the bleeding (8 hours and 15 minutes following onset of bleeding). The provider ordered STAT (immediate) labs, the blood specimen could not be obtained from the resident, and the provider was not notified timely. - Resident #2 had an intact left heel blister and a treatment was ordered. There was no documentation the resident's wound was monitored or assessed after the treatment was ordered, and the care plan was not updated to include interventions. - Resident #1's ordered Lidocaine Pain Patch was not obtained or administered timely. - Resident #4, a cognitively impaired resident, was found in Resident #5's room engaging in a sexual act and Residents #4 and #5 were not assessed timely by a qualified professional. - Resident #5 was pulled from their wheelchair to the floor by Resident #6 and was not assessed timely by a qualified professional. The facility's failure to complete timely assessments, notify the provider, and respond timely to Resident #3's change in condition placed 113 residents in the facility at risk. This resulted in actual harm that was Immediate Jeopardy and Substantial Quality of Care to resident health and safety. Findings include: The facility policy, STAT Orders, dated 6/2022, documented a STAT order was a medical order that needed to be executed immediately due to the urgency of the resident's medical condition. The provider determined the resident's condition required immediate medical intervention, and the provider clearly designated the order was STAT when issued either verbally or in writing. The nurse performed the ordered action as quickly as possible, and documented the exact time the intervention was performed. Any issues related to STAT order execution, such as delays, must be reported to the Director of Nursing for review and potential process improvements. The facility policy, Laboratory, Radiology and Other Diagnostic Services, revised 11/2020 documented if a STAT blood draw was required, the nursing supervisor could draw the lab, call the currier for pick up, or call the lab technician to draw STAT. The medical provider would be notified if a lab test could not be obtained in a timely manner. The medical provider would send resident to the hospital or emergency room as needed for follow up. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility policy, Change in Resident Condition, dated 3/7/2022 documented the Nurse Manager/Nursing Supervisor/designee would notify the resident's medical provider or medical provider on-call when there was significant change in the resident's physical/emotional/mental condition, or any situation which required a change in the resident's plan of care, medication, or treatment regimen; including the following: need for restraints, exacerbation of known condition, onset of new condition, abnormal labs, behavior, intake and output, appetite, weight loss, appointments, elopement and skin breakdown. A significant change of condition was a major decline or improvement in the resident's status that would not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. 1) Resident #3 had diagnoses including cerebral infarction (stroke), anemia in chronic kidney disease, and atrial fibrillation (irregular heart rhythm). The 11/28/2023 Admission Minimum Data Set assessment documented the resident has moderately impaired cognition, required substantial/maximal assistance with activities of daily living, and did not take anticoagulants (blood thinner). The 12/19/2023 physician order documented clopidogrel bisulfate (anticoagulant medication-blood thinner) 75 milligrams one time daily for stroke and aspirin (blood thinner) 81 milligrams daily for stroke. The 12/20/2023 Medication Administration Record documented clopidogrel bisulfate and aspirin were administered at 8:00 AM and scheduled again in 24 hours (12/21/24 at 8:00 AM). A 12/20/2023 at 9:55 PM Licensed Practical Nurse #17 progress note documented Resident #3 was noted with loose bloody stools and the supervisor (unidentified) was notified. There was no documented evidence the resident was assessed by a qualified professional until the following morning, over 11 hours after onset of bleeding, and no evidence the provider was notified until over 8 hours after the onset of bleeding. There was no evidence of a plan for continued monitoring of bleeding or when staff should notify the provider. The resident was prescribed anticoagulant medications and there was no evidence the medication was reviewed by the provider to determine if it should be held. The 12/20/2023 Perfect Serve Interaction Detail Report (on-call provider call log) documented no calls were received regarding the resident. During a telephone interview on 9/16/2024 at 10:13 AM, Licensed Practical Nurse #17 stated they could not recall what supervisor they notified on 12/20/2023 or if the supervisor assessed the resident. They were not sure if a provider was notified. The 12/20/2023 nursing schedule documented Registered Nurse Supervisor #12 was the evening shift Supervisor. During an interview on 9/16/2024 at 10:21 AM, Registered Nurse Supervisor #12 stated if they were notified about the resident's bleeding on the 12/20/2023 evening shift, they would have assessed the resident, called the provider, and documented a progress note. They stated they first heard about the resident's bleeding episode the next day. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A 12/21/2023 at 5:41 AM, Licensed Practical Nurse #18 progress note documented the resident continued to bleed copious amounts of blood from the vaginal area. Licensed Practical Nurse Supervisor #19 was notified and saw the resident. The 12/21/2023 at 5:49 AM Licensed Practical Nurse Supervisor #19 documented the resident continued with one episode of loose bloody stools. The 12/21/2023 at 6:10 AM Licensed Practical Nurse Supervisor #19 progress note documented Nurse Practitioner #21 was called, and they were awaiting a return call. The 12/21/2023 at 6:27 AM provider order entered by Licensed Practical Nurse Supervisor #19 documented to hold clopidogrel and aspirin, and STAT Complete Blood Count (blood test) and Basic Metabolic Panel (blood test). The 12/21/2023 untimed Nurse Practitioner #20 note documented the resident was seen that morning for blood in their brief and bleeding that started last night. The on-call provider was notified overnight (6:24 AM) and ordered to hold clopidogrel and aspirin and obtain STAT blood work. Staff were not able to draw labs this morning due to difficulty and staff stated the resident's fingers were blue. Staff showed them a saturated brief filled with blood and reported the resident had been passing large clots. Assessment: quite pale, fingers cool and capillary refill delay (indicative of poor blood flow). The plan was to send the resident to the hospital. There was no documented evidence a provider was notified timely that STAT labs could not be obtained. The 12/29/2023 hospital discharge summary documented the resident was admitted on [DATE] with gastrointestinal bleeding with acute blood loss anemia and received 3 Units of packed red blood cells (blood transfusion). During a telephone interview on 9/16/2024 at 12:57 PM, Nurse Practitioner #20 stated when the resident had their first episode of bleeding on 12/20/2023, they expected the resident to be assessed, the assessment documented, and a provider notified. If they had been notified, they would have held the resident's clopidegrel and aspirin, ordered vital signs, and ordered STAT labs. They would have also considered sending the resident to the hospital. They assessed the resident on 12/21/2023 around 9:30 AM and was shown the resident's blood and urine filled brief. STAT labs were to be drawn immediately, and they expected to be notified if the labs could not be obtained. A provider was not notified timely. During a telephone interview on 9/17/2024 at 2:16 PM, former Registered Nurse Manager #13 stated STAT labs should be obtained within an hour and if staff were not able to obtain the lab, they should notify a provider. They were not aware a provider was not called when the resident's STAT lab could not be obtained, and the provider should have been notified. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 9/25/2024 at 11:33 AM, the Medical Director stated if a resident was found with rectal bleeding, they expected the resident to be assessed. If that resident was on anticoagulants and was stable during the middle of the night, staff did not need to notify a provider until the morning. However, if a resident's brief was full of blood and vital signs were abnormal, they expected to be notified. They believed the facility contracted with a local lab and the turnaround times for STAT labs was defined by the lab. When it took over 8 hours for a provider to be notified of the resident's bleeding, they stated there was a breakdown in communication between nursing staff and it was the supervisor's responsibility to assess the resident when notified. If the Registered Nurse Supervisor did not assess the resident, they expected the licensed practical nurse to reach out to the next person in the chain of command. They reviewed the resident's record recently and did not see any signs the resident was unstable on 12/20/2023 and 12/21/2023 and the resident's vital signs and oxygen levels were stable. Procedurally, they thought there was an issue however from a clinical standpoint, they did not find any concerns with the resident during chart review. 