STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445162	A. Building B. Wing	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agape Rehabilitation & Nursing Center, A Waters CM	505 N Roan Street Johnson City, TN 37604

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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 - Few	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** 49786 Based on facility policy review, medical record review and interviews, the facility failed to report an allegation of abuse timely for 1 resident (Resident #20) of 24 residents reviewed for abuse. The findings include: Review of the facility's policy titled, Abuse Prevention Program dated 1/19/2017, showed .When an alleged or suspected case of abuse .is reported .the administrator, or person in charge of the facility, will notify the following .agencies of such incident immediately .State Licensing and Certification Agency . Resident #20 was admitted to the facility on [DATE] with diagnoses including Major Depressive Disorder, Mild Intellectual Disabilities, Anxiety Disorder, Osteoporosis and Hypertension. Review of Resident #20's comprehensive care plan dated 8/27/2021, showed .a DX [diagnosis]/HX [history] of mild intellectual disability .Behavior .has an alteration in behaviors as evidenced by .fixation on male staff and residents .refers to them as her boyfriends .exhibits attention seeking behaviors and confabulates stories .has made the statement that her brother in law sexually abused her in the past and her family denies this has occurred .Hx of hallucinations and delusions . Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] (assessment prior to allegation of abuse), showed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Review of a Nurse Practitioner (NP) Progress note dated 12/22/2023, showed .acute visit as pt [patient] reported she was inappropriately touched by a male .reports the male entered her room and grabbed her lotion and started rubbing lotion on her legs and then up her torso onto her breast then stuck his hand down her brief .discussed with Psych .the resident reports feeling safe in her current environment . (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Psychiatric NP note dated 12/22/2023, showed .patient required telehealth visit today after she made accusations that a custodian [Housekeeping Floor Technician] had made inappropriate contact with her of a sexual nature. Patient has a history of erotomanic delusions (when you think someone is in love with you, but they are not) there have been a few instances since the patient has been a resident here where she felt she had a romantic relationship with people whom she did not. Her sister reports this has happened frequently in the past. Her sister also reports long history of delusional thought processes and hallucinations . She [Resident # 20] reports she feels safe at the facility and has no concerns in regard to the custodian. She reports she has no concerns with him continuing to work at the facility including her room. With the patient's history of confabulations and delusional thought processes it is likely she is just currently having exacerbation of symptoms . During an interview on 2/20/2024 at 11:00 AM, Resident #20 stated the Housekeeping Floor Technician hurt her (the resident did not specify a date). The resident also stated the Housekeeping Floor Technician sat her up in the bed, laid her across the bed, and applied lotion to her private area (the resident demonstrated by rubbing between her thighs) without gloves on. The resident stated she did not have clothes on, it hurt her, she asked the Housekeeping Floor Technician to stop and he did. Resident #20 stated she reported the incident to the Administrator and Director of Nursing (DON). During an interview on 2/21/2024 at 8:00 AM, Licensed Practical Nurse (LPN) #1 stated Resident #20 made an allegation of abuse approximately 6 months ago (unsure of the exact date). The resident reported to another nurse (unsure of which nurse) the Housekeeping Floor Technician touched her inappropriately. During an interview on 2/21/2024 at 8:40 AM, Registered Nurse (RN) #1 stated she was familiar with Resident #20. The resident made an allegation (unsure of the exact date and who the resident reported it to) the Housekeeping Floor Technician had touched her inappropriately. During an interview on 2/22/2024 at 9:25 AM, Resident #20 stated 2-3 months ago (unable to give the exact date) she was sitting up on the side of the bed and the Housekeeping Floor Technician was mopping the floor in her room. The resident stated the Housekeeping Floor Technician grabbed her, walked to the bedside table to get