STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676381	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Houston Rehabilitation and Healthcare Center	13428 Bissonnet Houston, TX 77083

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45604 Based on observation, interview, and record review, the facility failed to consult with the resident's physician; and notify the resident representative for 2 of 21 residents (CR#2 and CR#3) reviewed for change of condition, in that, 1. LVN G failed to notify CR#3's Primary Care Physician that the resident was observed having difficulty breathing on [DATE] when transporting resident via non-ermergency which resulted in delay of emergency medical care. 2. LVN G failed to notify CR#3's Responsible Party that the resident had difficulty breathing and signs of a seizure [DATE]. 3. LVN F failed to notify the Responsible Party that CR#2's hospital transfer on [DATE] required assessment for a concern of sexual abuse after being observed with vaginal bleeding. An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 5:48pm. While the IJ was removed on [DATE] at 4:25 pm, the facility remained out of compliance scoped at isolated with no actual harm and potential for more than minimal harm due to the facility's need to complete in-service training and evaluate the effectiveness of their corrective systems. These failures could expose residents to delay in treatment, worsening of condition, hospitalization , and death. Findings included: CR#3 (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#3's facesheet dated [DATE], reflected she was a [AGE] year-old female, who admitted to the facility on [DATE] with a primary diagnosis of mild unspecified dementia with secondary diagnosis of down syndrome(genetic condition effecting brain development), hypothyroidism(underactive thyroid), generalized anxiety disorder, and unspecified convulsions(uncontrolled shaking). CR#3 was transfer to a local hospital at the family's request on [DATE] due to convulsions in the hand. CR#3 presented to the hospital on [DATE] with a chief complaint of altered mental state and shortness of breath. CR#3 expired on [DATE] at a local hospital with discharge diagnosis of massive intracerebral hemorrhage(brain bleed), acute hypoxic respiratory failure (lungs are unable to deliver enough oxygen to the body's tissues), pneumonia (lung infection), hypothyroidism, and down syndrome. Record review of CR#3's undated comprehensive care plan reflected: Focus: CR#3 has history of Seizures and is at risk for Injury. Goal: Resident will be free from Seizure Activity until the next review Intervention: Call MD and family for s/s of antiseizure medication toxicity. Document/notify family and MD to notify of any seizures. Ensure direct care staff are aware of residents history of Seizure Activity. Give medications per order, monitor labs--report abnormals to M.D. If a seizure occurs, protect from injury-do not restrain, turn to side, loosen tight clothing, etc, take vital signs-inform M.D. and R.P. Labs per MD order. Make resident comfortable after seizure activity. Monitor for efficacy and adverse consequences, abdominal pain, anorexia nausea, dermatologic reactions, blood dyscrasias. Monitor for warning signs-prior to seizure activity. Record review of CR#3's quarterly MDS (Minimum Data Set) assessment dated [DATE] reflected a BIMS(Brief Interview for Mental Status) was not available as the resident rarely /never understood with severely impaired cognitive skills for daily decision making. Record review of progress note completed [DATE] at 1:00pm completed by LVN G read in part, Family member at bedside notified nurse that resident was having a seizure. Upon assessment resident noted to have jerking movements to bilateral hands. Resident noted with eyes open. Vital signs obtained and as follows BP ,d+[DATE] P 84 R 17 T 97.6 O2 96% room air. Resident currently taking Keppra per MD orders. Clarified with medication aide that resident had received dose for morning. Notified NP of findings. Family then requested that resident be transferred to emergency room for further evaluation. Notified MD. DON notified. Rp notified per alternate contact whom was still present at bedside .notified for need of transport and en route. Resident lying in bed alert and jerking movement subsided. Record review of progress note completed [DATE] at 2:50pm completed by LVN G read in part, Family member requested writer reassess resident's o2 sats. Upon assessment resident's o2 noted at 90% room air with no apparent distress noted. At this time, EMS arrived to transport resident and were notified of resident's desaturation and EMTs(Emergency Medical Technician) placed resident on oxygen prior to exiting facility. Resident exited the facility stable per stretcher via (by way of) . family to follow to hospital. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#'3 SBAR dated [DATE] completed by LVN G reflected that CR#3 was assessed for signs, symptoms: Increased shaking that started on [DATE] and given hydroxyzine. O2 96 % on [DATE] at 1:32pm Method: Room Air. There was no mention of oxygen provide to the resident. Recommendation to monitor vitals signs and transfer to the hospital. Notification made with family at bed side at 1pm and NP at 1pm. SBAR reflected under the section for RP notification as the family member at the beside and not the RP as identified on the facesheet of CR#3. Record review of CR#3's contracted EMS run report dated [DATE] reflected LVN G contacted the transportation company at 1:18pm, transport arrived at the facility at 2:23pm, transported departed the facility at 2:43pm, and transport arrived to the hospital at 3:12pm. The note read in part .EMS made patient contact, finding the patient at 2:33pm in emergent (yellow) condition. EMS decided the patient required transport for respiratory distress not available at origin. On scene pt was O2 stat 88 on NC (Nasal cannula) placed patient on a non rebreather pt O2 rose to 96. Record review of CR#3's hospital medical records dated [DATE] with admission time at 3:22pm reflected a chief complaint for altered mental state and stated complaint of shortness of breather. History of present illness notes read in part XXX[AGE] year old female with history of Down syndrome, prior CVA(cerebrovascular accident/stroke) presenting for altered mental status and hypoxia. Patient was found slumped over and minimally responsive earlier today, was noted to be hypoxic to 60% on room air per EMS, was started on non-rebreather with improvement to 85 .CT (computed tomography) imaging was significant for large intracranial bleed with midline shift .Patient family wishes to proceed with comfort measures and hospice care. No indications for ICU (intensive care unit) intervention at this time due to DNR (do-not-resuscitate) status. Date of expiration [DATE]. Cause of death large left intracranial hemorrhage, acute hypoxic respiratory failure, pneumonia, down syndrome, and hypothyroidism. In an interview on [DATE] at 9:30am with a Registered Nurse at a local hospital, she said that CR#3 admitted on [DATE] with a chief complaint of altered mental state and shortness of breath. She said that CR#3 was DNR, the family did not want further treatment, so she was not transferred to ICU, placed on hospice for comfort care [DATE], and she expired on [DATE] with cause of death listed as massive intracerebral hemorrhage, acute hypoxic respiratory failure, pneumonia, hypothyroidism, and down syndrome. She said that transportation was contracted, EMT report noted CR#3 with O2 sat at facility at 60 and placed on non rebreather mask that increased to O2 stat to 85%. She said that contracted transportation should not have been used and EMS should have been used via 911. In a phone interview on [DATE] at 12:20pm with RP, who said that a relative visited CR#3 the morning of [DATE] at 10:00am. She said that the relative contacted her at 11:00am on [DATE], and said that CR#3 did not look well, was having a seizure when she arrived, she felt like something happened to the resident, and the residents breathing was not good. She said that she could her that CR#3's breathing was not normal over phone, and the relative sent her a video of her breathing. She said that she was told by the relative that she asked for CR#3 to be sent to the hospital. She arrived to the facility around 1:00pm when found out CR#3 was still at the facility and not at hospital. She said that no one from the facility contacted her about the condition of CR#3 and she received the information from the relative at the beside. Observation of video on [DATE] at 1:48pm provided by the Relative which showed that CR#3 was struggling to breath with date and time of [DATE] at 11:38am. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 3:00pm with CNA A. She said that she worked the 200 Hall from 2:00pm-0:00pm on [DATE]. She worked the 200 Hall from 10:30am-2:00pm on [DATE], and the 300 hall from 2:00pm-10:00pm. She said that CR#3 was on the 200 hall. She said at the start of her shift on [DATE] she was immediately alerted by a relative at the beside that CR#3 that something was wrong with CR#3. She said that when she entered the room CR#3's she found her breathing was labored, she was flush, she alerted LVN G who came to check vitals (results unknown), LVN G left the room, and she thought it was to contact the doctor. She said that when LVN G returned to the room she told the relative that CR#3 had received medication (Name unknown), she would monitor, would check on CR#3 in 1 hour, and the relative was not happy. She said that 11:30am she returned to check on CR#3, and resident breathing was still labored. She said that she alerted LVN G and they returned to the room, the