2) The facility policy, Pressure Injury Prevention and Management/Wound Rounds, revised 12/2023, documented when a resident had an actual pressure injury identified, the nurse in conjunction with the Comprehensive Care Plan Team would review and revise the preventative care plan interventions, implement a care plan for the care of the actual pressure ulcer, and conduct periodic evaluation of the care plan interventions with additional revisions, as appropriate. The nurse was responsible for initiating a Skin Tracking Assessment Sheet. The Registered Nurse Manager/designee was responsible for monitoring and assessing healing/deterioration, minimally on a weekly basis, during Pressure Injury/Wound Rounds. Resident #2 had diagnoses including dementia and heart failure. The 2/21/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, required partial/moderate assistance with rolling right/left, was dependent with transfers, was at risk for pressure ulcers, and had no unhealed pressure ulcers. The 2/22/2024 Comprehensive Care Plan documented the resident had potential for skin impairment and was incontinent. Interventions included turning and positioning every 2 hours, pressure relieving cushion in wheelchair and pressure relieving mattress, and check and change every 3 hours. The 3/4/2024 at 8:40 PM Registered Nurse Supervisor #12 progress note documented the resident had a left heel fluid filled blister found during care. Skin prep (protective skin barrier) was to be applied twice daily. The resident's foot was to be elevated and soft boots applied while at rest. The 3/4/2024 physician order documented to apply skin prep to left heel blister twice daily and leave open to air twice daily. There was no documented evidence the resident's Comprehensive Care Plan was updated to include the skin impairment, or to elevate the resident's foot and apply soft boots at rest. The 3/6/2024 Nurse Practitioner #20 progress note documented the resident's skin was visualized dry and intact and was fragile secondary to natural effects of aging. There was no documentation the resident had a left heel blister. Nursing progress notes dated 3/7/2024 to 3/18/2024 did not include assessments or monitoring of the resident's left heel blister. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The March 2024 Treatment Administration Record documented the resident received skin prep twice daily to their left heel blister from 3/5/2024-3/18/2024. There were 3 opportunities the treatment was not documented as completed. A 3/19/2024 at 2:50 PM former Registered Nurse Supervisor #13 progress note documented the resident was discharged to home with ARC (a national organization that advocates for people with intellectual and developmental disabilities) caregivers. The resident was in stable condition and had no noted skin issues, During a telephone interview on 9/17/2024 at 12:15 PM, Registered Nurse Supervisor #12 stated when a resident was found with a potential pressure ulcer, the provider should be notified to get a treatment order. The Nurse Manager and the Director of Nursing, who oversaw wound care, should also be notified. The team would become aware of skin impairments during morning report as notes were reviewed there. A blister on a bony prominence could lead to a pressure ulcer. On 3/4/2024, they left a note for the Nurse Manager in their office, and they notified the Director of Nursing about the blister on Resident #2's heel. They were not aware the resident's wound had no further follow up and it should have. The care givers should have been made aware of the blister upon discharge so they could continue care. During a telephone interview on 9/26/2024 at 10:39 AM, the Director of Nursing stated when a resident was found with a skin impairment a registered nurse needed to assess and notify the provider for a treatment order. The Nurse Manager was responsible for notifying the wound provider who would assess the resident on wound rounds. They stated they did not recall if they were notified by Registered Nurse Supervisor #12 of the resident's skin impairment and did not recall if the resident's skin impairment was reviewed during morning report the day after the note was written, all progress notes were reviewed during morning report. They stated the resident's skin impairment was a pressure ulcer and should have been monitored weekly by the wound provider. The resident's care plan should have been updated to include interventions noted in Registered Nurse Supervisor #12's note. During a telephone interview on 9/26/2024 at 12:13 PM, former Registered Nurse Manager #13 stated wounds should be assessed and the provider notified to determine a treatment. An Incident Report was also needed when a new wound was found. They did not recall if Registered Nurse Supervisor #12 notified them of the resident's skin issue. The resident should have followed up with the wound care provider and they were not sure why they did not. 3) Resident #1 had diagnoses including dementia and osteoarthritis. The 7/4/2024 Minimum Data Set assessment documented the resident had intact cognition, was independent with most activities of daily living, received a scheduled pain regimen, had occasional pain, and pain occasionally made it hard to sleep at night. The 6/27/2023 physician order documented Lidocaine Pain Relief Patch 4%, apply to back topically one time a day for back pain and remove per schedule. The 7/27/2023 Comprehensive Care Plan documented the resident had potential for pain. Interventions included to administer analgesics as per orders. A 4/5/2024 Medical Director progress note documented the resident had arthritis and pain appeared controlled with the use of Tylenol, Lidocaine Patch, and Voltaren gel. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The 5/2024 and 6/2024 Medication Administration Record documented Lidocaine Pain Relief External Patch 4%, apply to back topically one time a day at 8:00 AM and remove at 8:00 PM. The Lidocaine Pain Relief Patch 4% was documented as not available on: - 5/1, 5/4, 5/5, 5/6, 5/24 and 5/27/2024 by Licensed Practical Nurse #4; - 5/2, 5/9, 5/23, 5/26, 6/4-6/7, 6/11, 6/13, 6/14, 6/20, and 6/25/2024, by Licensed Practical Nurse #28; - 5/12/2024 by Registered Nurse Supervisor #12; - 5/13/2024 by Licensed Practical Nurse #29; - 5/14/2024 by Licensed Practical Nurse #9; and - 5/3 and 6/9/2024 by Licensed Practical Nurse #30. The resident was on a leave of absence with family from 5/15/2024 through 5/21/2024. There were no corresponding nursing notes documenting why the Lidocaine Pain Relief Patch was not available. During a telephone interview on 9/25/2024 at 10:32 AM, Licensed Practical Nurse #28 stated they let a Supervisor or Nurse Manager know if a medication or treatment was not available. They did not recall any issues with the Lidocaine Pain Patches not being available and stated the resident refused the patches most of the time and they should have documented it as a refusal and not as unavailable. During a telephone interview on 9/25/2024 at 12:40 PM, Licensed Practical Nurse Manager #3 stated if a medication was unavailable, the provider should be notified to determine if there was an alternative that could be used. Lidocaine Pain Patches were ordered in bulk by the facility through a distributer and not obtained through the pharmacy. When a resident refused a medication, the nurse would choose option 4 on the Medication Administration Record. This indicated refusal and prompted the nurse to document a note. Option 9 on the Medication Administration Record indicated not available, other, see progress notes, and prompted the nurse to document a progress note. Licensed Practical Nurse Manager #3 reviewed the Medication Administration Record during the telephone interview and stated Licensed Practical Nurse #4 mostly documented on the May 2024 and June 2024 Medication Administration Record the Lidocaine Patch was not available with no corresponding note. Licensed Practical Nurse #28 documented the Lidocaine Patch was on order and there were no corresponding notes. They stated they were only made aware on one occasion in May or June the Lidocaine Patch was not available. During a telephone interview on 9/25/2024 at 4:02 PM, Licensed Practical Nurse #4 stated when a medication or treatment was not available, they ordered it, let the Nurse Manager know or notified the pharmacy. They stated the resident's Lidocaine Pain Patch was frequently unavailable. They believed they let Licensed Practical Nurse Manager #3 know. During a telephone interview on 9/26/2024 at 10:39 AM, the Director of Nursing stated if a medication or treatment was not available the pharmacy should be notified. They were not aware the resident had multiple instances when their Lidocaine Patch was not available. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Utica Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2535 Genesee Street Utica, NY 13501	

