STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355038	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Gerard's Community of Care	613 1st Ave SW Hankinson, ND 58041

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40489 Based on observation, record review, review of facility policy, and family and staff interviews, the facility failed to ensure 3 of 3 supplemental residents (Resident #13, #19, and #23) with impaired cognition and unable to consent were free from resident to resident abuse. Failure to assess, care plan, and operationalize a plan/process may result in unwanted physical and/or sexual contact and may cause residents to experience fear, anxiety, and psychosocial harm. During the on-site recertification survey, the team consulted with the State Survey Agency (SSA) and determined an Immediate Jeopardy (IJ) situation existed on 06/09/24. The facility failed to assess, care plan, and operationalize a plan/process for; (1) a resident who seeks frequent close physical contact to do so safely and (2) cognitively impaired residents vulnerable to being the subject of unwanted physical and/or sexual contact, to ensure that all residents only had desired, safe contact with each other. The IJ was identified when a nurse's note in Resident #24's medical record, dated 06/09/24, identified he had kissed two female residents on the cheek (Resident #19 and #23). An observation on 06/12/24 at 3:07 p.m. showed Resident #24 seated on a chair beside Resident #13 who was sitting in a recliner chair facing forward. Resident #24 was sitting with his knees facing the side of Resident #13's chair. Resident #24 was leaning over the top of Resident #13 chest to chest with his left arm around Resident #13's right shoulder. Resident #24 was rubbing Resident #13's hair and the side of her face and they were holding hands. Resident #13 remained non-verbal throughout the observation. These findings placed the residents in immediate danger of fear, anxiety, or psychosocial harm in response to Resident #24's actions. * 06/12/24 at 7:20 p.m. - The survey team notified the administrator and director of nursing of the IJ situation, provided the IJ template, and requested a plan for removal of the immediate jeopardy. * 06/13/24 at 8:04 a.m. - The facility submitted a removal plan. * 06/13/24 at 1:00 p.m. - The survey team reviewed and accepted the facility's written plan for the removal of the IJ situation. The removal plan included the following: * Investigation of alleged resident to resident abuse completed including staff interviews. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	* Notification to the State Survey Agency. * Immediate constant observation of Resident #24. * Immediate education provided by the Director of Nursing (DON) or Assistant Director of Nursing (ADON) to all staff working on 06/12/24. All licensed nurses, certified nurse aides (CNAs), activity staff, social services and direct care staff not working on 06/12/24 will receive education prior to the start of their next shift. Education specifically focused on how to identify what constitutes resident to resident abuse or the potential of such abuse and the importance of implementing procedures to ensure the safety of the resident involved as well as the potential for all residents in the facility. * All staff assigned to healthcare academy (online training) regarding abuse to be completed within a week. * Will contact Great Plains Quality Innovation Network as a resource for education regarding this topic for Administrator, DON, Abuse Coordinator, and other leaders by 06/18/24. * To ensure compliance with this regulation is maintained, F600 will become part of the Quality Assurance program and completed by DON, ADON, or Abuse Coordinator. * Governing Board President and Secretary updated regarding most recent events and plan of correction. * 06/13/24 at 2:55 p.m. - The survey team verified the implementation of the removal plan as of 06/13/24 and removed the IJ. The deficient practice remained at an E scope and severity following the removal of the immediate jeopardy. Findings include: Review of the facility policy titled Abuse, Neglect and Exploitation Policy occurred on 06/13/24. This policy, dated June 2023, stated, . It is the policy of St. Gerard's Community of Care to provide protections for the health, welfare and rights of each resident . Assess, monitor, and develop appropriate plans of care for residents with needs and behaviors which may lead to conflict . Identify, correct, and intervene in situations in which abuse . is more likely to occur. Required to report . Sexual activity . where one of the resident's capacity to consent to sexual activity is unknown. Observation on 06/12/24 at 3:07 p.m. showed Resident #24 seated on a chair beside Resident #13 who was sitting in a recliner chair facing forward. Resident #24 was sitting with his knees facing the side of Resident #13's chair. Resident #24 was leaning over the top of Resident #13 chest to chest with his left arm around Resident #13's right shoulder. Resident #24 was rubbing Resident #13's hair and the side of her face and they were holding hands. Resident #13 remained non-verbal throughout the observation. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/12/24 at 3:08 p.m., the nurse (#3) stated, This happens everyday. If we try to take her away she gets mad. The nurse stated she was not aware if the facility notified the families of the situation and referred the surveyor to an administrative nurse. At 3:09 p.m., an administrative nurse (#2) stated, Yes, we contacted both family representative/guardians and they gave consent for hugging and holding hands. - Review of Resident #24's medical record occurred on June 12-13, 2024 and included a diagnosis of severe dementia. The quarterly Minimum Data Set (MDS), dated [DATE], identified a brief interview for mental status (BIMS) of 6, indicating severely impaired cognition. The care plan, dated 05/28/24, stated, . My wish to engage in consensual acts of hand holding, hugging, caressing each other, providing tenderness and comfort in the comfort of our public living area will be granted . Acts of tenderness will occur in the public common areas . My POA or representative will continue to approve of my desired relationship . Staff may redirect us if actions become inappropriate or if others in area provide concern. Resident #24's care plan failed to address interventions related to Resident #24 entering female residents' rooms. Resident #24's nurses' notes included the following: * 03/25/24 at 12:30 p.m., . Call placed to guardian [guardian's name] updates given that this resident and female resident have found comfort in each others companionship which at times leads to hugging and holding hands. Resident has gone into female residents [sic] room and is escorted out by staff at times to discontentment of both residents. Sought clearance from guardian on situation and states no concerns with same interactions and agrees resident does not have capacity for any further physical interactions. Will continue to allow contact in the form of holding hands and hugging, but will be mindful to prevent intimate physical relations. * 06/09/24 at 4:36 p.m. Resident was wandering into everyone's room this afternoon and trying to kiss different females multiple times. Resident does not listen even if the person asks him not to touch them. During an interview on 06/12/24 at 3:46 p.m., a nurse (#3) who witnessed the incidents on 06/09/24 stated Resident #24 kissed Resident #19 and Resident #23 on the cheek in a public area. The nurse stated, Usually he is just tapping people on the shoulders and most residents' do not like it when he does tap them on the shoulder. When the nurse (#3) told Resident #24 he could not kiss Resident #19, Resident #19 stated, He can do that. The nurse (#3) stated Resident #24's kiss elicited no response verbally or non-verbally from Resident #23. The nurse (#3) stated she immediately attempted to redirect Resident #24 who was difficult to redirect and just started talking about other things. The nurse verified she did not notify the DON, administrator, or abuse coordinator about the incident, stating, I didn't even think of it as abuse, but I should because I would not want my family member touched like that. - Review of Resident #13's medical record occurred on June 12-13, 2024 and included a diagnosis of dementia. The quarterly MDS, dated [DATE], identified moderately impaired cognition skills and may make poor decisions. The care plan stated, . My wish to engage in consensual acts of hand holding, hugging, caressing each other, providing tenderness and comfort in the comfort of our public living area will be granted. Acts of tenderness will occur in the public common areas . My POA or representative will continue to approve of my desired relationship . (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A nurses' note, dated, 03/25/24 at 12:31 p.m., stated, . Call placed to daughter [daughter's name] that this resident and a male resident have found comfort in each others companionship which at times leads to hugging and holding hands. Male resident has gone into residents [sic] room and is escorted out by staff at times to discontentment of both residents. Sought clearance from daughter on situation and states no concerns with same interactions and agrees resident does not have capacity for any further physical interactions. Will continue to allow contact in the form of holding hands and hugging, but will be mindful to prevent intimate physical relations. During an interview on 06/12/24 at 3:50 p.m., Resident #13's daughter (#2) stated, My sister and I do not want him [Resident #24] touching our mother. My sister has told the facility we do not want him [Resident #24] touching our mother. During an interview on 06/12/24 at 4:19 p.m., Resident #13's daughter and Power of Attorney (POA) (#1) stated, They [the facility] did contact me in March about the situation and at that time we were ok with hugging and holding hands. His [Resident #24's] behavior is progressing and we do not want him touching our mother. When my niece and I were visiting my mother one day in May that man [Resident #24] came into her room and my niece told him he needed to leave and he did. Then myself and my niece told staff we do not want him [Resident #24] in my mother's room or touching her. The surveyor asked daughter (#2) if her mother was cognitively intact, would she be ok with Resident #24's hugging, touching her face and holding hands and the daughter responded, Absolutely not. - Review of Resident #19's medical record occurred on June 12-13, 2024 and included a