STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Augusta Nursing & Rehab Center	83 Crossroads Lane Fishersville, VA 22939

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49456 Based on resident interviews, staff interviews, observations and facility documentation the facility staff failed to allow the residents to exercise their rights as a citizen of the United States for multiple residents residing on 2 of 2 units and failed to treat residents with and provide an environment that promoted respect and dignity for residents on 1 of 2 nursing units. The findings included: 1. The facility staff failed to ensure the resident rights regarding voting was upheld, affecting multiple residents on 2 of 2 units. On 10/15/24 at 11:15 am during the initial tour of the facility nursing units Resident #114 (R114) and Resident #123 (R123) asked the surveyor if they were allowed to vote. R114 and R123 both stated that no one from the facility had talked with them about voting. R114 stated, I want to vote and need to know what to do. R123 stated, I have a voter's card and would like to vote. On 10/15/24 at 11:40 am, an interview was conducted with the social service director. The social service director said she had only been in this position since 9/26/24. The social service director said, If the resident is not registered to vote, then we will get them registered. When asked about the lack of posted voting information, the social service director stated, I will have the information hung up before the end of the day for the residents to see. When questioned further, the social service director said that she had not contacted the register's office but would do so that day. On 10/15/24 at 11:50 a.m., an interview was conducted with the administrator. The administrator said that the preparation for voting should begin the month of September. The administrator stated, Generally social services does the prep for voting but I didn't have anyone in social services for one month. The administrator said, If the residents are not registered, then we would fill out the registration forms so they can vote. When questioned about the lack of observable voting information, the administrator said that the information for the right to vote should be posted. The administrator stated, Residents can do an absentee ballot if they wanted to or go to the polls, we would take them there. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/15/24 at 4:30 p.m., an observation was conducted for voting information. This surveyor observed signs posted that read, if a resident was interested in voting to see the social service director ASAP [as soon as possible]. These signs were posted in common areas on each unit at the bulletin boards at the nurse's station, outside the dining room, and in the vending machine area. On 10/16/24 at 9:00 a.m., a follow-up interview was conducted with R114 and R123. R114 and R123 verbalized that no one from the facility had talked with them about voting and they wanted to vote. On 10/16/24 at 12:10 p.m., an interview was conducted with Resident #103 (R103). R103 stated that over a month ago, I asked the activity assistant about voting and I didn't get a response. R103 said she wanted to vote and was registered in another county to vote so she was not sure how that worked. R103 said no one from the facility had discussed voting with her. R103 stated, if you don't vote, you are part of the problem. When the surveyor asked about being transported to the location where she is registered to vote, R103 stated that it was 2 hours away. On 10/16/24 at 12:20 p.m., an interview was conducted with Resident #106 (R106). R106 stated, I didn't know I could vote but I would like to. On 10/16/24 at 12:25 p.m., an interview was conducted with Resident #111 (R111). R111 said no one had spoken with her about voting from the facility. R111 said that she was registered, wanted to vote, and would like to do absentee ballot. On 10/16/24 at 12:30 p.m. an interview was conducted with Resident #113 (R113). R113 said that she was not registered to vote and does not know how to register. R113 said she would like to vote in this election. On 10/16/24 at 12:35 p.m., an interview was conducted with Resident #108 (R108). R108 said she wanted to vote and was registered to vote in another county. On 10/16/24 at 12:38 p.m., an interview was conducted with Resident #102 (R102). R102 said that no facility staff had spoken with him about voting. R102 said he was registered and wanted to vote. On 10/16/24 at 12:50 p.m., a telephone call was placed to the voter registration office in the locality where the facility was located. The registrar reported that the deadline for non-registered voters to register ended at 5 p.m. on 10/15/24. As for the residents who are registered at other locations, the registrar stated that it would be up to the registrar at each locality as to whether the resident would be able submit an absentee ballot there or not. The registrar reported that the deadline for absentee ballots is that they must be received in the local office by 5pm on Thursday, October 24, 2024. On 10/16/24 at 3:00 p.m., an interview was conducted with the social services director. The social services director said that she called the register's office yesterday and was told if the resident is registered, an absentee ballot can be completed, but must be mailed out by Monday. The social worker director said, If the resident is not registered, then we have missed that deadline. The cutoff date was yesterday. The surveyor asked how the residents would see the notice about voting if they do not come out of their rooms and the social worker director said, We will go room to room and ask each resident about voting. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/24 at approximately 5:00 p.m. the administrator provided a document titled, Center for Clinical Standards and Quality, that was a CMS (Centers for Medicare and Medicaid services) document, and she stated, We have no voting policy. This is all we have. The CMS document read in part, .certified long-term care facilities affirm and support the right of residents to vote. Nursing homes should have a plan to ensure residents can exercise their right to vote, whether in person, by mail, absentee ballot, or other authorized process. Assistance in registering to vote, requesting an absentee ballot or completing a ballot from an agent of the resident's choosing. 2. The facility staff failed to provide residents with an environment that promotes dignity on 1 of 2 units. On 10/15/24 at 2:30 p.m. an interview was conducted with Resident #104 (R104). R104 said she feels safe now and staff is good except some arguing. R104 said this morning that the unit manager was at the door screaming at the aide that was in the room with my roommate. R104 stated, I yelled to get out of here, close the door because it makes me anxious, and it bothers me. On 10/15/24 at 4:30 p.m. an interview was conducted with a licensed practical nurse, unit 3 manager, LPN# 5 (LPN5). When asked about the earlier altercation on the unit, LPN5 said that this morning she had words with certified nursing assistant, CNA #3 (CNA3). LPN#5 said, [CNA3 name redacted] started screaming at me. LPN5 said that she told CNA3 it was her responsibility to chart on residents and CNA3 began arguing and LPN5 stated, I told her to stop, I was not going to argue with her. LPN5 said that she told CNA3 to clock out and leave, then called the director of nursing (DON). LPN5 said that CNA3 was in the resident's room and yelling, You have no control of me! LPN5 said that CNA3 continued to work until her shift was done. On 10/15/24 at 5:00 p.m. an interview was conducted with the director of nursing (DON). The DON said that CNA3 worked until I came in this morning about 7:10 a.m. I had a conversation with CNA3 and CNA# 2 (CNA2), who was a witness to the incident, and we had the conversation with the human resource director. On 10/15/24 at 5:20 p.m. an interview was conducted with the treatment nurse, LPN#7 (LPN7). When asked about the staff altercation that happened that morning, LPN#7 said, At about 6:15 a.m., the aide [indicating CNA2] came up and said I changed the resident and then [LPN#5's name redacted] said you can tell me he had feces on his brief, but did you chart it, if not care has not been done. LPN7 said, Then the other aide [indicating CNA3] said, 'I cannot get in to chart, and we told you a week ago' and then [LPN5's name redacted] said 'advocate for yourself; it looks like you did not do your job. [LPN5's name redacted] said I am not human resources; I cannot help you.' Then [LPN5] said 'I am not going to argue with you and the aide [CNA3) said 'I don't know why you have such an attitude.' The aide [CNA3] went into the resident's room, had the door opened, it wasn't closed all the way, but [LPN5] and the aide [CNA3] were loud. LPN7 said that she had just stepped in, trying to calm the situation. LPN7 said that she had never witnessed other arguments on the floor but had heard that arguments do happen among the staff. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/15/24 at 7:15 p.m. an interview was conducted with CNA#2. CNA2 said that she was getting CNA3 to help her with R122's care. CNA2 reported that CNA3 went to the resident's room, opened the door, and yelled up to the nurse's station asking LPN5 why she was screaming at her. CNA2 said that LPN5 stood up out of her chair and began screaming at CNA3 to clock out. CNA2 reported that R104 had yelled out to CNA3, Close the door! Do that outside the door, not in my room! CNA2 stated that CNA3 closed the door but that she and LPN5 had kept yelling. CNA2 stated that when they finally stopped, CNA3 came into the room with me to help me with Resident #122's name redacted] care. While we were doing incontinence care for R122, LPN5 opened the resident's door and demanded CNA3 to come out of the room. CNA3 said to LPN5 I am providing care for a resident now and LPN5 just kept yelling for CNA3 to come out of the room and was getting louder and louder. When asked about the residents' response, CNA2 said that R104 had been sleeping when this argument started, and after being awakened like that, R104 appeared agitated. CNA2 said that R122 had looked uncomfortable and that all she could do was apologize to both residents. On 10/16/24 at 9:25 a.m. an interview was conducted with R104. When asked about yesterday's disruption, R104 said that she was shocked by all the yelling. When asked how it made her feel, R104 said that it made her feel anxious and agitated. When asked about the frequency of these types of disturbances, R104 stated, An almost fist throwing happened about 2 weeks ago. R104 said, the staff . should be more respectful because it scares us! On 10/16/24 at 9:30 a.m. an interview was conducted with R122. R122 stated, They were talking loudly over me and saying come out here now. I could hear them arguing until [roommate's name redacted] told them to get out and shut the door. R122 said, It was a rough morning! I didn't like it, and it made me uncomfortable! It didn't involve me, so take it elsewhere. On 10/16/24 at 4:45 an interview was conducted with the regional director of clinical services (RDCS). The RDCS said, We interviewed the resident after the incident, and we did not have anyone that stated they were fearful. On 10/16/24 at 5:43 p.m. an end of day meeting was conducted with the administrator, director of nursing and regional director of clinical services. When the above concerns were discussed, the facility administrator stated, We didn't know what was going on until you said something. The RDCS and administrator said that the reason they were not aware of the staff arguing was that the DON was on a medication cart . and then you all [surveyors] walked into the building, and it was forgotten. The RDCS and the administrator said that the altercation had been taken care of and reported, that they had suspended the employees involved, reported the incident as an allegation of abuse, and are investigating. The administrator stated that R104 had been interviewed. When asked about the other resident, R104's roommate, the administrator stated that she wasn't interviewable. The administrator was then made aware that according to R122's clinical record, R122 had a brief interview for mental status (BIMS) score of 15 out of 15 (indicating no cognitive impairments) and that R122 had answered questions when interviewed by the surveyor. The survey team explained that R122 had been the resident staff were providing care to when the altercation had taken place. The facility administrator stated that they would go talk with R122 immediately following the meeting/discussion with the survey team and that they were unaware R122 was involved. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During this same meeting, facility staff reported that they did not have a facility policy with regards to staff interactions in resident care areas. The facility did provide the survey team with a document titled, Employee Guidebook, and on page 16 it read in part, Professional Courtesy and Customer Service . The company is committed in our efforts to provide a high standard of resident/patient care and excellent customer service, and in the communication that takes place during the workday. You are also expected to approach customers, clients, residents, patients and families in a professional, courteous and efficient manner . The facility also provided a document titled, Code of Ethics. Within that document excerpts read, The company will not tolerate: . Any other conduct that creates an intimidating or hostile work environment . The facility provided a policy titled, Resident Rights, read in part .ensure that residents rights are known to staff. Ongoing training on resident rights will be given to staff members as required by state and/or federal regulations. No additional information was provided prior to exit.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. 41449 Based on observation, resident interview, staff interviews, facility documentation review, and clinical record review, the facility staff failed to assess and determine if four residents were safe to self-administer medications, Resident # 16 (R16), Resident # 17 (R17), Resident # 18 (R18) and Resident # 19 (R19), in a survey sample of 28 residents. The findings included: 1. For R16, who had medications stored in their room, the facility staff failed to assess if R16 was safe to self-administer medications. On 7/30/24 at approximately 4 p.m., a tour of the facility's 2 nursing units was conducted. During the tour R16's room was observed with nose spray and eye drops on the overbed table. On 7/30/24 in the afternoon, an interview was conducted with R16. During the interview, R16 said, I use my nose spray every morning and the eye drops when my eyes are dry. An interview was conducted with unit manager on unit 2, LPN# 2 (LPN2) on 7/31/24 at 10:05 a.m. During the interview LPN2 stated that medications are stored in the cart unless the medications need to be in the refrigerator, then the medication is stored in the medication room. LPN2 said, No medicine should be at bedside. LPN2 stated that nursing staff is aware residents should not have medication at bedside and if seen in the room, the medication should be removed. LPN2 accompanied the surveyor to R16's room and confirmed that the nasal spary & eye drops were at the bedside. LPN2 stated that R16's family brought the medications to the resident but added, I would expect my staff to look around when in the room and remove the medications from the residents' rooms. A review of the clinical record was conducted on 8/6/24. R16's care plan was reviewed, and the care plan indicated that the nurses were to administer R16's medications. The care plan did not address self-administration of any medications. A review of the physician orders found that R16 had no orders for medications to be kept at the bedside and that there were no active orders for the medications observed at bedside. The clinical record also revealed that R16 had no self-administration of medication evaluation completed in his clinical record or that self-administration has been addressed by the interdisciplinary team. 2. For R17, who had medications stored in their room, the facility staff failed to assess if R17 was safe to self-administer medications. On 7/30/24 at 4 p.m., a tour of the facility's two nursing units was conducted. During the tour, R17's room was observed with Flonase nasal spray sitting on the overbed table. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the clinical record was conducted on 8/6/24. R17's care plan was reviewed, and the care plan indicated that the nurses were to administer R17's medications. The physician orders were reviewed and R17 had no orders for the medication Flonase noted, no order for medications to be stored at bedside, nor for the resident to self-administer medications. R17 had no self-administration of medication evaluation completed in his record or that self-administration has been addressed by the interdisciplinary team. 3. For Resident R18, who had medications stored in their room, the facility staff failed to assess if R18 was safe to self-administer medications. On 7/30/24 at 4 p.m., a tour of the facility's two nursing units was conducted. During the tour, R18's room was observed to have two bottles of dermal wound cleanser, zinc oxide paste with the top of the label torn off, and antifungal powder sitting in view. On 7/31/24 at 10:05 a.m., an interview was conducted with the unit manager, LPN2. LPN2 stated that R18 was out of the facility at the moment and would be back in a little while. As requested, LPN2 accompanied the surveyor to R18's room and observed the medications at the bedside, unsecured. LPN2 removed the medications off the bedside table and said, I don't know why these were left in the room. They should be on the treatment cart. A review of the clinical record was conducted on 8/6/24. R18's care plan was reviewed, and the care plan indicated that the nurses were to administer R18's medications. A review of the physician orders revealed that R18 had no orders for medications to be kept at bedside or for the resident to self-administer any medications. The clinical record revealed that R18 had no evidence of a self-administration of medication evaluation having been completed in his clinical record or that self-administration has been addressed by the interdisciplinary team. 4. For R19, who had medications stored at their bedside, the facility staff failed to assess if R19 was safe to self-administer medications. On 7/30/24 at 4 p.m., a tour of the facility's two nursing units was conducted. During the tour, R19's room was observed with saline mist nasal spray and Aquaphor ointment with a partially removed label. On 7/30/24, an interview was conducted with R19 about the medications at their bedside. R19 stated, They brought it in here and told me to use it when I needed it for my stuffy nose. I use the ointment on my dry areas on my face and hands every day. A review of the clinical record was conducted on 8/6/24. R19's care plan was reviewed, and the care plan indicated that the nurses were to administer R19's medications. A review of the physician orders revealed that R19 had no orders to self-administer medication or for medications to be kept at bedside. The clinical record revealed that R19 had no self-administration of medication evaluation or that self-administration has been addressed by the interdisciplinary team. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with unit manager on unit 2, LPN# 2 (LPN2) on 7/31/24 at 10:05 a.m. During the interview, LPN2 stated that medications are stored in the cart unless the medications need to be in the refrigerator, then the medication is stored in the medication room. LPN2 said, No medicine should be at bedside. LPN2 stated that nursing staff is aware that residents should not have medication at bedside and if seen in the room, the medication should be removed. An interview was conducted with LPN2 on 8/6/24 at 9:07 a.m. LPN2 stated that for a resident to self-administer a form had to be filled out and the resident had to understand what the medication is, what the medication is used for, how to administer the medication, and how often to take the medication. LPN2 said, The medication had to be kept in their top drawer. A review of facility documentation was conducted. A policy titled, Self-Administration of Medication at Bedside, read in part, .Criteria must be met to determine if a resident is both mentally and physically capable of self-administering medication and to keep accurate documentation of these actions. A policy titled, Administering Medications, read in part, .27. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. An end of day meeting was held on 8/2/24 with the administrator, the director of nursing, the medical record coordinator and the social worker and they were made aware of the above concerns. No further information was provided. 49456

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 47067 Based on resident interviews, staff interviews, observations, and facility documentation, the facility staff failed to ensure multiple residents on 2 of 2 units had the opportunity to exercise autonomy regarding voting interests and preferences. The findings included: 1. The facility staff failed to ensure that multiple residents were able to pursue an activity that was important them. On 10/15/24 at 11:15 am, during the initial tour of the facility, Resident #114 (R114) and Resident #123 (R123) asked the surveyor if they were allowed to vote. R114 and R123 both stated that no one from the facility had talked with them about voting. R114 stated, I want to vote and need to know what to do. R123 stated, I have a voter's card and would like to vote. Also during this tour, no signage with voting information was observed. On 10/15/24 at 11:40 am, an interview was conducted with the social service director. The social service director said she had only been in this position since 9/26/24. The social service director said, If the resident is not registered to vote, then we will get them registered. When asked about the lack of posted voting information, the social service director stated, I will have the information hung up before the end of the day for the residents to see. When questioned further, the social service director said that she had not contacted the register's office but would do so that day. On 10/15/24 at 11:50 a.m., an interview was conducted with the administrator. The administrator said that the preparation for voting should begin the month of September. The administrator stated, Generally social services does the prep for voting but I didn't have anyone in social services for one month. The administrator said, If the residents are not registered, then we would fill out the registration forms so they can vote. When questioned about the lack of observable voting information, the administrator said that the information for the right to vote should be posted. The administrator stated, Residents can do an absentee ballot if they wanted to or go to the polls, we would take them there. On 10/15/24 at 4:30 p.m. an observation was conducted for voting information. This surveyor observed signs posted that read, If a resident was interested in voting to see the social service director ASAP [as soon as possible]. These signs were posted in common areas on each unit at the bulletin boards at the nurse's station, outside the dining room, and in the vending machine area. On 10/16/24 at 9:00 a.m., a follow-up interview was conducted with R114 and R123. R114 and R123 verbalized that no one from the facility had talked with them about voting and that they wanted to vote. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/24 at 12:10 p.m. an interview was conducted with Resident #103 (R103). R103 stated that over a month ago, I asked the activity assistant about voting and I didn't get a response. R103 said that she wanted to vote and was registered in another county to vote, so she was not sure how that worked. R103 said no one from the facility had discussed voting with her. R103 stated, If you don't vote, you are part of the problem. When the surveyor asked about being transported to the location where she is registered to vote, R103 stated that it was 2 hours away. On 10/16/24 at 12:20 p.m., an interview was conducted with Resident #106 (R106). R106 stated, I didn't know I could vote but I would like to. On 10/16/24 at 12:25 p.m., an interview was conducted with Resident #111 (R111). R111 said no one had spoken with her about voting from the facility. R111 said that she was registered, wanted to vote, and would like to do an absentee ballot. On 10/16/24 at 12:30 p.m., an interview was conducted with Resident #113 (R113). R113 said that she was not registered to vote and does not know how to register. R113 said she would like to vote in this election. On 10/16/24 at 12:35 p.m. an interview was conducted with Resident #108 (R108). R108 said she wanted to vote and was registered to vote in another county. On 10/16/24 at 12:38 p.m. an interview was conducted with Resident #102 (R102). R102 said that no facility staff had spoken with him about voting. R102 said he was registered and wanted to vote. On 10/16/24 at 12:50 p.m., a telephone call was placed to the voter registration office in the locality where the facility was located. The registrar reported that the deadline for non-registered voters to register ended at 5 p.m. on 10/15/24. As for the residents who are registered at other locations, the registrar stated that it would be up to the registrar at each locality as to whether the resident would be able submit an absentee ballot there or not. The registrar reported that the deadline for absentee ballots is that they must be received in the local office by 5pm on Thursday, October 24, 2024. On 10/16/24 at 3:00 p.m., an interview was conducted with the social services director. The social services director said that she called the register's office yesterday and was told if the resident is registered, an absentee ballot can be completed, but must be mailed out by Monday. The social worker director said, If the resident is not registered, then we have missed that deadline. The cutoff date was yesterday. The surveyor asked how the residents would see the notice about voting if they do not come out of their rooms and the social worker director said, We will go room to room and ask each resident about voting. On 10/16/24 at approximately 5:00 p.m., the administrator provided a document titled, Center for Clinical Standards and Quality, which was a CMS (Centers for Medicare and Medicaid services) guidance for nursing home policies. The administrator stated, We have no voting policy. This is all we have. The CMS document read in part, .certified long-term care facilities affirm and support the right of residents to vote. Nursing homes should have a plan to ensure residents can exercise their right to vote, whether in person, by mail, absentee ballot, or other authorized process. Assistance in registering to vote, requesting an absentee ballot or completing a ballot from an agent of the resident's choosing. (continued on next page)

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	495336	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Augusta Nursing & Rehab Center	83 Crossroads Lane Fishersville, VA 22939

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No other information was provided prior to survey exit.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 41449 Based on observation, resident and staff interviews, clinical record review, and facility documentation review, the facility staff failed to respond to a grievance for one resident (Resident #7- R7) in a survey sample of 28 residents. The findings included: For Resident #7- R7, the facility staff failed to respond to a grievance and take measures to ensure the resident felt safe from other residents entering their room. On 7/30/24, in the late afternoon, at approximately 4:30 p.m., observations were conducted, and it was noted that R7 did not have a stop sign mesh banner across her door. R7's door was closed. On 7/31/24 at 3:20 p.m., an interview was conducted with R7. R7 told the surveyor of a prior incident that occurred at the vending machine involving resident #10 (R10) talking to her about having sex and that R10 had said, My belly button is pushed out because a 250-pound lady was on top of me R7 stated that it had made R7 feel very uncomfortable. R7 reported having returned to her room, turned the lights off, and got into bed. R7 reported Someone came in and didn't say anything. Then a voice said 'I will talk to you tomorrow' and left. R7 reported that it had been R10 and that R10 had tried to stay away from him since then. He [R10] talks very nasty and disgusting. He always begins the conversation with I still like sex. R7 stated that she had told her daughter, who had talked with social services. R7 went on to say, I had a sign on my door that said stop, but it's gone. R7 stated rarely coming of out their room now, because I want to stay away from [R10]. R7 then stated not realizing how much R10's behaviors bothered her until stating that she rarely leaves her room. On 7/31/24 and 8/1/24, attempts were made by the surveyor to reach R7's daughter but were not successful. On 7/31/24, a clinical record review was conducted of R7's chart, which included the care plan and progress notes. There was no documentation regarding the incident with R10, the implementation of a stop-sign banner, or any concerns related to R10's unwanted interactions, or that R7 was no longer coming out of her room. On 7/31/24 and 8/1/24, the facility's grievance log was reviewed but no evidence of a grievance related to R7's report of R10 entering her room uninvited or unwanted interactions with R10. Daily observations were conducted of R7's room at various times of the day throughout 7/30/24-8/2/24. Each of the observations revealed a stop-sign banner was not in place at the doorway. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/5/24 at 4:32 p.m., during an interview with the director of nursing (DON), the DON reported speaking to R7's daughter in the hallway, when the social worker asked the DON to step into the office. The DON said that the social worker reported the incident where R10 went into R7's room. The DON said, I went to put the stop sign across the room door and [R7] denied that he had been back. I asked the resident and the daughter about placing the stop sign, and both agreed. I put it in place immediately. I wrote up a grievance and gave it to [previous social worker's name redacted]. [R7's name redacted] was assaulted at another facility, so this brought all that back for her. On 8/6/24 at 9:06 a.m., an interview was conducted with the facility administrator. The administrator reported that he was aware of the incident involving R7, when R10 entered the room. The administrator said, I did hear he had come in her room. I inquired about what they [nursing administration] had done, and I suggested a stop sign across the door. When asked where the grievance, or investigation regarding the incident was, the administrator said, I can't tell you, I relied on the director of nursing, she does all of the investigations. Review of the facility policy titled; Complaint/Grievance, was conducted. The policy read in part, The center will support each resident's right to voice a complaint/grievance without fear of discrimination or reprisal. The center will make prompt efforts to resolve the complaint/grievance and informed [sic] the resident of progress towards resolution . The executive director will designate a grievance officer at the facility. Procedure: 1. An employee receiving a complaint/grievance from a resident, family member and/or visitor will initiate a Complaint/Grievance Form . 2. Original grievance forms are then submitted to the grievance officer/designee for further action. 3. The grievance officer/designee shall act on the grievance and begin follow-up of the concern or submit it to the appropriate department director for follow-up. 4. The grievance follow-up should be completed in a reasonable time frame; this should not exceed 14 days. 5. The findings of the grievance shall be recorded on the Complaint/Grievance Form. 6. The results will be forwarded to the executive director for review and filing. 7. The grievance official will log complaints/grievance in monthly grievance log. 8. The individual voicing the grievance will receive follow up communication with the resolution, a copy of the grievance resolution will be provided to the resident upon request. On 8/6/24, during a mid-day meeting held with the facility's corporate staff, and a consultant, the above findings were presented. No additional information was provided.