the hand lotion, and began rubbing the lotion on her thighs and inside her brief. The resident stated the Housekeeping Floor Technician rubbed the lotion on her for approximately half an hour and when she told him to stop, he stopped. During a telephone interview on 2/22/2024 at 10:30 AM, Certified Nursing Assistant (CNA) #4 stated she cared for Resident #20 routinely on night shift (7:00 PM-7:00 AM). Resident #20 informed CNA #4 around 11:00 PM (unsure of exact date but it was in December) to watch out for the Housekeeping Floor Technician because he rubbed her [Resident #20] inappropriately on her legs and down there. The resident did not state a specific time or date the incident occurred. The CNA reported the allegation to LPN #2 and the LPN informed the DON. During a telephone interview on 2/22/2024 at 10:52 AM, LPN #2 stated she cared for Resident #20 when the resident reported an allegation of abuse. The LPN stated CNA #4 reported (unable to recall the exact date) Resident #20 had stated the Housekeeping Floor Technician had grabbed her and touched her inappropriately. LPN #2 reported the allegation of abuse to the DON immediately. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/22/2024 at 3:15 PM, with the Administrator and the DON, the DON stated LPN #2 had notified her on 12/21/2023 at approximately 11:15 PM, a report by Resident #20 of Housekeeping Floor Technician rubbing lotion on her thighs and down there. When the DON asked LPN #2 what down there meant, the LPN stated the resident pointed to her groin area. The DON stated she contacted the Administrator immediately of the alleged allegation. The Administrator stated he arrived at the facility approximately 20 minutes after he was notified of the allegation and the DON arrived at the facility a short time later. Interview continued and the Administrator stated he and the DON interviewed Resident #20 the night of 12/21/2024. The resident reported the Housekeeping Floor Technician came into her room around 8:00 AM on 12/21/2023 and rubbed lotion on Resident #20 down there (groin area) for 2 hours. The Administrator confirmed he did not report Resident #20's allegation of abuse to the state agency and Adult Protective Services in the 2 hour timeframe required.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48100 Based on facility policy review, medical record review and interview, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASARR) screen was accurate after a mental health diagnosis was identified for 2 of 5 residents (Resident #2 and #38) reviewed for PASARR. The findings include: Review of the facility's policy titled, PASRR [PASARR] PROCESS undated, showed .federally mandated process that requires all states to pre-screen all residents .identify people, including adults, (residents), with mental illness .to ensure people [residents], receive the required services for mental illness . Resident #2 admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Anxiety, Alcohol Dependence, Major Depressive Disorder, and Post Traumatic Stress Disorder (PTSD). Review of a PASARR dated 1/4/2022, showed Resident #2 had mental health conditions of Major Depression and Anxiety Disorder with a substance abuse related disorder for Alcohol use. PTSD was not included as a mental health condition. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], showed Resident #2 had an active diagnosis of PTSD. Resident #38 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Diabetes Mellitus, PTSD, and Anxiety. Review of a PASARR dated 9/23/2019, showed Resident #38 had mental health conditions of Depression and Anxiety Disorder. PTSD was not included as a mental health condition. Review of a quarterly MDS assessment dated [DATE], showed Resident #38 had an active diagnosis of PTSD. During an interview on 2/22/2024 at 11:11 AM, the Director of Nursing (DON) confirmed Resident #2 and #38's mental health condition of PTSD had not been captured on the readmission/admission PASARR.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48100 Based on facility policy review, observations and interview, the facility failed to ensure kitchen cooking/serving equipment was maintained in a sanitary condition, failed to ensure food items were sealed properly, and failed to ensure dented cans were discarded, which had the potential to affect 65 of 65 residents. The findings include: Review of the facility's policy titled, Food Storage dated 11/25/2019, showed .Food storage areas are clean . containers for bulk items .have tight-fitting lids .dented cans are returned to the vendor upon delivery or stored in a separate area . Review of the facility's policy titled, Cleaning & Sanitization dated 