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 9/26/2024 at 12:13 PM, former Registered Nurse Manager #13 stated the facility utilized a warehouse to order multiple over the counter medications and treatments that were kept in Central Supply. There were issues with ordering those supplies because staff in charge changed hands over the course of several months and supplies ran out. Registered Nurse Manager #13 stated they were made aware that resident's Lidocaine Patch had run out. They checked with Central Supply when they were told, and Central Supply told them the supplies were on order. The physician should have been notified for an alternate treatment. They stated they told the Director of Nursing and the Assistant Director of Nursing on multiple occasions of the shortage. 10 NYCRR 415.12 -- Immediate Jeopardy was identified, and the Administrator was notified on 9/18/2024 at 4:28 PM. Immediate Jeopardy was removed on 9/20/2024 at 5:17 PM prior to survey exit based on the following corrective actions taken: - As of 9/20/2024, 83% of nursing staff (registered nurses, licensed practical nurses, and certified nurse aides) and therapy staff had been educated on recognizing a change in condition, actions for staff to take when a change in condition was identified, notification of the registered nurse, notification of the medical provider, monitoring and follow-up, and follow-up responsibilities. - The remaining staff would be educated prior to the start of their next shift. - Staff education sign in sheets were reviewed and compared to the current nursing/therapy staff list and no discrepancies were identified. - 100% of nursing staff and therapy staff currently working on 9/20/2024 received education. - Staff education was verified during an onsite visit on 9/20/2024, multiple nursing staff on multiple units along with therapy staff were interviewed. - Staff were able to report content of education. - 30 days of 24-hour reports were reviewed to identify other affected residents related to change in condition.