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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** 41449 Based on resident interview, facility staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure five residents were free from abuse (Resident #9- R9, Resident #7- R7, Resident #8- R8, Resident #12- R12, and Resident #13-R13), which resulted in psychosocial harm, and had the potential to affect the 59 female residents residing in the facility, as the perpetrator was targeting female residents. This resulted in immediate jeopardy. The facility staff also failed to ensure two residents (Resident #20 and Resident #21), in a survey sample of 28, were free from neglect. The findings included: 1. For R9, who was known to have delusions, the facility staff failed to protect the resident from sexual abuse by ensuring the resident had been assessed to determine the capacity to consent to sexual relations. On 7/31/24 at 2:50 p.m., an interview was conducted with Resident #9 (R9). When asked if any residents had been bothering her or making her feel uncomfortable, R9 said, Oh no, they would have a bloody nose and two black eyes. R9 was noted to be very frail and not able to move her left extremities freely. On 7/31/24 at 2:55 p.m., an interview was conducted with R9's roommate, Resident #15 (R15). R15 stated that R9 had not been telling the truth earlier during the interview with the surveyor and said that R9's . boyfriend put a [NAME] on her neck. R15 went on to say that R9 has had her hand on R10's penis while he stands beside the bed and kisses her. R15 reported, The curtain wasn't pulled, and I don't want to see that mess. R15 indicated that she had seen multiple incidents of sexual activity between R10 & R9. On 7/31/24 at 4:49 p.m., an interview was conducted with Resident #10 (R10). R10 was asked about his relationship with the female residents within the facility. R10 said, [referring to R9] She thought we were married. She sais she was going to fly me to a retreat. We are friends and we get involved and live out her fantasies . [facility administrator's name redacted] had talked to me. When asked about sexual activity, R10 confirmed he had put a [NAME] on R9's neck. When asked if anything more had occurred, R10 said, She's bipolar and she's not going to tell you, and neither am I. They can't prove it. R10 was asked about the other women within the facility, and he called R12 by name and said, She's bipolar too. We enjoy spending time together. Indicating that there was no problems with his interactions with the female residents, R10 stated, The first time I got in trouble was about an aide. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 7/31/24 at 2:55 p.m., an interview was conducted with certified nursing assistant (CNA) #11. CNA #11 reported that she has seen R10 at the doorway of R9's room. CNA #11 reported that R9 did have a [NAME] on her neck about the end of June or early July. When asked if there were any other instances that indicated R10 and R9 were having any sexual activity, CNA #11 said, I was here the day it happened, but I didn't' see it, I heard about it. CNA #11 went on to say, [R9] said that [activity director's name redacted] had married them. [R9] would ask if I got the mustang she bought me, her mind isn't exactly right. On 7/31/24 at 2:58 p.m., an interview was conducted with CNA #6. CNA #6 said, I heard about her touching his penis about a month or month and a half ago, but I haven't seen it. I heard about the [NAME]. I've seen them holding hands. CNA #6 was asked if anyone in management was aware and she said, Someone made them aware, and I don't know how they handled it. We had some Inservice that we no longer have to separate residents who want to have sex . [R9] is aware but has some confusion . [R9] is a little off, she talks about having to go pick up her baby and stuff. On 7/31/24 at 3 p.m., an interview was conducted with LPN #3, the unit manager where R9 and R10 reside. When asked about R9's cognitive skills, LPN #3 said, With everyday stuff she seems ok, she can request food, drink, pain meds, etc. but she does have delusions, she owns jets, corvettes, etc. When asked if she was aware of any sexual activity between R9 and R10, LPN #3 said, There has been quite a bit of hearsay about that. I don't know if anyone saw it. [R10] can be verbally inappropriate. He does like the ladies, but I've never caught him being inappropriate. When asked if she had any knowledge of R9 having a [NAME], LPN #3 said, Yes, they spoke to the daughter [R9's daughter] and that she had made it very clear she wanted him to be able to visit her mom. She said she knew her Mom had a [NAME], and it didn't bother her. LPN #3 went on to talk about how R9 reports that she married R10 and that when she sees other women walk by, R9 will accuse R10 of sleeping with them. When asked if administration was aware of the [NAME] and the allegation of R9 having R10's penis in her hand, LPN #3 said, Administration is aware, they said they had an incident at [sister facility's name redacted] and that for people who are capable of having relations, its ok and we may think it is inappropriate. LPN #3 went on to talk about R9's delusions and how R9 says that she has brought the staff cars, is sending them on elaborate vacations, etc. LPN #3 said, I've looked, and she doesn't have any diagnosis for the delusions, but she has always had them. I don't know if they haven't spent enough time with her to notice or what, but something is off [cognitively]. On 8/1/24 at 8:55 a.m., an interview was conducted with certified nursing assistant (CNA) #12. CNA #12 was asked about R10 and R9 interactions. CNA #12 reported, [R10] is a socializer, he rolls around all over the place, all day. I've seen him stop at [R9's name redacted] room, stop and wave, but I've never seen him in there. When asked about R9 having a [NAME], CNA #12 said, I saw the [NAME], but I didn't know he did it. When asked about any sexual activity, CNA #12 said, I heard about the penis incident weeks ago, but I don't know who saw it . One day [R9] was crying, she said she wanted to marry him, and was upset . [R10] used to stop at [another resident's name redacted]'s door but she started closing her door, so now he just goes on. He bothers a lot of people honestly. On 8/1/24 at 9:05 a.m., R9 was visited in her room by the surveyor again. R9 had a rose in a cup by the bedside and when asked about it, R9 said, My boyfriend gave it to me. When asked who her boyfriend was, R9 said R10's name. R9 went on to say, We are supposed to get married today. Did you know I am a princess of Allett, a country off Spain? My Mom and Dad are Queen and King When asked about having a [NAME], R9 said, Yes and admitted that R10 had given her a [NAME]. When asked if they had had sex, R9 said, No, that's for marriage, and we are getting married today. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/1/24 at 9:16 a.m., an interview was conducted again with R9's roommate, R15. R15 said, Mr. [R10's name redacted] gave her a [NAME]. R15 went on to talk about R10 is putting his tongue down [R9]'s throat. When asked if anything sexual has occurred, R15 said, Yes, I saw it. He walked over to her bed and she had her right hand on him, his penis, but [CNA #4's name redacted] got him out. I don't want to see that stuff, but they don't even pull the curtain. On 8/1/24 at 9:25 a.m., an interview was conducted with licensed practical nurse (LPN) #1. LPN #1 was asked about R10. LPN #1 said, Last week [CNA #4's name redacted] saw [R9] with his penis in her hand. Maybe Sunday, I went and talked to Ms. [R15's name redacted], who said that she didn't want him in her room. The nurse went down and told him, if he went in that room he would be removed. She [R15] said she didn't want to see what they do, that incident [where R9 had R10's penis in her hand] is why she doesn't want him in there. During the above interview with LPN #1, she was asked about R9's cognitive ability. LPN #1 said, [R9] says she has had 3 babies, and we stole them, that she has an airplane . I don't believe she is mentally capable, but they [management] say she has a BIMS [brief interview for mental status] of 15. On 8/1/24 at 9:48 a.m., an interview was conducted with CNA #4. CNA #4 stated that she has seen R10 . with his hands down [R9's] pants, fondling her. He has been caught jacking off. On Thursday at 2:15 p.m., he was standing up, had his penis out, jacking off while kissing her. I told the nurses, and they went down but he had finished. It's been reported, we have all been telling it, but they don't listen to us. On 8/1/24, a clinical record review was conducted of R9's chart. There was no documentation within the record of any interactions between R9 and R10. There was no documentation of the [NAME], nor of R10 being at the bedside masturbating. R9's most recent brief interview for mental status (BIMS) assessment was conducted on 6/14/24, which scored R9 as 12 of 15, indicating moderately impaired cognitive skills. On 8/1/24 at approximately 1:30 p.m., an interview was conducted with the medical nurse practitioner (NP)/Other staff #3. When asked about R10's sexual behaviors, the interactions with R9, and the fact that R9 had sustained a [NAME] on her neck, the NP said, It got brought to my attention Tuesday morning. I talked to [R9's name redacted] and she said she is widowed for 7 years. She has always had delusions; she doesn't have a psychiatric diagnosis to go with that. Her daughter allows her to make decisions. When asked if she had assessed R9's ability to consent for sexual activity, the NP said, They are able to give consent even when in memory care units, so just because she has delusions doesn't mean she can't consent. The NP went on to say that she had talked to the director of nursing (DON) and she has talked to the daughter, and she is aware. When asked if she was aware of any other interactions involving R9 and R10, the NP said, I am not aware of any other issues or concerns. The NP added that she would have the psychiatric nurse practitioner see R9 with regards to the delusions because she (the NP) wasn't comfortable diagnosing that. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/1/24 at 2:09 p.m., a telephone interview was conducted with the psychiatric nurse practitioner (Psych NP)/ Other staff #4. The Psych NP said that she was not aware of any relationship between R9 and R10. The Psych NP said that she sees R10, that he was last seen 6/20/24, that she had made no notes with regards to any sexual tendencies or behaviors, and was not aware of any concerns. When asked if R9 had been seen or assessed for the ability to consent to sexual activity, the Psych NP said, No, I wasn't aware of any of this and wouldn't really know how to go about doing that. On 8/1/24 at 4:33 p.m., a telephone interview was conducted with R9's daughter, who was listed as emergency contact. The daughter was asked about her knowledge of R9 and R10's relationship. The daughter said, I know they say they are boyfriend and girlfriend, and he visits her. My Mom is not right in the head, she thinks they are getting married. When asked if she was aware her mother had a [NAME] on her neck, she said, I was aware of that and I was kind of shocked by that. When asked if she had any knowledge of them kissing or having anything more intimate occurring, the daughter said, No, I told them they had to behave, you can't do that. As far as having any other pleasure, that's not appropriate. I don't know how they could do that with Mom's condition anyway. Mom's not right in her head, I don't know if she has Alzheimer's or dementia or what. I've talked to [LPN #3, the unit manager's name redacted] but the doctor never said anything. It kind of gets old, she is talking about helicopters, new vehicles, money, all the time. It's a fantasy. On the afternoon of 8/2/24, the director of nursing provided the survey team with a Witness Statement, which read, me and [name of medical records coordinator redacted] spoke with resident [R9's name redacted] regarding concerns of a bruise on right side of neck. [R9's name redacted] stated it was a [NAME] from [R10's name redacted] and they had gotten married over the weekend. She was asked if she wanted this and if it feels good, it feels good, stated by [R9's name redacted]. She was smiling and in no distress noted. Asked if [R10's name redacted] did anything to you that you did not want him to do to you, her reply was No, don't worry about him, I can handle him. The statement, dated 6/24/24, was signed by the Director of Nursing and medical records coordinator. On 8/6/24 at 9:06 a.m., an interview was conducted with the facility administrator. When asked about R9 having a [NAME], the administrator stated, I heard about it about an hour before we met on Thursday. When asked if he was aware that reports had been made that R10 was at R9's bedside pleasuring himself, the administrator said, I was told the day it happened, the roommate was in there. When asked if he, the administrator, had done anything to investigate this incident, he said, I know it was done by the nursing department. When asked for the credible evidence, the administrator said, As far as I know, they just looked at her BIMS. 2. For R7, the facility staff failed to ensure the resident was free from verbal abuse and sexual harassment, which resulted in the resident altering daily social patterns to avoid the perpetrator (R10) and caused R7 to self-isolate. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 7/31/24 at 3:20 p.m., an interview was conducted with R7. R7 told the surveyor of a prior incident that occurred at the vending machine involving resident #10 (R10) talking to her about having sex and that R10 had said, My belly button is pushed out because a 250-pound lady was on top of me R7 stated that it had made R7 feel very uncomfortable. R7 reported having returned to her room, turned the lights off, and got into bed. R7 said, Someone came in and didn't say anything. Then a voice said 'I will talk to you tomorrow' and left. R7 reported that it had been R10 and that R7 had tried to stay away from him since then. He [R10] talks very nasty and disgusting. He always begins the conversation with I still like sex. R7 stated that she had told her daughter, who had talked with social services. R7 went on to say, I had a sign on my door that said stop, but it's gone. R7 stated rarely coming of out their room now, because I want to stay away from [R10]. R7 then stated having not realized how much R10's behaviors bothered her until saying that she rarely leaves her room. On 8/1/24 at 9 a.m., a follow-up interview was conducted with R7, in her room. R7 again talked about R10 saying he was still capable of having sex. R7 reported that she .froze in one spot and didn't know what to do. I went to my room, he wanted to walk to my room. I was uncomfortable, scared, and didn't know what to do. He said he got in trouble . I stay in my room more and don't want to go out. He has something going on with the resident in [R12's room number redacted] . He is on the unit a lot. I don't go out as much, I don't like running into him. I was scared the night he came into my room in the dark. I am very uncomfortable to even pass him in the hall. On 7/31/24 and 8/1/24, attempts were made by the surveyor to reach R7's daughter but were not successful. On 8/5/24 at 4:32 p.m., during a telephone interview, the director of nursing (DON) reported that one day she was talking to R7's daughter in the hallway, when the social worker asked the DON to step into the office. The DON stated that the social worker had reported the incident when R10 had gone into R7's room. The DON said, I went to put the stop sign across her door and [R7]denied that he had been back. I asked the resident and her daughter about using the stop sign, and both agreed. I put it in place immediately. I wrote up a grievance and gave it to [previous social worker's name redacted]. [R7's name redacted] was assaulted at another facility, so this brought all that back for her. On 8/6/24 at 9:06 a.m., an interview was conducted with the facility administrator. The administrator reported that he was aware of the incident involving R7, when R10 entered the room. The administrator said, I did hear he had come into her room. I inquired about what they had done, and I suggested a stop sign across the door. When asked if any information regarding the incident was available, the administrator said, I can't tell you, I relied on the director of nursing, she does all of the investigations. No further information was provided with regards to R7. 3. For R8, the facility staff failed to ensure the resident was free from abuse and sexual harassment, which caused R8 to change her daily routine to avoid the perpetrator, who was resident #10 (R10). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/1/24 at 10:18 a.m., an interview was conducted with resident #8 (R8). R8 was asked about R10. R8 said, He is not a person you want to be around. I avoid him. He has a foul mouth. I get on him about it, so he does better with me than others. He would say he loves me. He discusses what he likes to do to women, says he likes older women's stuff, and wants to have sex. He doesn't know how to talk to women and thinks he is God's gift to women. I avoid him, he makes me uncomfortable. If he passes me in the hall he tries to grab my hand, but I pull away. I go outside more to get away from him, because he doesn't go outside. He doesn't see anything wrong with sticking his tongue down [resident #9's name redacted] throat. He put a [NAME] on her neck, he so called got married to her. He really does think all women are crazy about him. I tell him he is going to end up getting kicked out of here, he says he probably will but says that's who he is. During the interview R8 was noted to be anxious and was constantly fidgeting with a snack on her over bed table. When R8 stopped talking about R10, she was noted to calm down and not be fidgety. 4. For R12, the facility staff failed to respond to reports of inappropriate behavior by R10 and failed to ensure R12 was free from abuse and sexual harassment, which resulted in psychosocial harm. On 8/1/24 at 10 a.m., an interview was conducted with R12. R12 said, [R10's name redacted] we are friends I thought, until last night. Another woman came around in the library, it went too far with his [R10's] personal behavior. His nasty talking, I felt very uncomfortable. There are things I don't tolerate with my friends. [R13's name redacted] felt very uncomfortable. I don't want to be around him. I won't be making any attempt to see him anymore, things he was doing, and talking provocative, talking about sex. I have had a stroke and common sense doesn't kick in all the time. I'm nervous just talking about it. During the interview, R12's hands were observed to be shaking. On 8/1/24 at 4:20 p.m., Resident #12 was observed in the common area room on the unit crying. On 8/1/24 at approximately 4:25 p.m., Resident #12 was interviewed. When asked about the crying, R12 said that R10 .was pressuring me to have sex. We [referring to her and R10] argued last night. I am scared. I don't want to have sex and he is wanting to have sex. On 8/1/24 at 10:46 a.m., an interview was conducted with the facility administrator and director of nursing (DON). When asked about R10, the DON said, [R10's name redacted] been here a while. He is very polite and respectful to me. I've seen nothing. I've heard rumors. I tell people I don't go by rumors and gossip, you put it in black and white and I will listen. When asked what rumors she had heard, the DON said, That with female residents, doing sexual things to them and making sexual comments. It was consensual. Yesterday he was touching a lady, it was a big whohaa. He had his hands between her legs, it was gossip, that's the talk. He had his hands between a lady with the last name beginning with the letter [letter redacted], in the dining room, but they never put it in writing. That's the protocol, I tell them I do not go by gossip or hearsay and I'm not going to until they put it in writing in black and white. If they saw something inappropriate, they have to put it in writing. When asked if this was the case for all allegations, that they must be put in writing, the DON said, Yes. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/5/24 at 4:32 p.m., during a telephone interview with the director of nursing (DON), the DON was asked if she identified who the resident was that [R10] had his hands between the legs of that she mentioned on 8/1/24. The DON said, Yes, I spoke to a staff member who told me it was [R12]. The witness statement is in my office. The on-site corporate staff was able to provide the surveyor with the statement which read, I the author of this note was made ware by overhearing staff talking amongst themselves about [R10] had his hand down the pants of [R12] while sitting together in the dining room for lunch. I inquired further after informed by state surveyor of this incident. I was told by a staff member what she saw and what she did. Stated she saw [R10] have his hand down [R12s] pants, [R12} had her legs spread open, while he had his hand in her pants. She didn't do anything- walked away. Thought with both residents are a & o [alert and oriented] w/o [without] any cognitive deficits it was okay. I spoke with [R12] and asked her if she opposed to this behavior or it was not wanted, she replied No. It was fine. At this time, it was determined no abuse had occurred. This statement was signed by the DON and dated 8/1/24. On 8/6/24 at 9:06 a.m., an interview was conducted with the facility administrator. The administrator said, When I heard the pants thing [referring to R10 having his hands down R12's pants], I was appalled. When asked what had been done since he was made aware of the that, the administrator replied, I can't speak to it. 5. Resident #13 (R13) was subjected to sexual harassment which caused her to avoid common areas within the facility to prevent encounters with R10. On 8/1/24 at 10:11 a.m., an interview was conducted with R13, who said, He [referring to R10] has a filthy mouth. My husband didn't like what he was saying. He would tell women, I want to eat her p#$$y. He said he put a [NAME] on one woman's neck. I don't go down there [to the library] anymore. He always talks dirty talk and I tell him to shut up, don't nobody want to hear that. He keeps on and so I leave because of it. I don't stay anymore and my husband told me to stay away from him. Staff interviews were conducted which included the following: On 8/1/24 at 8:55 a.m., an interview was conducted with certified nursing assistant (CNA) #12. CNA #12 was asked about R10. CNA #12 said, He [R10] used to stop at [another resident's name redacted]'s door but she started closing her door, so now he just goes on. He bothers a lot of people honestly. On 8/1/24 at 9:25 a.m., an interview was conducted with licensed practical nurse (LPN) #1. LPN #1 was asked about R10. LPN #1 said, There are a couple of ladies that do not want him in their room. They don't like the way he talks. LPN #1 went on to say, [Resident #15's name redacted] says he and [Resident #9's name redacted] kiss. The ladies in room [room number redacted] don't like him; they say they get a bad feeling from him. LPN #1 identified R13 and said, She is friends with him, but I've never seen anything inappropriate. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/1/24 at 9:48 a.m., an interview was conducted with CNA #4. CNA #4 reported she has seen R10 with his hands down [R9's] pants fondling her. He has been caught jacking off. On Thursday at 2:15 p.m., he was standing up, had his penis out jacking off while kissing her. I told the nurses, and they went down but he had finished. It's been reported, we have all been telling it, but they don't listen to us. He thinks he can do it to all the ladies. He's been doing it to the residents on the down low and we didn't know it. He told me, in the hall in front of the women, old ladies are good in bed, elderly ladies have the best p#$$y. This lady [R9], her mind is not right, she is going to buy me a car, owns this place, the nurses say the daughter can say its ok. I don't understand these people. We are telling the nurses, and no one acknowledges us. They say her daughter knows. [The unit manger's name redacted] knows. One time he had his hand in her diaper, and he was kissing her, just last week. I've seen him in the back hall near laundry and he was talking stuff to them [the staff], he goes to unit 2. [Resident #26's name redacted] says to close her door from that pervert just a few days ago. [R13's name redacted] tells me she doesn't like him, he's a pervert. Please help us, help these residents, it's not right what he is doing, they know and won't do nothing. On 8/1/24 at 10:46 a.m., an interview was conducted with the facility administrator and director of nursing (DON). When asked about R10, the DON said, [R10's name redacted] been here a while. He is very polite and respectful to me. I've seen nothing. I've heard rumors. I tell people I don't go by rumors and gossip, you put it in black and white and I will listen. When asked what rumors she has heard, the DON said, that with female residents doing sexual things to them and making sexual comments, it was consensual. Yesterday he was touching a lady, it was a big whoa. He has his hands between her legs, it was gossip, that's the talk. He had his hands between a lady with the last name beginning with the letter [letter redacted], in the dining room, but they never put it in writing. That's the protocol, I tell them I do not go by gossip or hearsay and I'm not going to until they put it in writing in black and white. If they saw something inappropriate, they have to put it in writing. The DON was asked if this was the case for all allegations, they must be put in writing, she said yes. During the above interview, the administrator stated, yesterday I went into the library to read and [R10's name redacted] was in there and everything was kosher. The administrator went on to say that R10 had written a note to one of the students that he wanted to meet them after graduation, and she felt uncomfortable. I brought him in the office and in general showed him the note and explained that when people are uncomfortable, they can call the cops and if they feel threatened, they can go further. He said he won't ever do it again. He is as 2 faced as they come. He knew he had done wrong, he listened to what I said, it may have lasted 5 minutes. It was about 2-3 weeks ago. I haven't heard anything else about it. The administrator went on to say, our old social worker wanted me to give him a 30-day discharge, because they were thinking it was about to be a pattern and wanted me to react, but I've never put people out in all my years. The administrator was asked if he knew R9 had a [NAME] on her neck. The administrator said, I heard about it this morning. I didn't know she had a [NAME]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The DON went on to say, I called my regional DON, and she said no, you cannot, 1st let's do a medication review. I let [medical nurse practitioner's name redacted] and [psychiatric nurse practitioner's name redacted] know for a medication review, because I know some antidepressants can help curb sexual tendances. When asked about R9 having a [NAME], the DON said, I interviewed [R9's name redacted], her BIMS is 13-15 so I dropped it, it was consensual, she was very excited about it. Her daughter is aware and approves. It was a bruise of unknown origin and the nurse put a note in the chart and me and [name of medical records coordinator redacted] went and talked to the resident. According to the facility document of the communication book for the medical providers, an entry was made on 7/17/24, that noted R10's name and read, increased sexuality. On 8/1/24 at 10:46 a.m., the administrator and DON were made aware of the above interviews and that R7, R8, R12, R13, and R15 reporting being scared and changing their daily routine because of R10's behaviors. The DON said, I didn't know residents are scared of him or afraid to come out of their room. The administrator said, I'm just hearing about this. After talking with him the other week, his brother came in and I told him about it, and he said he tells him all the time he is not God's gift to women. The administrator reported he had no documentation or credible evidence to provide the survey team with regards to the conversation he had with R10. The facility administrator was asked to provide the survey team with the minutes from their morning meetings and the 24-hour report for the past 3 months. On the afternoon of 8/1/24, the administrator reported to the survey team that he had not keep the notes from the daily department managers meeting and only had the notes available for the current week. The 24-hour reports were reviewed with no mention of R10's behaviors or interactions with any residents. The administrator explained that he conducts the morning meeting each day and grievances, the 24-hour report and anything going on within the facility is discussed. On 8/1/24 in the afternoon, LPN #3 who was the unit manager, assisted the surveyor with locating the communication book used to communicate issues to the providers. The medical nurse practitioner had the medical communication book. LPN #3 provided the surveyor with a copy of the psychiatric communication form where on 7/17/24, she made an entry at the direction of the director of nursing and it read, [R10's name redacted] increased sexuality. LPN #3 said she put the same entry in the book for the medical provider. The surveyor reviewed the medical provider's communication book, but the previous pages had been removed and were not available. On 8/2/24 at 8:45 a.m., the facility staff had failed to provide the survey team with any evidence that the resident's reports and allegations of misconduct by R10 had been investigated, reported or acted upon. On 8/2/24 at 8:50 a.m., the survey team identified the facility was in immediate jeopardy (IJ) in Abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/2/24 at 2:34 p.m., the facility's medical director/physician (MD) met with the survey team. The MD expressed frustration over the survey's team identification of immediate jeopardy and stated, This is bonkers. There has to be a standard that applies at one and every facility . If the standard is an old man that makes inappropriate comments would be an IJ, then every facility you go into would have IJ. For anyone to walk in and throw around IJ's at will, for something that can't be fixed . He [referring to R10] has knowingly made inappropriate comments to my assistant. She's blonde and 30 and he makes comments about her looks and dress. It's common and there is not a lot to do about it. It is not criminal. As a facility everyone wants people to have a good experience . if he is not threatening, it's not a crime. He is an inappropriate dirty old man who makes some residents not want to be around him. It won't get him kicked out, it isn't going to get a TDO [temporary detaining order] . We can't impose our own jail or lock him up . When the survey team explained that R10 was doing more than just commenting on how someone looks and making comments about how they dress, the MD responded, I don't suspect him . it would surprise me if he has aggression . I don't call putting hands between someone's legs aggressive. On 8/2/24 at 4:22 p.m., the facility administration provided the survey team with an accepted removal plan. The facility's plan to remove IJ read as follows: Resident #10 was put on one-to-one supervision on 8/1/2024 at approximately 2:30pm. Facility staff completed a FRI and submitted it to the Virginia Department of Health, Adult Protective Services, and Ombudsman. Local police were notified of resident-to-resident allegation (report number 2024-0002626). Residents with a BIMS of 9 or above were interviewed about potential abuse, instances of abuse and reporting a [TRUNCATED]