diagnosis of Alzheimer's disease. The quarterly MDS, dated [DATE], showed a brief interview for mental status (BIMS) score of 5, indicating severely impaired cognition. Resident #19's care plan, updated 08/14/23, failed to address the resident's wishes for engaging in physical contact with other residents. - Review of Resident #23's medical record occurred on June 12-13, 2024 and included a diagnosis of dementia. The admission MDS, dated [DATE], identified severely impaired cognition. Resident #23's care plan, updated 04/10/24, failed to address the resident's wishes for engaging in physical contact with other residents. During an interview on 06/12/24 at 4:07 p.m., four administrative staff members (Administrator, Director of Nursing, Assistant Director of Nursing and Abuse Coordinator) all stated they had not been notified of Resident #34's behaviors and they did not identify the actions as sexual abuse. Administrative staff (#10) stated all staff received abuse orientation upon hire and annually and staff are expected to report any abuse immediately to the administrator, DON, and ADON, who in return notify the state health department. The facility failed to have a system and policy and procedures in place for assessing all resident 's needs, desires, and usual preferences to determine how to care plan according to the assessment.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 19864 Based on review of facility policy, record review, and staff interview, the facility failed to protect all residents in the facility (31 of 31 residents) by failing to screen unlicensed employees prior to employment. Failure to screen unlicensed employees placed all residents at risk for abuse, neglect, exploitation, and misappropriation of resident property. Findings included: Review of the facility policy titled Abuse, Neglect, and Exploitation occurred on 06/13/24. This policy, revised June 2023, stated, It is the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. A. Screening 1. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. a. Background, reference, and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. b. Screenings will be conducted by the facility itself, third-part agency or academic institution. Review of the facility's 802 Centers for Medicare and Medicaid Services (CMS) Matrix showed 31 residents resided in the facility on the first day of survey, 06/11/24. During an interview on 6/13/2024, at 11:50 a.m., the administrator stated the facility did not conduct criminal history checks on unlicensed employees or new hires. Instead, employees are asked on the application form if they have been convicted of any felonies, and the facility relies on their honesty. The administrator stated the facility would run all unlicensed employees through the nurse aide registry. The administrator acknowledged that without a license, the facility cannot verify if an individual had a conviction that would disqualify them from employment. She stated the facility's process for conducting background and criminal history checks on unlicensed employees and new hires needed improvement. She said the facility is in a small-town setting; therefore, the facility also depends on community word-of-mouth to identify any criminal activity or convictions of employees or new hires. The administrator stated there is no system in place to screen non-licensed staff to ensure they have not been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40489 Based on observation, record review, review of facility policy, and family and staff interview, the facility failed to report incidents of resident to resident abuse to the Administrator and State Survey Agency (SSA) for 3 of 3 supplemental residents (Resident #13, #19, and #23) with cognitive impairments and unable to consent. Failure to report incidents of abuse may result in unwanted physical and/or sexual contact and may cause residents to experience fear, anxiety, and psychosocial harm. Findings include: Review of the facility policy titled, Abuse, Neglect and Exploitation Policy occurred on 06/13/24. This policy, dated June 2023 stated, . It is the policy of St. Gerard's Community of Care to provide protections for the health, welfare and rights of each resident . A. Any staff witnessing or possessing reliable knowledge of any act, or suspect act, involving . abuse . must notify their department supervisor immediately. Observation on 06/12/24 at 3:07 p.m. showed Resident #24 seated on a chair beside Resident #13 who was sitting in a recliner chair facing forward. Resident #24 was sitting with his knees facing the side of Resident #13's chair. Resident #24 was leaning over the top of Resident #13 chest to chest with his left arm around Resident #13's right shoulder. Resident #24 was rubbing Resident #13's hair and the side of her face and they were holding hands. Resident #13 remained non-verbal throughout the observation. During an interview on 06/12/24 at 3:08 p.m., the nurse (#3) stated, This happens everyday. If we try to take her away she gets mad. The nurse stated she was not aware if the facility notified the families of the situation and referred the surveyor to an administrative nurse. At 3:09 p.m., an administrative nurse (#2) stated, Yes, we contacted both family representative/guardians and they gave consent for hugging and holding