STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525359	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Ridge Health Services	2730 W Ramsey Ave Milwaukee, WI 53221

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40533 Based on interview and record review, the facility did not thoroughly investigate 1 of 2 Facility Reported Incidents (FRI) reviewed for alleged abuse. R1 and R2 were found in R1's room and R2 was fondling R1's breasts. An investigation was opened and FRI submitted to the State Agency. The staff member who found the residents, Licensed Practical Nurse (LPN)-F, was not interviewed by the management preparing the investigation. No residents were interviewed to rule out the extent of R2's behavior or if others witnessed or had knowledge of potential inappropriate contact between R1 and R2. Findings include: Surveyor reviewed the facility's Abuse, Neglect and Exploitation policy with a revision date of 7/15/2022. Documented was: .V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when allegation or suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g not destroying evidence); 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation(s); 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation . (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1 was admitted to the facility on [DATE] with diagnoses that included Cerebral Atherosclerosis, Cognitive Communication Deficit, Anxiety and Symptoms and Signs Involving Cognitive Function and Awareness. Surveyor reviewed R1's MDS (Minimum Data Set) Assessment with an assessment reference date of 1/31/24. Documented under Cognition was a BIMS (brief interview mental status) score of 10 which indicated moderate cognitive impairment. R2 was admitted to the facility on [DATE] with diagnoses that included Orthostatic Hypotension, Dementia, Anxiety and Alcohol Induced Amnestic Disorder. Surveyor reviewed R2's MDS Assessment with an assessment reference date of 4/19/24. Documented under Cognition was a BIMS score of 10 which indicated moderate cognitive impairment. Surveyor reviewed the FRI submitted to the state agency on 4/25/24. Included with the Misconduct Incident Report was an Investigation Summary, Face Sheets for both residents, staff questionnaire sheets and Appendix 1 - Recommendations for Addressing Resident Relationships Intimacy & Sexuality History. Surveyor noted there were no interviews with other residents asking if R2 had any concerns with R2's behavior towards them or if they had witnessed any potentially inappropriate contact between R1 and R2. There were also no witness statements or an interview with LPN-F who witnessed the incident. Documented under Investigation Summary was: .Description of Incident: .On 4/20/2024, [LPN-F], was completing her rounds and observed [R2] in [R1's] room. [LPN-F] stated [R1] had her breasts exposed and [R2] was touching her breasts. She removed [R2] from [R1's] room and notified [Nursing Home Administrator (NHA)-A] immediately. Investigation protocol was initiated, and the investigation was started immediately . [Assistant Executive Director/Social Services Director (SSD)-C) and [Social Services Coordinator (SSC)-G] interviewed [R1] and [R2]. The State of Wisconsin's Board on Aging and Long-Term Care's presentation on Balancing Rights and Protection: Inclusive Relationships, Sexuality and Consent was used as a guide to interview both Residents. [R1] denied the above allegation, stating she and [R2] were just watching TV. She denied that he touched her in any way and expressed she was aware of her rights to maintain a relationship with [R2] should she wish. She acknowledged her awareness of her right to say no if she felt uncomfortable with any interactions with [R2] however denied any concerns at this time. She said she is not interested in pursuing anything beyond friendship with [R2] and enjoys spending time with him, as they have a lot in common. She denied any concerns and verbalized she feels safe and comfortable at [the facility]. [R2] also denied the above allegations. He stated that he and [R1] are very good friends and he feels thankful to have met someone he can share companionship with. He stated he is not interested in pursuing anything but friendship with [R1]. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	He expressed awareness of his rights to pursue relationships and his right to say no if he felt uncomfortable with any interactions. He denied any concerns and stated he feels safe and comfortable at [the facility]. Both [R2] and [R1's] activated POA's (Power of Attorney) were notified of the interaction. Neither voiced any concerns and both stated they were happy their loved ones had found companionship in each other. [R1] and [R2] had increased monitoring post interaction. Skin assessments were completed with no evidence of trauma. [R1] and [R2] were noted to be watching TV in the common area and chatting per usual. No behaviors or complications noted as a result of the interaction . On 5/6/24, at 12:17 PM, Surveyor interviewed SSD-C and Social Service Coordinator (SSC)-G. Surveyor asked what happened on the day of the