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28106 Based on resident interview, staff interview, clinical record review, and facility document review, the facility failed to implement abuse policies for two of seven residents, Resident #'s 203 and 207. The Findings Include: 1. The facility did not implement facility abuse policy in regards to reporting suspicion of physical abuse/mistreatment for Resident #203 (R203). According to the clinical record, diagnoses for R203 included, Multiple sclerosis, quadriplegia, pulmonary embolism, and depression. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/6/24, which assessed R203 with a cognitive score of 15 out of 15, indicating cognitively intact. Review of R203's clinical record documented a social workers note, dated 12/3/24, that indicated a certified nursing assistant (CNA) had been rude and rough during care (when turning R203) and alluded to R203 not feeling safe during the care provided. On 12/9/24 at 1:50 p.m., R203 was interviewed regarding the incident. R203 verbalized asking for help to turn in bed, CNA #1 came into the room to assist and turned R203 abruptly and roughly. R203 stated that it scared her to the point that it felt like CNA #1 was going to [NAME] her out the bed. When asked if she felt CNA #1 was intending to harm her and if R203 felt safe around CNA #1, R203 verbalized not feeling that CNA #1's intended to harm her but just didn't feel safe while being turned. R203 went onto say that in general CNA #1 seems to be in a hurry, doesn't really speak while providing care, and seems rude. R203 verbalized trying to speak with CNA #1 and thank her for helping but that usually there is no response. A witness statement from R203 was reviewed and indicated CNA #1 was rough when handling R203, grabbed the pad to turn R203 and felt like R203 was being flung on her side. The witness statement documented that R203 goes on to state that CNA #1 is rushing and feels that CNA #1 does not like her (R203). The witness statement also documented that R203 stated that she doesn't feel that CNA #1 would intentionally hurt but doesn't feel safe when CNA #1 works with her (R203). On 12/9/24 at 3:25 p.m., the administrator and the director of nursing (DON) were interviewed regarding not reporting the above allegations to state agency. The DON verbalized that R203 had reported the incident to the wound nurse and the wound nurse had then reported the incident to the DON and administrator. The administrator verbalized that the incident was investigated at the time, along with a skin assessment and talking with R203 (along with the DON), indicated no concerns. The administrator stated that the interview with R203 did not indicate CNA #1 was intentional in her actions and felt that it was more of a customer service concern. The administrator verbalized that education was planned for CNA #1, but that CNA #1 does not work full time and has not worked since the incident. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/9/24 at 3:45 p.m., R203 was interviewed again. R203 verbalized, in general CNA #1 seems rude, does not talk, and seems to be in a rush. R203 said that she has tried talking with CNA #1 and thanking her for the help to show kindness but CNA #1 does not converse when providing care. R203 verbalized not feeling that CNA #1 would intentionally harm her, but that particular day felt that CNA #1 would've thrown R203 out of the bed if she thought she (CNA #1) could get away with it. When asked if she (R203) felt that 'CNA #1 would've thrown her out of bed, if CNA #1 could get away with it' sounds intentional, R203 responded, I guess so, I wasn't looking at it like that. R203 then verbalized, This is just how [CNA #1's name redacted] made me feel at the time. On 12/10/24 at 8:45 a.m., an interview was conducted with licensed practical nurse (LPN #1), to whom R203 reported the allegation. LPN #2 verbalized that R203 reported the incident and LPN #1 wrote a witness statement and reported the concern to the DON. LPN #1 said that while talking with R203, it came across that she didn't do anything intentional, but just did not want that particular CNA working with R203. On 12/10/24 at 9:00 a.m., the social worker was interviewed (other staff, OS #1). OS #1 said that after the incident had been reported and the DON and administrator had assessed R203, the OS #1 also assessed and talked with R203. During the conversation with R203, OS #1 verbalized that R203 said this was the first time this had happened. When OS #1 was asked about her notation in the progress notes, OS #1 reviewed the note and agreed that the note does indicate R203 not feeling safe around CNA #1. On 12/10/24 at 10:00 a.m. The DON was interviewed. After reviewing the information, the DON verbalized that it should have been reported, but went onto say, We did do an investigation, which did not yield anything was intentional, and there was no physical evidence to indicate suspicion of abuse. On 12/10/24 at 11:25 a.m., the administrator was interviewed. The administrator verbalized that CNA #1 has not worked since this incident and is currently suspended pending investigation. No other information was presented prior to exit conference on 12/10/24. 2. The facility did not implement facility abuse policy in regards to timely reporting for suspicion of physical abuse/mistreatment for Resident #207 (R207). According to the clinical record, diagnoses for R207 included: Dementia, diabetes, hemiplegia, and anxiety. The most current MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 10/3/24 assessed R207 with a cognitive score of 11 out of 15, indicating moderately cognitively intact. Review of facility documentation indicated that the facility had reported an allegation of abuse/mistreatment on 12/9/24, with the incident date of 12/6/24. Review of R207's clinical record documented a social workers note dated 12/6/24 that indicated R207 was upset due to missing drinks and chips were stale after coming back from a leave of absence and was blaming a CNA (identified as CNA #2), and CNA #2 was pointing her finger in R207's face. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 8:30 a.m. R207 was interviewed regarding the incident. R207 verbalized feeling that the CNA #2 did point her fingers in R203's face but is aware that CNA #2 has been noted to talk with her hands. When asked if R207 felt safe, R207 verbalized feeling safe and went onto verbalized knowing how to handle herself. R207 also said that the CNA #2 has not worked with her since. On 12/10/24 at 9:10 a.m. the social worker (OS #1) was interviewed. OS #1 explained that during a conversation with R207, R207 reported CNA #2 had pointed her finger in R207's face. OS #1 said at the time of the discussion with R207 the social worker assistant (OS #2) was present and wrote the note and also talked with CNA #2. OS #1 was asked who reported the incident and who was the incident reported to. OS #1 verbalized she (OS #1 reported the incident on 12/6/24 and it was reported to the regional administrator as the DON was not in the facility that day. OS #1 then left the room and returned a few minutes later and verbalized she was not 100 percent sure that she reported to the regional administrator, but verbalized it was reported on 12/6/24. On 12/10/24 at 10:00 a.m., the DON and regional administrator was interviewed. The DON verbalized not working on the day of the incident. The regional administrator verbalized that she was not aware of anyone reporting the incident to her on 12/6/24, and that she became aware of the incident on 12/9/24, while reviewing progress notes and reports with the DON. The regional administrator also verbalized that on 12/9/24 the DON had found a typed note in her mail box from the social worker reporting an incident, but then realized that was a different incident. The regional administrator verbalized that after reviewing everything, the incident should have been sent within 24 hours of the incident. On 12/10/24 at 11:25 a.m., the administrator was interviewed. The administrator verbalized that this incident was still being investigated, but the CNA in question had been terminated due to unrelated concerns regarding call outs. Review of the facilities abuse policy read in part: [.] Any employee or contracted service provider who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment [.] is obligated to report such information immediately, but no later that 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator and to other officials [.]. Once the allegation is reported, the Executive Director, as the abuse coordinator, is responsible for ensuring that the reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations. No other information was presented prior to exit conference on 12/10/24.

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety 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** 41449 Based on resident interviews, facility staff interviews, clinical record review and facility documentation review, the facility staff failed to report allegations of abuse and sexual harassment by resident #10 (R10), affecting five residents and resulted in psychosocial harm for all five (resident #9, Resident #7, Resident #8, Resident #12 and Resident #13). This failure resulted in immediate jeopardy being identified. The findings included: 1. For resident #9 (R9), the facility staff failed to report the sexual behavior endured by R10, when R9's ability to consent had not been assessed. Failure to report to other regulatory and protective services did not afford R9 the opportunity to have other agencies which can provide protective services and conduct an investigation. On 7/31/24 at 2:50 p.m., an interview was conducted with Resident #9 (R9). R9 was asked about if any residents had bothered her and she said, oh no, they would have a bloody nose and 2 black eyes. On 7/31/24 at 2:52 p.m., an interview was conducted with R9's roommate, resident #15 (R15). R15 reported that R9 was not telling the truth during the interview with the surveyor and said R9's boyfriend put a [NAME] on her neck. R15 went on to say that R9 has had her hand on R10's penis while he stands beside the bed and kisses her. R15 reported, the curtain wasn't pulled, and I don't want to see that mess. On 7/31/24 at 2:55 p.m., an interview was conducted with certified nursing assistant (CNA) #11. CNA #11 reported that she has seen R10 at the doorway of R9's room. CNA #11 reported R9 did have a [NAME] on her neck the end of June or early July. When asked if she was aware of any instances where R10 and R9 were having any sexual activity, CNA #11 said, I was here the day it happened, but I didn't' see it, I heard about it. CNA #11 went on to say, R9 said [activity director's name redacted] married them. She will ask if I got the mustang she bought me, her mind isn't exactly right. On 7/31/24 at 2:58 p.m., an interview was conducted with CNA #6. CNA #6 said, I heard about her touching his penis about a month or month and a half ago, but I haven't seen it. I heard about the [NAME]. I've seen them holding hands. CNA #6 was asked if anyone in management was aware and she said, someone made them aware, and I don't know how they handled it. We had some Inservice about we no longer have to separate residents who want to have sex. She [R9] is aware but has some confusion. She is a little off, she talks about having to go pick up her baby and stuff. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 7/31/24 at 3 p.m., an interview was conducted with LPN #3, the unit manager where R9 and R10 reside. When asked about R9's cognitive skills, LPN #3 said, with everyday stuff she seems ok, she can request food, drink, pain meds, etc. But she does have delusions, she owns jets, corvettes, etc. When asked if she was aware of any sexual activity between R9 and R10, LPN #3 said, There has been quite a bit of hearsay about that. I don't know if anyone saw it. He [R10] can be verbally inappropriate. He does like the ladies, but I've never caught him being inappropriate. When asked if she had any knowledge of R9 having a [NAME], LPN #3 said, yes, they spoke to the daughter [R9's daughter] and she made it very clear she wanted him to be able to visit her mom. She said she knew her Mom had a [NAME], and it didn't bother her. LPN #3 went on to talk about how R9 reports she married R10 and when she sees other women walk by, R9 will accuse R10 of sleeping with them. When asked if administration was aware of the [NAME] and the allegation of R9 having R10's penis in her hand, LPN #3 said, Administration is aware, they said they had an incident at [sister facility's name redacted] and that people who are capable of having relations its ok and we may think it is inappropriate. LPN #3 went on to talk about R9's delusions and how R9 says she has brought the staff cars, is sending them on elaborate vacations, etc. LPN #3 said, I've looked, and she doesn't have any diagnosis for the delusions, but she has always had them, I don't know if they haven't spent enough time with her to notice or what, but something is off [cognitively]. On 7/31/24 at 4:49 p.m., an interview was conducted with resident #10 (R10). R10 was asked about his relationship with the female residents within the facility. R10 said, [referring to R9] she thought we were married. She was going to fly me to a retreat. We are friends and we get involved and live out her fantasies. [facility administrator's name redacted] had talked to me. R10 was asked about sexual activity and confirmed he had put a [NAME] on R9's neck. When asked if anything more had occurred, R10 said, she's bipolar and she's not going to tell you, and neither am I. They can't prove it. R10 was asked about the other women within the facility, and he called R12 by name and said, she is bipolar too, we enjoy spending time together. R10 reported that the first time I got in trouble was about an aide. On 8/1/24 at 8:55 a.m., an interview was conducted with certified nursing assistant (CNA) #12. CNA #12 was asked about R10 and R9. CNA #12 reported, he [referring to R10] is a socializer, he rolls around all over the place all day. I've seen him stop at [R9's name redacted] room, stop and wave but I've never seen him in there. When asked about R9 having a [NAME], CNA #12 said, I saw the [NAME], but I didn't know he did it. When asked about any sexual activity, CNA #12 said, I heard about the penis incident weeks ago, but I don't know who saw it . One day she [R9] was crying, she said she wanted to marry him and was upset . He [R10] used to stop at [another resident's name redacted] door but she started closing her door, so now he just goes on. He bothers a lot of people honestly. On 8/1/24 at 9:05 a.m., R9 was visited in her room by the surveyor again. R9 had a rose in a cup by the bedside and when asked about it, R9 said, my boyfriend gave it to me. When asked who her boyfriend was R9 said R10's name. R9 went on to say, we are supposed to get married today. Did you know I am a princess of Allett, a country off Spain? My Mom and Dad are Queen and King When asked about a [NAME], R9 said, yes and admitted that R10 had given her a [NAME]. When asked if they had done anything sexual, R9 said, no, that's for marriage, and we are getting married today. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/1/24 at 9:16 a.m., an interview was conducted again with R9's roommate, R15. R15 said, Mr. [R10's name redacted] gave her a [NAME]. R15 went on to talk about R10 is putting his tongue down her [R9]'s throat. When asked if anything sexual has occurred R15 said, yes, I saw it, he walked over to her bed and she had her right hand on him, his penis, but [CNA #4's name redacted] got him out. I don't want to see that stuff, but they don't even pull the curtain. On 8/1/24 at 9:25 a.m., an interview was conducted with licensed practical nurse (LPN) #1. LPN #1 was asked about R10. LPN #1 said, Last week [CNA #4's name redacted] saw her [R9] with his penis in her hand. Maybe Sunday. I went and talked to Ms. [R15's name redacted], she said she didn't want him in her room. The nurse went down and told him and told him, if he went in that room he would be removed. She [R15] said she didn't want to see what they do, that incident [where R9 had R10's penis in her hand] is why she doesn't want him in there. During the above interview with LPN #1, she was asked about R9's cognitive ability. LPN #1 said, she says she has had 3 babies, and we stole them, she has an airplane, I don't believe she is mentally capable, but they [management] say she has a BIMS [brief interview for mental status] of 15. On 8/1/24 at 9:48 a.m., an interview was conducted with CNA #4. CNA #4 reported she has seen R10 with his hands down her [R9's] pants fondling her. He has been caught jacking off. On Thursday at 2:15 p.m., he was standing up, had his penis out jacking off while kissing her. I told the nurses, and they went down but he had finished. It's been reported, we have all been telling it, but they don't listen to us. On 8/1/24, a clinical record review was conducted of R9's chart. There was no documentation within the record of any interactions between R9 and R10. There was no documentation of the [NAME], nor of R10 being at the bedside masturbating. R9's most recent brief interview for mental status (BIMS) assessment was conducted on 6/14/24. R9 scored 12 of 15, which noted moderately impaired cognitive skills. R9 had last been seen by the physician on 5/13/24, and there was no mention to R9's cognitive ability other than noting awake, alert . Neurologic: Cranial Nerves Grossly Intact. There was no indication of any concerns other than with R9's skin. On 8/1/24 at approximately 1:30 p.m., an interview was conducted with the medical nurse practitioner (NP)/Other staff #3. When asked about R10's behaviors and interactions with R9, and the fact that R9 had a [NAME] on her neck. The NP said, it got brought to my attention Tuesday morning. I talked to [R9's name redacted] and she said she is widowed for 7 years. She has always had delusions; she doesn't have a psychiatric diagnosis to go with that. Her daughter allows her to make decisions. When asked if she has assessed R9's ability to consent for sexual activity had been assessed, the NP said, They are able to give consent even when in memory care units, so just because she has delusions doesn't mean she can't consent. The NP went on to say she had talked to the director of nursing (DON) and she has talked to the daughter, and she is aware. When asked if she was aware of any other interactions involving R9 and R10, she said, I am not aware of any other issues or concerns. The NP went on to say she would have the psychiatric nurse practitioner see R9 with regards to the delusions because she (the NP) wasn't comfortable diagnosing that. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/1/24 at 2:09 p.m., a telephone interview was conducted with the psychiatric nurse practitioner (Psych NP)/ Other staff #4. The Psych NP said she was not aware of any relationship between R9 and R10. The Psych NP said she sees R10, and he was last seen 6/20/24, and she made no notes with regards to any sexual tendencies or behaviors and was not aware of any concerns. When asked if she had seen R9 or assessed for the ability to consent to romantic activity, the Psych NP said, No, I wasn't aware of any of this and wouldn't really know how to go about doing that. On 8/1/24 at 4:33 p.m., a telephone interview was conducted with R9's daughter, who was listed as emergency contact. The daughter was asked about her knowledge of R9 and R10's relationship. The daughter said, I know they say they are boyfriend and girlfriend, and he visits her. My Mom is not right in the head, she thinks they are getting married. When asked if she was aware her mother had a [NAME] on her neck, she said, I was aware of that and I was kind of shocked by that. When asked if she had any knowledge of them kissing or having anything more intimate occurring, the daughter said, No, I told them they had to behave, you can't do that. As far as having any other pleasure that's not appropriate. I don't know how they could do that with Mom's condition anyway. Mom's not right in her head, I don't know if she has Alzheimer's or dementia or what. I've talked to [LPN #3, the unit manager's name redacted] but the doctor never said anything. It kind of gets old, she is talking about helicopters, new vehicles, money, all the time, it's a fantasy. On 8/1/24, the facility administrator provided the survey team with the only two investigations that had been conducted in the past three months. Neither of which involved R9 or R10. On the afternoon of 8/2/24, the director of nursing provided the survey team with a Witness Statement. The statement read, me and [name of medical records coordinator redacted] spoke with resident [R9's name redacted] regarding concerns of a bruise on right side of neck. [R9's name redated] stated it was a [NAME] from [R10's name redacted] and they had gotten married over the weekend. She was asked if she wanted this and if it feels good, it feels good, stated by [R9's name redacted]. She was smiling and in no distress noted. Asked if [R10's name redacted] did anything to you that you did not want him to do to you, her reply was no, don't worry about him, I can handle him. The statement was signed by the Director of Nursing and medical records coordinator and dated 6/24/24. On 8/6/24 at 9:06 a.m., an interview was conducted with the facility administrator. When asked about R9 having a [NAME], the administrator stated, I heard about it about an hour before we met on Thursday. When asked if he was aware that reports had been made that R10 was at R9's bedside pleasuring himself, the administrator said, I was told the day it happened, the roommate was in there. When asked if he, the administrator, had done anything to investigate or report this incident to regulatory agencies such as the state survey agency, adult protective services, ombudsman, or police, he said, I know an investigation was done by the nursing department. When asked where the credible evidence was, he said, as far as I know they just looked at her BIMS. No evidence was provided that the allegation was reported. 2. For R7, the facility staff failed to report an allegation of verbal abuse and sexual harassment, which resulted in the resident changing her daily routine to avoid the perpetrator (R10) and caused R7 to self-isolate. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 7/31/24 at 3:20 p.m., an interview was conducted with resident #7- R7. R7 told the surveyor of a prior incident that occurred at the vending machine involving resident #10 (R10) talking about sex and saying that my belly button is pushed out because a 250-pound lady was on top of me ., that made her very uncomfortable. R7 reported she returned to her room, turned the lights off and got in bed. R7 reported someone came in and didn't say anything, then a voice said I will talk to you tomorrow. R7 reported it was R10 and she has stayed away from him since then as R10 talks very nasty and disgusting, he always begins the conversation with I still like sex. R7 reported she told her daughter and the daughter talked with social services. R7 went on to say, I had a sign on my door that said stop, but it is gone. R7 reported that she rarely comes of out her room, because she wants to stay away from Resident #10. R7 reported, she didn't realize how much R10's behaviors bothered her until she realized she rarely leaves her room now. On 8/1/24 at 9 a.m., a follow-up interview was conducted with R7, in her room. R7 again talked about R10 saying he was still capable of having sex. R7 reported she froze in one spot and didn't know what to do. I went to my room, he wanted to walk to my room. I was uncomfortable, scared and didn't know what to do. He said he got in trouble . I stay in my room more and don't want to go out. He has something going on with the resident in [R12's room number redacted], he is on the unit a lot. I don't go out as much, I don't like running into him. I was scared the night he came into the room in the dark. I am very uncomfortable to even pass him in the hall. On 7/31/24 and 8/1/24, attempts were made by the surveyor to reach R7's daughter but were not successful. On 8/5/24 at 4:32 p.m., during a telephone interview with the director of nursing (DON), the DON reported that one day she was talking to R7's daughter in the hallway and the social worker asked the DON to step into the office. The DON said the social worker reported the incident where R10 went into R7's room. The DON said, I went to put the stop sign across her door and she denied that he had been back. I asked the resident and her daughter about the stop sign, and both agreed. I put it in place immediately. I wrote up a grievance and gave it to [previous social worker's name redacted]. [R7's name redacted] was assaulted at another facility, so this brought all that back for her. On 8/6/24 at 9:06 a.m., an interview was conducted with the facility administrator. The administrator reported that he was aware of the incident involving R7, when R10 entered the room. The administrator said, I did hear he had come in her room. I inquired about what they had done, and I suggested a stop sign across the door. When asked if any information regarding the incident/allegation was available, the administrator said, I can't tell you, I relied on the director of nursing, she does all of the investigations, which would include reporting incidents to regulatory and protective agencies. No further information was provided with regards to R7. 3. For R8, the facility staff failed to report an allegation of abuse and sexual harassment, which caused R8 psychosocial harm, R8 changed her daily routine to avoid the perpetrator, who was resident #10 (R10). (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/1/24 at 10:18 a.m., an interview was conducted with resident #8 (R8). R8 was asked about R10. R8 said, he is not a person you want to be around. I avoid him. He has a foul mouth. I get on him about it, so he does better with me than others. He will say he loves me. He discusses what he likes to do to women, says he likes older women's stuff and wants to have sex. He doesn't know how to talk to women and thinks he is God's gift to women. I avoid him, he makes me uncomfortable. If he passes me in the hall he tries to grab my hand, but I pull away. I go outside more to get away from him, because he doesn't go outside. He doesn't see anything wrong with sticking his tongue down [resident #9's name redacted] throat. He put a [NAME] on her neck, he so called got married to her. He really does think all women are crazy about him. I tell him he is going to end up getting kicked out of here, he says he probably will but says that's who he is. During the interview R8 was noted to be anxious and was constantly fidgeting with a snack on her over bed table. When R8 stopped talking about R10, she was noted to calm down and not be fidgety. 4. For R12, the facility staff failed to report allegations of inappropriate behavior by R10, to ensure R12 was free from abuse and sexual harassment, which resulted in psychosocial harm. On 8/1/24 at 10 a.m., an interview was conducted with R12. R12 said, [R10's name redacted] we are friends I thought, until last night. Another woman came around in the library, it went too far with his [R10] personal behavior. His nasty talking, I felt very uncomfortable. There are things I don't tolerate with my friends. [R13's name redacted] felt very uncomfortable. I don't want to be around him. I won't be making any attempt to see him anymore, things he was doing and talking provocative, talking about sex. I have had a stroke and common sense doesn't kick in all the time. I am nervous talking about it. During the interview, R12's hands were noted to be shaking. On 8/1/24 at 4:20 p.m., resident #12 was observed in the common area room on the unit crying. On 8/1/24 at approximately 4:25 p.m., Resident #12 was interviewed and said that Resident #10 was pressuring me to have sex. We [referring to her and resident #10] argued last night. I am scared. I don't want to have sex and he is wanting to have sex. On 8/1/24 at 10:46 a.m., an interview was conducted with the facility administrator and director of nursing (DON). When asked about R10, the DON said, [R10's name redacted] been here a while. He is very polite and respectful to me. I've seen nothing. I've heard rumors. I tell people I don't go by rumors and gossip, you put it in black and white and I will listen. When asked what rumors she has heard, the DON said, that with female residents doing sexual things to them and making sexual comments, it was consensual. Yesterday he was touching a lady, it was a big whoa. He has his hands between her legs, it was gossip, that's the talk. He had his hands between a lady with the last name beginning with the letter [letter redacted], in the dining room, but they never put it in writing. That's the protocol, I tell them I do not go by gossip or hearsay and I'm not going to until they put it in writing in black and white. If they saw something inappropriate, they have to put it in writing. The DON was asked if this was the case for all allegations, they must be put in writing, she said yes. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/5/24 at 4:32 p.m., during a telephone interview with the director of nursing (DON), the DON was asked if she identified who the resident was that R10 had his hands between the legs of that she mentioned on 8/1/24. The DON said yes, she spoke to a staff member who told her it was R10 and R12 and that a witness statement was in her office. The on-site corporate staff was able to provide the surveyor with the statement which read, I the author of this note was made ware by overhearing staff talking amongst themselves about resident #10 had his hand down the pants of resident #12 while sitting together in the dining room for lunch. I inquired further after informed by state surveyor of this incident. I was told by a staff member what she saw and what she did. Stated she saw resident #10 have his hand down resident #12s pants resident #12 had her legs spread open, while he had his hand in her pants. She didn't do anything- walked away. Thought with both residents are a & o [alert and oriented] w/o [without] any cognitive deficits it was okay. I spoke with resident #12 and asked her if she opposed to this behavior or it was not wanted, she replied no it was fine at this time it was determined no abuse had occurred. The note was signed by the DON and dated 8/1/24. On 8/6/24 at 9:06 a.m., an interview was conducted with the facility administrator. The administrator said, When I heard the pants thing [referring to R10 having his hands down R12's pants], I was appalled. When asked what had been done since he was made aware of the that, the administrator replied, I can't speak to it. 5. For Resident #13 (R13) who was subjected to sexual harassment which caused her to avoid common areas within the facility to prevent encountering R10, the facility staff failed to report such allegations to adult protective services and the state survey agency. On 8/1/24 at 10:11 a.m., an interview was conducted with resident #13- R13. R13 said, he [referring to R10] has a filthy mouth. My husband didn't like what he was saying. He would tell women, I want to eat her p#$$y. He said he put a [NAME] on one woman's neck. I don't go down there [to the library] anymore. He always talks dirty talk and I tell him to shut up, don't nobody want to hear that. He keeps on and I leave because of it. I don't stay and my husband told me to stay away from him. Review of the facility's communication book, used to communicate resident changes had an entry dated 7/17/24, that noted Resident #10's name and read, concern: increased sexuality, which at the time of survey had yet to be addressed. Resident #10 was observed throughout the duration of the survey to self-propel his wheelchair. He was observed at the doorway of female resident's rooms, visiting with and interacting with female residents on each of the nursing units, which puts all residents at risk for continued abuse and sexual harassment. Throughout the survey multiple interviews were conducted with facility staff. Interviews included: On 8/1/24 at 8:55 a.m., an interview was conducted with certified nursing assistant (CNA) #12. CNA #12 was asked about R10. CNA #12 said, He [R10] used to stop at [another resident's name redacted] door but she started closing her door, so now he just goes on. He bothers a lot of people honestly. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/1/24 at 9:25 a.m., an interview was conducted with licensed practical nurse (LPN) #1. LPN #1 was asked about R10. LPN #1 said, there are a couple of ladies that do not want him in their room. They don't like the way he talks. LPN #1 went on to say, the ladies in room [room number redacted] they don't like him; they say they get a bad feeling from him. LPN #1 identified resident #13 (R13) and said, she is friends with him, but I've never seen anything inappropriate. On 8/1/24 at 9:48 a.m., an interview was conducted with CNA #4. CNA #4 reported she has seen R10 with his hands down her [R9's] pants fondling her. He has been caught jacking off. On Thursday at 2:15 p.m., he was standing up, had his penis out jacking off while kissing her. I told the nurses, and they went down but he had finished. It's been reported, we have all been telling it, but they don't listen to us. He thinks he can do it to all the ladies. He's been doing it to the residents on the down low and we didn't know it. He told me, in the hall in front of the women, old ladies are good in bed, elderly ladies have the best p#$$y. I don't understand these people. We are telling the nurses, and no one acknowledges us. On 8/1/24 at 10:46 a.m., an interview was conducted with the facility administrator and director of nursing (DON). When asked about R10, the DON said, [R10's name redacted] been here a while. He is very polite and respectful to me. I've seen nothing. I've heard rumors. I tell people I don't go by rumors and gossip, you put it in black and white and I will listen. When asked what rumors she has heard, the DON said, that with female residents doing sexual things to them and making sexual comments, it was consensual. Yesterday he was touching a lady, it was a big whoa. He has his hands between her legs, it was gossip, that's the talk. He had his hands between a lady with the last name beginning with the letter [letter redacted], in the dining room, but they never put it in writing. That's the protocol, I tell them I do not go by gossip or hearsay and I'm not going to until they put it in writing in black and white. If they saw something inappropriate, they have to put it in writing. The DON was asked if this was the case for all allegations, they must be put in writing, she said yes. During the above interview with the facility administrator and DON, they were asked if any of the allegations had been reported. They replied no. Following surveyor intervention the facility staff reported the allegations of abuse to the local police, adult protective services and state survey agency. Review of the facility policy titled, Abuse, Neglect, Exploitation & Misappropriation was conducted. The policy read in part, . 7. Reporting/Response. Any employee or contracted service provider who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property , to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator and to other officials in accordance with State law. In the absence of the Executive Director, the Director of nursing is the designated abuse coordinator. Once an allegation of abuse if reported, the Executive Director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations, including notification of Law Enforcement if a reasonable suspicion of crime has occurred . (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/2/24 at 8:50 a.m., the survey team identified the facility was in immediate jeopardy (IJ) regarding reporting allegations of abuse. On 8/2/24 at 4 p.m., the facility submitted an approved plan of removal for IJ. The plan read as follows: F609-Reporting Facility staff completed an FRI and submitted it to the Virginia Department of Health, Adult Protective Services and Ombudsman. Local police were notified (case number 20240002626). Residents with a BIMS of 9 or above were interviewed about potential abuse. Facility Reportable Incident that was submitted yesterday has been updated on 8/2/2024 to represent #7, #8, #12 and #13 for allegation of abuse. Resident #10 will remain on 1:1 until he has been evaluated by psychiatric services for abuse towards others and seen to address increased sexual behaviors. Resident #9 will be assessed by two physicians/practitioners for her ability to consent to sexual activity. Social worker is no longer employed by the center. All facility staff will be educated in reporting all allegations of abuse. Residents with BIM score of 9 or greater will be educated in reporting abuse and who to report to. Allegation of compliance 8/3/2024 at 11:59pm On 8/5/24, the survey team returned to verify that the plan for IJ removal had been implemented and the immediacy had been removed. The FRI submitted by the facility was reviewed to ensure all agencies were notified as required. The local police notification was verified. On 8/5/24, the survey team made multiple observations of Resident #10 to ensure that one to one supervision was in place. The survey team observed the log of staff who had provided one to one, since the initiation of one to one began on 8/4/24. Using the resident census report, the surveyor attempted to verify that each resident with a BIMS of 9 and above were interviewed regarding abuse, while the remaining residents had a skin check. It was found that there were 14 residents identified that the facility had not either interviewed or conducted a skin check on. Resident #9 was assessed by the nurse practitioner (NP) and mental health nurse practitioner. The medical NP noted R9 has capacity to consent. The mental health practitioner note did not indicate the resident did or did not have capacity to consent to sexual activity. On 8/5/24 at 1:04 p.m., the survey team identified that the IJ had not been removed because R9's capacity to consent was noted indicated by a second provider, the facility had not either conducted interviews or skin checks of all residents, and that there was no evidence of staff or responsible party interviews available for review. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On the afternoon of 8/5/24, the facility administration made the survey team aware that the residents identified without having been interviewed or having had a skin check conducted were new admissions, had not been assessed for a BIMS score, and therefore were missed. The facility conducted interviews accordingly and provided evidence as noted. The survey team conducted staff interviews with a sample of staff from all departments to confirm they were educated on the abuse policy, aware that sexual harassment is considered abuse, and that their role is to protect the residents and report any allegations of abuse. On 8/5/24 at 4:30 p.m., the facility administration provided the survey team with an amended note from the psychiatric nurse practitioner that stated Resident #9 had the capacity to consent to sexual activity. IJ was abated on 8/5/24 at 4:30 p.m. The scope and severity of the remaining noncompliance was lowered to a level three, pattern.