9/2/2020, showed .ensure the food service department is maintained according to state and federal regulations as well as a clean, sanitary, and safe environment . Observation of the cooking and food preparation area with the Certified Dietary Manager (CDM) on 2/20/2024 at 10:40 AM, showed the following: - Gas stovetop ranges had dried, black, greasy food debris present on surface and inner area. - Griddle cooktop had black, grease-like food debris present on inner corners of the cooktop. - Boiler-less Steamer had greasy, brown-yellow residue present on the metal pan insert, standing water in the bottom of steamer was observed to be turbid, brown, and contained free floating brown food debris, and crusty yellow food debris was impacted on the insulated strip of the streamer door. - Stagnant brownish-yellow water was present on the floor behind steamer. - Convection oven temperature dials on the top and bottom ovens had dried, brownish-yellow food debris. - Toaster Oven temperature dials x [times] 3 had dried food debris present. - One 15-ounce (oz) (3/4 full) container of Ground Cumin was not sealed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- One 36-oz box of Iodized Salt (1/4 full) was not sealed. Observation of the dry storage area with the CDM on 2/20/2024 at 10:45 AM, showed the following: - Two 49.5-oz cans of mushroom soup were dented. - One 50-oz can of tomato soup was dented. Observation of the clean dish storage area with the CDM on 2/20/2024 at 10:50 AM, showed the following: - Two 1/2-inch-deep roasting pans had dried, crusty, yellow food debris. - Two 6-inch small plates had crusty yellow food debris present to the bottom of each plate. - Two small bowls had dried, yellow food debris present on the inside of the bowls. During an interview on 2/20/2024 at 11:36 AM, the CDM confirmed the dented cans had not been discarded, spices were not sealed appropriately, and the kitchen equipment (gas stove, griddle cooktop, steamer, roasting pans, serving dishware, etc) was not maintained in a sanitary condition.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 48100 Based on facility policy review, observations and interview, the facility failed to ensure garbage and refuse were properly contained in 2 of 2 dumpsters (dumpster A and B). The findings include: Review of the facility's policy titled, Waste Disposal dated 2/29/2016, showed .dispose of waste in a manner that does not create a nuisance or breeding place for insects and rodents .keep dumpster lids closed at all times .keep dumpster and dumpster site areas clean and free of debris . Observation of the outside dumpster area on 2/20/2024 at 11:15 AM, with the Certified Dietary Manager (CDM), showed 2 dumpsters present for waste disposal. The entry door (right door) to the dumpster area had come off the hinge and was propped up on the wall beside dumpster B. The area around dumpster A had 2 torn plastic bags, 3 used disposable gloves, and pieces of paper debris present on the ground. Dumpster A had a wet, decayed wooden pallet exposed to the elements, propped up beside the dumpster. The hard plastic roof covering dumpster A was missing and left dumpster A's contents open to air, elements, and potential exposure to pests. Dumpster B had no drain plug intact and the outer doors were open, which left dumpster B's contents open to air, elements, and potential exposure to pests. Dumpster B had a wooden door propped up on the wall and had a discarded toilet stored behind the dumpster with trash debris (paper, disposable gloves, leaves) observed inside the toilet bowl. During an interview on 2/20/2024 at 11:36 AM, the CDM confirmed the dumpster area had not been maintained in a good working order or sanitary conditions.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 48100 Based on observation and interview, the facility failed to repair the handwashing soap dispensers in 2 of 4 handwashing stations (station A and C), failed to ensure hot water was available in 1 of 4 handwashing stations (station D), and failed to repair 2 of 4 paper towel dispensers (station A and C) observed during the initial kitchen tour. The findings include: Observation of the food preparation area on 2/20/2024 at 11:00 AM, with the Certified Dietary Manager (CDM), showed the paper towel holder and soap dispenser above handwashing stations A and C were not in a good working order and hot water was not assessable on handwashing station D. During an interview on 2/20/2024 at 11:36 AM, the CDM stated handwashing station B was the only fully functioning handwashing station present in kitchen. The CDM confirmed the essential kitchen equipment had not been maintained in a good working order.