relative said she no longer wanted to wait, she wanted CR#3 to got the hospital. She said that she did not know if the relative at the beside was the RP, and she would have assumed that LVN G would have confirmed. She said that CR#3 left the facility with scheduled non-emergency transport after 2:00pm. She said that it's the families right to request 911 for a resident. She said that if resident is having trouble breathing that's a change in condition, and the RP and are to be notified. She said that a resident and RP have the right to asked to be transferred and be notified. She said that if the relative at the beside was not the RP she would have thought LVN G would have confirmed. In a phone interview on [DATE] at 3:38pm with LVN G, she said that she worked on [DATE] from 6:00am-6:00pm. She said at 9:00am she was alerted that someone at the beside of CR#3 thought the resident was having a seizure. She said that she assessed the resident to have increased hand tremors which was her baseline, she checked vitals that were in normal range, and she gave PRN (as needed) Hydroxyzine for anxiety. She said she returned to the room in 30 minutes to check on CR#3, the tremors had subsided, the family was not happy, she told the relative she could have CR#3 go to the hospital, the relative wanted to wait a little longer, did not request that CR#3 go to the hospital until 11:00am, and never requested transportation by 911. She said that she notified NP I that the family was requesting CR#3 be sent to the hospital for concerns of hand shaking, and she scheduled non emergency transportation. She said that she did could not remember exact time, it could have been around 1:00pm, and it took the transport 45minutes to1 hour to arrive. She said that CR#3's breathing was normal when she assessed the resident, and she never received information from anyone that CR#3 was having trouble breathing. She said a physician should notified with change in condition, CR#3 did not have change in condition until right before transportation arrived, and she did not need to notify because CR#3 had left the building. She said that there was no risk because CR#3 did not have any respiratory issues prior to the transport arriving. She said that if a resident is in respiratory distress that would be a change in condition, the physician should be notified, and non emergency transportation would not be appropriate. She said that a risk of delay in treatment for respiratory issues could be the condition could worsen, require longer hospitalization , or death. She said that the relative at the beside was the RP, she did not confirm, and another staff (name unknown) told her that it was the RP. She did not answer when asked if that was a delay in treatment. She did not answer when asked should she have confirmed that family at beside was the RP and able to make decisions. She did not answer when asked if it was the RP/Resident had the right to be informed about a change in condition. She said that she resigned on today and ended the call. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 4:00pm with Unit Manager, she said that she worked on [DATE], and she arrived between 9:30am-10:00am. She said that LVN G asked her to help assess CR#3 between 12:45pm-1:00 pm because the family at the beside though she was a having seizure, and LVN G assessed the resident with hand shakes that was her baseline, the nurse had given PRN medication for the hand shakes, and CR#3 had received daily medication Keppra for seizures. She said that CR#3 was not seizing when they got to the room, was responsive, her breathing was normal, and she did not have tremors in the hands. She said that the family at the beside was not the RP. She said that the family at the beside came to the nurse station , said she felt something was wrong, and she asked that CR#3 go to the hospital. She said that she told LVN G to contact the RP and Physician. She said that LVN G setup scheduled non emergency transport because the resident was not in distress. She said that if CR#3 was assessed with respiratory issues that morning and notification to NP and transport was not scheduled until 1:00pm, that would be delay in treatment. She said that if resident is in respiratory distress would contact call 911 immediately and she would call the physician and RP after, and the risk of delay in treatment when there is respiratory issues could be death. She said that a RP have the right to be notified with a change of condition. She said that if a relative request transfer, the RP should still be contacted and you must go by what the RP said. She said that nurses use a facility cell phone to contact physicians and their NP's, and if nurse made notification by texted, the thread would be there and they do not delete. Record Review on [DATE] at 5:18pm of facility cell phone used by LVN G to notified NP I on [DATE] at 