incident. SSD-C stated LPN-F found R2 fondling R1's breasts in R1's room. LPN-F removed R2 from R1's room and called Nursing Home Administrator (NHA)-A. SSD-C stated she and SSC-G came to the facility and started interviewing. They interviewed R1 and R2 and the staff that was available at the time. Surveyor asked if any other residents were interviewed. SSD-C stated no, only the 2 involved in the incident. Surveyor asked if LPN-F was interviewed. SSD-C stated she was interviewed by NHA-A. On 5/6/24, at 1:30 PM, Surveyor interviewed NHA-A. Surveyor asked about the interview with LPN-F. NHA-A stated she did not interview LPN-F. NHA-A stated when the incident occurred, LPN-F called the on-call manager. That day it was Scheduler-E. Scheduler-E then called her and reported what happened. She called SSD-C and reported what LPN-F had said to Scheduler-E. Surveyor noted that SSD-C stated she had taken LPN-F's statement, which meant no one interviewed LPN-F as the main witness. Surveyor also note no other residents besides R1 and R2 were interviewed. NHA-A stated SSD-C was new to the Assistant Executive Director role and still learning how to do FRI's. Surveyor expressed concerns that a thorough investigation did not occur and asked for any other documentation of interviews being completed. No other documentation was provided.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40533 Based on interview and record review, the facility did not comprehensively assess 2 (R1 and R2) of 4 residents reviewed for alleged abuse. The facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, to have the highest practicable physical, mental, and psychosocial well-being. R1 and R2 were found in R1's room and R2 was fondling R1's breasts. Prior to this incident, R1 and R2 were spending lots of time together including being found holding hands. The residents were not assessed for competency, ability to consent to a sexual relationship or intimacy and sexual history assessment completed. Findings include: R1 was admitted to the facility on [DATE] with diagnoses that included Cerebral Atherosclerosis, Cognitive Communication Deficit, Anxiety and Symptoms and Signs Involving Cognitive Function and Awareness. Surveyor reviewed R1's MDS (Minimum Data Set) Assessment with an assessment reference date of 1/31/24. Documented under Cognition was a BIMS (brief interview mental status) score of 10 which indicated moderate cognitive impairment. R2 was admitted to the facility on [DATE] with diagnoses that included Orthostatic Hypotension, Dementia, Anxiety and Alcohol Induced Amnestic Disorder. Surveyor reviewed R2's MDS Assessment with an assessment reference date of 4/19/24. Documented under Cognition was a BIMS score of 10 which indicated moderate cognitive impairment. Surveyor reviewed FRI submitted to the state agency on 4/25/24 prepared by [Assistant Executive Director/Social Services Director (SSD)-C)]. Included with the Misconduct Incident Report were an Investigation Summary, Face Sheets for both residents, staff questionnaire sheets and 2 copies of Appendix 1 - Recommendations for Addressing Resident Relationships Intimacy & Sexuality History that included an attached page of resident specific questions related to the relationship between R1 and R2. One copy had R1's name on the top and 1 copy had R2's name on the top. Both assessments and additional page of questions were blank. 3 of the 17 staff questionnaire sheets noted staff had seen R1 and R2 holding hands prior to the incident on 4/20/24. Documented under Investigation Summary was: .Description of Incident: On 4/20/2024, Licensed Practical Nurse [LPN-F], was completing her rounds and observed [R2] in [R1's] room. [LPN-F] stated [R1] had her breasts exposed and [R2] was touching her breasts. She removed [R2] from [R1's] room and notified [Nursing Home Administrator (NHA)-A] immediately. Investigation protocol was initiated, and the investigation was started immediately. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon report of the above allegation, the following was initiated: Interview of affected residents Investigation protocol initiated Skin check completed on affected residents Self-report submitted Provider notified for both residents Residents monitored post interaction Police department notified of incident- declined to respond or pursue investigation Notification to [State Ombudsmen-J] Results of Investigation: [SSD-C] and [Social Services Coordinator (SSC)-G] interviewed [R1] and [R2]. The State of Wisconsin's Board on Aging and Long-Term Care's presentation on Balancing Rights and Protection: Inclusive Relationships, Sexuality and Consent was used as a guide to interview both Residents. [R1] denied the above allegation, stating she and [R2] were just watching TV. She denied that [R2] touched her in any way and expressed she was aware of her rights to maintain a relationship with [R2] should she wish. She acknowledged her awareness of her right to say no if she felt uncomfortable with any interactions with [R2] however denied any concerns at this time. She said she is not interested in pursuing anything beyond friendship