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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** 41449 Based on resident interviews, facility staff interviews, clinical record review and facility documentation review, the facility staff failed to investigate allegations of abuse and sexual harassment by Resident #10 (R10) who was targeting female residents, and to take measures to protect residents and prevent further potential abuse, which had the potential to affect 59 residents that were female out of 98 residents residing in the facility. This failure resulted in immediate jeopardy being identified and resulted in psychosocial harm for six residents. The findings included: 1. For Resident #9 (R9), the facility staff failed to take measures to protect the resident from further potential abuse and conduct an investigation to determine if R9 had the capacity to consent to sexual activity. On 7/31/24 at 2:50 p.m., an interview was conducted with Resident #9 (R9). When asked if any residents had been bothering her or making her feel uncomfortable, R9 said, Oh no, they would have a bloody nose and two black eyes. R9 was noted to be very frail and not able to move her left extremities freely. On 7/31/24 at 2:55 p.m., an interview was conducted with R9's roommate, Resident #15 (R15). R15 stated that R9 had not been telling the truth earlier during the interview with the surveyor and said that R9's . boyfriend put a [NAME] on her neck. R15 went on to say that R9 has had her hand on R10's penis while he stands beside the bed and kisses her. R15 reported, The curtain wasn't pulled. I don't want to see that mess. On 7/31/24 at 2:55 p.m., an interview was conducted with certified nursing assistant (CNA) #11. CNA #11 reported that she has seen R10 at the doorway of R9's room. CNA #11 reported R9 did have a [NAME] on her neck the end of June or early July. When asked if she was aware of any instances where R10 and R9 were having any sexual activity, CNA #11 said, I was here the day it happened, but I didn't' see it, I heard about it. CNA #11 went on to say, [R9] said [activity director's name redacted] married them. She will ask if I got the mustang she bought me, her mind isn't exactly right. On 7/31/24 at 2:58 p.m., an interview was conducted with CNA #6. CNA #6 said, I heard about her touching his penis about a month or month and a half ago, but I haven't seen it. I heard about the [NAME]. I've seen them holding hands. CNA #6 was asked if anyone in management was aware and she said, someone made them aware, and I don't know how they handled it. We had some Inservice about we no longer have to separate residents who want to have sex. She [R9] is aware but has some confusion. She is a little off, she talks about having to go pick up her baby and stuff. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 7/31/24 at 3 p.m., an interview was conducted with LPN #3, the unit manager where R9 and R10 reside. When asked about R9's cognitive skills, LPN #3 said, with everyday stuff she seems ok, she can request food, drink, pain meds, etc. But she does have delusions, she owns jets, corvettes, etc. When asked if she was aware of any sexual activity between R9 and R10, LPN #3 said, There has been quite a bit of hearsay about that. I don't know if anyone saw it. He [R10] can be verbally inappropriate. He does like the ladies, but I've never caught him being inappropriate. When asked if she had any knowledge of R9 having a [NAME], LPN #3 said, yes, they spoke to the daughter [R9's daughter] and she made it very clear she wanted him to be able to visit her mom. She said she knew her Mom had a [NAME], and it didn't bother her. LPN #3 went on to talk about how R9 reports she married R10 and when she sees other women walk by, R9 will accuse R10 of sleeping with them. When asked if administration was aware of the [NAME] and the allegation of R9 having R10's penis in her hand, LPN #3 said, Administration is aware, they said they had an incident at [sister facility's name redacted] and that people who are capable of having relations its ok and we may think it is inappropriate. LPN #3 went on to talk about R9's delusions and how R9 says she has brought the staff cars, is sending them on elaborate vacations, etc. LPN #3 said, I've looked, and she doesn't have any diagnosis for the delusions, but she has always had them, I don't know if they haven't spent enough time with her to notice or what, but something is off [cognitively]. On 7/31/24 at 4:49 p.m., an interview was conducted with Resident #10 (R10). R10 was asked about his relationship with the female residents within the facility. R10 said, She [referring to R9] thought we were married. She was going to fly me to a retreat. We are friends and we get involved and live out her fantasies. [Facility administrator's name redacted] had talked to me. R10 was asked about sexual activity and confirmed he had put a [NAME] on R9's neck. When asked if anything more had occurred, R10 said, She's bipolar and she's not going to tell you, and neither am I. They can't prove it. R10 was asked about the other women within the facility, and he called R12 by name and said, She's bipolar too. We enjoy spending time together. R10 stated, The first time I got in trouble was about an aide. On 8/1/24 at 8:55 a.m., an interview was conducted with certified nursing assistant (CNA) #12. CNA #12 was asked about R10 and R9. CNA #12 reported, He [referring to R10] is a socializer. He rolls around all over the place all day. I've seen him stop at [R9's name redacted] room, stop and wave but I've never seen him in there. When asked about R9 having a [NAME], CNA #12 said, I saw the [NAME], but I didn't know he did it. When asked about any sexual activity, CNA #12 said, I heard about the penis incident weeks ago, but I don't know who saw it . One day she [R9] was crying, she said she wanted to marry him and was upset . He [R10] used to stop at [another resident's name redacted] door but she started closing her door, so now he just goes on. He bothers a lot of people honestly. On 8/1/24 at 9:05 a.m., R9 was visited in her room by the surveyor again. R9 had a rose in a cup by the bedside and when asked about it, R9 said, my boyfriend gave it to me. When asked who was her boyfriend, R9 said R10's name. R9 went on to say, We are supposed to get married today. Did you know I am a Princess of Allett, a country off Spain? My Mom and Dad are Queen and King When asked about a [NAME], R9 said, Yes and admitted that R10 had given her a [NAME]. When asked if they had done anything sexual, R9 said, No, that's for marriage, and we are getting married today. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/1/24 at 9:16 a.m., an interview was conducted again with R15. R15 said, Mr. [R10's name redacted] gave her [R9] a [NAME]. R15 went on to talk about what she had seen between R10 and R9. He [referring to R10] puts his tongue down her [R9]'s throat. When asked if anything sexual has occurred R15 said, Yes, I saw it, he walked over to her bed and she had her right hand on him, his penis, but [CNA #4's name redacted] got him out. I don't want to see that stuff, but they don't even pull the curtain. R15 indicated that she had felt like she didn't matter. During the above interview with LPN #1, she was asked about R9's cognitive ability. LPN #1 said, she says she has had 3 babies, and we stole them, she has an airplane, I don't believe she is mentally capable, but they [management] say she has a BIMS [brief interview for mental status] of 15. On 8/1/24 at 9:48 a.m., an interview was conducted with CNA #4. CNA #4 reported she has seen R10 with his hands down her [R9's] pants fondling her . He has been caught jacking off . On Thursday at 2:15 p.m., he was standing up, had his penis out jacking off while kissing her. I told the nurses, and they went down but he had finished. It's been reported, we have all been telling it, but they don't listen to us. On 8/1/24, a clinical record review was conducted of R9's chart. There was no documentation within the record of any interactions between R9 and R10. There was no documentation of the [NAME], nor of R10 being at the bedside masturbating. R9's most recent brief interview for mental status (BIMS) assessment was conducted on 6/14/24 and scored R9 as 12 of 15, which noted moderately impaired cognitive skills for daily decision making. R9 had last been seen by the physician on 5/13/24, and there was no mention to R9's cognitive ability other than noting awake, alert . Neurologic: Cranial Nerves Grossly Intact. There was no indication of any concerns other than with R9's skin. There was no evidence of any investigation or assessment of R9's ability to consent to sexual contact documented within the clinical record. On 8/1/24 at approximately 1:30 p.m., an interview was conducted with the medical nurse practitioner (NP)/Other staff #3. When asked about R10's behaviors and interactions with R9, and the fact that R9 had a [NAME] on her neck, the NP said, It got brought to my attention Tuesday morning [7/30/24]. I talked to [R9's name redacted] and she said she is widowed for 7 years. She has always had delusions; she doesn't have a psychiatric diagnosis to go with that. Her daughter allows her to make decisions. When asked if she had assessed R9's ability to consent for sexual activity, the NP said, They are able to give consent even when in memory care units. So just because she has delusions doesn't mean she can't consent. The NP went on to say she had talked to the director of nursing (DON) and she has talked to the daughter, and she is aware. When asked if she was aware of any other interactions involving R9 and R10, the NP said, I am not aware of any other issues or concerns. The NP went on to say she would have the psychiatric nurse practitioner see R9 with regards to the delusions because she (the NP) wasn't comfortable diagnosing that. On 8/1/24 at 2:09 p.m., a telephone interview was conducted with the psychiatric nurse practitioner (Psych NP)/ Other staff #4. The Psych NP said she was not aware of any relationship between R9 and R10. The Psych NP said that she sees R10, that he was last seen 6/20/24, and that she made no notes with regards to any sexual tendencies or behaviors and was not aware of any concerns. When asked if she had seen R9 or assessed for the ability to consent to sexual activity, the Psych NP said, No, I wasn't aware of any of this and wouldn't really know how to go about doing that. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/1/24 at 4:33 p.m., a telephone interview was conducted with R9's daughter, who was listed as emergency contact. The daughter was asked about her knowledge of R9 and R10's relationship. The daughter said, I know they say they are boyfriend and girlfriend, and he visits her. My Mom is not right in the head, she thinks they are getting married. When asked if she was aware her mother had a [NAME] on her neck, she said, I was aware of that and I was kind of shocked by that. When asked if she had any knowledge of them kissing or having anything more intimate occurring, the daughter said, No, I told them they had to behave, you can't do that. As far as having any other pleasure, that's not appropriate. I don't know how they could do that with Mom's condition anyway. Mom's not right in her head, I don't know if she has Alzheimer's or dementia or what. I've talked to [LPN #3, the unit manager's name redacted] but the doctor never said anything. It kind of gets old, she is talking about helicopters, new vehicles, money, all the time. It's a fantasy. On 8/1/24, the facility administrator provided the survey team with the only two investigations that had been conducted in the past three months. Neither of which involved R9 or R10. On the afternoon of 8/2/24, the director of nursing provided the survey team with a Witness Statement. The statement read, Me and [name of medical records coordinator redacted] spoke with resident [R9's name redacted] regarding concerns of a bruise on right side of neck. [R9's name redated] stated it was a [NAME] from [R10's name redacted] and they had gotten married over the weekend. She was asked if she wanted this and if it feels good, it feels good, stated by [R9's name redacted]. She was smiling and in no distress noted. Asked if [R10's name redacted] did anything to you that you did not want him to do to you, her reply was No, don't worry about him, I can handle him. The statement was signed by the Director of Nursing and medical records coordinator and dated 6/24/24. On 8/6/24 at 9:06 a.m., an interview was conducted with the facility administrator. When asked about R9 having a [NAME], the administrator stated, I heard about it about an hour before we met on Thursday. When asked if he was aware that reports had been made that R10 was at R9's bedside pleasuring himself, the administrator said, I was told the day it happened, the roommate was in there. When asked if he, the administrator, had done anything to investigate or report this incident to regulatory agencies such as the state survey agency, adult protective services, ombudsman, or police, the administrator said, I know an investigation was done by the nursing department. When asked where the credible evidence was, the administrator said, As far as I know, they just looked at her BIMS. No evidence was provided that the allegation was reported. 2. For R7, the facility staff failed to take measures to protect the resident and investigate an allegation of abuse, which resulted in the resident changing her daily routine to avoid the perpetrator (R10) and caused R7 to self-isolate. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 7/31/24 at 3:20 p.m., an interview was conducted with resident #7- R7. R7 told the surveyor of a prior incident that occurred at the vending machine involving resident #10 (R10) talking about sex and saying that my belly button is pushed out because a 250-pound lady was on top of me ., that made her very uncomfortable. R7 reported she returned to her room, turned the lights off and got in bed. R7 reported someone came in and didn't say anything, then a voice said I will talk to you tomorrow. R7 reported it was R10 and she has stayed away from him since then as R10 talks very nasty and disgusting, he always begins the conversation with I still like sex. R7 reported she told her daughter and the daughter talked with social services. R7 went on to say, I had a sign on my door that said stop, but it is gone. R7 reported that she rarely comes of out her room, because she wants to stay away from Resident #10. R7 reported, she didn't realize how much R10's behaviors bothered her until she realized she rarely leaves her room now. On 8/1/24 at 9 a.m., a follow-up interview was conducted with R7, in her room. R7 again talked about R10 saying he was still capable of having sex. R7 reported she froze in one spot and didn't know what to do. I went to my room, he wanted to walk to my room. I was uncomfortable, scared and didn't know what to do. He said he got in trouble . I stay in my room more and don't want to go out. He has something going on with the resident in [R12's room number redacted], he is on the unit a lot. I don't go out as much, I don't like running into him. I was scared the night he came into the room in the dark. I am very uncomfortable to even pass him in the hall. On 7/31/24 and 8/1/24, attempts were made by the surveyor to reach R7's daughter but were not successful. On 7/31/24, a clinical record review was conducted of R7's chart. This review included the care plan and progress notes. There was no documentation regarding the incident with R10, the implementation of a stop-sign banner, or any concerns related to R10 and R7 no longer coming out of her room. On 7/31/24 and 8/1/24, the facility's grievance log was reviewed and there was no evidence of a grievance related to R7's report of R10 entering her room uninvited. Daily observations were conducted of R7's room at various times of the day throughout 7/30/24-8/2/24. Each of the observations revealed a stop-sign banner was not in place at the doorway. On 8/5/24 at approximately 1:30 p.m., an observation of R7's room revealed the stop sign mesh banner to be in place at the doorway. On 8/5/24 at 4:32 p.m., during a telephone interview with the director of nursing (DON), the DON reported that one day she was talking to R7's daughter in the hallway and the social worker asked the DON to step into the office. The DON said the social worker reported the incident where R10 went into R7's room. The DON said, I went to put the stop sign across her door and she denied that he had been back. I asked the resident and her daughter about the stop sign, and both agreed. I put it in place immediately. I wrote up a grievance and gave it to [previous social worker's name redacted]. [R7's name redacted] was assaulted at another facility, so this brought all that back for her. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/6/24 at 9:06 a.m., an interview was conducted with the facility administrator. The administrator reported that he was aware of the incident involving R7, when R10 entered the room. The administrator said, I did hear he had come in her room. I inquired about what they had done, and I suggested a stop sign across the door. When asked if any information regarding the incident/allegation was available, the administrator said, I can't tell you, I relied on the director of nursing, she does all of the investigations, which would include reporting incidents to regulatory and protective agencies. No further information was provided with regards to R7. 3. For R8, the facility staff failed to investigate and take measures to protect the resident following an allegation of abuse. On 8/1/24 at 10:18 a.m., an interview was conducted with resident #8 (R8). R8 was asked about R10. R8 said, he is not a person you want to be around. I avoid him. He has a foul mouth. I get on him about it, so he does better with me than others. He will say he loves me. He discusses what he likes to do to women, says he likes older women's stuff and wants to have sex. He doesn't know how to talk to women and thinks he is God's gift to women. I avoid him, he makes me uncomfortable. If he passes me in the hall he tries to grab my hand, but I pull away. I go outside more to get away from him, because he doesn't go outside. He doesn't see anything wrong with sticking his tongue down [resident #9's name redacted] throat. He put a [NAME] on her neck, he so called got married to her. He really does think all women are crazy about him. I tell him he is going to end up getting kicked out of here, he says he probably will but says that's who he is. During the interview R8 was noted to be anxious and was constantly fidgeting with a snack on her over bed table. When R8 stopped talking about R10, she was noted to calm down and not be fidgety. 4. For R12, the facility staff failed to investigate allegations of inappropriate behavior by R10, to ensure R12 was free from continued abuse, which resulted in psychosocial harm. On 8/1/24 at 10 a.m., an interview was conducted with R12. R12 said, [R10's name redacted] we are friends I thought, until last night. Another woman came around in the library, it went too far with his [R10] personal behavior. His nasty talking, I felt very uncomfortable. There are things I don't tolerate with my friends. [R13's name redacted] felt very uncomfortable. I don't want to be around him. I won't be making any attempt to see him anymore, things he was doing and talking provocative, talking about sex. I have had a stroke and common sense doesn't kick in all the time. I am nervous talking about it. During the interview, R12's hands were noted to be shaking. On 8/1/24 at 4:20 p.m., R12 was observed in the common area room on the unit crying. On 8/1/24 at approximately 4:25 p.m., Resident #12 was interviewed and said that Resident #10 was pressuring me to have sex. We [referring to her and resident #10] argued last night. I am scared. I don't want to have sex and he is wanting to have sex. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/1/24 at 10:46 a.m., an interview was conducted with the facility administrator and director of nursing (DON). When asked about R10, the DON said, [R10's name redacted] been here a while. He is very polite and respectful to me. I've seen nothing. I've heard rumors. I tell people I don't go by rumors and gossip, you put it in black and white and I will listen. When asked what rumors she has heard, the DON said, that with female residents doing sexual things to them and making sexual comments, it was consensual. Yesterday he was touching a lady, it was a big whoa. He has his hands between her legs, it was gossip, that's the talk. He had his hands between a lady with the last name beginning with the letter [letter redacted], in the dining room, but they never put it in writing. That's the protocol, I tell them I do not go by gossip or hearsay and I'm not going to until they put it in writing in black and white. If they saw something inappropriate, they have to put it in writing. The DON was asked if this was the case for all allegations, they must be put in writing, she said Yes. On 8/5/24 at 4:32 p.m., during a telephone interview with the director of nursing (DON), the DON was asked if she identified who the resident was that R10 had his hands between the legs of that she mentioned on 8/1/24. The DON said, Yes, I spoke to a staff member who told me it was [R10 and R12 names redacted]. The witness statement was in my office. The on-site corporate staff was able to provide the surveyor with the statement which read, I the author of this note was made ware by overhearing staff talking amongst themselves about resident #10 had his hand down the pants of resident #12 while sitting together in the dining room for lunch. I inquired further after informed by state surveyor of this incident. I was told by a staff member what she saw and what she did. Stated she saw resident #10 have his hand down resident #12's pants resident #12 had her legs spread open, while he had his hand in her pants. She didn't do anything-walked away. Thought with both residents are a & o [alert and oriented] w/o [without] any cognitive deficits it was okay. I spoke with resident #12 and asked her if she opposed to this behavior or it was not wanted, she replied no it was fine at this time it was determined no abuse had occurred. This statement was signed by the DON and dated 8/1/24. On 8/6/24 at 9:06 a.m., an interview was conducted with the facility administrator. The administrator said, When I heard the pants thing [referring to R10 having his hands down R12's pants], I was appalled. When asked what had been done since he was made aware of the that, the administrator replied, I can't speak to it. 5. For Resident #13 (R13) who was subjected to sexual harassment which caused her to avoid common areas within the facility to prevent encountering R10, the facility staff failed to conduct an investigation. On 8/1/24 at 10:11 a.m., an interview was conducted with resident #13- R13. R13 said, he [referring to R10] has a filthy mouth. My husband didn't like what he was saying. He would tell women, I want to eat her p#$$y. He said he put a [NAME] on one woman's neck. I don't go down there [to the library] anymore. He always talks dirty talk and I tell him to shut up, don't nobody want to hear that. He keeps on and so I leave because of it. I don't stay anymore and my husband told me to stay away from him. 6. For Resident #15 (R15), was subjected Resident #15, who was the roommate of Resident #9, reported she had witnessed multiple occurrences of sexual activity between Resident #9 and #10 because the privacy curtain was not pulled. Resident #15 said that she didn't desire to see such activity and was not comfortable around Resident #10. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's communication book, used to communicate resident changes had an entry dated 7/17/24, that noted Resident #10's name and read, concern: increased sexuality, which at the time of survey had yet to be addressed. Resident #10 was observed throughout the duration of the survey to self-propel his wheelchair. He was observed at the doorway of female resident's rooms, visiting with and interacting with female residents on each of the nursing units, which puts all residents at risk for continued abuse and sexual harassment. Throughout the survey multiple interviews were conducted with facility staff. Interviews included: On 8/1/24 at 8:55 a.m., an interview was conducted with certified nursing assistant (CNA) #12. CNA #12 was asked about R10. CNA #12 said, He [R10] used to stop at [another resident's name redacted] door but she started closing her door, so now he just goes on. He bothers a lot of people honestly. On 8/1/24 at 9:25 a.m., an interview was conducted with licensed practical nurse (LPN) #1. LPN #1 was asked about R10. LPN #1 said, There are a couple of ladies that do not want him in their room. They don't like the way he talks. LPN #1 went on to say, The ladies in room [room number redacted] they don't like him; they say they get a bad feeling from him. LPN #1 identified Resident #13 (R13) and said, She is friends with him, but I've never seen anything inappropriate. On 8/1/24 at 9:48 a.m., an interview was conducted with CNA #4. CNA #4 reported she has seen R10 with his hands down her [R9's] pants .fondling her. He has been caught jacking off. On Thursday at 2:15 p.m., he was standing up, had his penis out jacking off while kissing her. I told the nurses, and they went down but he had finished. It's been reported, we have all been telling it, but they don't listen to us. He thinks he can do it to all the ladies. He's been doing it to the residents on the down low and we didn't know it. He told me, in the hall in front of the women, 'Old ladies are good in bed. Elderly ladies have the best p#$$y.' I don't understand these people. We are telling the nurses, and no one acknowledges us. On 8/1/24 at 10:46 a.m., an interview was conducted with the facility administrator and director of nursing (DON). When asked about R10, the DON said, [R10's name redacted] been here a while. He is very polite and respectful to me. I've seen nothing. I've heard rumors. I tell people I don't go by rumors and gossip, you put it in black and white and I will listen. When asked what rumors she has heard, the DON said, that with female residents doing sexual things to them and making sexual comments, it was consensual. Yesterday he was touching a lady, it was a big whoa. He has his hands between her legs, it was gossip, that's the talk. He had his hands between a lady with the last name beginning with the letter [letter redacted], in the dining room, but they never put it in writing. That's the protocol, I tell them I do not go by gossip or hearsay and I'm not going to until they put it in writing in black and white. If they saw something inappropriate, they have to put it in writing. When asked if this was the case for all allegations, that they must be put in writing, the DON said Yes. During the above interview with the facility administrator and DON, they were asked if they had any evidence to provide the survey team regarding investigations that had been conducted. They both replied, No. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Following surveyor inquiries, the facility staff reported that the allegations of abuse and that an investigation had been initiated. Review of the facility policy titled, Abuse, Neglect, Exploitation & Misappropriation was conducted. The policy read in part, . 5. Investigation: The abuse Coordinator or his/her designee shall investigate all reprots or allegations of abuse, neglect, misappropriation and exploitation. A Social Services representative may be offered in the role of resident advocate during any questioning of or interivewing of residents .6. Protection: . The resident will be evaluated for any signs of injury, including a physical exam and/or psychosocial assessment, as appropriate. Increased supervision of the alleged victim and residents. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator. Protection from retaliation. Provide the resident with emotional support and counseling during and after the investigation, if needed . On 8/2/24 at 8:50 a.m., the survey team identified that the facility was in immediate jeopardy (IJ) regarding failure to protect residents from abuse and failure to investigate allegations of abuse. On 8/2/24 at 4:45 p.m., the facility submitted an approved plan of removal for IJ. The plan read as follows: F610-Investigate and Protection Resident #10 placed on 1:1 on 8/1/24. Resident will be seen by MD/NP to address increased sexual behaviors. Resident #15 has been offered to move to another room. All residents with a BIMS of 9 and above will be interviewed about potential abuse to identify any other residents with psychosocial harm. Facility Reportable Incident that was submitted 8/1/24 has been updated to represent #7, #8, #12, and #13 for alleged abuse and re-submitted on 8/2/24. Residents #7, #8, #12, and #13 will be reminded that it is safe to come out of their room and how to report to staff if they experience or witness any type of abuse. All facility staff will be educated on recognizing all types of abuse and assuring resident is immediately protected upon recognition/allegation followed by reporting appropriately all allegations of abuse. Residents will be reminded what constitutes abuse and how/who to report any allegations or suspicions. The DON will be educated by the RDCS [regional director of clinical services] on abuse recognition, protection, investigating, and reporting. Allegation of compliance 8/3/2024 at 11:59pm. On 8/5/24, the survey team conducted the following activity to verify IJ removal: On 8/5/24, the survey team made multiple observations of Resident #10 to ensure that one to one supervision was in place. The survey team reviewed the log of staff who had provided one-to-one since the initiation of the one-to-one supervision began on 8/4/24. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #15 being offered a room change was verified through documentation review and interview with the resident. The surveyor used a resident census report and ensured that each resident with a BIMS of 9 and above were interviewed regarding abuse. The remaining residents had a skin check. There were 14 residents identified that the facility had not interviewed or performed a skin check. The submitted FRI was reviewed to ensure all agencies were notified as required. The local police notification was verified. Resident #7, #8, #12, and #13's documentation of being educated that they can resume normal activity was verified. On 8/5/24 at 1:04 p.m., the survey team identified that IJ had not been removed/abated because R9's capacity to consent was only addressed by one provider. The facility was also informed that the resident interview or skin checks had not been performed for all residents. There were also no staff or responsible party interviews available for review. On the afternoon of 8/5/24, the facility administration made the survey team aware that the residents identified without having been interviewed or having had a skin check conducted were all new admissions and had not been assessed for a BIMS score and therefore were missed. The facility conducted interviews accordingly, which were verified by the survey team. The survey team conducted staff interviews with a sample of staff from all departments to confirm that they were educated on the abuse policy, aware that sexual harassment is considered abuse, that their role is to protect the residents, and to report any allegations of abuse. The education of the DON on abuse was also verified. IJ was abated on 8/5/24 at 4:30 p.m. The scope and severity of the remaining noncompliance was lowered to a level three, pattern.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to develop and implement a comprehensive resident centered care plan for one resident (Resident #10- R10) in a survey sample of 28 residents. The findings included: For R10, the facility staff failed to develop and implement a comprehensive resident centered care plan to address the resident's medical and nursing needs. On 7/31/24 and 8/1/24, a clinical record review was conducted. According to the census tab of the record, R10 was admitted to the facility on [DATE], and remained an active resident at the time of survey. Review of the care plan for R10 revealed the following focus areas: activities, refusal of care, discharge plan/plan to stay long-term, mood problem/depression, nutritional risk, psychosocial well-being, and code status of full code. There were no care plans to address R10's nursing or medical needs. On 7/31/24 at 4:49 p.m., an interview was conducted with R10. During the conversation, R10 reported he had been a resident of the facility previously about five years ago but had been here this time since January. It was noted that R10 was wearing oxygen. On 8/2/24 at 11 a.m., an interview was conducted with the two care plan coordinators, licensed practical nurse (LPN #6) and registered nurse (RN #5). When asked about care plans, they reported they are a road map, it is to create a plan for nursing and the IDT [interdisciplinary] team to plan out their stay and treatment. If staff has a question about them and how they would perform anything or if they have preferences, it is resident centered. They should be using them [the care plan] as a roadmap for their care. They reported that the comprehensive care plans are developed following the resident's admission assessment and then reviewed every 92 days with the quarterly assessment, or with any significant changes. LPN #6 accessed R10's care plan and confirmed that a comprehensive care plan had not been developed, despite the resident being an active resident since January. During the above interview, LPN #6 reported that the nurse that conducted R10's admission assessment was working remotely/outside of the facility and did not follow through with the care plan piece. R10 is dependent on oxygen and receives an anticoagulant, which LPN #6 confirmed should have been on the care plan. LPN #6 and RN #5 both confirmed that a resident's physical functioning and level of support/assistance needed with activities of daily living should be noted within the care plan as well. When asked, how several quarters have passed where R10's care plan should have been reviewed, how it was missed? LPN #6 did not answer and would not answer any further questions asked by the surveyor. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled; Plans of Care was conducted. The policy read in part, Develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. On 8/1/24, during an end of day meeting held with the facility administrator, director of nursing and other administrative staff, the above findings were discussed. No additional information was provided.