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F 0745

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide medically-related social services to help each resident achieve the highest possible quality of life.

37385

Based on record review and interviews during the Abbreviated Survey (NY00330966), the facility did not ensure medically related social services were provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 3 of 7 residents (Residents #4, #5, and #13) reviewed. Specifically:

- Resident #5 had intact cognitive function, a known history of sexually inappropriate behaviors, was at risk for sexually abusing cognitively impaired residents, and was moved to a unit with cognitively impaired residents. The resident did not have person-centered mental/behavioral health interventions, responses to inappropriate behaviors were ineffective and punitive in nature, and the licensed psychologist's recommendations were not implemented into the resident's plan of care.

- Resident #4 had a behaviors of wandering, resided on the same unit as Resident #5, and had instances of wandering into Resident #5's room. There were no documented interventions from social services to address Resident #4's risk of going into Resident #5's room.

- Resident #13 who had cognitive impairment, had an improper request from Resident #5 that was not addressed by social services appropriately and there were no documented interventions from social services to address the Resident #13's risk related to Resident #5.

-Additionally, the facility's social work staff did not have academic degrees or licensure in the field of social work, and the facility's contracted Licensed Master Social Worker was not contacted at any time for consultation related to Resident #5's high-risk behaviors.

Findings include:

The facility's job description for the Director of Social Services documented they were responsible for:

- Monitoring other social services staff to ensure compliance with documentation and overall comportment with the facility.

- Participation in daily or weekly management team meetings to discuss resident status, census changes, or resident complaints or concerns.

- Ensuring delivery of compassionate quality care as evidenced by resident/resident representative feedback, observation, and chart review.