with [R2] and enjoys spending time with him, as they have a lot in common. She denied any concerns and verbalized that she feels safe and comfortable at [the facility]. [R2] also denied the above allegations. He stated he and [R1] are very good friends and he feels thankful to have met someone he can share companionship with. He stated he is not interested in pursuing anything but friendship with [R1]. [R1] expressed awareness of his rights to pursue relationships and his right to say no if he felt uncomfortable with any interactions. He denied any concerns and stated he feels safe and comfortable at [the facility]. Both [R2] and [R1's] activated POA's (Power of Attorney) were notified of the interaction. Neither voiced any concerns and both stated they were happy their loved ones had found companionship in each other. [R1] and [R2] had increased monitoring post interaction. Skin assessments were completed with no evidence of trauma. [R1] and [R2] were noted to be watching TV in the common area and chatting per usual. No behaviors or complications noted as a result of the interaction . Surveyor reviewed documentation of email correspondence between SSD-C and Ombudsman-J. Documented to Ombudsman-J from SSD-C on 4/22/24, at 4:34 PM, was: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	We have 2 Residents here that have been pursuing a very close friendship recently. Over the weekend, they were noted to be engaging in some sexual behavior. We did submit a self report right away and interviewed both Residents regarding the incident however they both denied that anything happened. During the interviews, they both made it very clear they were only interested in pursuing a friendship with each other and were not interested in anything further. I was able to refer back to the presentation Balancing Rights and Protection from a few months ago for reference. Just wanted to make [sic] aware and see if you had any recommendations or suggestions on how to handle this moving forward. Thanks! Documented to SSD-C from Ombudsman-J on 4/23/24, at 4:55 PM, was: I have attached some documents about sexuality and intimacy you might find helpful. The important thing, if the residents decide to pursue something beyond friendship, is their ability to understand and give consent to one another. One of the documents attached is a guide in determining the ability to consent. The residents should not be deterred from pursuing a relationship, if they choose, as long as they still have an understanding of intimacy and can consent. Let me know if you have any additional questions. Attached to the email was Balancing Rights and Protection: Inclusive Relationships, Sexuality and Consent PowerPoint, Recommendations for Addressing Resident Relationships, Appendix 1 - Recommendations for Addressing Resident Relationships Intimacy & Sexuality History and Appendix 2 - Recommendations for Addressing Resident Relationship Assessment for Consent to Physical Sexual Expressions. Surveyor reviewed Recommendations for Addressing Resident Relationships. Documented was: This document provides guidance to facilities suggesting what might be included in a Resident Relationships Policy that addresses intimacy and sexuality issues. It does not in any way constitute a regulation, mandate or requirement. Facilities are encouraged to write their own policies related to these issues . Surveyor reviewed Appendix 1 - Recommendations for Addressing Resident Relationships Intimacy & Sexuality History. Documented was: This appendix is not legal advice or mandated, but is intended to be used as a guide for facilities to obtain information about a resident's intimacy and sexuality history. This history is to be completed with the resident, and the information obtained may be helpful overall in assisting residents to feel at home, comfortable and secure. This information may be best gathered once rapport is gained between a resident and staff skilled at interviewing. If additional information is needed, a family member or legal decision maker could be interviewed. It may be helpful to take notes about the resident's statements, as the actual verbal response often reveals a lot about the person's level of understanding of the topic. It should also be understood that the resident has the right to refuse to participate in this conversation, and that refusal should not constitute an inability to consent to an intimate or sexual relationship . Surveyor reviewed Appendix 2 - Recommendations for Addressing Resident Relationship Assessment for Consent to Physical Sexual Expressions. Documented was: Wisconsin has not specifically defined what an individual must understand in order to consent to sexual contact. However, discussion in the Guardianship of Adults (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(http://www.dhs.wisconsin.gov/publications/P2/p20460.pdf), implies that there may be indications that the following four guidelines could be used as the basis for an assessment to determine a person's ability to consent to sexual contact. Depending on the uniqueness of each situation, additional considerations might be appropriate. Assessment efforts should focus on the resident revealing his/her understanding of the following four guidelines: 1. The person understands the distinctively sexual nature of the conduct. That is, that the acts have a special status as sexual. 