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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** 41449 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to review and revise the care plan for two residents (Resident #10- R10 and Resident #1-R1) in a survey sample of 28 residents. The findings included: 1. For R10, who fell and had to be sent to the emergency departement, the facility staff failed to review and revise the care plan to address the fall and implement interventions to prevent reoccurrence. On 7/31/24 and 8/1/24, a clinical record review was conducted. According to the census tab of the record, R10 was admitted to the facility on [DATE], and remained an active resident at the time of survey. Review of the care plan for R10 revealed the following focus areas: activities, refusal of care, discharge plan/plan to stay long-term, mood problem/depression, nutritional risk, psychosocial well-being, and code status of full code. There were no care plans to address R10's actual fall, or fall risk. According to the progress notes, R10 had a fall on 7/13/24. The nursing note read in part, Resident had a fall at about 2342hrs in the library, witnessed by a peer while on wheelchair, the resident was unable to provide details of the cause, but it seemed he was dozing off. he hit his head and sustained am hematoma on the left lower eyelid. he was assessed physically and neurologically, assisted back on chair. he refused being sent to the hospital, the oxygen saturation was 80% on room air, he refused oxygen therapy . There was another nursing note dated 7/14/24 at 1:21 a.m., that read, Resident was offered ice pack to reduce the swelling on the left eyelid resulted from the fall, he was advised to visit ER for further evaluation, and he consented, he was sent to ER through rescue squad at 0105, call to ER to give report was not answered but the paper version of his electronic report and bed hold policy sent with him. On 7/31/24 at 4:49 p.m., an interview was conducted with R10. During the conversation, R10 reported he had been a resident of the facility previously about five years ago but had been here this time since January. R10 reported he had a coughing episode and blacked out causing him to fall. On 8/1/24, an interview was conducted with the two care plan coordinators, licensed practical nurse (LPN #6) and registered nurse (RN #5). When asked about care plans, they reported they are a road map to direct staff in how to care for a resident. They reported that the comprehensive care plans are developed following the resident's admission assessment and then reviewed quarterly, or with any significant changes. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the above interview, LPN #6 was asked if R10's fall would be noted on the care plan. LPN #6 confirmed it should be and reported R10 had gone to the emergency room following the fall. LPN #6 accessed R10's care plan and confirmed that the care plan did not include any information with regards to fall risk, actual fall, or have any interventions to prevent reoccurrence. Review of the facility policy titled; Plans of Care was conducted. The policy read in part, . Review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of hte resident and in response to current interventions after the completion of each . assessment and as needed. The interdisciplinary team shall ensure the plan of care addresses any resident needs and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental and psychosocial well-being . On 8/1/24, during an end of day meeting held with the facility administrator, director of nursing and other administrative staff, the above findings were discussed. No additional information was provided. 49456 2. The facility staff failed to revise the care plan for Resident #1 (R1) following a fall, to indicate interventions that were put in place to prevent recurrence. A review of R1's clinical record was performed on 8/6/24. R1 had an unwitnessed fall on 7/2/24. A review of R1's care plan was conducted. This review revealed that the fall care plan had no interventions added or revised since 9/25/23. No interventions were put in place following R1's fall on 7/2/24, to prevent recurrence. A review of the fall incident report was conducted on 8/6/24. R1 had a fall in his room and the report had poor lighting and gait imbalance was the predisposing factors of the fall. The report had that R1 had on normal socks and not non-skid socks. A change in condition note was reviewed on 8/6/24. On 7/2/24 a change in condition form was completed for R1's unwitnessed fall. No new interventions following the fall was noted on the form. R1 had new pain and discoloration to the sacral area due to the fall. The pain section of R1's care plan had not been revised since 7/22/21. R1's skin section of the care plan was last revised on 8/12/22 and the sacral discoloration from the fall on 7/2/24 is not in the care plan. On 8/4/24 another change in condition form was completed for R1. The form indicated no to the question asking if the resident had a history of falls in the last 6 months. The interventions noted on the form were not updated or reflected on the care plan. An interview was conducted with the MDS (minimum data set) coordinator, LPN#6 (LPN6) on 8/6/24. LPN6 stated that revisions to the care plan should be completed with change in conditions, falls or with any incident when it happens. LPN6 stated, with fall a new intervention should be placed. An interview with the Regional Director of Clinical Services (RDCS) was conducted on 8/6/24. The RDCS stated, that the interventions in the change of condition are being added to the care plan right now. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the policy titled, Plans of Care, was conducted on 8/6/24 and read in part, .Review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions after the completion of each OBRA [Omnibus Budget Reconciliation Act] MDS assessment and as needed. An end of day meeting was held on 8/6/24 at 4:00 p.m. with RDCS and a facility consultant, to discuss the above concerns. No new information was provided.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 41449 Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to follow professional standards of care during medication administration for two residents (Resident #111- R111 and resident #121- R121) in a survey sample of 29 residents. The findings included: 1. For R111, the facility nurse failed to follow professional standards of practice during medication administration by not observing the resident to take the medications before exiting the room. On 10/15/24 at 11:10 a.m., R111 was observed sitting in a wheelchair at the bedside. R111 had an over bed table in front of her and on the table was a cup of medication that included two round, white tablets. When asked what it was, R111 stated she didn't know. A visitor in the room, told R111, that's your morning medications, you need to take those. Upon the surveyor exiting the room, licensed practical nurse (LPN #4) was in the hallway at the medication cart. When asked about mediation administration and R111 having 2 white tablets in a cup in her room. LPN #4 identified that the medication was sodium bicarbonate. When asked if she normally leaves medications at the bedside for a resident to take, LPN #4 said, I don't normally, I had just given them to her and came back to the cart to get insulin. When asked what the accepted practice is, LPN #4 stated, To watch to make sure they take them and don't drop them or whatever. On 10/15/24, a review of R111's clinical record revealed an active physician's order for Sodium Bicarbonate Oral Tablet 325 MG (Sodium Bicarbonate (Antacid)) Give 2 tablet by mouth four times a day for CKD [chronic kidney disease]. There were no orders indicating the resident could self-administer medications. On 10/15/24, at approximately 1 p.m., the facility administrator provided the survey team with a listing of residents who had been determined and had an order that they were permitted to self-administer medications. R111 was not on the list. 2. For R121, the facility nurse left medications in the room at the bedside for the resident to self-administer versus staying with the resident to ensure and observe the medications being taken. On 10/15/24, at approximately 1 p.m., the facility administrator provided the survey team with a listing of residents who had been determined and had an order that they were permitted to self-administer medications. R121 was not on the list. On 10/15/24 at 2:06 p.m., R121 was visited in his room. While talking with R121, it was noted that on the over bed table was a medication cup with two large tablets. When the resident was asked about the medication, the resident stated, it was tums that had had been given that morning to take since I got the ulcer. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 2:11 p.m., an interview was conducted with registered nurse #2 (RN #2). RN #2 confirmed she was R121's nurse. When asked about the pills at the bedside, RN #2 said, I don't recall, I will have to look. On 10/15/24, in the afternoon a clinical record review was conducted. This review revealed that R121 did not have any physician orders in his clinical record, nor any record of any medications being administered. On 10/15/24 at approximately 2:20 p.m., an interview was conducted with the unit manager, who was a licensed practical nurse (LPN #4). LPN #4 confirmed that there had been a problem with R121's physician orders and said she did not give R121 the medications that were observed at the bedside. On 10/15/24 at 2:35 p.m., an interview was conducted with the Director of Nursing (DON). When asked about her expectation when nurses are administering mediations, the DON stated, during administration they should pull up the medication administration record (MAR) and follow the five rights of medication administration. They should not leave the patient until the pills are consumed and watch to make sure they take them. According to the facility policy titled, Medication- Oral Administration of it read in part, . Chart on nurse's notes: pertinent observations after administration. Education provided to resident or family regarding medication. On 10/15/24 at 5:30 p.m., during an end of day meeting, the facility administrator, director of nursing and regional director of clinical services were made aware of the above findings.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on staff interviews, clinical record review, and facility documentation review, the facility staff failed to develop and implement an effective discharge plan for one resident (Resident #11-R11), in a survey sample of 28 residents. The findings included: For R11, the facility failed to develop and implement a discharge plan to include assisting with post-discharge services to ensure the resident was able to receive assistance with daily care and medications. On 7/31/24, the survey team was made aware of a concern from R11's spouse who reported the resident discharged and no home health services or arrangements for the resident to receive medications were made by the facility staff. On 7/31/24, a clinical record review was conducted of R11's closed chart. This review revealed that R11 was admitted to the facility on [DATE], following a left hip replacement. On 7/29/24, the resident discharged home. According to a nursing progress note dated 7/29/24 at 12:37 p.m., the note read, Pt [patient] discharged home with home health and physical therapy. Care plan and discharge instructions reviewed with pts wife. According to the discharge plan and instructions form which was in R11's closed record, it was grossly incomplete. Section 1 had multiple areas that were blank, to include a contact phone number for the facility if the resident and/or family had questions. Section 2 had no information with regards to the physician that had overseen R11's care while a resident of the facility, therefore no contact information was noted. According to the form home health services were needed and an agency name was listed. There was no evidence within the clinical record to indicate the resident's medications were called into or sent to the pharmacy prior to discharge nor that any information had been sent to the home health agency. On 7/31/24 at 4:31 p.m., an interview was conducted with the social worker (SW), who was from a sister facility and was on-site assisting. The SW stated, if they are discharged home, the doctor will call meds into or electronically send them to the pharmacy. The SW also stated that the facility's social worker sends clinical records to the home health agency to arrange for services. The social worker confirmed that she could not find any evidence within the record or in the social services office to indicate that records had been sent to arrange for home health. She attempted to call the home health office, but it was closed for the day. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24 at 5:10 p.m., an interview was conducted with the facility's nurse practitioner (NP). The NP was questioned about the medications for R11. The NP reported she was on vacation last week and had just returned to work today. The NP went on to say that the medical director was on-site Monday afternoon and he had already left when notified of the discharge. The NP was able to access records on her computer and noted that R11's medications were sent to the pharmacy of choice on 7/29/24 at 11 p.m. The NP said, This one fell through the cracks. On 8/1/24, the SW provided the survey team with documents which included emails where the home health agency was contacted on 7/31/24, to arrange for services. The required documents needed for home health to be initiated were sent on 7/31/24 at 3:56 p.m. On 8/1/24, the SW also reported to the survey team that she had spoken with R11's spouse, who was very upset because she had called the home health agency and they had reported they didn't have any information to arrange for services prior to 7/31/24. The SW reported the family was also upset with regards to R11 not having any medications until the day after discharge. Review of the facility policy titled; Interdisciplinary Discharge Planning was conducted. The policy read in part, .2. b. Care Management/Social Services responsible for coordinating necessary outside services. 1. Outside services will be contacted for services . On 8/1/24, during an end of day meeting, the facility administrator and director of nursing were made aware of the above findings. No additional information was provided.