- Exercising overall supervision of resident assessments and care plans to ensure department's compliance.

- Collaborating with physicians, consultants, community agencies and institutions to improve the quality of services and to resolve identified problems.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Monitoring complaint reports daily for allegations of potential abuse, neglect, exploitation, and participates in these investigations. The facility policy, Behavioral Health Service, Including Substance Abuse, effective 2/2023, documented: - The resident and/or representative were included in the comprehensive assessment process along with the interdisciplinary team and outside sources, as indicated. - The care plan shall: have interventions that were person-centered, evidence-based, culturally competent, trauma-informed, and in accordance with professional standards of practice; provide for meaningful activities which promoted engagement and positive, meaningful relationships; accounted for the resident's experiences and preferences; and be reviewed and revised as needed, such as when interventions were not effective or when the resident experienced a change in condition. - If a behavioral contract was used, it would only be used with residents who had the capacity to understand it. A contract would only be used as a method of encouraging the resident to follow their plan of care, and not as a system of reward and punishment. The contract would not conflict with resident rights or other requirements of participation. - The Social Services Director served as the facility's contact person for questions regarding behavioral services provided by the facility and outside sources such as physician, psychiatrists, or neurologists. The facility policy, Abuse Prevention, Component 3, effective 8/2020, documented prevention strategies included: - Identify residents whose personal histories and diagnoses rendered them at risk for abusing other residents. Develop strategies to prevent occurrences and monitor for changes that would trigger abusive behavior. Systematically reassess these interventions to monitor their effectiveness. - Ensure adequate assessment, care planning and monitoring of residents with needs and behaviors with potential for conflict or neglect. In particular, focus on residents with history of aggressive, wandering, or self-injurious behaviors, residents with limited communication, and residents who were heavily dependent on staff for their care needs. 1) Resident #5 had diagnoses including cerebral infarction (stroke), dementia, and impulse disorder. The 10/11/2023 Minimum Data Set assessment documented the resident had intact cognition and exhibited verbal behaviors toward others which impacted others by significant intrusion of privacy or activity and significant disruption of care or the living environment. Resident #5's admission records included medical and psychiatric provider notes from the long-term care facility from where they were transferred. On 8/21/2023 and 9/11/2023, Nurse Practitioner # 25 (also a provider for the current facility) documented the resident made very explicit inappropriate comments to residents and staff. The resident was redirected and stated they could not help themselves. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/30/2023, Psychiatric Nurse Practitioner #24 from the resident's prior facility documented the resident had a history of sexually inappropriate behaviors, a history of touching other residents in a sexual manner and remained verbally inappropriate. The 10/7/2023 Social Worker #23 progress note documented a Brief Interview for Mental Status was completed. The resident's score was 14 (range 0-15, a score of 13-15 indicates intact cognitive function). The 10/9/2023 at 8:04 PM Licensed Practical Nurse #11 progress note documented the resident was very inappropriate to another (unidentified) resident, asking them for sexual favors. The 10/10/2023 at 9:51 AM Director of Social Services progress note documented they reviewed reports from the previous facility and determined Resident #5 did not do well with roommates and did not get along with peers since admission. The Director of Social Services offered the resident a private room on the fourth floor (unit designated for residents with dementia). The resident agreed and was moved to the fourth floor. The Comprehensive Care Plan initiated 10/11/2023 documented the resident made sexual comments toward staff and others, related to dementia, ineffective coping skills, mental/emotional illness, and poor impulse control. Interventions included: administer medications as ordered; analyze key times places, circumstances, triggers, what de-escalates behavior and document; assess and anticipate needs, food, thirst, toileting needs, comfort level, body positioning, pain; positive feedback for good behavior; psychiatric/psychology consult as needed; and redirect when inappropriate. On 11/1/2023 at 12:08 PM, Licensed Practical Nurse #10 documented the resident made sexual comments to two (unidentified) female residents stating, come sit on my mustache. When addressed, the resident stated one of the residents showed them their breasts. The 11/2/2023 at 2:12 PM Director of Social Services progress note documented they spoke to the resident about recent reports of speaking inappropriately in a sexual manner. Today, a resident (later identified as Resident #4 in an interview) was reportedly wandering into Resident #5's room and Resident #5 requested they (Resident #4) disrobe. Staff intervened, and Resident #5 said they could not help themselves. The Director of Social Services suggested they learn to change this behavior as this would lead to someone pressing charges and the resident certainly would not want to deal with that at this age. The Director of Social Services suggested if the resident could not change, the next step would be to issue a discharge notice. There was no documented evidence of steps taken to protect Resident #4 following the report of Resident #5 asking them to undress in their room. There were no documented interventions for Resident #5 to address Resident #4 or any other residents who may wander into Resident #5's private room. The 11/13/2023 at 8:19 PM progress note entered by Social Worker #23 documented the resident continued to make vulgar comments to staff and other residents. The social worker told the resident if they continued to make others feel uncomfortable in the dining room, the resident would be asked to eat in their room. When speaking to the resident about their behavior, the resident often brushed it off. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 11/15/2023 Psychologist #26 evaluation documented Resident #5 was referred for making sexually inappropriate comments to staff and residents. Staff were particularly concerned that Resident #5 was inviting female residents with dementia to go to their room, apparently for sexual favors. The resident admitted to making comments, found it funny, and reported they had no interest in changing their behavior. The resident was at moderate risk of sexual offense with concern about them sexually abusing non-consenting demented females. Recommendations included close supervision, refrain from overreaction, as any reaction could reinforce their behavior, keep them busy, and encourage them to work on model cars. There was no documented evidence of steps taken to address Psychologist #26's recommendations and no documented evidence the evaluation was reviewed by the Director of Social Services. The 12/17/2023 at 10:22 PM Licensed Practical Nurse #16 progress note documented the resident asked another (unidentified) resident to go to their room and sleep with them. The 12/20/2023 at 8:17 PM Social Worker #23 progress note documented they met with Resident #5 again over their inappropriate language. The resident often agreed they would no longer make these comments but continued with this behavior. The social worker reminded the resident they could be in a lot of trouble if they continued with this behavior. The 12/30/2023 at 5:30 PM Licensed Practical Nurse #16 progress note documented staff reported a resident was observed in Resident #5's room, acts being performed by the other resident, and they were taken out of the room immediately. The supervisor was made aware. The Monthly Licensed Master Social Work Consultant Reports Documented: - 10/2023, pending issues discussed with the Director of Social Services included a resident rights issue, via email or phone call. - 11/2023, pending issues discussed with the Director of Social Services included resident behaviors/screen process, via email or phone call. -12/2023, there were no, pending issues discussed with the Director of Social Services. Resident #5 was not included in any of the Monthly Licensed Master Social Work Consultant Reports. There was no documented evidence the Director of Social Services consulted with the Psychiatric Nurse Practitioner or Psychologist #26 related to the ongoing behavioral concerns with Resident #5. The 1/1/2024 at 2:00 PM Social Worker #23 progress note documented they met with Resident #5 after recent inappropriate behaviors with another resident. The resident stated they had no memory of this event; it did not occur, and they could not state the reason they were moved to the third floor. The Comprehensive Care Plan initiated 1/1/2024 documented: (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The resident was abusive toward others, acted out impulsively, attempted to extort or manipulate others for personal gain, demonstrated inappropriate sexual behaviors, was abusive to caregivers. The resident often made sexual advances toward staff and other residents. On 12/30/2023, they had sexually inappropriate behaviors with another resident. Interventions included involve family and notify of incident, medication per physician order and monitor effectiveness, psychiatry consult and follow up as needed, room change/floor change, and 1:1 supervision. The care plan was updated on 1/22/2024 to remove 1:1 supervision and added 15-minute checks. -The resident's room was changed from the fourth floor to the third floor due to sexually inappropriate behaviors with another resident. Nursing progress notes on 2/19/2024, 3/23/2024, 4/12/2024, and 4/22/2024 documented the resident continued to make sexually inappropriate comments to staff. The 5/12/2024 at 9:21 PM Licensed Practical Nurse #17 progress note documented the resident was verbally abusive to residents and staff in the dining room. The 5/25/2024 at 11:44 AM Social Worker #23 progress note documented they met with Resident #5 to complete a behavioral contract. The social worker did not feel the resident would have the ability to recall the contract or the rules set in place. The 5/27/2024 Behavioral Contract documented: - Resident #5's goals: no inappropriate comments toward others, not engaging in arguments with other residents, and call staff if they had an issue with someone. - Rewards if goals were met: positive reinforcements such as extra snacks (chips, cake, chocolate). - The ways the resident knew they were upset and when they felt angry. - The successful coping strategies: going back to their room to relax, leave the situation The contract was signed by Resident #5 and Social Worker #23 on 5/27/2024. The 7/15/2024 at 2:46 PM Registered Nurse Supervisor #13 progress note documented Resident #5 was overheard asking a peer in the dining room for a kiss. Before leaving the dining room, the resident (Resident #13) leaned over and kissed Resident #5 on the lips. The residents were counseled individually on appropriate behaviors. The 7/15/2024 Director of Social Services progress note documented they were made aware that Resident #5 was the recipient of a sign of affection from a peer (later identified as Resident #13). The Director of Social Services reminded the resident they had been spoken to many times for encouraging such behavior from peers. The Director of Social Services emphasized the brevity of the situation including the possibility of family making charges against the resident. There was no documented evidence of review of Resident #5's care plan, or of person-centered interventions to address their ongoing behaviors toward other residents. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Resident #4 had diagnoses including dementia and anxiety disorder. The 12/1/2023 Minimum Data Set assessment documented the resident had severe cognitive impairment, exhibited behaviors of wandering, and was independent for transfers and walking. Resident #4's comprehensive care plan initiated 10/6/2022 documented: - the resident was at risk of wandering related to a diagnosis of dementia, was disoriented to place, had impaired safety awareness, and wandered without regard of a specific destination. Interventions included: distract from wandering by offering pleasant diversions, structured activities, food, conversation, television, books, walking outside, reorientation, toileting. The resident preferred visits with family and reminiscent therapy. - The resident had the potential to be abused by others and was a victim of resident abuse previously. The resident was vulnerable due to cognitive disabilities, touched other residents when passing, bumped into other residents, liked to push other residents in their wheelchairs, was unable to perceive harmful situations, and unable to communicate needs effectively. On 5/23/2023, there was a resident-to-resident incident. Interventions included: attempt to respect resident's personal space, invite to activities/remove to room when bothersome to others, and remove to quiet environment when showing sign of potential of abuse. The 11/2/2023 at 2:12 PM Director of Social Services progress note (documented in Resident #5's record) included a resident (later identified as Resident #4 during an interview) was reportedly wandering into Resident #5's room and Resident #5 requested they (Resident #4) disrobe. There was no documented updates or interventions related to Resident #4 being at risk of sexual abuse by another resident on the unit who made an inappropriate sexual request. The Resident Accident/Incident Report documented on 12/30/2023, Resident #4 was observed in Resident #5's bed, engaging in a sexual act. 3) Resident #13 had diagnoses including Alzheimer's Disease. The 4/23/2024 Minimum Data Set assessment documented the resident had severe cognitive impairment and did not exhibit behavioral symptoms. The 7/15/2024 at 2:39 PM Registered Nurse Supervisor #13 progress note documented the resident was eating lunch when a peer (Resident #5) asked the resident for a kiss, before leaving the room, Resident #13 leaned over and kissed Resident #5 on the lips. Both residents were counseled individually by staff regarding appropriate behaviors. Seating changes were made to prevent recurrence. Resident #13 was slightly standoffish with staff but accepting of the information. The 7/15/2024 at 3:10 PM Director of Social Services progress note documented Resident #13 gave a peer (Resident #5) a kiss during the lunch meal. The Director of Social Services noted Resident #13 grinned and was blushing like a schoolgirl when they spoke to the resident, and it was a positive seeing them smile. The Director of Social Services added that they suspected the peer (Resident #5) was giving Resident #13 some positive attention, and they were aware of Resident #5's reputation. The Director of Social Services noted their fear was Resident #13 would feel like they were being punished for expressing affection. The situation would bear some monitoring. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Comprehensive Care Plan last updated 8/31/2024 did not contain any documented updates or interventions related to Resident #13 being at risk of abuse by another resident on the unit who made an inappropriate sexual request. During an interview on 9/16/2024 at 3:31 PM the Director of Social Services stated they were responsible for behavioral care planning and behavioral healthcare referrals and oversight. When Resident #5 was admitted , they had intact cognitive function and made their own healthcare decisions. The decision to move Resident #5 to the fourth floor was based on their potential to have an altercation with a roommate and provided them a private room. The Director of Social Services was aware of Resident's #5's history, and they knew they had to be worried about females on the unit. The Director of Social Services stated their 11/2/2023 progress note about Resident #5 asking a female resident to undress was referring to Resident #4. Resident #4 was known to wander at times. They were unaware of any interventions put in place to protect Resident #4 after the 11/2/2023 incident, aside from redirection. If a resident made sexual comments or sexual requests to other residents, this was indicative of a potential for abuse. Resident #5 received ongoing reminders about their inappropriate behaviors and the resident did not care to acknowledge it. The Director of Social Services reviewed Resident #5's 11/15/2023 evaluation completed by Psychologist #26. They did not recall if there were any recommendations and did not recall discussing Resident #5 with the psychologist. When asked if steps should have been taken to address Psychologist #26's note that Resident #5 was at risk of sexually offending on demented, non-consenting females, the Director of Social Services stated they were unaware of how to respond. They were unaware of the reason Resident #5 remained on the fourth floor despite the risk to female residents with dementia. The Director of Social Services stated in [Resident #5's] defense, sometimes it was innocent, but [Resident #5] was labeled. They stated when Resident #5 kissed another resident (later identified as Resident #13), as a social worker, they knew it was not ok due to their history, but nobody was doing anything wrong showing affection and the other resident felt wonderful because [they] got some attention. When asked if behavioral care plans were discussed at the interdisciplinary team meetings, they stated if that meant hey [name, Director of Social Services] make a behavioral care plan for this, then yes. The Director of Social Services addressed Resident #5's behaviors by talking to them about it. The resident received constant counseling and reminders about their inappropriate behaviors. The verbal intervention was not effective as the resident continued to exhibit a pattern of sexually inappropriately behaviors. There were no other interventions in place to protect other residents or address Resident #5's behaviors. The Director of Social Services stated they did not reach out to Psychologist #26 related to Resident #5's ongoing behaviors. When asked if they had a Licensed Social Work Consultant from 10/2023 through 2024, they stated they did not know how to respond and preferred to refrain from answering. When asked if the facility employed a Licensed Social Work consultant, did the Director of Social Services ever speak to them about Resident #5's behaviors, and they stated they had not. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Administrator on 9/16/2024 at 4:51 PM, they stated Social Services was responsible for maintaining behavioral care plans. If interventions were not effective, it should be addressed in morning meetings, at care plan meetings, or discussed with the team as soon as possible. A resident who made sexually inappropriate verbal requests to other residents had the potential for abuse. A care plan should be implemented to address the resident making the request as well as the resident who was asked. Residents who had cognitive impairments were vulnerable to abuse. The intervention of the Director of Social Services speaking to Resident #5 repeatedly was not sufficient to address their behaviors. The care plan was not individualized to address Resident #5's behaviors. The Administrator stated the Social Services response to Resident #5 and the other residents at risk of abuse was not sufficient. They expected that Psychologist #26's recommendations were discussed and acted upon. The Director of Social Services should have consulted with the Licensed Social Work Consultant. During an interview on 9/26/2024 at 2:00 PM Licensed Master Social Worker #36 stated they were contracted to provide consultation, audits, review of high-risk residents, referrals for services as needed, recommendations, interventions/care-planning review, and any other consultation as needed by the facility. When they first initiated their services, the Licensed Social Worker went to the facility on at least two occasions to make introductions and provide their contact information. They spoke to the Director of Social Services to review means of contact, including video conferencing, emails, phone calls, and on-site visits as needed. The Licensed Social Worker Consultant attempted to contact the Director of Social Services several times since the start of their services and received no response. They had never been contacted by the Director of Social Services or any other social worker at the facility to address any high-risk residents or behavioral concerns. The consultant reviewed resident records remotely and selected them randomly each month. They had not contacted the facility's Administrator related to having no communication from the facility's Social Services Department and having no reports of suggested resident records to review. After their first year, they heard from someone in the corporate office who asked for more detail in their monthly reports. They did not address a means to select records to review and continued to select them randomly each month. The reports noted they were reviewed or discussed with the Director of social Services based on the format of the form and the consultant emailing the reports to the facility. During an interview with Social Worker #23 on 10/2/2024 at 11:48 AM, they stated they worked at the facility part time, mostly evenings and weekends. They reported directly to the Director of Social Services who primarily oversaw the residents behavioral/social services needs in the facility. Resident #5 had sexually inappropriate behavior and the social worker addressed them by talking to the resident about it. Sometimes they told the resident they could get into trouble to let the resident know the severity of their behaviors. Talking to the resident was not effective and they could not recall any other interventions to address Resident #5's behaviors or the safety of the other residents. When they reviewed the Behavioral Contract on 5/27/2023, the Social Worker did not know if it was effective. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Utica Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2535 Genesee Street Utica, NY 13501	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow up interview on 10/7/2024 at 1:00 PM the Administrator stated they were unaware of the means the Licensed Social Work Consultant selected records to review or how contact was facilitated with the Director of Social Services. If the Director of Social Services did not contact the Licensed Social Work Consultant, that would not be a concern, as they had in-house behavioral healthcare providers. The Administrator stated it was appropriate to tell the resident of the possible consequences of their behavior, such as discharge or police involvement. When the Director of Social Services addressed the incident on 7/15/2024 with Resident #13, the Administrator stated it could have been viewed as a positive interaction for a resident who may have been depressed. Resident #5's behaviors at that time were not as they had been in the past and they were not as worried the resident would act out as they had before. During a telephone interview on 10/7/2024 at 3:52 PM Psychologist #26 stated their only involvement with Resident #5 was on 11/15/2023 when they completed the comprehensive evaluation. They were not notified by the facility for any follow up consultation related to Resident #5's behaviors. They stated their recommendations should have been followed and they could not comment on any additional steps the facility could have taken to address the resident's behaviors. The psychologist stated the only recommendation they had at this time was for the facility staff to make sure they reviewed their evaluations. 10 NYCRR 483.40 (d)