2. The person understands that their body is private and they have the right to refuse, or say no. They should also understand the other person should respect their right of refusal. 3. The person understands there may be health risks associated with the sexual act. (pregnancy, STD's, cardiac, other health risks) 4. The person understands there may be negative societal response to the conduct. (Gossip, name calling, social fallout, stigmatized.) . On 5/6/24, at 12:17 PM, Surveyor interviewed Social Service Director (SSD)-C and (Social Service Coordinator) SSC-G. Surveyor asked about the information provided by Ombudsman-J. SSD-C stated that is what they used to determine that both residents could consent and were allowed to have a relationship if they wanted to, but at this time they only wanted a friendship. Surveyor noted the blank copied of Appendix 1 with R1 and R2's names on them. Surveyor asked why the assessments were blank. SSD-C stated both residents refused to answer the questions. Surveyor asked if either resident were assessed prior to the 4/20/24 incident. SSD-C stated no. Surveyor noted that R1 and R2 were observed by staff holding hands and spending lots of time together. Surveyor asked why they were not assessed prior to the incident. SSD-C stated she was not sure. Surveyor asked if either resident was reapproached to answer any of the questions from Appendix 1 after the incident. SSD-C stated no because they were adamant it did not happen and it was just a friendship. Surveyor noted LPN-F had witnessed the incident. SSD-C and SSC-G did not respond. Surveyor asked where the refusal to answer the questions was documented. SSD-C stated it was not. Surveyor asked how they determined R1 and R2 were able to consent. SSD-C stated she asked the two questions, if they understood their rights to have a relationship and if they understood if the other one was reluctant to be in a relationship and the right to say no. Surveyor noted if they were using the information provided by Ombudsman-J, Appendix-J has four specific questions to determine competency. Surveyor asked if they had used Appendix 2. SSD-C stated no. Surveyor asked if either R1 or R2 had been assessed for consent prior to the incident on 4/20/24. SSD-C stated no. SSD-C stated R1 and R2 only want a friendship so consent was not needed. Surveyor asked what would warrant a sexual/intimacy assessment and consent assessment. SSD-C stated a resident wanting to pursue a relationship with someone in the facility. On 5/6/24, at 1:30 PM, Surveyor interviewed (Nursing Home Administrator (NHA)-A. Surveyor explained the concerns with no assessments being completed to determine a residents' ability to consent to a potentially sexual relationship prior to the 4/20/24 incident where R1 and R2 were observed touching each other in a sexual manner. NHA-A stated she was concerned about resident rights issues but understood the concerns about the assessments and they will be completed to avoid this situation.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40533 Based on record review and interview, the facility did not comprehensively assess 2 (R1 and R3) of 3 residents reviewed for trauma informed care and care plan approaches to mitigate any triggers to prevent re-traumatization. ~ R1 was admitted [DATE] and during her admission psychosocial assessment, the facility did not identify R1 as having a history of physical abuse. On 5/1/24 the facility completed Trauma Informed Care Assessments for all high risk residents. R1's past history of physical abuse was then identified. A care plan and approaches to mitigate any triggers to prevent re-traumatization was not put in place after the assessment for R1 had been completed. ~ R3 was admitted on [DATE] and during her admission psychosocial assessment, the facility identified R3 as having a history of physical abuse. This information was not transferred to R3's plan of care. On 5/1/24 the facility completed Trauma Informed Care Assessments for all high risk residents and identified R3 as having a history of physical and sexual abuse. Prior to that R3 had no care plan approaches to mitigate any triggers to prevent re-traumatization. Findings include: Surveyor reviewed the facility's Trauma Informed Care policy with a revision date of 10/18/2022. Documented was: Policy: It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization. Definitions: Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Common sources of trauma may include, but are not limited to: a. Natural and human caused disasters b. Accidents c. War d. Physical, sexual, mental, and/or emotional abuse (past or present) e. Rape (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. Violent crime g. History of imprisonment h. History of homelessness i. Traumatic life events (death of a loved one, personal illness, etc.) Trauma-Informed Care is