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to provide care and services to ensure residents attain or maintain the highest practicable physical, mental, and psychosocial well-being, which resulted in psychosocial harm for five residents (Resident #7- R7, Resident #8- R8, Resident #12- R12, Resident #13- R13, and Resident #15- R15). The resident who was the known aggressor, was targeting female residents. Therefore 59 of the 98 residents residing in the facility who were female, had the potential to be affected. This deficient practice resulted in immediate jeopardy. The findings included: 1. For R7, who was self-isolating because of R10, the facility staff failed to implement interventions so that the resident could maintain the highest practicable psychosocial well-being. On 7/31/24 at 3:20 p.m., an interview was conducted with resident #7- R7. R7 told the surveyor of an incident that occurred at the vending machine involving resident #10 (R10) talking about sex and saying that my belly button is pushed out because a 250-pound lady was on top of me R7 reported that R10's comments made her very uncomfortable. R7 reported that she returned to her room, turned the lights off, and got in bed. R7 reported that someone came in and didn't say anything, then a voice [she identified as R10] said I will talk to you tomorrow. R7 reported that she has stayed away from R10 since then and said, He talks very nasty and disgusting . He always begins the conversation with I still like sex. R7 reported that she told her daughter and the daughter talked with social services. R7 went on to say, I had a sign on my door that said stop, but it is gone. R7 reported that she rarely comes of out her room, because she wants to stay away from Resident #10. R7 reported, she didn't realize how much R10's behaviors bothered her until she realized that she rarely leaves her room now. On 7/31/24, a clinical record review was conducted of R7's chart. This review included the care plan and progress notes. There was no documentation regarding the incident with R10, the implementation of a stop-sign banner, or any concerns related to R10 and R7 no longer coming out of her room. On 7/31/24 and 8/1/24, the facility's grievance log was reviewed and there was no evidence of a grievance related to R7's report of R10 entering her room uninvited. On 8/1/24 at 9 a.m., a follow-up interview was conducted with R7, in her room. R7 again talked about R10 saying that he was still capable of having sex. R7 reported that she .froze in one spot and didn't know what to do. I went to my room, he wanted to walk to my room. I was uncomfortable, scared and didn't know what to do. He said he got in trouble . I stay in my room more and don't want to go out. He has something going on with the resident in [R12's room number redacted], he is on the unit a lot. I don't go out as much, I don't like running into him. I was scared the night he came into the room in the dark. I am very uncomfortable to even pass him in the hall. Daily observations were conducted of R7's room at various times of the day throughout 7/30/24-8/2/24. Each of the observations revealed no stop-sign banner present or in use. (continued on next page)

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/5/24 at 4:32 p.m., during an interview with the director of nursing (DON), the DON reported that one day she was talking to R7's daughter in the hallway and the social worker asked the DON to step into the office. The DON said the social worker reported the incident where R10 went into R7's room. The DON said, I went to put the stop sign across her door and she denied that he had been back. I asked the resident and her daughter about the stop sign, and both agreed. I put it in place immediately. I wrote up a grievance and gave it to [previous social worker's name redacted]. [R7's name redacted] was assaulted at another facility, so this brought all that back for her. On 8/6/24 at 9:06 a.m., an interview was conducted with the facility administrator. The administrator reported that he was aware of the incident involving R7, when R10 entered her room. The administrator said, I did hear he had come in her room. I inquired about what they had done, and I suggested a stop sign across the door. When asked where the grievance, or investigation regarding the incident was, the administrator said, I can't tell you, I relied on the director of nursing, she does all of the investigations. 2. For R8, the facility staff failed to provide care and services to provide the resident with the highest practicable psychosocial well-being, which resulted in R8 no longer visiting a common area within the facility, to avoid Resident #10. On 8/1/24 at 10:18 a.m., an interview was conducted with resident #8 (R8). R8 was asked about R10. R8 said, He is not a person you want to be around. I avoid him. He has a foul mouth. I get on him about it, so he does better with me than others. He will say he loves me. He discusses what he likes to do to women, says he likes older women's stuff and wants to have sex. He doesn't know how to talk to women and thinks he is God's gift to women. I avoid him, he makes me uncomfortable. If he passes me in the hall he tries to grab my hand, but I pull away. I go outside more to get away from him, because he doesn't go outside. He doesn't see anything wrong with sticking his tongue down [resident #9's name redacted] throat. He put a [NAME] on her neck, he so called got married to her. He really does think all women are crazy about him. I tell him he is going to end up getting kicked out of here, he says he probably will but says that's who he is. During the interview R8 was noted to be anxious and was constantly fidgeting with a snack on her over bed table. When R8 stopped talking about R10, she was noted to calm down and not be fidgety. 3. For R12, the facility staff failed to ensure the resident was able to maintain her highest practicable psychosocial well-being and without being fearful of another resident. On 8/1/24 at 4:20 p.m., Resident #12 was observed in the common area on the 400 unit. Resident #12 was observed crying, when asked what was wrong, she reported that she and Resident #10 got into an argument last night because he is pressuring me to have sex and I'm just not that kind of woman. Resident #12 reported that she is scared and uncomfortable. On 8/1/24 at 10 a.m., an interview was conducted with R12. R12 said, [R10's name redacted], we are friends I thought, until last night. Another woman came around in the library, it went too far with his [R10] personal behavior, his nasty talking. I felt very uncomfortable. There are things I don't tolerate with my friends . I don't want to be around him. I won't be making any attempt to see him anymore, things he was doing and talking provocative, talking about sex. I have had a stroke and common sense doesn't kick in all the time. I am nervous talking about it. During the interview, R12's hands were observed to be shaking. (continued on next page)

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/1/24 at 10:46 a.m., an interview was conducted with the facility administrator and director of nursing (DON). The DON said, I've heard rumors. I tell people I don't go by rumors and gossip, you put it in black and white and I will listen. When asked what rumors she has heard, the DON said, That with female residents, he [R10] is doing sexual things to them, and making sexual comments, it was consensual. Yesterday he was touching a lady, it was a big who-ha. He has his hands between her legs, it was gossip, that's the talk. He had his hands between a lady with the last name beginning with the letter [letter redacted], in the dining room, but they never put it in writing. That's the protocol, I tell them I do not go by gossip or hearsay and I'm not going to until they put it in writing in black and white. If they saw something inappropriate, they have to put it in writing. On 8/5/24, during an interview with the DON, she was asked if she identified who the resident was that R10 had his hands between the legs of that she mentioned on 8/1/24. The DON said, Yes, I spoke to a staff member who told me it was [names redacted, R10 and R12]. The witness statement is in my office. The on-site corporate staff was able to provide the surveyor with the statement which read, I the author of this note was made aware by overhearing staff talking amongst themselves about resident #10 had his hand down the pants of resident #12 while sitting together in the dining room for lunch. I inquired further after informed by state surveyor of this incident. I was told by a staff member what she saw and what she did. Stated she saw resident #10 have his hand down resident #12s pants resident #12 had her legs spread open, while he had his hand in her pants. She didn't do anything- walked away. Thought with both residents are a & o [alert and oriented] w/o [without] any cognitive deficits it was okay. I spoke with resident #12 and asked her if she opposed to this behavior or it was not wanted, she replied no it was fine at this time it was determined no abuse had occurred. [SIC] The statement was signed by the DON and dated 8/1/24. On 8/6/24 at 9:06 a.m., an interview was conducted with the facility administrator. When asked about his role in ensuring residents are safe and free from sexual harassment by R10, the administrator said, When I heard the pants thing [referring to R10 having his hands down R12's pants], I was appalled. When asked what had been done since he was made aware of the that, the administrator replied, I can't speak to it . It's all just a total cluster, because when she [the DON] heard that, you start an investigation by talking to staff and residents. 4. Resident #13 was not afforded care and services to maintain the highest practicable psychosocial wellbeing as she had altered usual social patterns and was avoiding common areas due to the unwanted behaviors of R10. On 8/1/24 at 10:11 a.m., an interview was conducted with Resident #13 (R13). R13 said, He [referring to R10] has a filthy mouth. My husband didn't like what he was saying. He would tell women, I want to eat her p#$$y. He said he put a [NAME] on one woman's neck. I don't go down there [to the library] anymore. He always talks dirty talk and I tell him to shut up, don't nobody want to hear that. He keeps on and so I leave because of it. I don't stay anymore and my husband told me to stay away from him. 5. R15, who was subjected to witness multiple occurrences of sexual activity between Resident #9 [who was the roommate of R15] and R10, because the privacy curtain was not pulled, which affected R15's psychosocial well-being. (continued on next page)

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 7/31/24 at 2:55 p.m., an interview was conducted with resident #15 (R15). R15 reported that R9's [who was her roommate] . boyfriend put a [NAME] on her neck. R15 went on to say that R9 .has had her hand on R10's penis while he stands beside the bed and kisses her. R15 reported, The curtain wasn't pulled. I don't want to see that mess. R15 indicated that these types of observations were recurrent and appeared visibly upset. On 8/1/24 at 9:16 a.m., an interview was conducted again with R15. R15 said, Mr. [R10's name redacted] gave her [R9] a [NAME]. R15 went on to talk about what she had seen between R10 and R9. He [referring to R10] puts his tongue down her [R9]'s throat. When asked if anything sexual has occurred R15 said, Yes, I saw it, he walked over to her bed and she had her right hand on him, his penis, but [CNA #4's name redacted] got him out. I don't want to see that stuff, but they don't even pull the curtain. R15 indicated that she had felt like she didn't matter. On 8/1/24 at 9:25 a.m., an interview was conducted with licensed practical nurse (LPN) #1. LPN #1 was asked about R10. LPN #1 said, There are a couple of ladies that do not want him in their room. They don't like the way he talks. LPN #1 went on to say, Last week [CNA #4's name redacted] saw her [R9] [which is R15's roommate] with his penis in her hand. Maybe Sunday. I went and talked to Ms. [R15's name redacted], she said she didn't want him in her room. The nurse went down and told him and told him, if he went in that room he would be removed. She [R15] said she didn't want to see what they do, that incident [where R9 had R10's penis in her hand] is why she doesn't want him in there. On 8/1/24 at 10:46 a.m., the administrator and DON were made aware of the above interviews and that R7, R8, R12, R13, and R15 were reporting being scared and changing their daily routine because of R10's behaviors. The DON said, I didn't know residents are scared of him or afraid to come out of their room. The administrator said, I'm just hearing about this. After talking with him the other week, his brother came in and I told him about it, and he said he tells him all the time he is not God's gift to women. The administrator reported that he had no documentation or credible evidence to provide the survey team with regards to the conversation he had with R10. On 8/2/24 at 8:50 a.m., the survey team identified the facility was in immediate jeopardy for failure to provide care and services to ensure residents attain or maintain the highest practicable physical, mental, and psychosocial well-being. On 8/2/24 at 5:43 p.m., the facility submitted an IJ removal plan that was accepted. The plan of removal read as follows: F675- Quality of Life. Resident #10 was placed on 1:1 supervision. The resident will be educated on appropriate behaviors towards others including verbal abuse and unwanted/inappropriate sexual activity. Resident #7 will be reminded that resident #10 is on 1:1 supervision and will be provided reassurance that she is safe to come out of her room whenever she desires. Resident #8 will be reminded that resident #10 is on 1:1 supervision and will be provided reassurance that she can covert back to her preferred daily routine and that she can go to the library and outside safely whenever she desires. Resident #12 will be reminded that resident #10 is on 1:1 supervision. Resident #12 will be reminded to report to facility staff if/when she is scared or uncomfortable. (continued on next page)

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #13 2ill be reminded that resident #10 is on 1:1 supervision and will be provided reassurance that she can go to the library and common area safely whenever she desires. Resident #15 has been offered a room change. Resident #15 will be reminded resident #10 is on 1:1 supervision and to call for staff assistance should she ever need the privacy curtain pulled. Residents #7, #8, #12, #13 and #15 will receive daily social services/designee visits to ensure their psychosocial needs are being met and that they feel safe and are able to enjoy their resident centered activities of their choice and timing. Residents #7, #8, #12, #13 and #15 will be evaluated by Psychiatric NP for any psychosocial harm that may have occurred. Care plans for residents # 7, #8, #12, #13 and #15 will be updated to address psychosocial needs and protection from verbal/mental abuse. All facility staff will be educated on the abuse policy to include providing immediate protection to any resident that reports any allegation of abuse to include psychosocial harm and capacity to consent. Allegation of compliance 8/3/24 at 11:50 p.m. On 8/5/24, the survey team made multiple observations of Resident #10 to verify that one to one supervision was being provided. The survey team reviewed the log of one-to-one supervision to ensure that the supervision had been continuous since initiated. The survey team reviewed and verified that resident #7, #8, #12, and #13 had been educated that resident #10 was on one-to-one supervision and they were safe to resume normal daily routines. The survey team confirmed that resident #15 had been offered a room change and knew to call staff if the privacy curtain needed to be pulled. The survey team confirmed that residents #7, #8, #12, #13, and #15 had received daily social services visits which were documented within the clinical records. The survey team reviewed the progress notes from the psychiatric nurse practitioner to confirm residents #7, #8, #12, #13 and #15, had been seen. The survey team reviewed the sign in sheets from the staff education and used a sample of staff on the as worked schedule for 8/5/24, to confirm they had been trained. The survey team then conducted interviews with a sample of employees, across all departments, to ensure they had received abuse training, were aware of sexual harassment as being considered abuse, and if residents have questionable cognitive impairment, they need to be assessed to determine capacity to consent to sexual relations. The IJ was removed/abated on 8/5/24 at 4:30 p.m. and the scope and severity was lowered to a level three, pattern.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 49456 Based on observation, staff interviews, resident interviews and facility documentation review, the facility staff failed to provide services to residents by answering the call bell(s)/requests for assistance, in a timely manner on one of two nursing units. The findings included: Observations were made on 8/6/24 at 10:25 a.m. on unit three. It was noted that several call lights were on, which was indicated by a light illuminated outside of resident rooms in the hallway and a bell was sounding at the nurse's station. The surveyor was standing at the nurse's station, which is in the middle of the unit and there were call bells alarming on each of the four hallways. When the surveyor arrived on the unit, it was three call bells sounding and two additional came on while the surveyor was on the unit. Facility staff were observed walking up and down the hallways and not responding to or answering the call bells. There were two housekeepers on one hallway and a CNA across the hallway folding linen, and none of them answered the lights. The administrator and social worker came to the floor and the social worker answered one light but left the unit with all the other lights still sounding. One aide came to the board and looked at the board which identified which rooms had the call bell engaged, and then that CNA left the unit, without responding to all the residents calls for assistance. There was one nurse and one aide sitting at the desk, talking and never went to answer any of the call bells. The first call bell was answered at 10:50 a.m. and the last one that was on was answered at 11:15 a.m. The call bells were sounding for 25 - 30 minutes before any were responded to, with staff available on the unit. An interview was conducted with the supply clerk, CNA#9 (CNA9) on 8/6/24 at 11:00 a.m. CNA9 stated, that anyone can answer the call bells but only CNA's can give direct care. An interview was conducted with the housekeeping aide, OS6 and OS8 on 8/6/24 at 12:15 p.m. OS6 and OS8 stated, we can answer call bells but cannot do direct care. If the resident wants water or ice, we can get that for them, but we check with the nurse first. An interview was conducted with Resident #27 (R27) on 8/6/24 at 11:20 a.m. R27's call bell was sounding from 10:50 a.m. - 11:15 a.m. when the supply clerk answered the light. R27 wanted his water cup filled. R27 stated it depends on how busy the aides are or if there were only two aides on the floor to how long it takes for the call bell to be answered. R27 stated, I wait a long time most of the time. An interview was conducted with Resident #26 (R26) on 8/6/24 at 11:25. R26 stated that she had put her call bell on because she was wet and needed to be changed. R26 said it took over 30 minutes for the call bell to be answered. R27 stated, when I ring the bell a lot of the time it is over 30 minutes before they come but occasionally it is shorter time. What do you do but sit here and wait and just think they are with someone else. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the unit manager on unit three, LPN#3 (LPN3). LPN3 stated that everyone can answer a call bell. She stated, anyone walking down the hallway but only nursing can provide direct care, but anyone can go knock on the door and find out what the resident needs and go get a nurse if needed. A review of a policy titled, Call light, read in part, .All call lights will be answered promptly by all staff regardless of assignment. As soon as call bell is activated, go to residents' room or let resident know that the light was noticed, and you will be with the resident as soon as possible. An end of day meeting was held on 8/6/24 and the regional director of clinical services stated, call bells should be answered in less than 10 to 15 minutes. The facility administrator and corporate staff were made aware of the above findings. No other information was provided

