STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385018	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Benedictine Nursing Center	540 South Main Street Mount Angel, OR 97362

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 - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 36494 Based on observation, interview, and record review it was determined the facility failed to protect the resident's right to be free from sexual abuse by another resident for 1 of 2 sampled residents (#1) reviewed for sexual abuse. This resulted in Resident 1 experiencing psychosocial harm and increased distress. Findings include: Resident 1 was admitted to the facility in 3/2024 with diagnoses including dementia, mood disturbance, anxiety and developmental disorder of speech and language. A 3/22/24 Cognitive Loss and Dementia CAA revealed Resident 1 required one-step cueing for tasks, time to process cues and communication, and 24-hour supervision for safety. Resident 1 required a floor alarm because the resident did not remember to use the call light. Staff were to provide simple direct communication and interpret Resident 1's tone of voice and facial expressions. Resident 2 was admitted to the facility in 3/2024 with diagnoses including stroke and encephalopathy (damage or disease that affects the brain). Resident 2's care plan, initiated on 3/26/24, revealed Resident 2 had a stroke with left-sided weakness, was Spanish speaking only, had impaired eyesight and impaired cognition. A revision on 3/27/24 revealed Resident 2 had inappropriate physical behaviors and spoke inappropriately towards female caregivers. The resident was to be continuously supervised when in a public space, was impulsive and left her/his room independently. The staff were to provide care in pairs and remind Resident 2 what appropriate behavior and language were. Staff were to draw appropriate verbal and physical boundaries. Progress Notes revealed the following: -3/27/24 at 3:39 PM Staff 10 (Pastoral Care) visited Resident 2 but was unable to complete the assessment due to a language barrier. Resident 2 attempted inappropriate touch, which Staff 10 deflected. -3/27/24 at 6:08 PM Three CNAs reported Resident 2 grabbed and touched them during their shift, and made inappropriate remarks towards staff. Resident 2 was placed at a table away from other female residents. Staff 3 (LPN-Agency) spoke with Resident 2, with assistance from a Spanish-speaking CNA, and informed Resident 2 she/he was not allowed to touch staff inappropriately. (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 - Actual harm Residents Affected - Few	-3/30/24 at 2:49 AM Staff 4 (LPN) revealed Resident 2 exposed herself/himself earlier in the shift, while a resident was outside of Resident 2's room. It was unclear if the exposure was intentional or not as Resident 2 made prior gestures to use her/his urinal. -3/30/24 [recorded as Late Entry on 4/2/24 at 10:15 AM] Staff 2 (DNS) was notified Resident 1 was inappropriately touched by Resident 2. The touch was unsolicited and not consensual. Staff were instructed to monitor Resident 2 and keep Resident 2 distanced from other patients for safety. Resident 2 was sent to the hospital at approximately 4:55 PM for nonemergent care related to inappropriate sexual behaviors. Random observations from 4/2/24 through 4/3/24 revealed Resident 1 was either in her/his room in bed, or up in her/his wheelchair out in the hallway, and was able to self-propel up and down the halls. Resident 2 was no longer in the building. On 4/2/24 at 11:07 AM Witness 10 (Police Officer) was interviewed and stated the following: -Witness 10 received a call from Staff 2 to report Resident 2 touched Resident 1 in an inappropriate sexual manner during breakfast on 3/30/24. -Witness 10 arrived at the facility and interviewed all parties involved. -Witness 10 stated Staff 5 (CNA) witnessed Resident 2 and Resident 1 move around the breakfast table toward one another when Staff 5 noticed Resident 2 started rubbing Resident 1's thigh in a sexual manner. Staff 5 moved Resident 2 out to the hallway, left both residents for approximately 90 seconds and returned with Staff 3. Resident 2 approached Resident 1 again and rubbed Resident 1's private area. Staff 3 and Staff 5 stopped Resident 2 and took Resident 2 back to her/his room. -Staff 5 reported Resident 2 attempted to touch her inappropriately when she took her/his blood sugar measurement, but was able to move out of the way. - Staff 3 reported Resident 2 was zeroing in on Resident 1 but did not give specific details as to what zeroing in meant. -Witness 10 interviewed Resident 1 but the resident was unable to recall what occurred. Resident 1 was upset, and stated to be nice because Resident 2 was her/his friend. -Witness 10 interviewed Resident 2, who denied touching Resident 1 in an inappropriate sexual manner. Resident 2 was able to carry a full conversation in Spanish with Witness 10 and understood Staff 5 told Resident 2 to go back to her/his room. -Witness 10 asked Resident 2 about sexually inappropriate behavior towards staff, such as offering money to staff for sexual favors. Resident 2 stated she/he did not have any money and then indicated she/he offered the nurse some money for the shower she/he received. On 4/2/24 at 11:35 AM Resident 1 stated she/he did not know how long she/he was at the facility. When asked if she/he recalled being inappropriately touched by another resident, Resident 1 replied, I don't remember, and mentioned she/he had difficulty remembering things. Resident 1 stated she/he had a bit of a headache. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 4/2/24 at 11:52 AM Staff 3 (LPN-Agency) stated she was familiar with Resident 1 and Resident 2. Staff 3 stated Resident 2 was Spanish-speaking but was able to communicate her/his needs. Resident 2 was impulsive and was sexually inappropriate towards staff. Resident 1 was pleasantly confused, impulsive and easily redirected. Staff 3 stated on 3/30/24 Resident 1 and Resident 2 were in the North Hall dining room, both within eyesight of staff. Staff 3 stated Staff 5 approached Staff 3 and indicated she needed assistance because Resident 2 rubbed Resident 1's leg and knee, and Staff 5 wheeled Resident 2 to the nurses station. Staff 3 entered the dining area with Staff 5, where they observed Resident 2 back at the dining table with Resident 1. Resident 2's hand was between Resident 1's legs, and Resident 2 was rubbing Resident 1's private area over Resident 1's brief and pants. Staff 3 stated she immediately wheeled Resident 2 away from Resident 1, and firmly stated, No, you can't touch people like that. Resident 2 understood the word no and Staff 3 escorted Resident 2 to her/his room. Staff 3 stated Resident 1 was initially upset when Resident 2 was removed from the area. Staff 3 stated Resident 1 was unable to answer questions and did not recall the incident. Later, Resident 1 requested to lay down for the day, which was uncharacteristic behavior. Resident 1 also expressed concern, stating, Don't let anyone sneak into my room. Staff 3 stated she believed Resident 1 had some awareness of what happened but was unable to voice it due to her/his dementia. On 4/2/24 at 1:22 PM Staff 5 (CNA) stated she worked with Resident 2 prior to the incident on 3/30/24. Resident 2 exhibited sexual behavior towards staff but not toward residents. Resident 2's care plan required two staff members in the room when interacting with Resident 2. Staff 5 recalled she heard about one incident when Resident 2 attempted to entice Resident 1 out of her/his room by flashing money. Resident 1 did not witness the behavior. Staff 5 stated during breakfast on 3/30/24 at approximately 8:30 AM Resident 1 and Resident 2 were seated across from each other in the dining room area. A nurse was at the nurses station and the residents were visible from the nurses station. Staff 5 stated she avoided an attempt by Resident 2 to inappropriately touch her when she checked Resident 2's blood sugar. Resident 1 and Resident 2 received their breakfast trays and as Staff 5 emerged from a room around the corner she observed Resident 1 and Resident 2 scooted closer to one another. Resident 2 was rubbing Resident 1's leg and knee back and forth. In response to the situation, Staff 5 promptly wheeled Resident 2 to the nurses station and sought assistance from Staff 3, urgently stating, I need you right now. Staff 5 and Staff 3 rushed to the dining area. Resident 2, who was able to self-propel, approached Resident 1 and grabbed Resident 1's private area over Resident 1's brief and pants. Resident 2 glanced around to ensure no one was watching. Staff 3 firmly told Resident 2, No, no, and Resident 2 raised her/his hands in response. Staff 3 wheeled Resident 2 back to her/his room. Staff 5 stated Resident 1 initially indicated Resident 2 did not harm her/him and Resident 2 was a friend. Resident 1 later became upset and reacted negatively. Approximately an hour afterward, Resident 1 expressed fatigue and a desire to rest her/his legs. Resident 1 stated, Hopefully I could get some sleep and no one will sneak in my room. Staff 5 stated she noticed Resident 1 seemed unusually agitated during the day shift, as her/his typical baseline behavior was pleasantly confused. When Staff 5 checked on Resident 1, she/he firmly stated, Don't touch me, and I don't want anything from you. On 4/2/24 at 1:59 PM and 4/3/24 at 12:14 PM Staff 4 (LPN) stated she worked with Resident 2, who was Spanish speaking. Staff 4 stated in the early AM hours prior to 8:30 AM on 3/30/24 Resident 2 was in bed with her/his genitalia exposed. Staff 4 believed the exposure was directed at Resident 1, although Resident 1 did not observe it. Staff 4 stated she was uncertain whether Resident 2 intentionally exposed herself/himself or needed to use the urinal. Staff 4 stated Resident 1 was confused at baseline and on 3/31/24 expressed concern and asked if, that man was still there. Staff 4 reassured Resident 1 no one was in her/his room. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 4/2/24 at 3:27 PM Witness 11 (Family Member) stated she received a call on 3/30/24 regarding Resident 1. Witness 11 stated another resident maneuvered to the opposite side of the table while Resident 1 was having breakfast and the resident engaged in inappropriate sexual behavior, touching Resident 1's private area. Witness 11 stated a staff member witnessed the incident, intervened, and separated the residents. Witness 11 stated staff retrieved assistance and when the staff returned the resident made her/his way back to Resident 1 and was rubbing Resident 1's private area, necessitating a second separation. Witness 11 stated she was upset about the incident and Resident 1, who lacked awareness of the situation, couldn't recall her/his own name, or effectively communicate. Witness 11 was uncertain whether the touching occurred over or under Resident 1's clothing, but regardless, such behavior should not have occurred. On 