hands. - Review of Resident #13's medical record occurred on June 12-13, 2024 and included a diagnosis of dementia. The quarterly Minimum Data Set (MDS), dated [DATE], identified moderately impaired cognition and poor daily decision making skills. A nurses' note, dated, 03/25/24 at 12:31 p.m., stated, . Call placed to daughter [daughter's name] that this resident and a male resident have found comfort in each others companionship which at times leads to hugging and holding hands. Will continue to allow contact in the form of holding hands and hugging, but will be mindful to prevent intimate physical relations. During an interview on 06/12/24 at 3:50 p.m., Resident #13's daughter (#2) stated, My sister and I do not want him [Resident #24] touching our mother. My sister has told the facility we do not want him [Resident #24] touching our mother. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/12/24 at 4:19 p.m., Resident #13's daughter and Power of Attorney (POA) (#1) stated, They [the facility] did contact me in March about the situation and at that time we were ok with hugging and holding hands. His [Resident #24's] behavior is progressing and we do not want him touching our mother. When my niece and I were visiting my mother one day in May that man [Resident #24] came into her room and my niece told him he needed to leave and he did. Then myself and my niece told staff we do not want him [Resident #24] in my mother's room or touching her. The surveyor asked daughter (#2) about her mother's cognition and if she would be ok with Resident #24's hugging, touching her face and holding hands and the daughter responded, Absolutely not. The staff member who Resident #13's daughter and niece reported the incident to in May failed to identify this as abuse and failed to report this to the administrator. - Review of Resident #24's medical record occurred on June 12-13, 2024 and included a diagnosis of severe dementia. The quarterly MDS, dated [DATE], identified a brief interview for mental status (BIMS) of 6, indicating severely impaired cognition. A nurses' note, dated 06/09/24 at 4:36 p.m., stated, . Resident was wandering into everyone's room this afternoon and trying to kiss different females multiple times. Resident does not listen even if the person asks him not to touch them. During an interview on 06/12/24 at 3:46 p.m., a nurse (#3) who witnessed the incidents on 06/09/24 stated Resident #24 kissed Resident #19 and Resident #23 on the cheek in a public area. The nurse stated, Usually he is just tapping people on the shoulders and most residents do not like it when he does tap them on the shoulder. When the nurse (#3) told Resident #24 he could not kiss Resident #19, Resident #19 stated, He can do that. The nurse (#3) stated Resident #24's kiss elicited no response verbally or non-verbally from Resident #23. The nurse (#3) stated she immediately attempted to redirect Resident #24 who was difficult to redirect and just started talking about other things. The nurse verified she did not notify the DON, administrator, or abuse coordinator about the incident, stating, I didn't even think of it as abuse, but I should because I would not want my family member touched like that. - Review of Resident #19's medical record occurred on June 12-13, 2024 and included a diagnosis of Alzheimer's disease. The quarterly Minimum Data Set (MDS), dated [DATE], identified a brief interview for mental status (BIMS) of 5, indicating severely impaired cognition. - Review of Resident #23's medical record occurred on June 12-13, 2024 and included a diagnosis of dementia. The admission MDS, dated [DATE], identified severely impaired cognition. During an interview on 06/12/24 at 4:07 p.m., four administrative staff members (Administrator, Director of Nursing, Assistant Director of Nursing ,and Abuse Coordinator) stated they had not been notified of Resident #24's behaviors and staff are expected to report any abuse immediately to the administrator, DON, and ADON, who notify the SSA. The facility lacked evidence the above incidents (06/09/24 and 06/12/24) were reported to the administrator and the SSA.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40489 Based on observation, record review, review of facility policy, and family and staff interview, the facility failed investigate incidents of resident to resident abuse for 3 or 3 supplemental resident (Resident #13, #19, and #23) with impaired cognition and unable to consent. Failure to investigate incidents of abuse may result in unwanted physical and/or sexual contact and may cause residents to experience fear, anxiety, and psychosocial harm. During the on-site recertification survey, the team consulted with the State Survey Agency (SSA) and determined an Immediate Jeopardy (IJ) situation existed on 06/09/24. The facility failed to investigate resident to resident abuse. The IJ was identified when a nurse's note in Resident #24's medical record, dated 06/09/24, stated he had kissed two female residents on the cheek (Resident #19 and #23). An observation on 06/12/24 at 3:07 p.m. showed Resident #24 seated on a chair beside Resident #13 who was sitting in a recliner chair facing forward. Resident #24 was sitting with his knees facing the side of Resident #13's chair. Resident #24 was leaning over the top of Resident #13 chest to chest with his left