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F 0835

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Administer the facility in a manner that enables it to use its resources effectively and efficiently.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 37385

Based on record review, and interview during the abbreviated survey (NY00330966, NY00335730, NY00340854, NY00340963, NY00344094, and NY00344130), the facility failed to ensure it was administered in a manner that ensured residents received appropriate quality of care, allowing the following deficient practices to exist, placing residents at risk for serious injury, serious harm, serious impairment, or death: F 684 Quality of Care and F 600 Free from Abuse and Neglect. Specifically, facility Administration, including the Director of Nursing and Director of Social Services did not ensure:

- residents were free from sexual abuse and did not ensure residents were protected from further abuse and all alleged violations were thoroughly investigated;

- Comprehensive Care Plans were reviewed and revised to meet the needs of each resident;

- residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices; and

- medically-related social services were provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being.

Findings include:

The facility policy, Quality Assurance and Performance Improvement Program-Governance and Leadership, effective ,d+[DATE], documented the Administrator, whether a member of the Quality Assurance and Performance Improvement Committee or not, was ultimately responsible for the Quality Assurance and Performance Improvement program and for interpreting its results and findings to the governing body. The committee would include: the Administrator or designee in a leadership role, Director of Social Services, Director of Nursing, Medical Director or designee, Infection Preventionist, in addition to other staff (board member, owner, leadership) and representatives from facility departments.

The facility policy, Analyzing Occurrences of Abuse, Neglect, Mistreatment and Misappropriation of Resident Property, effective ,d+[DATE], documented the Quality Assurance and Performance Improvement Committee would review all reports of abuse, neglect, mistreatment, during their regularly scheduled meetings. Cases of physical or sexual abuse required immediate corrective action and tracking by the Quality Assurance and Performance Improvement Committee.

Free from Abuse and Neglect, refer to the citation text under F600.