an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization. Policy Explanation and Compliance Guidelines: 1. The facility will work to facilitate the principles of trauma informed care which include: a. Safety - Ensuring residents have a sense of emotional and physical safety. b. Trustworthiness and transparency - Efforts to establish a relationship based on trust, and clear and open communication between the staff and the resident. c. Peer support and mutual self-help - If practicable, assist the resident in locating and arranging to attend support groups (potentially hosted by the facility) which are organized by qualified professionals. d. Collaboration - an emphasis on partnering between residents and/or his or her representative, and all staff and disciplines involved in the resident's care in developing the plan of care. e. Empowerment, voice, and choice - Ensuring that resident's choice and preferences are honored and that residents are empowered to be active participants in their care and decision-making, including recognition of, and building on resident's strengths. 2. The facility will use a multi-pronged approach to identifying a resident's history of trauma. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as reviewing documentation such as the history and physical, consultation notes, or information received from family/responsible party . 4. The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions. 5. The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan. While most triggers are highly individualized, some common triggers may include, but are not limited to: (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Experiencing a lack of privacy or confinement in a crowded or small space. b. Exposure to loud noises, or bright/flashing lights. c. Certain sights, such as objects that are associated with their abuser. d. Sounds, smells, and physical touch. 6. Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety. These interventions will also recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery. 7. The facility will evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization. The resident and/or his or her family or representative will be included in this evaluation to ensure clear and open discussion and better understand if interventions must be modified. 8. In situations where a trauma survivor is reluctant to share their history, the facility will still try to identify triggers which may re-traumatize the resident and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident. ~ R1 was admitted to the facility on [DATE] with diagnoses that included Cerebral Atherosclerosis, Cognitive Communication Deficit, Anxiety and Symptoms and Signs Involving Cognitive Function and Awareness. Surveyor reviewed R1's MDS (Minimum Data Set) Assessment with an assessment reference date of 1/31/24. Documented under Cognition was a BIMS (brief interview mental status) score of 10 which indicated moderate cognitive impairment. Surveyor reviewed R1's Psychosocial Assessment Admission with an effective date of 1/27/24 prepared by Former Registered Nurse/Case Manager (RN)-I. Documented was Prior Trauma or [history/diagnosis (hx/dx)] of [Post Traumatic Stress Disorder (PTSD)]? c. none of the above. Surveyor noted the assessment did not identify R1's history of physical abuse. Surveyor reviewed R1's Trauma-Informed Care Observation with an effective date of 5/1/24 prepared by Social Services Director (SSD)-C. Documented was: .5. Have you ever experienced, witnessed, learned about a physical assault (e.g. attacked, hit, beaten up, etc.)? b. Personally experienced . Experience 1. Did any of these events bother you? b. Yes (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Comments on events resident was bothered by: Resident states her ex-husband was physically abusive. He has since passed away. She remarried and stated her most recent husband was the best thing that ever happened to me. States she always has the memories of the abuse she suffered with her first husband however tries to remember the good memories with her second husband . Effects . 2. How much did the event(s) bother you emotionally? d. Much 3. What are the triggers that remind you of the event (e.g, loud noises, confined spaces, bath tubs, hot surfaces, sirens, etc.)? Verbalized no current triggers, just often thinks about the events. Has a close relationship with peer and daughter; states spending time with them helps her forget about negative memories. 