arm around Resident #13's right shoulder. Resident #24 was rubbing Resident #13's hair and the side of her face and they were holding hands. Resident #13 remained non-verbal throughout the observation. These findings placed the residents in immediate danger of fear, anxiety, or psychosocial harm in response to Resident #24's actions. * 06/12/24 at 7:20 p.m. - The survey team notified the administrator and director of nursing of the IJ situation, provided the IJ template, and requested a plan for removal of the immediate jeopardy. * 06/13/24 at 8:04 a.m. - The facility submitted a removal plan. * 06/13/24 at 1:00 p.m. - The survey team reviewed and accepted the facility's written plan for the removal of the IJ situation. The removal plan included the following: * Investigation of alleged resident to resident abuse completed including staff interviews. * Notification to the State Survey Agency. * Immediate constant observation of Resident #24. * Immediate education provided by the Director of Nursing (DON) or Assistant Director of Nursing (ADON) to all staff working on 06/12/24. All licensed nurses, certified nurse aides (CNAs), activity staff, social services and direct care staff not working on 06/12/24 will receive education prior to the start of their next shift. The education specifically stated that all alleged abuse allegations of any kind will be investigated. The investigation will include interviews with all staff members and non-staff individuals involved. * All staff assigned to healthcare academy (online training) to be completed within a week. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	* Will contact Great Plains Quality Innovation Network as a resource for education regarding this topic for Administrator, DON, Abuse Coordinator, and other leaders by 06/18/24. * To ensure compliance with this regulation is maintained, F610 will become part of the QA [Quality Assurance] program and completed by DON, ADON, or Abuse Coordinator. * Governing Board President and Secretary updated regarding most recent events and plan of corrections. * 06/13/24 at 2:55 p.m. - The survey team verified the implementation of the removal plan as of 06/13/24 and the IJ removal. The deficient practice remained at an E scope and severity following the removal of the immediate jeopardy. Findings include: Review of the facility policy titled, Abuse, Neglect and Exploitation occurred on 06/13/24. This policy, dated June 2023, stated, To provide protections for the health, welfare and rights of each resident . that prohibit and prevent abuse . When suspicion of abuse . or reports of abuse . occur, an investigation is immediately warranted. Once the resident is immediately cared for and initial reporting has been shared between the charge nurse and DON an investigation will be conducted, and the administrator must be notified. Observation showed Resident #24 seated on a chair beside Resident #13 who was sitting in a recliner chair facing forward. Resident #24 was sitting with his knees facing the side of Resident #13's chair. Resident #24 was leaning over the top of Resident #13 chest to chest with his left arm around Resident #13's right shoulder. Resident #24 was rubbing Resident #13's hair and the side of her face and they were holding hands. Resident #13 remained non-verbal throughout the observation. During an interview on 06/12/24 at 3:08 p.m., the nurse (#3) stated, This happens everyday. If we try to take her away she gets mad. The nurse stated she was not aware if the facility notified the families of the situation and referred the surveyor to an administrative nurse. At 3:09 p.m., an administrative nurse (#2) stated, Yes, we contacted both family representative/guardians and they gave consent for hugging and holding hands. - Review of Resident #13's medical record occurred on June 12-13, 2024 and included a diagnosis of dementia. The quarterly Minimum Data Set (MDS), dated [DATE], identified moderately impaired cognition. A nurses' note, dated, 03/25/24 at 12:31 p.m., stated, . Call placed to daughter [daughter's name] that this resident and a male resident have found comfort in each others companionship which at times leads to hugging and holding hands. Will continue to allow contact in the form of holding hands and hugging, but will be mindful to prevent intimate physical relations. During an interview on 06/12/24 at 3:50 p.m., Resident #13's daughter (#2) stated, My sister and I do not want him [Resident #24] touching our mother. My sister has told the facility we do not want him [Resident #24] touching our mother. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/12/24 at 4:19 p.m., Resident #13's daughter and Power of Attorney (POA) (#1) stated, They [the facility] did contact me in March about the situation and at that time we were ok with hugging and holding hands. His [Resident #24's] behavior is progressing and we do not want him touching our mother. When my niece and I were visiting my mother one day in May that man [Resident #24] came into her room and my niece told him he needed to leave and he did. Then myself and my niece told staff we do not want him [Resident #24] in my mother's room or touching her. The surveyor asked daughter (#2) if her mother was cognitively intact, would she be ok with Resident #24's hugging, touching her face and holding hands and the daughter responded, Absolutely not. Resident #13's daughter and niece reported Resident #24's behaviors to a staff member in May and the staff member failed to identify Resident #24's actions as abuse, failed to report it to the administrator therefore, the facility didn't know abuse existed and failed to investigate. - Review of Resident #24's medical record occurred on June 12-13, 2024 and included a diagnosis of severe dementia. The quarterly Minimum Data Set (MDS), dated [DATE], identified a brief interview for mental status (BIMS) of 6, indicating severely impaired cognition. A nurse's note, dated 06/09/24 at 4:36 p.m., stated, . Resident was wandering into everyone's room this afternoon and trying to kiss different females multiple times. Resident does not listen even if the person asks him not to touch them. During an interview on 06/12/24 at 3:46 p.m., a nurse (#3) who witnessed the incidents on 06/09/24 stated Resident #24 kissed Resident #19 and Resident #23 on the cheek in a public area. The nurse stated, Usually he is just tapping people on the shoulders and most residents' do not like it when he does tap them on the shoulder. When the nurse (#3) told Resident #24 he could not kiss Resident #19, Resident #19 stated, He can do that. The nurse (#3) stated Resident #24's kiss elicited no response verbally or non-verbally from Resident #23. The nurse (#3) stated she immediately attempted to redirect Resident #24 who was difficult to redirect and just started talking about other things. The nurse verified she did not notify the DON, administrator, or abuse coordinator about the incident, stating, I didn't even think of it as abuse, but I should because I would not want my family member touched like that. Failure to report the observations does not allow the facility to investigate and protect these residents and all residents from the actions of Resident #24. - Review of Resident #19's medical record occurred on June 12-13, 2024 and included a diagnosis of Alzheimer's disease. The quarterly MDS, dated [DATE], identified a BIMS score of 5, indicating severely impaired cognition. - Review of Resident #23's medical record occurred on June 12-13, 2024 and included a diagnosis of dementia. The admission Minimum Data Set (MDS), dated [DATE], indicated severely impaired cognition. During an interview on 06/12/24 at 4:07 p.m., four administrative staff members (Administrator, Director of Nursing, Assistant Director of Nursing and abuse coordinator) all stated they had not been notified of Resident #24's behaviors therefore did not investigate any of his actions as abuse and did not report them to the SSA.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40489 Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise care plans to reflect residents' current status for 2 of 3 sampled residents (Resident #4 and #10). Failure to update care plans limited staffs' ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled Nursing Care Plans occurred on 06/13/24. This policy, dated November 2017, stated, . POLICY: A person centered plan of care shall be developed . Evaluation of approaches and goals shall be charted on care plans by the nurse doing the monthly charting for the resident. - Review of Resident #4's medical record occurred on all days of survey and included diagnoses of traumatic brain disorder and epilepsy. The current care plan stated, . No water in room . The significant change Minimum Data Set (MDS), dated [DATE], identified a brief interview for mental status (BIMS) score of 15, indicating cognitively intact. Observation on 06/11/24 at 10:57 a.m. showed no water cup in Resident #4's room. When asked why he doesn't have a water cup in his room, the resident stated, When I finish drinking the water they take the cup and then bring some [water] back to me later. Observation on 06/12/24 at 8:37 a.m. showed no water cup in Resident #4's room. When the resident asked for water a certified nurse aide (CNA) (#9) stated, You already had your water. During an interview on 06/12/24 at 11:32 a.m., Resident #4 stated he has to request water when he wants it and the staff have not told him why he cannot have a water cup in his room. During an interview on 06/12/24 at 11:44 a.m., when asked why Resident #4 has to ask for water instead of water being available for him in his room at all times, a licensed nurse (#3) stated, We can't give him excessive amounts of water due to his medications, specifically lithium. He has an obsessive-compulsive disorder and would drink large amounts if it is left in his room. There are very specific times he requests water. There is no specific amount of water he can have. During an interview on 06/12/24 at 11:49 a.m., when asked about Resident #4's care plan stating no water in room, an administrative nurse (#2) stated, There are very specific times that he [Resident #4] requests and receives water. Resident #4's care plan failed to address specific times to provide the resident with water/fluids and reason why he is not able to have a water cup in his room. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Review of Resident #10's medical record occurred on all days of survey and included a diagnosis of osteoarthritis. The current care plan stated, . I will transfer with . EZ stand [sit-to-stand mechanical lift] with 1x [1 staff assist] assist . I am at risk to fall . The physician's orders included, . Transfer: EZ stand 1x assist with buttocks and leg strap . Observation on 06/11/24 at 3:08 p.m. showed a CNA (#8) transferred Resident #10 from the wheelchair to the bathroom using the EZ stand lift without using the buttocks sling and leg strap. Resident #10's care plan failed to include use of the leg strap and buttocks sling with the EZ stand lift transfers. During an interview on 06/12/24 at 2:41 p.m., an administrative nurse (#1) stated she expected care plans to be individualized.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40489 Based on observation, record review, review of facility policy, review of manufacturer's instructions, review of facility investigation reports, and staff interview, the facility failed to provide adequate assistance for 2 of 2 sampled residents (Resident #3 and #10) observed during a sit-to-stand mechanical lift transfer and failed to complete an investigation for 1 of 1 sampled resident (Resident #4) with a history of falls and a fracture. Failure to ensure proper use of the stand lift, including use of the seat and leg strap, and failure complete a fall investigation, including intervention to alleviate falls, placed the residents at risk of experiencing pain/discomfort and/or possible accidents with/without injury. Findings include: Review of the facility policy titled RESIDENT INCIDENT FOLLOWUP REPORT occurred on 06/13/24. This policy, dated March 2016, stated, . To review the individual incident reports and state the corrective action taken . 1. The DON [director of nursing] or charge nurse will review each incident report within 24 hours of the occurrence. 2. After reviewing the incident report, the nurse is responsible for completing the Resident incident report concerning that incident. Review of the facility policy titled EZ WAY STAND AID occurred on 06/13/24. This policy, dated December 2021, stated, . The EZ Way Stand Aid will be used as a resident transferring device for those residents who have adequate arm strength to pull themselves upward and enough leg strength to support their own weight. The manufacturer's instructions for the EZ Way Seat Strap stated, . Applying the seat strap: Stand behind the patient, and using the hand control, press the UP button to raise the patient slightly off the surface. Tighten the harness buckle. 7. Slide the seat strap under the patient's buttocks. - Review of Resident #3's medical record occurred on all days of survey and included diagnoses of muscle weakness and arthritis. The current care plan stated, . I am at risk to fall . I will utilize the EZ Stand with seat strap and 1 assist for transfers. Observation on 06/11/24 at 10:03 a.m. showed a certified nurse aide (CNA) (#12) transferred Resident #3 from the wheelchair to the toilet using the EZ way stand lift. As the CNA began to raise the resident, the resident failed to hold onto the handles. The CNA stated, I better use the butt sling [seat strap]. The CNA then utilized the seat strap. The resident, unable to bear weight, hung from the chest harness in a semi-seated position. The harness straps pulled upward into Resident #3's axillae and caused the shoulders to raise to ear level with the elbows extended horizontally. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/12/24 at 10:04 a.m. showed a CNA (#7) transferred Resident #3 from the wheelchair to the bathroom using the EZ way stand lift with the seat strap positioned above the resident's buttocks rather than under the buttocks. The resident could not lift his upper body enough to hold onto the handle bars and grabbed onto another part of the lift directly in front of him. The CNA placed the resident's hands on the handle bars. His hands immediately fell off and the resident grabbed the part of the lift in front him. The resident, unable to bear weight, hung from the chest harness in a semi-seated position. The harness straps pulled upward into Resident #3's axillae and caused the shoulders raised to ear level with the elbows extended horizontally. During an interview on 06/12/24 at 11:36 a.m., a licensed nurse (#3) stated, I know he [Resident #3] hangs there, but there is no way we could get the hoyer [full body lift] into the bathroom. - Review of Resident #10's medical record occurred on all days of survey and included diagnoses of dementia and osteoarthritis. The current care plan stated, . I will transfer . EZ stand with 1x [one staff] assist. I am at risk to fall . The medical record included the following physicians order, Transfer: EZ stand 1x assist with butt [buttocks] and leg strap . Observation on 06/11/24 at 3:08 p.m. showed a CNA (#8) transferred Resident #10 from the wheelchair to the toilet using the EZ way stand lift and failed to apply the seat/buttocks and leg straps. - Review of Resident #4's medical record occurred on all days of survey and included a diagnosis of hemiplegia (one-sided weakness or paralysis). The current care plan stated, . I am at risk to fall . monitor my falls for any pattern. The medical record showed Resident #4 experienced seven falls between 03/31/24 to 05/31/24, one with a major injury. Resident #4 progress notes included the following: * 05/09/2024 at 9:45 p.m. Res [resident] chair alarm was sounding, Staff entered room to find res on the floor. this [sic] nurse