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49456 Based on observations, staff interviews, resident interviews, clinical record review, and facility documentation review, the facility staff failed to provide an environment that was free from accident hazards and provide adequate supervision to prevent an avoidable accident/elopement for one resident (Resident #113-R113) in a survey sample of 29 residents. R113, while wearing a wander guard device, eloped from the facility, left the premises, fell , and was unable to get up, which resulted in complaints of back pain, requiring treatment, and new order for x-rays, constituting harm. During the survey, the survey team identified that the wander guard system was not consistently functioning properly, and immediate jeopardy was identified. The findings included: The facility staff failed to provide adequate supervision and have a consistently functioning wander guard system to prevent residents with a known elopement risk from the ability to exit the facility without staff knowledge, which resulted in immediate jeopardy. Resident #113, who was a known elopement risk and had a wander guard in place, exited the facility, left facility grounds, fell into a drainage ditch 465.7 feet away from the buidling, was unable to get herself up, and crawled to the edge of the road. After an unknown amount of time, a staff member driving to work saw R113, assisted her off the ground, and drove her to the facility. R113 subsequently complained of pain in her back, requiring new physician orders to be written, which constituted harm. On 10/15/24 at 10:50 a.m. an interview was conducted with R113. R113 said that she walked out to the parking lot and then went on down to the road to smoke a cigarette. R113 said that she stepped into the grass and slid into the mud. R113 said that it took her about half an hour to crawl out of the mud. R113 said that she managed to get out of the mud and back to the side of the road, when an employee saw her, and picked her up in her vehicle. R113 stated. I go outside whenever I want to go out. No signing out or telling anyone. On 10/15/24 and 10/16/24, a clinical record review was conducted. This review revealed that on 9/19/24, according to Resident #113's (R113) care plan, R113 was identified as being at risk for elopement and as a wanderer. R113's care plan included a focus area, which was initiated on 9/24/24, that read in part, [R113's name redacted] is an elopement risk & wanderer r/t [related to] dementia and being a smoker. She exit seeks to try to go outside to smoke. Interventions for this focus area, included but were not limited to, an intervention entered 9/24/24, which read, monitor location every 2 hours and prn. That intervention was resolved on 10/2/24. On 10/8/24, a new intervention was added to R113's care plan which read, monitor location every 30 minutes and prn. On 10/17/24, the facility staff were only able to provide evidence of 15-minute checks being conducted on 10/8/24 from 12:30 p.m., until 6:30 p.m. R113's hospital discharge summary, dated 8/31/24, noted R113 with confusion, unsteady gait, cognitive decline, and unable to live alone. This summary indicated R113 as being unsafe to live alone because of her poor decision making, and noted an example of her placing a paper plate into a toaster oven to support that assessment. On 9/23/24, an elopement risk assessment was completed by the facility, which determined R113 to be an elopement risk and a wander guard was ordered. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 9/20/24 at 6:38 p.m., a nursing progress note in R113's chart read in part, Resident noted setting [sic] on porch this evening. When staff was leaving the facility, found resident walking next to stop sign on property. Assisted back to porch and this nurse walked resident to her unit. Resident watching tv at this time. Resident also had two cigarettes and a lighter on her person. Cigarettes placed in med cart until further direction. On 10/17/24 at 11:20 a.m., the regional director of clinical services measured the distance the resident had achieved on 9/20/24, with the surveyor and facility administrator observing. Although there was no stop sign noted in the designated area that the facility indicated R113 had been found on 9/20/24, it was measured as being 244.4 feet from the front door of the facility. The closest stop sign found in the area by the surveyor was approximately 0.25 miles or 1320 feet from the facility. On 9/23/24 at 7:02 p.m., a nursing progress note was entered into R113's record that read, Pt [patient] was seen walking outside upon returning inside facility she requested to speak with the speech therapist she informed her that she wants to leave the facility to go home. ADON [assistant director of nursing] was contacted via phone an instructed the writer to conduct an elopement assessment, this was done and pt is an elopement risk. Grand daughter was contacted and informed and message left on phone for Dr [medical director name redacted]. Wander guard place on pts Lt [left] ankle for safety. SIC On 9/24/24, R113's care plan was revised to add an intervention, which read, Monitor location every 2 hours and prn [as needed]. This intervention was discontinued on 10/2/24. On 10/17/24, the facility administration was asked to provide the survey team with evidence of the safety monitoring. On 10/17/24, the facility staff were only able to provide evidence of 15-minute checks being conducted on 10/8/24 from 12:30 p.m. 6:30 p. m. On 9/25/25 and 9/26/24, nursing note entries in R113's chart both read in part, .Often wonders outside and off sidewalk. Wonderguard in place . SIC On 10/2/24, a nursing progress note in R113's chart read, Resident had fall outside and was assisted back into facility by [certified nursing assistant #6's name redacted], CNA and no injury noted. Wandergaurd is intact and was let out to set on front porch by receptionist and wanderguard does work. On 10/3/24, a progress note from the nurse practitioner was entered into R113's clinical record, which read in part, Patient presented with complaints of lower back pain following a fall. On examination, pain was noted along the spine in the LS [lumbar spine] region. This pain is consistent with a potential injury to the thoracic spine. Plan: Prescribed Tylenol, 1 gram, twice a day for 7 days, with additional doses as needed for pain management. An x-ray will be ordered to rule out a compression fracture. According to facility documents, on 10/2/24, one of the two statements was by certified nursing assistant #1 (CNA#1) who had spotted R113 lying on the ground and had assisted R113 back to the building. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/16/24 at 5:21 p.m., an interview was conducted with CNA #1. CNA #1 stated that she had discovered R113 at 2:45 p.m., while driving to work, lying beside the road. CNA#1 stated that R113 had reported that she had fallen into a drainage ditch, off the facility property, and was unable to get up. CNA#1 stated that she had assisted R113 up off the ground, into her jeep, and took R113 back to the facility. According to CNA#1, R113 was wet, had mud all over her, and required a shower. CNA#1 stated that upon entering the building with R113, she had alerted staff, who had been unaware of R113's absence or how long she was gone, and that there had been no audible alarm sounding when they entered the building. On 10/16/24 at 11:20 a.m., the survey team, facility administrator, and regional nurse consultant measured the distance from the facility's front entrance/exit door to the location where R113 was found on 10/2/24, determining that the distance was 465.7 feet. The width of the ditch the resident fell into was measured at 7.2 feet and 0.87 feet in depth. The distance from the hard surface road to the ditch was measured to be 23.5 feet of grass and rough terrain. On 10/16/24 at 11:24 a.m., during an interview, other staff member #1 (OS #1) reported that frequently the front door wander guard system doesn't function properly. OS#1 said, There are times she has it on and it [the door alarm] doesn't go off, they check it and have to make adjustments. It doesn't always go off. Earlier this week [Resident #109's name redacted] went out and it didn't work. OS #1 reported that on 10/2/24, she was helping with answering the phones but was bouncing around and was not at the front desk/lobby when R113 went outside. OS #1 reported that she was on one of the nursing units helping a resident when R113 was brought back to the facility. OS #1 also stated, She [R113] is a difficult one. We never know when she has a wander guard or not, one day she has it and other days she doesn't. On 10/16/24 at 12:28 p.m., an interview was conducted with Other Staff #2 (OS #2), who worked as a back-up receptionist. OS #2 reported that just a few weeks ago she was working on a Sunday and about 1:10 p.m., when she arrived, R113 was in the parking lot. OS #2 said, Since she had a wander guard on, she wasn't supposed to be outside. I told her she needed to come back inside because she had a fall, and I didn't want her to fall again. OS #2 reported that this was about 2-3 weeks ago. According to OS #2's timecard, she had worked 9/22/24, which was prior to R113's fall incident and then worked again on Sunday, 10/6/24. OS #2 went on to state that, They [administration] kept changing their minds. At one time they would let her go out on the porch. Another time they said someone had to be with her. When asked about the door alarm and functioning, OS #2 said, Sometimes the things don't go off. It is really sporadic. On 10/16/24 at approximately 2:00 p.m., R124, who wears a wander guard, was observed by the survey team to be in the lobby, beyond the sensor for the wander guard alarm, past the receptionist desk, and only 8 feet from the exit door. Yet, there was no audible alarm triggered by the wander guard system. R124 was redirected back to his room by facility staff, away from the exit doors. On 10/16/24 at approximately 2:30 p.m., an interview was conducted with the maintenance assistant. The maintenance assistant reported that he checks the door alarms daily, Monday through Friday, and at times the front door's wander guard system doesn't work and they have to make adjustments. On 10/16/24 at 3:27 p.m., an interview was conducted with maintenance director. The maintenance director did report that in his short tenure of a few months that . once in a while, the receptionist will say that when a resident goes out, it doesn't alarm, and we have to make adjustments. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/16/24 in the early afternoon, the front door wander guard system was tested with the director of nursing (DON). The DON placed a wander guard into her sock, to mimic the location where the wander guard is placed on resident's ankle. The DON was able to walk through the lobby and open the front door, without the locking mechanism of the wander guard system engaging to lock the door and prevent exit. On 10/16/24, in the late afternoon, the front door was again tested using a wander guard by the maintenance director. Initially when the maintenance director had the device pass through the lobby area, the sensor did not pick up the signal, and made no alarm. On the second attempt, the alarm sounded, and the door locked. On the third attempt, the alarm sounded but the door remained unlocked and a resident could have exited. On 10/16/24 at 5:43 p.m., during an end of day meeting with the facility administrator, director of nursing (DON) and regional director of clinical services (RDCS), the incident on 10/2/24, involving R113 was discussed. The facility administrator reported she was not at the facility and was out of town at the time of the incident. The administrator went on to say that there wasn't a receptionist the day of the incident. When the survey team questioned that the nursing progress note indicated that the receptionist had let the resident out, as well as being noted likewise in the investigation summary, but that both receptionists had denied letting the resident out of the facility on 10/2/24, the Administrator and RDCS both stated they didn't know who had let R113 outside. During the end of day meeting held on 10/16/24, the RDCS provided the survey team with an Action Plan they had implemented following R113's elopement on 10/2/24. According to the action plan residents with a wander guard were reviewed to ensure appropriateness. The RDCS and Administrator stated that they determined R113 was not an elopement risk and was not appropriate to have a wander guard. On 10/17/24 at 9:00 a.m. another interview was conducted with R113. R113 stated, I just went out the front door, the door was unlocked, and people were outside, and no alarm sounded. I would go up sometimes and the alarm would sound, and they would turn it off, and I would go out the door. On 10/17/24 at 9:19 a.m., the facility administrator was asked about the functioning of the wander guard system. The administrator said, I am not aware of an issue. The survey team reported that in staff interviews multiple staff reported that the wander guard system is inconsistent and doesn't always operate properly. It was also reported that during the testing of the system by the DON and by the maintenance director the day prior, the wander guard system had not functioned properly. The administrator stated, This is the first I've heard of it. I always thought there was a mag [magnetic] lock, that if the door isn't closing enough, they may not latch. We just adjust those sensors on the side regularly. There is some sort of sensitivity, different things can affect it. That's usually what's going on. On 10/17/24 at 11:15 a.m. an interview was conducted with the business office assistant (other staff #2, OS2). OS2 verbalized that residents with wander guards were able to go out and sit on the front porch without staff going with them, until R113 fell outside. OS#2 stated, Now, if a resident with a wander guard wants to go outside, staff or a family member had to be with the resident. On 10/17/24 at 9:00 a.m. an interview with R113 was conducted. R113 was complaining of her back hurting from her waist down and that her chest was hurting. The surveyor notified R113's nurse, LPN#6. When notified, the physician ordered an x-ray of R113's lumbar spine on 10/17/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/17/24 at 3:15 p.m., the survey team identified the facility was in immediate jeopardy (IJ) in the care area of Quality of Care, as confirmed by the state agency. Given the findings that the facility failed to provide adequate supervision and failed to have a consistently functioning wander guard system to prevent residents identified as an elopement risk the ability to exit the facility without staff knowledge, the survey team determined that this noncompliance made the occurrence of serious adverse outcome likely and that the facility needed to take immediate corrective action. The survey team met with the facility administrator, director of nursing, and corporate staff and reviewed the IJ findings. On 10/18/24 at 6:20 p.m., the facility administration provided the survey team with an accepted IJ removal plan. The facility's plan to remove IJ read as follows: At approximately 0930 on 10/17/24 a staff member was posted at the front door to monitor entrance and exit and to ensure residents at risk were not allowed to exit without supervision. A staff member was assigned to relieve the scheduled staff when needed. [NAME] Security Services was contacted and on-site at arrived on site 10/17/24 at approximately 3:00 pm to work on functionality of the door alarming and latching when triggered by the Wander guard alarm. A staff person has been scheduled for 1:1 supervision of the front door for next 24 hours and until maintenance has verified door functionality; staff will be educated on responsibility of supervising the front door. All current staff in the building will be educated on their responsibility of preventing resident elopements beginning 10/17/24 evening shift and additional staff will be educated at their assigned shift. The facility alleged they would have the IJ removal plan completed on 10/17/24 at 6:30 p.m. On 10/17/24 at 6:20 p.m. the front receptionist was interviewed. The receptionist was able to verbalize that she was not able to leave the desk for any reason, unless someone came to relieve her. The receptionist was able to verbalize that residents with wander guards are not able to exit the front door unless a staff member was with them and also showed the surveyor an elopement book which identified the residents with wander guards. On 10/18/24 at 8:15 am the survey team returned on-site to verify the removal of IJ. A receptionist was sitting at the front desk in the lobby. The receptionist was interviewed and was able to verbalize that residents with wander guards are not permitted to go outside unless accompanied by staff or family. The receptionist also stated that she was not able to leave from monitoring the front desk/door unless someone was present to relieve her. Sign off sheets were verified that since 5 p.m. on 10/17/24 staff signed every 15 minutes that they were watching the front door, and it was continuously monitored. A statement from the maintenance director indicated that he had worked on the front door on 10/17/24 and had called a contractor in to work on it. The contractor bill dated 10/17/24 was provided which showed that the lever trim function of the front exterior door had been changed. The facility reported that the front door wander guard system was now operating properly. The survey team verified this with the Director of Nursing, noting that the system alarmed and locked the door when a wander guard approached the door. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A copy of the schedule for all departments on 10/17/24 and 10/18/24 was received. Staff education sign-in sheets were also received, and a comparison was made to ensure that all staff working in the facility at 6:30 p.m., on 10/17/24 signed that they were educated on elopement, how to manage elopement risks, etc. Several staff were identified that had worked the evening/night shift that had not signed as having received education. Also identified was a certified nursing assistant (CNA #4) who was currently working who had not signed as having received education. CNA #4 was interviewed and confirmed she had not received any education. A sample of staff across all departments to include therapy, housekeeping, laundry, nursing and dietary were interviewed to ensure that they received training and understood elopement risk, how to respond in the event of a missing resident, and how to respond if the wander guard alarm sounds, etc. On 10/18/24 at 10 a.m., the administrator was asked to come to the conference room. When shown the staff that that had not signed as being educated, the administrator provided additional sign-in sheets that the survey team had not been given. The survey team was able to identify that all staff currently working and who had worked since 6:30 pm on 10/17/24 had received training except for CNA #4. On 10/18/24 at 10:10 a.m., the facility administrator was made aware the survey team had found that a staff member had not been educated. The administrator was notified that the survey team could not verify abatement of IJ until CNA #4 was trained. On 10/18/24 at 10:20 a.m., the facility administrator provided evidence that CNA #4 had been educated. On 10/18/24 at 10:20 a.m., the survey team was able to confirm that the immediacy had been removed. Following the removal of immediate jeopardy the scope and severity was lowered to a level three, isolated, as R113 suffered pain following the elopement incident and fall. No more information was provided.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 49456 Based on observation, staff interviews, resident interviews, clinical record reviews and facility documentation the facility staff failed to ensure residents received the appropriate treatment and services for incontinence of bowel and bladder for two residents (resident #20 and resident #21) in a survey sample of 28 residents. The findings included: 1. The facility staff failed to provide incontinence care in a timely manner for Resident #20 (R20). On 8/2/24 at approximately 1:30 p.m., an observation was conducted of facility staff providing incontinence care to R20. CNA#4 (CNA4), CNA#13 (CNA13) and CNA#14 (CNA14) was in R20's room to provide afternoon incontinence care to the resident. This surveyor observed feces and urine on the sheet and incontinent pad under the resident from R21's shoulders to her knees. There was a strong smell of ammonia and odor from the bowel movement. The brief was saturated, and urine and feces had leaked out of the incontinence brief onto the incontinent pad under the resident and the bed sheets. The CNA's had to change the linen on the entire bed. The surveyor questioned when the last time incontinence care was had been given and the CNAs did not answer the question. An interview was conducted with the unit manager, LPN2 on 8/6/24 at 9:07 a.m. LPN2 said that incontinence care should be done every two hours and as needed. An interview was conducted with CNA7 on 8/6/24 at 9:16 a.m. CNA7 said that incontinence care should be done every two hours and as needed and that I just assist the aides with incontinence care and give feeding assistance if needed. A clinical record review was conducted on 8/6/24. The review included R20's care plan and minimum data set, an assessment, which indicated the resident needed assistance with all her activities of daily living, was incontinent of bowel and bladder and needed two people assist with daily care. 2. The facility staff failed to provide incontinence care in a timely manner for Resident #21 (R21). An observation was made of R21 in her room eating her lunch meal on 8/2/24 at 2:00 p.m. The surveyors observed a puddle of liquid under the wheelchair. R21's pants were wet on the front and back from the waist to the knees. R21's roommate had visitor in the room and the surveyor observed the visitor spraying Lysol around R20's wheelchair and saying how horrible the ammonia odor was in the room. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The unit manager on unit two, licensed practical nurse LPN#2 (LPN2) was made aware of the situation by the surveyor and LPN#2 responded and went to R21's room. LPN2 entered R21's room and stated, oh my god this is unacceptable. LPN2 removed the lunch tray and stated she was going to get some assistance and take R21 to the shower room. Then certified nursing assistant, CNA#7 (CNA7) came to the room to assist with R21's incontinence care and was shaking her head and CNA7 stated, this is awful. LPN2 and CNA7 assisted R21 to the shower room and when she was assisted out of the wheelchair, R21's wheelchair seat was saturated and smelled like ammonia. An interview was conducted with CNA#5 (CNA5) and CNA#3 (CNA3) on 8/2/24 at 2:04 p.m. the only CNAs on the unit for this shift. They said that they gave R21 a shower early that morning around 8:00 a.m. and had not been back to R21 since then. CNA #5 said, It is just the two of us and we are doing the best that we can. An interview was conducted with the unit manager, LPN2 on 8/6/24 at 9:07 a.m. LPN2 said that incontinence care should be done every two hours and as needed. An interview was conducted with CNA7 on 8/6/24 at 9:16 a.m. CNA7 said that incontinence care should be done every two hours and as needed and said, I just assist the aides with incontinence care and give feeding assistance if needed. A clinical record review was conducted on 8/6/24. The record indicated R20 required assistance with all her activities of daily living, was incontinent of bowel and bladder and needed two people assist with transfers. An end of the day meeting was held on 8/6/24 at 4:15 p.m., the above concerns were discussed with the regional director of clinical services and facility consultant. A review of a policy titled, Activities of Daily Living, read in part, .provide oversight, cuing and assistance as necessary. ADL's [activities of daily living] includes bathing, dressing, grooming, hygiene, toileting and eating. No new information was provided prior to exit conference.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49456 Based on observation, staff interviews and facility documentation review, the facility staff failed to have sufficient nursing staff to provide nursing and related services to multiple residents on 1 of 2 units. The findings included: The facility staff failed to have adequate nurse staffing to provide for resident care on 1 of 2 nursing units. On 10/17/24 at 4:15 p.m. an observation was completed on unit 2 nursing unit. When the surveyor entered the unit there were two nurses at the nurse's station and they were the only staff observed on the unit at that time. There were 4 call bells (rooms 223, 238, 241 and 410) sounding and a family member was standing at the nurse's station. The family member needed assistance, and the surveyor was unable to find any staff on the unit that could assist the family member, and the two nurses were no longer on the unit. The surveyor started toward the front offices to get assistance, and the regional traveling director of nursing was coming toward the unit, so she assisted the family member. The 4 call bells observed to still be sounding. Visitors were observed exiting room [ROOM NUMBER] and were heard telling the resident, I hope you get some help soon. rooms [ROOM NUMBERS] call bells were answered at 4:39 p.m. and 4:40 p.m. room [ROOM NUMBER] and 410's call bell was answered at 4:45 p.m. On 10/17/24 at 4:30 p.m. an interview was conducted with the CNA #7 (CNA7). CNA7 was at the nurse's station and was asked about staffing on the unit and she said she was on Unit 2 by herself at that time. On 10/17/24 at 4:35 p.m. the supply clerk, CNA # 8 came up to the nurse's station and stated, I am here to help out. On 10/17/24 at 4:45 p.m. the regional director of clinical services and the director of nursing confirmed that the unit 2 had only one aide at this time. Then the regional director of clinical services stated, here comes CNA5 [CNA's name redacted] back from lunch break now, so we have 2 aides now. On 10/17/24 at 5:00 p.m. an interview was conducted with other staff #3 (OS3), who does scheduling. OS3 stated, the unit manager asked another aide to stay over until 6:00 p.m. and OS3 did not know where she was while all the call bells were on and why she was not on the unit. On 10/17/24 a review of the nursing schedule was conducted. Unit 2 had only one aide scheduled from 3:00 p.m. until 7:00 pm. On 10/17/24 an end of day meeting was conducted with the administrator and corporate staff. The above concerns were discussed. No more information was provided.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 49456 Based on staff interviews and facility documentation the facility staff failed to complete a yearly performance review for one staff member (Certified nursing assistant, CNA #15) in a sample of eight staff records reviewed. The findings included: The facility staff failed to conduct a yearly performance review for one certified nursing assistant, CNA#15 (CNA15). A review of CNA15 personnel record was conducted on 8/5/24. According to the file, CNA15 was hired on 11/16/21. There was a performance review in the file dated 7/21/22. There were no other performance reviews within the personnel file. An interview was conducted with the Human Resource Coordinator on 8/5/24 at 4:41 p.m. The human resource coordinator stated that performance evaluations were printed and given to the supervisors to do for the month. She stated, we have 90-day evaluations and annual evaluations, and the annual evaluations are due one week prior to the anniversary date or one week after the anniversary date but no earlier or later. A facility document review was conducted on 8/5/24. A policy titled, Employee job performance evaluations, and read in part, .Performance evaluations are to be conducted before the completion of the introductory period and annually thereafter. The anniversary of your start date is the date you should receive your formal review and performance evaluation, unless a job change has taken place. A facility document review was conducted on 8/5/24. An employee guidebook was reviewed and, in the section, performance evaluations, it read in part, .following your 90-day introductory period and on the anniversary of your start date, or your promotion date, you should receive your formal reviews and performance evaluations unless a job change has taken place. An interview with the human resource coordinator was conducted on 8/6/24 at 8:39 a.m. The human resource coordinator verified that CNA15's hire date was 11/16/21 and she was still employed as an aide at the facility. An end of the day meeting was held on 8/6/24 at 4:15 p.m. to discuss the above concern, with the regional director of clinical services and a facility consultant to discuss the above concerns. No additional information was provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41449 49456 Based on observation, resident interview, staff interviews, facility documentation review, and clinical record review, the facility staff failed to assure that medications were secure and inaccessible to unauthorized staff and residents, for four residents (Resident # 16 (R16), Resident # 17 (R17), Resident # 18 (R18), and Resident # 19 (R19)) in a survey sample of 28 residents. The findings included: 1. For Resident R16, who had medications stored in their room, the facility staff failed to remove and secure the medications. On 7/30/24 in the afternoon, an interview was conducted with R16. During the interview R16 said, I use my nose spray every morning and eye drops when my eyes are dry. An interview was conducted with unit manager on unit 2, LPN# 2 (LPN2) on 7/31/24 at 10:05 a.m. During the interview LPN2 stated that medications are to be stored in the medication cart unless the medications need to be in the refrigerator, then the medication is stored in the medication room. LPN2 said, No medicine should be at bedside. LPN2 stated that nursing staff is aware residents should not have medication at bedside and if seen in the room the medication should be removed. Following the above interview, LPN2 accompanied the surveyor to R16's room and confirmed the medications at the bedside. LPN2 stated that R16's family brought the medication into the room but said, I would expect my staff to look around when in the room and remove the medications from the residents' rooms. A review of the clinical record was conducted on 8/6/24. The physician orders were reviewed and R16 had no orders for medications to be kept at the bedside or to self-medicate. Neither was an assessment of R16's ability for safe self-administration of medications found. 2. For Resident R17, who had medications stored at the bedside, the facility staff failed to remove the unsecured medications. On 7/30/24 at 4 p.m., during a facility tour, R17's room was observed with Flonase nasal spray on the overbed table. A review of the clinical record was conducted on 8/6/24. R17's care plan was reviewed, and the care plan was for the nurses to administer R17's medications. The physician orders were reviewed and R17 had no orders for medications to be stored at the bedside or to self-medicate. No assessment of the R17's ability to self-medicate safely was found. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. For Resident R18, who had medications stored in his room, the facility staff failed to remove and store the medications appropriately. On 7/30/24 at 4 p.m., during a facility tour R18's room was observed with 2 bottles of dermal wound cleanser, zinc oxide paste in a prescription container with the top of the label torn off, and antifungal powder at the bedside, all unsecured. On 7/31/24 at 10:05 a.m., an interview was conducted with the unit manager, LPN2. LPN2 stated that R18 was out of the facility at the moment and would be back in a little while. LPN2 removed the medication off the bedside table. LPN2 said, I don't know why these were left in the room. They should be on the treatment cart. A review of the clinical record was conducted on 8/6/24. R18's care plan was reviewed, and the care plan was noted for the nurses to administer R18's medications. The physician orders were reviewed and R18 had no orders for medications may be kept at bedside or to self-medicate. No assessment of the R18's ability to self-medicate safely was found. 4. For Resident R19, who had medications stored in his room, the facility staff failed to remove the unsecured medications from R19's room. On 7/30/24 at 4 p.m., a tour of the facility's nursing units was conducted. During the tour, R19's room was observed with saline mist spray and Aquaphor ointment. An interview was conducted with R19 about the medications at his bedside on 7/30/24, following the observation of medications from the hallway. R19 stated, They brought it in here and told me to use it when I needed it for my stuffy nose. I use the ointment on my dry areas on my face and hands every day. On 7/31/24 at 10:05 a.m., an interview was conducted with unit manager on unit 2, LPN# 2 (LPN2). During the interview LPN2 stated that medications are stored in the cart unless the medications need to be refrigerated, then the medication is stored in the medication room. LPN2 said, No medicine should be at bedside. LPN2 stated that nursing staff is aware residents should not have medication at bedside and if seen in the room the medication should be removed. On 8/6/24 a review of R19's clinical record was conducted. The physician orders were reviewed and revealed that R19 had no orders that medications may be kept at bedside or for self-administrations of medications. No assessment of R19's ability to safely self-medicate was found. A review of facility documentation was conducted. A policy titled, Medication and Medication Supply Storage and Disposal, reads in part, .meds will be kept in a medication cart that locks and keys are only accessible to the licensed personnel distributing medications. An end of day meeting was held on 8/2/24 with the administrator, the director of nursing, the medical record coordinator and the social worker and they were made aware of the above concerns. No further information was provided.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 49456 Based on observation, staff interviews, clinical records and facility documents the facility staff failed to provide therapeutic diets for two residents, Resident # 1 (R1) and Resident #2 (R2) in a survey sample of 28 residents. The findings included: 1. The facility staff failed to ensure R1 received fortified foods and large portions with his meal as ordered. An observation was made on 7/30/24 at 4:30 p.m. in the main kitchen during plating of evening meal. During the plating of R1's meal for dinner it was observed that the meal ticket noted fortified foods and large portions. The dietary manager, OS #1 (OS1) was plating the food and prepared R1's plate with regular portions of the meal and no fortified food was observed on his meal tray. R1's meal ticket read, Regular Dysphagia Advanced Fortified Foods and Large portions. On 7/30/24 at approximately 5:10 p.m., an observation was made of R1's meal tray once it had been delivered to the resident. There was no change to the tray/meal provided to the resident from what was observed when prepared in the kitchen, no large portions or fortified foods were provided. On 7/30/24 at 5:18 p.m., an interview was conducted with certified nursing assistant (CNA) #16, who observed R1's meal tray and confirmed that the portion size was the same as every other resident she served the meal to and was not large portions. A clinical record review was conducted on 7/31/24. R1's care plan was reviewed and had that a therapeutic diet was ordered, and interventions included but were not limited to provide and serve diet and supplements as ordered. According to the physician orders R1 had an order for fortified foods. According to the recommendations of the registered dietician, R1 was to receive large portions. An interview was conducted with the dietary manager on 7/31/24 at 10:45 a.m. The dietary manager stated that R1 did not get large portions or fortified foods with his meal on the evening of 7/30/24. The dietary manager said, it's separate potatoes for fortified foods and I didn't serve those. The dietary manager stated that large portions was one and a half servings of the protein entree of the meal. The dietary manager stated the fortified foods have extra butter and milk added to the mashed potatoes and are separate from the regular mashed potatoes on the serving line. An interview was conducted with the regional dietary consultant, (OS#2) on 8/6/24 at 4:30 p.m. The regional dietary consultant stated large portions was for the entire meal and each food served unless specified to be only the entree. She stated that large portions were a scoop and a half of each food item, and the entree was one and a half servings. A review of facility documentation was conducted. The policy titled, Therapeutic Diets, read in part, .The purpose of a therapeutic diet is to eliminate or decrease specific nutrients in the diet or to increase specific nutrients in the diet. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The facility staff failed to ensure R2 received large portions with his meal as ordered. An observation was made on 7/30/24 at 4:30 p.m. in the main kitchen during plating of the dinnertime meal. During the plating of R1's meal for dinner the meal ticket indicated fortified foods and large portions. The dietary manager, OS #1 (OS1) was plating the food and served R2 regular portions of the meal. R2's meal ticket read, large portions, No Red Sauce with meals. On 7/30/24 at 5:09 p.m., the meal trays arrived at the nursing unit and were distributed to residents. Following R2 being served the meal, it was noted that it did not contain large portions. CNA #16 was asked to observe R2's food and confirmed the portion size was the same as what every other resident received, whose food she had served. A clinical record review was conducted on 7/31/24. R2's care plan was reviewed and had to provide and serve diet as ordered. According to the physician orders, R2 was to receive large portions with meals. An interview was conducted with the dietary manager on 7/31/24 at 10:45 a.m. The dietary manager stated that R2 did not get large portions with his meal on 7/30/24. The dietary manager stated that large portions was one and a half serving of the protein entree of the meal. An interview was conducted with the regional dietary consultant, (OS#2) on 8/6/24 at 4:30 p.m. The regional dietary consultant stated large portions was for the entire meal unless specified to be only the entree. She stated that large portions were a scoop and a half of each food item, and the entree was one and a half servings. A review of facility documentation was conducted. The policy titled, Therapeutic Diets, read in part, .The purpose of a therapeutic diet is to eliminate or decrease specific nutrients in the diet or to increase specific nutrients in the diet. On 7/31/24, during an end of day meeting, the facility administrator and director of nursing were made aware of the above findings. No further information was provided prior to exit.