4/3/24 at 8:52 AM Staff 8 (CNA) stated she was not present on 3/30/24, when Resident 2 inappropriately touched Resident 1. Staff 8 stated Resident 2 was Spanish-speaking only, and she assisted with Resident 2's admission due to the language barrier. Resident 2 reported a sexually inappropriate act to her, when Resident 2 became aroused by a staff member at the hospital. Staff 8 stated she reported the conversation to Staff 9 (RN) who was in the room. Staff 9 indicated Resident 2 made inappropriate sexual comments at the hospital. Staff 8 stated she worked with Resident 1 on multiple occasions and the resident was pleasantly confused. Staff 8 stated she worked with Resident 1 on 3/31/24, the day after the incident with Resident 2. During charting, Resident 1 was in her/his wheelchair, lifted her/his shirt, exposing her/his breast. Staff 8 addressed the unusual behavior and was concerned. Staff 8 stated later in the evening, during her shift, Staff 8 assisted Resident 1 to bed. Resident 1 immediately called and asked if someone was in her/his room and Resident 1 asked, is that guy still there? Staff 8 assured Resident 1 there was no one in her/his room. Approximately five minutes later, around 9:30 PM Staff 8 returned to Resident 1's room, and Resident 1 again asked if that man was still out there. Staff 8 reassured Resident 1 once more. Staff 8 stated she reported her concern to Staff 4 (LPN) and she charted the incident. Staff 8 further stated she was fairly certain she knew Resident 1 was referring to Resident 2. On 4/3/24 at 1:29 PM Staff 9 (RN) stated she assessed Resident 2 upon admission to the facility. Staff 9 stated Resident 2, who spoke only Spanish, received assistance from Staff 8, who was also fluent in Spanish, for communication. Staff 9 stated Resident 2 had confusion, and Staff 8 relayed Resident 2 stated he experienced a sexual incident at the hospital and became aroused. Staff 9 stated she stepped out of the room with Staff 8 and shared hospital records indicated Resident 2 made inappropriate sexual comments to staff during her/his hospitalization . Staff 9 stated on one occasion Resident 2 offered staff money for sexual favors, but staff members firmly declined. Staff 9 stated Resident 2 put the money away, and Staff 9 believed this was an isolated occurrence. Staff 9 stated the money incident occurred prior to the 3/30/24 incident, during which Staff 9 was not present. Staff 9 stated upon returning to work, Resident 2 was no longer in the building. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The 4/3/24 Investigation Summary Abuse Allegation revealed Resident 2 exhibited inappropriate behaviors while at the hospital, but no known knowledge of sexual assault. After admission to the facility, Resident 2 demonstrated growing behavioral concerns, prompting appropriate response from staff. Resident 2's care plan was updated to include increased behavior monitoring, two-person cares, redirection and setting appropriate boundaries. On 3/30/24 Staff 5 was assigned to Resident 2 and brought Resident 2 to the common area for breakfast, placing Resident 2 across the table from Resident 1. A nurse was at the nurses station and the residents were visible from the nurses station. At approximately 8:30 AM, Staff 5 delivered a meal tray down the hall. Upon returning, Resident 2 and Resident 1 both came around the table and met. Resident 2 was looking around while also reaching to rub Resident 1's thigh. Staff 5 intervened and expressed Resident 2's behavior was not appropriate. Staff 5 indicated despite the language barrier, Resident 2 indicated understanding and played it off with hand signals, suggesting Resident 2 was not doing anything wrong. Resident 1 expressed confusion and reported Resident 2 was my friend. Staff 5 moved Resident 2 into a separate hall and then sought help. Staff 5 returned in less than a minute with Staff 3. Resident 2 returned to the table and was witnessed rubbing between Resident 1's thighs and on her/his groin area. Staff 5 and Staff 3 separated Resident 1 and Resident 2, emphasizing Resident 2's behavior was not acceptable. Staff 5 indicated Resident 1 expressed frustration regarding their separation and Resident 2 was being nice. Staff 5 educated Resident 1 regarding the inappropriate touch. Resident 1 was agitated and in a poor mood for the remainder of the shift and requested to lie down because she/he was tired. After laying Resident 1 down, Resident 1 told Staff 5, Don't let anyone sneak into my room. Reassurance was offered. Although Resident 1 remained agitated into the evening, Resident 1 returned to her/his baseline according to Staff 5. The encounter between Resident 2 and Resident 1 on 3/30/24 was documented as unavoidable. Staff monitored Resident 2 and kept Resident 2 separated from other residents to the best of their ability. Resident 2 was sent to the hospital at approximately 4:55 PM for further evaluation due to her/his behavioral concerns. Resident 1 experienced a temporary change in her/his mood but returned to her/his baseline; no long-term harm occurred. Resident to resident sexual abuse was substantiated. On 4/3/24 at 2:18 PM Staff 2 (DNS) stated she initiated an investigation and concluded Resident 1 was sexually abused by Resident 2 based on her interviews and record review. The incident on 3/30/24 was witnessed by staff, and Resident 2 engaged in inappropriate sexual touch which was not consensual with Resident 1, as Resident 1 was unable to consent due to her/his cognition.