entered room to find res lying on his left side with his backside facing the dresser in his room. TV [television] had ended up on the floor behind res unplugged and cord under his left leg. no injuries noted at this time, ROM [range of motion] WNL [within normal limits] for resident. Will continue to monitor. * 05/10/2024 at 6:27 a.m. Res started to c/o [complain of] left elbow pain during the night. No swelling noted, tender to touch just above the elbow. Tylenol given at 2AM [2:00 a.m.] with some relief noted at the time. Res currently c/o pain again, will have med aid give another dose of Tylenol. * 5/10/2024 at 7:48 a.m. updates to [nurse practitioner] provided on fall with pain complaints. Decision that resident will go for clinic appt [appointment] . today at 2pm for x-ray and seen by . * 05/10/2024 at 4:28 p.m. Resident returned from appointment with . x-ray showed a fractured left ulna [bone in forearm] proximal-non displaced. The investigation related to the above fall and fracture stated, . [Resident #4] with no additional injury. He has been noted to fluctuate in his physical abilities. He is working with therapy regarding his positioning in chair. We will work with therapists to determine best method for transfers at this time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/12/24 at 2:41 p.m., an administrative nurse (#1) confirmed staff failed to complete the investigation including a corrective action plan related to Resident #4's falls and failed to update the care plan since 2020.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 19864 Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure an effective infection prevention and control program for a safe, sanitary, and comfortable environment and to help prevent the development and transmission of infections for 2 of 3 sampled residents (Resident #10 and #18) observed during care and 1 of 2 certified nurse aides (CNAs) reviewed for handwashing (CNA #4). Failure to removed soiled gloves and perform hand hygiene after incontinence cares and failure to disinfect multi-use equipment may result in exposure of infections to residents, staff, and visitors. Findings included: Review of the facility policy titled Infectious Disease Control Manual occurred on 06/12/24. This undated policy stated, General Aseptic Technique section: ii. 10 key times to wash your hands 2.) Should be first thing you do when you enter the resident room and the last thing you do before leaving. 4.) Between resident contacts. 5.) Before and after tending to any personal needs or contact with your face, or mouth (sneezing, blowing your nose, combing your hair, using the toilet, before and after you smoke). 7.) After removing our gloves. 8.) Before and after handling dressings, catheters, bedpans, specimens, and urinals. Between procedures on the same resident. 9.) Before and after assisting residents with any personal needs. - Observation on 06/11/24 at 10:08 a.m. showed the CNA (#4) left Resident #11's room after transferring her to a wheelchair using a sit-to-stand lift. The CNA (#4) failed to clean or disinfect the lift after using it with Resident #11 and taking it to Resident #18's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/11/24 at 10:11 a.m. showed the CNA (#4) applied gloves and transferred Resident #18 from the bed to the toilet using the sit-to-stand lift just used for Resident #11's transfer. The CNA removed Resident #18's pants and brief, sat the resident on the toilet, and removed her gloves. The CNA (#4) failed to sanitize her hand and touched the resident's blanket and sheets and straightened the bed cover. The CNA (#4) sat on Resident #18's bed until the resident finished using the toilet. The CNA applied gloves and provided perineal cares for the resident. While still wearing the soiled gloves, the CNA retrieved a clean brief, placed it on the resident, pulled up the resident's pants, and used the sit-to-stand lift to transfer Resident #18 into her wheelchair. The (CNA) #4 removed her gloves, placed the oxygen tubing into the resident's nose, flushed the toilet, disposed of the soiled brief in the trash can, and then washed her hands. During an interview with CNA (#4) on 6/11/24 at 2:38 p.m., she confirmed she did not wash her hands or change her gloves appropriately while providing care to Resident #18. She acknowledged that she should have washed her hands after removing her gloves and before touching clean items with dirty hands or gloves. During an interview with an the DON on 6/12/24 at 10:30 a.m., she stated staff were to wash their hands before they initiated care for a resident, after, and after gloves were removed. The DON said the staff should clean and disinfect the sit-to-stand lift between each resident to prevent the spread of infection. 40489 - Observation on 06/11/24 at 3:08 p.m. showed a CNA (#8) assisted Resident #10 to the bathroom using the sit-to-stand lift. After assisting the resident, the CNA exited the resident's room without disinfecting the lift. During interview on 6/13/24 at 9:17 a.m., the CNA (#8) stated she used the sit-to-stand lift to transfer residents, but does not clean or disinfect the lift between uses. She added housekeeping handles the cleaning, as her routine involves using the lift to assist residents and then placing it at the end of the hall for others to use.