1:12pm red in part . CR#3 is having increased shaking . All medications were given. PRN hydralazine was given. Family requesting, she be sent to ER (emergency room). Sending to local hospital per family's request. Phone interview on [DATE] at 6:02pm with NP I, she said that she was contacted by the facility after 1:00pm on [DATE] in regard to CR#3 as the family wanted to send her to hospital after she was observed with handshakes. She said that CR#3 hand tremors were her baseline. She called the nurse who sent the message (LVN G), the nurse said the resident did not have a seizure only the hand tremor, the medication given was effective, the facility had to honor the request of the family, and she said okay after she spoke to the IDON to confirm. She said that if any resident was observed to be in respiratory distress know matter what the oxygen saturation range was, notification to the physician or NP should be done immediately when it was first identified, and the resident should have been sent to the hospital with EMS by calling 911. She said that the believed the facility policy was to notify the physician, RP, and DON with any change of condition. She said that if the resident was seen at 10:30am with trouble breathing she should have been notified, she was not, if the resident did not leave the facility until after 2:00pm it was a delay in treatment, if CR#3 was in respiratory distress it could cause death. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 6:46pm with IDON, she said that notification should be made the MD, NP, RP, and DON immediately when there is a change of condition. She said that if notification was not immediate it could be delay in treatment depending on the issue. She said that staff should still notify the RP even if family was at the beside and it was their right to be notified. She said that if family request a hospital transfer staff should call RP to confirm they approve. She said that the physician should be notified of all clinical details immediately after a change of condition. She expressed concern that the family at the beside, RP, CNA and EMT observed CR#3 with difficulty breathing, there was video footage of CR#3 seen with difficulty breathing, and that nurses that entered the room denied knowing the resident had difficulty breathing. She said that if CR#3 had a change in condition at 10:30am and the physician was not notified, and transportation was not scheduled until 1pm it would be a delay in treatment with harm to the resident. She said that LVN G resigned. In an interview on [DATE] at 7:33pm with Administrator, he said that notification should be made the MD, NP, RP, and DON immediately when there is a change of condition. He said that the physician should be notified of all clinical details immediately after a change of condition. He said that staff should still notify the RP even if family was at the beside and it was their right to be notified. He said that if family request a hospital transfer staff should call RP to confirm they approve. He expressed concern that family at the beside, RP, CNA and EMT observed CR#3 with difficulty breathing, there was video footage of CR#3 seen with difficulty breathing, and the nurses that entered the room denied knowing the resident had difficulty breathing. He said that if CR#3 had a change in condition at 10:30am and the physician was not notified, and transportation was not scheduled until 1pm it would be a delay in treatment with harm to the resident. He said that the nurse resigned but he was unsure why. Record Review of facility policy titled Notification of Changes Dated [DATE] read in part, The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistently with his or her authority, the resident's representative when there is a change requiring notification .Circumstances requiring notification include: 2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: a. life-threatening conditions, .4. A transfer or discharge of the resident from the facility . Record Review of facility policy titled Resident Rights Dated February 2023 read in part, Resident Rights. The resident has the right o a dignified existence, self -determination, and communication with and access to persons and services inside and outside the facility. 