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F 0835 Level of Harm - 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** 41449 Based on resident interviews, staff interviews, and facility documentation review, the facility staff failed to administer the facility in a manner that enables residents to attain or maintain their highest practicable psychosocial well-being and be free from sexual harassment and abuse by a male resident who was targeting female residents, which had the potential to affect the 59 female residents residing on 2 of 2 nursing units, and caused psychosocial harm to residents. The findings included: The facility administrator, who had knowlege of or should have been aware, failed to respond and implement interventions in response to several instances where a male resident (resident #10- R10), was displaying inappropriate sexual behaviors and sexually harassing multiple female residents and staff, to stop the abuse and harassment, which resulted in psychosocial harm for four residents. On 7/30/24, during a survey entrance conference, the facility administrator identified himself as the interim administrator and reported he had been at the facility for a few months. On 7/31/24, the survey team was made aware of an allegation of multiple residents being sexually abused and several residents were identified as having been affected. The survey team began interviewing residents. On 7/31/24 at 3:20 p.m., an interview was conducted with resident #7- R7. R7 told the surveyor of a prior incident that occurred at the vending machine involving resident #10 (R10) talking about sex and saying that my belly button is pushed out because a 250-pound lady was on top of me ., that made her very uncomfortable. R7 reported she returned to her room, turned the lights off and got in bed. R7 reported someone came in and didn't say anything, then a voice said I will talk to you tomorrow. R7 reported it was R10 and she has stayed away from him since then as R10 talks very nasty and disgusting, he always begins the conversation with I still like sex. R7 reported she told her daughter and the daughter talked with social services. R7 went on to say, I had a sign on my door that said stop, but it is gone. R7 reported that she rarely comes of out her room, because she wants to stay away from Resident #10. R7 reported, she didn't realize how much R10's behaviors bothered her until she realized she rarely leaves her room now. On 7/31/24 at 2:50 p.m., an interview was conducted with Resident #9 (R9). R9 was asked about if any residents had bothered her and she said, oh no, they would have a bloody nose and 2 black eyes. On 7/31/24 at 2:55 p.m., an interview was conducted with R9's roommate, resident #15 (R15). R15 reported that R9 was not telling the truth during the interview with the surveyor and said R9's boyfriend put a [NAME] on her neck. R15 went on to say that R9 has had her hand on R10's penis while he stands beside the bed and kisses her. R15 reported, the curtain wasn't pulled, and I don't want to see that mess. (continued on next page)

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	495336	A. Building B. Wing	08/06/2024

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Augusta Nursing & Rehab Center	83 Crossroads Lane Fishersville, VA 22939

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F 0835 Level of Harm - Actual harm Residents Affected - Some	On 7/31/24 at 4:49 p.m., an interview was conducted with resident #10 (R10). R10 was asked about his relationship with the female residents within the facility. R10 said, [referring to R9] she thought we were married. She was going to fly me to a retreat. We are friends and we get involved and live out her fantasies. [facility administrator's name redacted] had talked to me. R10 was asked about sexual activity and confirmed he had put a [NAME] on R9's neck. When asked if anything more had occurred, R10 said, she's bipolar and she's not going to tell you, and neither am I. They can't prove it. R10 was asked about the other women within the facility, and he called R12 by name and said, she is bipolar too, we enjoy spending time together. R10 reported that the first time I got in trouble was about an aide. On 8/1/24 at 9 a.m., a follow-up interview was conducted with R7, in her room. R7 again talked about R10 saying he was still capable of having sex. R7 reported she froze in one spot and didn't know what to do. I went to my room, he wanted to walk to my room. I was uncomfortable, scared and didn't know what to do. He said he got in trouble . I stay in my room more and don't want to go out. He has something going on with the resident in [R12's room number redacted], he is on the unit a lot. I don't go out as much, I don't like running into him. I was scared the night he came into the room in the dark. I am very uncomfortable to even pass him in the hall. On 8/1/24 at 9:05 a.m., R9 was visited in her room by the surveyor again. R9 had a rose in a cup by the bedside and when asked about it, R9 said, my boyfriend gave it to me. When asked who her boyfriend was R9 said R10's name. R9 went on to say, we are supposed to get married today. Did you know I am a princess of Allett, a country off Spain? My Mom and Dad are Queen and King When asked about a [NAME], R9 said, yes and admitted that R10 had given her a [NAME]. When asked if they had done anything sexual, R9 said, no, that's for marriage, and we are getting married today. On 8/1/24 at 9:16 a.m., an interview was conducted again with R9's roommate, R15. R15 said, Mr. [R10's name redacted] gave her a [NAME]. R15 went on to talk about R10 is putting his tongue down her [R9]'s throat. When asked if anything sexual has occurred R15 said, yes, I saw it, he walked over to her bed and she had her right hand on him, his penis, but [CNA #4's name redacted] got him out. I don't want to see that stuff, but they don't even pull the curtain. On 8/1/24 at 9:30 a.m., an interview was conducted with resident #14- R14. R14 said, I know who [resident #10's name redacted] is, and he has tried to have every lady here. [Resident #12's name redacted] and R10 hang out all day long together. He feeds her certain things. He tells [R12's name redacted] he loves her . On 8/1/24 at 10 a.m., an interview was conducted with R12. R12 said, [R10's name redacted] we are friends I thought, until last night. Another woman came around in the library, it went too far with his [R10] personal behavior. His nasty talking, I felt very uncomfortable. There are things I don't tolerate with my friends. [R13's name redacted] felt very uncomfortable. I don't want to be around him. I won't be making any attempt to see him anymore, things he was doing and talking provocative, talking about sex. I have had a stroke and common sense doesn't kick in all the time. I am nervous talking about it. During the interview, R12's hands were noted to be shaking. (continued on next page)

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F 0835 Level of Harm - Actual harm Residents Affected - Some	On 8/1/24 at 10:11 a.m., an interview was conducted with resident #13- R13. R13 said, he [referring to R10] has a filthy mouth. My husband didn't like what he was saying. He would tell women, I want to eat her p#$$y. He said he put a [NAME] on one woman's neck. I don't go down there [to the library] anymore. He always talks dirty talk and I tell him to shut up, don't nobody want to hear that. He keeps on and I leave because of it. I don't stay and my husband told me to stay away from him. On 8/1/24 at 10:18 a.m., an interview was conducted with resident #8 (R8). R8 was asked about R10. R8 said, he is not a person you want to be around. I avoid him. He has a foul mouth. I get on him about it, so he does better with me than others. He will say he loves me. He discusses what he likes to do to women, says he likes older women's stuff and wants to have sex. He doesn't know how to talk to women and thinks he is God's gift to women. I avoid him, he makes me uncomfortable. If he passes me in the hall he tries to grab my hand, but I pull away. I go outside more to get away from him, because he doesn't go outside. He doesn't see anything wrong with sticking his tongue down [resident #9's name redacted] throat. He put a [NAME] on her neck, he so called got married to her. He really does think all women are crazy about him. I tell him he is going to end up getting kicked out of here, he says he probably will but says that's who he is. During the interview R8 was noted to be anxious and was constantly fidgeting with a snack on her over bed table. When R8 stopped talking about R10, she was noted to calm down and not be fidgety. On 8/1/24 at 4:20 p.m., resident #12 was observed in the common area room on the unit crying. Resident #7 reported to the surveyor that Resident #10 was pressuring her to have sex. On 8/1/24 at approximately 4:25 p.m., Resident #12 was interviewed and said, we [referring to her and resident #10] argued last night. I am scared. I don't want to have sex and he is wanting to have sex. Facility staff were interviewed, and those interviews are as follows: On 7/31/24 at 2:55 p.m., an interview was conducted with certified nursing assistant (CNA) #11. CNA #11 reported that she has seen R10 at the doorway of R9's room. CNA #11 reported R9 did have a [NAME] on her neck the end of June or early July. When asked if she was aware of any instances where R10 and R9 were having any sexual activity, CNA #11 said, I was here the day it happened, but I didn't' see it, I heard about it. CNA #11 went on to say, R9 said [activity director's name redacted] married them. She will ask if I got the mustang she bought me, her mind isn't exactly right. On 7/31/24 at 2:58 p.m., an interview was conducted with CNA #6. CNA #6 said, I heard about her touching his penis about a month or month and a half ago, but I haven't seen it. I heard about the [NAME]. I've seen them holding hands. CNA #6 was asked if anyone in management was aware and she said, someone made them aware, and I don't know how they handled it. We had some Inservice about we no longer have to separate residents who want to have sex. She [R9] is aware but has some confusion. She is a little off, she talks about having to go pick up her baby and stuff. (continued on next page)

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F 0835 Level of Harm - Actual harm Residents Affected - Some	On 7/31/24 at 3 p.m., an interview was conducted with LPN #3, the unit manager where R9 and R10 reside. When asked about R9's cognitive skills, LPN #3 said, with everyday stuff she seems ok, she can request food, drink, pain meds, etc. But she does have delusions, she owns jets, corvettes, etc. When asked if she was aware of any sexual activity between R9 and R10, LPN #3 said, There has been quite a bit of hearsay about that. I don't know if anyone saw it. He [R10] can be verbally inappropriate. He does like the ladies, but I've never caught him being inappropriate. When asked if she had any knowledge of R9 having a [NAME], LPN #3 said, yes, they spoke to the daughter [R9's daughter] and she made it very clear she wanted him to be able to visit her mom. She said she knew her Mom had a [NAME], and it didn't bother her. LPN #3 went on to talk about how R9 reports she married R10 and when she sees other women walk by, R9 will accuse R10 of sleeping with them. When asked if administration was aware of the [NAME] and the allegation of R9 having R10's penis in her hand, LPN #3 said, Administration is aware, they said they had an incident at [sister facility's name redacted] and that people who are capable of having relations its ok and we may think it is inappropriate. LPN #3 went on to talk about R9's delusions and how R9 says she has brought the staff cars, is sending them on elaborate vacations, etc. LPN #3 said, I've looked, and she doesn't have any diagnosis for the delusions, but she has always had them, I don't know if they haven't spent enough time with her to notice or what, but something is off [cognitively]. On 8/1/24 at 8:55 a.m., an interview was conducted with certified nursing assistant (CNA) #12. CNA #12 was asked about R10 and R9. CNA #12 reported, he [referring to R10] is a socializer, he rolls around all over the place all day. I've seen him stop at [R9's name redacted] room, stop and wave but I've never seen him in there. When asked about R9 having a [NAME], CNA #12 said, I saw the [NAME], but I didn't know he did it. When asked about any sexual activity, CNA #12 said, I heard about the penis incident weeks ago, but I don't know who saw it . One day she [R9] was crying, she said she wanted to marry him and was upset . He [R10] used to stop at [another resident's name redacted] door but she started closing her door, so now he just goes on. He bothers a lot of people honestly. On 8/1/24 at 9:25 a.m., an interview was conducted with licensed practical nurse (LPN) #1. LPN #1 was asked about R10. LPN #1 said, there are a couple of ladies that do not want him in their room. They don't like the way he talks. LPN #1 went on to say, [Resident #15's name redacted] says he and [Resident #9's name redacted] kiss and the ladies in room [room number redacted] they don't like him, they say they get a bad feeling from him. LPN #1 identified resident #13 (R13) and said, she is friends with him, but I've never seen anything inappropriate. Last week [CNA #4's name redacted] saw her [R9] with his penis in her hand. Maybe Sunday. I went and talked to Ms. [R15's name redacted], she said she didn't want him in her room. The nurse went down and told him and told him, if he went in that room he would be removed. She [R15] said she didn't want to see what they do, that incident [where R9 had R10's penis in her hand] is why she doesn't want him in there. During the above interview with LPN #1, she was asked about R9's cognitive ability. LPN #1 said, she says she has had 3 babies, and we stole them, she has an airplane, I don't believe she is mentally capable, but they [management] say she has a BIMS [brief interview for mental status] of 15. He [R10] said this morning he has a lady over on the 400 unit, that he likes but her daughter doesn't like him. (continued on next page)

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F 0835 Level of Harm - Actual harm Residents Affected - Some	On 8/1/24 at 9:48 a.m., an interview was conducted with CNA #4. CNA #4 reported she has seen R10 with his hands down her [R9's] pants fondling her. He has been caught jacking off. On Thursday at 2:15 p.m., he was standing up, had his penis out jacking off while kissing her. I told the nurses, and they went down but he had finished. It's been reported, we have all been telling it, but they don't listen to us. He thinks he can do it to all the ladies. He's been doing it to the residents on the down low and we didn't know it. He told me, in the hall in front of the women, old ladies are good in bed, elderly ladies have the best p#$$y. This lady [R9], her mind is not right, she is going to buy me a car, owns this place, the nurses say the daughter can say its ok. I don't understand these people. We are telling the nurses, and no one acknowledges us. They say her daughter knows. [The unit manger's name redacted] knows. One time he had his hand in her diaper, and he was kissing her, just last week. I've seen him in the back hall near laundry and he was talking stuff to them [the staff], he goes to unit 2. [Resident #26's name redacted] says to close her door from that pervert just a few days ago. [R13's name redacted] tells me she doesn't like him, he's a pervert. Please help us, help these residents, it's not right what he is doing, they know and won't do nothing. On 8/1/24 at 10:46 a.m., an interview was conducted with the facility administrator and director of nursing (DON). When asked about R10, the DON said, [R10's name redacted] been here a while. He is very polite and respectful to me. I've seen nothing. I've heard rumors. I tell people I don't go by rumors and gossip, you put it in black and white and I will listen. When asked what rumors she has heard, the DON said, that with female residents doing sexual things to them and making sexual comments, it was consensual. Yesterday he was touching a lady, it was a big whoa. He has his hands between her legs, it was gossip, that's the talk. He had his hands between a lady with the last name beginning with the letter [letter redacted], in the dining room, but they never put it in writing. That's the protocol, I tell them I do not go by gossip or hearsay and I'm not going to until they put it in writing in black and white. If they saw something inappropriate, they have to put it in writing. The DON was asked if this was the case for all allegations, they must be put in writing, she said yes. During the above interview, the administrator stated, yesterday I went into the library to read and [R10's name redacted] was in there and everything was kosher. The administrator went on to say that R10 had written a note to one of the students that he wanted to meet them after graduation, and she felt uncomfortable. I brought him in the office and in general showed him the note and explained that when people are uncomfortable, they can call the cops and if they feel threatened, they can go further. He said he won't ever do it again. He is as 2 faced as they come. He knew he had done wrong, he listened to what I said, it may have lasted 5 minutes. It was about 2-3 weeks ago. I haven't heard anything else about it. The administrator went on to say, our old social worker wanted me to give him a 30-day discharge, because they were thinking it was about to be a pattern and wanted me to react, but I've never put people out in all my years. The administrator was asked if he knew R9 had a [NAME] on her neck. The administrator said, I heard about it this morning. I didn't know she had a [NAME]. The DON went on to say, I called my regional DON, and she said no, you cannot, 1st let's do a medication review. I let [medical nurse practitioner's name redacted] and [psychiatric nurse practitioner's name redacted] know for a medication review, because I know some antidepressants can help curb sexual tendances. When asked about R9 having a [NAME], the DON said, I interviewed [R9's name redacted], her BIMS is 13-15 so I dropped it, it was consensual, she was very excited about it. Her daughter is aware and approves. It was a bruise of unknown origin and the nurse put a note in the chart and me and [name of medical records coordinator redacted]. (continued on next page)

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F 0835 Level of Harm - Actual harm Residents Affected - Some	On 8/1/24 at 10:46 a.m., the administrator and DON were made aware of the above interviews and that R7, R8, R12, R13, and R15 reporting being scared and changing their daily routine because of R10's behaviors. The DON said, I didn't know residents are scared of him or afraid to come out of their room. The administrator said, I'm just hearing about this. After talking with him the other week, his brother came in and I told him about it, and he said he tells him all the time he is not God's gift to women. The administrator reported he had no documentation or credible evidence to provide the survey team with regards to the conversation he had with R10. The facility administrator was asked to provide the survey team with the minutes from their morning meetings and the 24-hour report for the past 3 months. On the afternoon of 8/1/24, the administrator reported to the survey team that he had not keep the notes from the daily department managers meeting and only had the notes available for the current week. The 24-hour reports were reviewed with no mention of R10's above noted behaviors or interactions with any residents. The administrator explained that he conducts the morning meeting each day and grievances, the 24-hour report and anything going on within the facility is discussed. On 8/1/24 in the afternoon, LPN #3 who was the unit manager, assisted the surveyor with locating the communication book used to communicate issues to the providers. The medical nurse practitioner had the medical communication book. LPN #3 provided the surveyor with a copy of the psychiatric communication form where on 7/17/24, she made an entry at the direction of the director of nursing and it read, [R10's name redacted] increased sexuality. LPN #3 said she put the same entry in the book for the medical provider. The surveyor reviewed the medical provider's communication book, but the previous pages had been removed and were not available. On 8/2/24 at 8:45 a.m., the facility staff had failed to provide the survey team with any evidence that the resident's reports and allegations of misconduct by R10 had been investigated, reported or acted upon. The survey team identified the facility was in immediate jeopardy in the areas of Abuse and Quality of Life on 8/2/24 at 8:50 a.m. On the afternoon of 8/2/24, the director of nursing provided the survey team with a Witness Statement. The statement read, myself and [name of medical records coordinator redacted] spoke with resident [R9's name redacted] regarding concerns of a bruise on right side of neck. [R9's name redated] stated it was a [NAME] from [R10's name redacted] and they had gotten married over the weekend. She was asked if she wanted this and if it feels good, it feels good, stated by [R9's name redacted]. She was smiling and in no distress noted. Asked if [R10's name redacted] did anything to you that you did not want him to do to you, her reply was no, don't worry about him, I can handle him. The statement was signed by the Director of Nursing and medical records coordinator and dated 6/24/24. According to a clinical record review, R9's most recent brief interview for mental status (BIMS) assessment conducted prior to the incident was dated 6/14/24, and R9 scored a 12, which noted moderately impaired cognitive skills. There was no evidence of any further assessment(s) being conducted. On 8/5/24 at 4:32 p.m., during a telephone interview with the director of nursing (DON), the DON reported that one day she was talking to R7's daughter in the hallway and the social worker asked the DON to step into the office. The DON said the social worker reported the incident where R10 went into R7's room. The DON said, I went to put the stop sign across her door and she denied that he had been back. I asked the resident and her daughter about the stop sign, and both agreed. I put it in place immediately. I wrote up a grievance and gave it to [previous social worker's name redacted]. [R7's name redacted] was assaulted at another facility, so this brought all that back for her. (continued on next page)

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F 0835 Level of Harm - Actual harm Residents Affected - Some	During the above interview on 8/6/24 at 9:06 a.m., with the facility administrator, when asked, as the abuse coordinator should you have known what was going on in your building? The administrator said, I depended on the DON to follow through on it all as we discussed it. When asked if he had a role in it, since he was the abuse coordinator, the administrator said, I've had oversight, and they would talk to me about it. I would ask a lot of questions. On 8/6/24 at 9:30 a.m., the facility's corporate staff and consultant were made aware of the above findings. They said, we deserve everything we get in this 2567 [survey report], rightfully so. We will fix it and we will suspend both of them [the administrator and DON]. A review of the facility provided document that was the job description of the Executive Director 1 (Administrator), was conducted. The document read in part, . The primary purpose of the Executive Director is to direct the day-to-day functioning of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern nursing facilities to ensure that the highest degree of quality care can be provided to our residents at all times . You will also provide leadership to all facility staff in meeting the goal of providing quality resident care . The facility policy titled, Abuse, Neglect, Exploitation & Misappropriation, was reviewed. The facility read in part, . Once an allegation of abuse if reported, the Executive Director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations, including notification of Law Enforcement if a responsible suspicion of crime has occurred . The Abuse Coordinator will endeavor to protect the rights of resident and employees . No additional information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Augusta Nursing & Rehab Center	83 Crossroads Lane Fishersville, VA 22939

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on resident interview, staff interview, and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for one resident (Resident #9) in a survey sample of 28 residents. The findings included: For Resident #9 (R9), the facility staff failed to maintain a complete and accurate clinical record to include documentation with regards to R9 having a [NAME] on her neck which was from another resident. On 7/31/24 at 2:55 p.m., an interview was conducted with R9's roommate, resident #15 (R15). R15 reported that R9's boyfriend put a [NAME] on her neck. On 7/31/24 at 4:49 p.m., an interview was conducted with resident #10 (R10). R10 was asked about his relationship with the female residents within the facility. R10 confirmed he had put a [NAME] on R9's neck. On 7/31/24 at 2:55 p.m., an interview was conducted with certified nursing assistant (CNA) #11. CNA #11 reported R9 did have a [NAME] on her neck the end of June or early July. On 7/31/24 at 2:58 p.m., an interview was conducted with CNA #6. CNA #6 said, I heard about the [NAME]. I've seen them holding hands. CNA #6 was asked if anyone in management was aware and she said, someone made them aware, and I don't know how they handled it On 7/31/24 at 3 p.m., an interview was conducted with LPN #3, the unit manager where R9 and R10 reside. When asked if she was aware of any sexual activity between R9 and R10, LPN #3 said, There was been quite a bit of hearsay about that. I don't know if anyone saw it. He [R10] can be verbally inappropriate. He does like the ladies, but I've never caught him being inappropriate. When asked if she had any knowledge of R9 having a [NAME], LPN #3 said, yes, they spoke to the daughter [R9's daughter] and she made it very clear she wanted him to be able to visit her mom. She said she knew her Mom had a [NAME], and it didn't bother her. On 8/1/24 at 8:55 a.m., an interview was conducted with certified nursing assistant (CNA) #12. CNA #12 was asked R9 having a [NAME], CNA #12 said, I saw the [NAME], but I didn't know he did it. On 8/1/24 at 9:05 a.m., R9 was visited in her room by the surveyor again. R9 had a rose in a cup by the bedside and when asked about it, R9 said, my boyfriend gave it to me. When asked who her boyfriend was R9 said R10's name. R9 went on to say, we are supposed to get married today. Did you know I am a princess of Allett, a country off Spain? My Mom and Dad are Queen and King When asked about a [NAME], R9 said, yes and admitted that R10 had given her a [NAME]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/24 at 9:16 a.m., an interview was conducted again with R9's roommate, R15. R15 said, Mr. [R10's name redacted] gave her a [NAME]. R15 went on to talk about R10 is putting his tongue down her [R9]'s throat. On 8/1/24 at 9:25 a.m., an interview was conducted with licensed practical nurse (LPN) #1. LPN #1 was asked about R10 & R9. LPN #1 said, Last week [CNA #4's name redacted] saw her [R9] with his penis in her hand. Maybe Sunday. I went and talked to Ms. [R15's name redacted], she said she didn't want him in her room. The nurse went down and told him and told him, if he went in that room he would be removed. She [R15] said she didn't want to see what they do, that incident [where R9 had R10's penis in her hand] is why she doesn't want him in there. On 8/1/24 at 9:48 a.m., an interview was conducted with CNA #4. CNA #4 reported she has seen R10 with his hands down her [R9's] pants fondling her. He has been caught jacking off. On Thursday at 2:15 p.m., he was standing up, had his penis out jacking off while kissing her. I told the nurses, and they went down there but he had finished. It's been reported, we have all been telling it, but they don't listen to us. On 8/1/24, a clinical record review was conducted of R9's chart. There was no documentation within the record of any interactions between R9 and R10. There was no documentation of the [NAME], nor of R10 being at the bedside masturbating. On 8/1/24 at approximately 1:30 p.m., an interview was conducted with the medical nurse practitioner (NP)/Other staff #3. When asked about R10's behaviors and interactions with R9, and the fact that R9 had a [NAME] on her neck. The NP said, it got brought to my attention Tuesday morning . On 8/1/24 at 4:33 p.m., a telephone interview was conducted with R9's daughter, who was listed as emergency contact. The daughter was asked about her knowledge of R9 and R10's relationship. The daughter said, I know they say they are boyfriend and girlfriend, and he visits her. My Mom is not right in the head, she thinks they are getting married. When asked if she was aware her mother had a [NAME] on her neck, she said, I was aware of that and I was kind of shocked by that. On the afternoon of 8/2/24, the director of nursing provided the survey team with a Witness Statement. The statement read, me and [name of medical records coordinator redacted] spoke with resident [R9's name redacted] regarding concerns of a bruise on right side of neck. [R9's name redated] stated it was a [NAME] from [R10's name redacted] and they had gotten married over the weekend. She was asked if she wanted this and if it feels good, it feels good, stated by [R9's name redacted]. She was smiling and in no distress noted. Asked if [R10's name redacted] did anything to you that you did not want him to do to you, her reply was no, don't worry about him, I can handle him. The statement was signed by the Director of Nursing and medical records coordinator and dated 6/24/24. The DON stated that a nurse had written a note about the [NAME] and it being a bruise of unknown origin. On 8/5/24 at 4:32 p.m., during a telephone interview with the director of nursing (DON), the DON was asked about the progress note entry in R9's chart, because the surveyor had been unable to find it. The DON confirmed she too had been unable to find any documentation with regards to it. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/6/24 at 9:06 a.m., an interview was conducted with the facility administrator. When asked about R9 having a [NAME], the administrator stated, I heard about it about an hour before we met on Thursday. When asked if he was aware that reports had been made that R10 was at R9's bedside pleasuring himself, the administrator said, I was told the day it happened, the roommate was in there. On 8/6/24, in the mid-morning, the facility's corporate staff and consultant were made aware that R9's clinical record had no documentation of the [NAME] or interactions between R9 and R10. They confirmed that they would have expected such to be a part of the clinical record and documentation. No further information was provided.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 49456 Based on staff interview and facility documentation review, the facility staff failed to provide employee QAPI training for six employees in a survey sample of eight employee records reviewed. The findings included: The facility failed to provide QAPI training to six of the eight employee's, who's personnel files were reviewed. An interview with the facility consultant and regional director of clinical services was conducted on 8/5/24. The interview was a discussion about the lack of training that was in the employee's files, and they said that they would look through and see what they would be able to find for proof of education but we have what we have, and the rest is missing, and we will do better going forward. A review of eight personnel files, RN#1,RN#3, LPN#1, CNA#15, CNA#17, CNA#18, CNA#19 and CNA#20 was conducted on 8/5/24. The employee personnel files reviewed had no QAPI training in eight of the personnel files, but the regional director of clinical services was able to locate proof of two employee's that had the QAPI training. A review of a facility documents was conducted, which included an orientation checklist which included a roadmap which contained the training which included QAPI and only two of the employees (RN#1 and CNA#20) reviewed had evidence of that training. An interview was conducted with the regional vice president of operations on 8/6/24 at 1:45 p.m. The regional vice president of operations stated that the importance for staff to be educated on the QAPI plan was because staff needed to know the process and system. She said that the floor staff was the eyes on the floor and able to see what needs to be address and bring it to QAPI. She gave an example of an aide that came to QAPI last year and brought to their attention about the Hoyer lifts not working properly and she stated that it was brought to QAPI three times until the issue was resolved. She said, QAPI training was the only way for the floor staff to know to let administration know so we have more insight with stuff on the floor. An end of the day meeting was held on 8/6/24 at 4:15 p.m. to discuss the above concerns was held with the regional director of clinical services and the facility consultant to discuss the above concerns. No new information was provided prior to exit.