Resident #5 had a history of sexually inappropriate behaviors, and continued to exhibit sexually inappropriate behaviors and there were no documented interventions to protect residents from abuse. Resident #4, a cognitively impaired resident, was found in Resident #5's room engaging in a sexual act. Interventions to protect Resident #4 and other vulnerable residents were not implemented timely. The facility's failure to protect residents from sexual abuse resulted in harm that was Immediate Jeopardy and Substantial Quality of Care for Resident #4 which had the likelihood to affect 114 residents in the facility.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 3:31 PM the Director of Social Services stated they were aware of Resident #5's history of sexually inappropriate behavior when they arranged to have the resident moved to the fourth floor (primarily for residents with dementia). When asked if they had concerns with Resident #5 being on the fourth floor, the Director of Social Services stated they did. Following multiple reports of Resident #5's sexually inappropriate behaviors, including making a sexual request to Resident #4, the Director of Social Services stated they spoke to the resident. There were no other interventions in place to address their behaviors or the safety of the residents on the unit. When the licensed psychologist evaluated the resident and made specific recommendations, the Director of Social Services did not recall the recommendations and stated they did not know how to respond the surveyor's question about steps that could have been taken to prevent abuse. During an interview on [DATE] at 4:51 PM the Administrator stated Resident #5 should have been moved from the fourth-floor following incidents when they were inappropriate or attempted to be sexually inappropriate with female residents. Additionally, following the [DATE] licensed psychologist evaluation, the resident was not appropriate to remain on the fourth floor. The Administrator stated staff should have acted sooner to prevent sexual abuse. Investigate/Prevent/Correct Alleged Violations, refer to the citation text under F610. Facility investigations did not identify concerns related to: - Resident #4, a cognitively impaired resident, was found in Resident #5's room engaging in a sexual act and was not assessed by a qualified professional timely, protective interventions were not implemented timely, police, family, and the medical provider were not notified timely, and a staff member left the residents after discovering them engaged in a sexual act. - Resident #5 was involved in a physical altercation with Resident #6, they were not assessed by a qualified professional timely and a staff member documented they notified a supervisor who declined to assess the resident at the time. - Resident #9 was given vaccinations by an unqualified staff member who was not suspended pending the investigation. - Resident #5 had sexually inappropriate behaviors toward other residents documented in their medical record on 6 instances. The 6 residents involved were not identified and there were no corresponding investigations related to the incidents. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on [DATE] at 12:38 PM with the Director of Nursing and the Administrator, they stated on [DATE], Resident #4 should have been assessed immediately following the incident. In the absence of the Director of Nursing and Administrator following the incident o on [DATE], Registered Nurse Supervisor #12 was responsible to ensure timely notifications, assessment, and interventions. They did not address the discrepancies in the times and days of the notification to family, medical, and police. The notifications should have been made the day of the incident and the protective interventions should have been put in place immediately. The Administrator and Director of Nursing stated Residents #5 and 6 should have been assessed immediately following the incident on [DATE]. The medical provider and family/resident representatives should have been notified on [DATE] after the incident. The investigation was not thoroughly completed and should have addressed the delays in notification and assessment. Regarding the [DATE] incident, they were unaware of the reason Certified Nurse Aide #1's timecard showed they continued to work on [DATE] and [DATE] following notification of the allegation of administering an injection to a resident. The aide was suspended on [DATE] and should not have worked. During a follow up interview on [DATE] at 1:00 PM the Administrator stated all reportable incidents, most of the Accident/Incident Reports, falls, and recurring issues were addressed at the monthly Quality Assessment and performance Improvement Committee. They could not recall what was addressed at the committee related to the [DATE] sexual abuse incident. When incidents were reviewed, the committee revived the incident only, and did not review the record for background information. The Administrator expected the background record review of the incident to have been included in the investigation, where any discrepancies would be identified and addressed. Care Plan Timing and Revision, refer to the citation text under F657. Resident #5 exhibited sexually inappropriate behaviors and did not have an individualized care plan to address their behaviors. When their behaviors continued, the care plan was not updated to ensure protection of other residents. Residents #4 and #13 were at risk of being sexually abused and their care plans were not updated to prevent abuse. During an interview on [DATE] at 3:31 PM the Director of Social Services stated they were responsible for behavioral care planning. The verbal intervention was not effective as Resident #5 continued to exhibit a pattern of sexually inappropriately behaviors. There were no other interventions in place to protect other residents or address Resident #5's behaviors. They were unaware of any interventions put in place to protect Resident #4 after Resident #5 asked them to remove their clothing when Resident #4 went into Resident #5's room, aside from redirection. If a resident made sexual comments or sexual requests to other residents, this was indicative of a potential for abuse. The Director of Social Services stated in Resident #5's defense, sometimes it was innocent, and Resident #5 was labeled. They stated when Resident #5 kissed another resident (later identified as Resident #13), they were showing affection and the other resident felt wonderful because they got some attention. During an interview on [DATE] at 4:51 PM the Administrator stated if interventions were not effective, it should be addressed in morning meetings, at care plan meetings, or discussed with the team as soon as possible. Residents who had cognitive impairments were vulnerable to abuse. Resident #4 should have had a specific care plan to address the potential to be victimized due to wandering into other rooms. The intervention of the Director of Social Services speaking to Resident #5 repeatedly was not sufficient to address their behaviors. The care plan was not individualized to address Resident #5's behaviors. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow up interview on [DATE] at 1:00 PM the Administrator stated they were uncertain if the Director of Social Services addressed the [DATE] incident with Residents #5 and #13 appropriately, stating it was possibly not appropriate. If Resident #5 had improved behaviors over the past year, then they were not worried the resident would act out. If Resident #13 was previously depressed and had a positive reaction from Resident #5's attention, they could understand that the Director of Social Services was happy to see a positive response. Quality of Care, refer to citation text under F684. Resident #3, had episodes of vaginal/rectal bleeding, was not assessed by a qualified professional, and the medical provider was not notified timely of the bleeding (8 hours and 15 minutes following onset of bleeding). The provider ordered STAT (immediate) labs, the blood specimen could not be obtained from the resident, and the provider was not notified timely. The facility's failure to complete timely assessments, notify the provider, and respond timely to Resident #3's change in condition placed 113 residents in the facility at risk. This resulted in actual harm that was Immediate Jeopardy and Substantial Quality of Care to resident health and safety. Resident #2 had an intact left heel blister, and a treatment was ordered. There was no documentation the resident's wound was monitored or assessed after the treatment was ordered, and the care plan was not updated to include interventions. Resident #1's ordered Lidocaine Pain Patch was not obtained or administered timely. Resident #4, a cognitively impaired resident, was found in Resident #5's room engaging in a sexual act and Residents #4 and #5 were not assessed timely by a qualified professional. Resident #5 was pulled from their wheelchair to the floor by Resident #6 and was not assessed timely by a qualified professional. During a telephone interview on [DATE] at 11:33 AM, the Medical Director stated they reviewed Resident #3's record recently and did not see any signs the resident was unstable on [DATE] and [DATE]. Procedurally, they thought there was an issue however from a clinical standpoint, they did not find any concerns with the resident during chart review. During a telephone interview on [DATE] at 10:39 AM, the Director of Nursing stated. they did not recall if Resident #2's skin impairment was reviewed during morning report the day after the note was written, all progress notes were reviewed during morning report. They stated the resident's skin impairment was a pressure ulcer and should have been monitored weekly by the wound provider. The Director of Nursing stated if a medication or treatment was not available the pharmacy should be notified. They were not aware Resident #1 had multiple instances when their Lidocaine Patch was not available. Provision of Medically Related Social Services, refer to the citation text under F745. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #5 had intact cognitive function, a known history of sexually inappropriate behaviors, was at risk of sexually abusing cognitively impaired residents, and was moved to a unit with cognitively impaired residents. The resident did not have person-centered mental/behavioral health interventions, responses to inappropriate behaviors were ineffective and punitive in nature, the licensed psychologist's recommendations were not implemented into the resident's plan of care. Resident #4 had a behaviors of wandering, resided on the same unit as Resident #5, had instances of wandering into Resident #5's room, and there were no documented interventions from social services to address their risk of going into Resident #5's room. Resident #13 had cognitive impairment and an inappropriate request from Resident #5 was not addressed by social services appropriately and there were no documented interventions from social services to address their risk related to Resident #5. Additionally, the facility's social work staff did not have academic degrees or licensure in the field of social work, and the facility's contracted Licensed Master Social Worker was not contacted at any time for consultation related to Resident #5's high-risk behaviors. During an interview on [DATE] at 3:31 PM the Director of Social Services stated they were responsible for behavioral care planning and behavioral healthcare referrals and oversight. They were aware of Resident #5's history, stating they knew they had to be worried about females on the unit. When asked if steps should have been taken to address the psychologist's note that Resident #5 was at risk of sexually offending on demented, non-consenting females, the Director of Social Services stated they were unaware of how to respond. They were unaware of the reason Resident #5 remained on the fourth floor despite the risk to female residents with dementia. The Director of Social work spoke to Resident #5 repeatedly about their behaviors and did not address further intervention when the verbal approach was ineffective. The Director of Social Services did not seek consultation from the facility's contracted Licensed Master Social Worker or the licensed psychologist. They stated when Resident #5 kissed another resident (later identified as Resident #13), as a social worker, they knew it was not ok due to their history, but nobody was doing anything wrong showing affection and the other resident felt wonderful because [they] got some attention. During an interview on [DATE] at 1:00 PM the Administrator stated they oversaw the role and duties of the Director of Social Services. The Administrator reviewed the work of the Director of Social Service if concerns came to their attention, such as an overdue assessment, an issue from a family member, or if they were notified of an issue that arose from a care plan meeting or family meeting. The Administrator stated the Director of Social Services could utilize the facility's Licensed Master Social Work Consultant for review of challenging issues. They were unaware of the extent of the consultant's involvement or that the Director of Social Services did not consult with them. The Administrator stated if the Director of Social Services referred to their in-house psychiatric provider, that would be a better option than reaching out to the consultant. 10NYCRR 415.26(a)