4. How do you react when you are reminded of the event(s)? Becomes sad/tearful. Treatment 1. When you are reacting to the event(s), what helps you refocus? Spending time with friend/family, watching tv. Enjoys going for walks, going to group activities, enjoying nice weather, etc . Surveyor reviewed R1's Comprehensive Care Plan. There was no Trauma Informed Care care plan put in place after this assessment was completed. On 5/7/24, at 11:00 AM, Surveyor interviewed SSD-C. Surveyor asked why R1's physical abuse was not identified on her admission psychosocial assessment. SSD-C stated she was not sure and RN-I no longer worked at the facility. Surveyor asked why the Trauma Informed Care assessment was not done until 5/1/24. SSD-C stated R1 had an incident with another resident on 4/20/24 so they decided to assess all the high-risk residents. Surveyor asked who should receive a Trauma Informed Care assessment. SSD-C stated anyone who triggers for trauma on the psychosocial assessment. SSD-C stated she was unsure why R1's assessment did not identify the physical abuse. ~ R3 was admitted to the facility on [DATE] with diagnoses that included a Right Fibula Fracture, Personality Disorder, Anxiety and Schizoaffective Disorder. Surveyor reviewed R3's MDS (Minimum Data Set) Assessment with an assessment reference date of 12/6/23. Documented under Cognition was a BIMS (brief interview mental status) score of 06 which indicated severe cognitive impairment. (continued on next page)

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	525359	A. Building B. Wing	05/07/2024

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R3's Psychosocial Assessment Admission with an effective date of 11/30/23 prepared by Former Registered Nurse/Case Manager (RN)-I. Documented was: Social History . 5. Other important relationships: [Sister] - POA for healthcare (not active) Prior Trauma or [history/diagnosis (hx/dx)] of [Post Traumatic Stress Disorder (PTSD)]? a. Prior trauma 5aa. Describe prior trauma Resident states parents were physically abusive D. Care Planning Check all that apply to add care plan 2. Trauma Informed Care Surveyor noted the assessment did not identify R1's history of sexual abuse. Surveyor also noted no Focus, Goals or Interventions were checked under care planning. Surveyor reviewed R3's Comprehensive Care Plan. There was no Trauma Informed Care care plan put in place after this assessment was completed. R3 did have a care plan addressing her behaviors with an initiation date of 12/1/23. Documented was: Focus: At risk for adverse effects [related to (r/t)] use of antipsychotic medication, mood stabilizer Dx schizoaffective disorder, bipolar type anxiety disorder, personality disorder. Goal: - To show minimum side effects of medications taken - Show no signs of hallucinating or delusional thinking - Will have medication dose reduction/elimination as indicated Interventions/Tasks: - AIMS testing per facility guidelines (upon admission, initiation of, change of, every 6 months and [as needed (PRN)] (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs - Provide resident teaching of risks and benefits of medications as needed - Psychiatrist consult and follow up as needed - TARGET BEHAVIOR 1: Resident will become paranoid, believe that someone is trying to murder her and her family, someone is going to rape her and as a result can become verbally and physically aggressive. Intervention #1: Offer 1:1 opportunity to express feelings and validate. Intervention #2: Offer to assist in contacting sister. Intervention #3: Allow Resident time to calm and reapproach as needed. Offer to take for a walk to get some fresh air. - TARGET BEHAVIOR 2: Resident will become tearful when feeling depressed. Intervention #1: Offer 1:1 opportunity to express feelings and validate. Intervention #2: Offer to assist in contacting sister. Intervention #3: Offer diversionary activity. Resident enjoys watching tv, 1:1 visits, talking with sister. Surveyor reviewed R3's Trauma-Informed Care Observation with an effective date of 5/1/24 prepared by Nursing Home Administrator (NHA)-A. Documented was: .5. Have you ever experienced, witnessed, learned about a physical assault (e.g. attacked, hit, beaten up, etc.)? b. Personally experienced . 6. Have you ever experienced, witnessed, learned about a sexual assault (e.g. rape, attempted rape, mad perform a sexual act via force or threat of harm, etc.) b. Personally experienced . Experience . 2. Comments on events resident was bothered by: Sexual and physical abuse Effects (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/24, at 1:30 PM, Surveyor interviewed NHA-A. Surveyor asked why the sexual abuse trauma for R3 was not identified earlier. NHA-A stated they found that information out from her sister/POA who was not involved until a few weeks ago. Surveyor noted on the 11/30/23 Psychosocial Assessment prepared by RN-I it stated Sister/POA as important person in her life. NHA-A stated she was unaware of that. Surveyor asked why all the Trauma Informed Care assessments were not completed until 5/1/24. NHA-A stated after the incident with R1 and R2 they identified the residents that were at risk for trauma and completed the assessment on them. Surveyor noted R3 did trigger for physical trauma on 11/30/23 and also had a care plan in place with behaviors that she will become paranoid, believe that someone is trying to murder her and her family and someone is going to rape her. NHA-A stated that is part her delusions and psych issues. Surveyor noted could these behaviors possibly be part of past trauma. NHA-A stated she understands the concerns. NHA-A stated R3 is working closely with Psych currently and will be transferred to a Psych group home which is a more appropriate setting for her.