1. Exercise of rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United State. d. The resident representative has the right to exercise the resident rights to the extent those rights are delegated to the resident representative. This was determined to be an Immediate Jeopardy (IJ) on [DATE]. The Administrator was notified on [DATE]. The IJ template was provided to the facility on [DATE] at 5:48pm The following Plan of Removal (POR) submitted by the facility was accepted on [DATE] 2:14pm. The plan of removal reflected the following PLAN OF REMOVAL (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Name of facility: Date: [DATE] F -580 Notification of Changes. Problem: -The facility failed to notify CR#3's Primary Care Physician that the resident was observed having difficulty breathing -The facility failed to notify CR#3's Responsible Party that the resident had difficulty breathing and signs of a seizure CR#3 no longer resides at the facility. Immediate action: 35. On [DATE] the facility nursing management staff immediately initiated assessments of current residents focusing on changes in conditions to include shortness of breath and signs of seizure activity. no issues noted. Completed [DATE] 36. On [DATE] the Admin/Don/Designee initiated an investigation of events statements from staff who had worked with the resident indicating observation of resident were collected. Completed [DATE]. 37. On [DATE] LVN G is no longer employed by the facility. 38. On [DATE] the facility initiated an audit of resident's changes in conditions/SBARs within the last 4 weeks to ensure appropriate assessments and notification to the MD/NP and responsible party took place. Any issues identified will be addressed immediately. Completed [DATE] 1. [DATE] The facility Notification of Changes Policy was reviewed by the facility Administrator, DON and Regional nurse. No changes made. Interventions 2. On [DATE] the facility DON/Designee immediately initiated a 1:1 in-service with the licensed nurses to review and overview the facility Notification of Changes Policy to include circumstances requiring notification of changes to the MD/NP. Completed [DATE]. 3. On [DATE] the [NAME] /designee initiated an in-service with the licensed nurses regarding timely notification to the MD/NP, this includes confirming who is RP when notifications are made at bedside. Completed [DATE] 4. On [DATE] the DON/Designee initiated an in-service with the licensed nurses on when situations that required 911 services vs when to schedule emergency transportation services. Completed [DATE]. 5. On [DATE] the DON/Designee initiated in-service with the facility licensed nurses on the interact tools: Resident Changes in condition, when to report to the MD/NP, this includes Immediate notification and Non-immediate notifications. Completed [DATE] (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. On [DATE] the DON/Designee initiated in-service with the facility licensed nurses on the Care Pathway Assessment tool: Shortness of Breath (SOB). This exhibit shows the licensed nurse steps to take with SOB symptoms, Assessment, Further nursing evaluation, consideration of order to obtain, Evaluation, etc. Completed [DATE] 7. The DON or administrator is notified of resident changes in condition, emergencies, and resident transfers to provide guidance and ensure proper assessment, interventions and transfers are done appropriately. Issues identified will be immediately addressed through further education, disciplinary action and or termination of employmentXXX[DATE] Ongoing Projected completion [DATE]. Any staff member not present or in service on [DATE]- [DATE] will not be allowed to assume their duties until in-serviced. Ongoing In-service will be completed by DON/ADON/WC NURSE/or weekend nurse supervisor, until all staff, weekend, prn, and agency staff in completed. Monitoring 8. On [DATE] The DON/designee began a questionnaire to validate the effectiveness of the training. The questionnaire is conducted with facility staff. Immediate re-education will be completed by the DNS/designee if any staff is unable to answer appropriately to the questions on the questionnaire. Staff will not be allowed to work until after completion of the questionnaire. Projected completion [DATE]. 9. An impromptu QAPI meeting was conducted with the facility's Medical Director on [DATE] to notify of the potential for non-compliance and the action plan implemented for approval. Plan approved on [DATE]. The Plan of Removal was confirmed for the IJ by monitoring from [DATE] through [DATE] as follows: In an interview on [DATE] at 10:20am with Physician Y, he is the primary physician for CR#3. He said that the MD/NP and RP should be notified with any change of condition. He said that NP I or he were notified about a respiratory issue on [DATE], and NP I was contacted about hand tremors. He viewed the video dated [DATE] at 11:12am, and he indicated that the resident in the video was CR#3. He viewed the text threat to show that the notification to NP I was made on [DATE] at 1:12pm by LVN G. He said that the breathing of CR#3 was unstable in the video and she was in clear respiratory distress. He said that anyone that went into the room should have been able to see that CR#3 was in respiratory distress, and it was even more concerning if nursing staff could not see what he saw on the video. He said that notification should have been made to MD/NP. He said that if CR#3 had a respiratory change that morning at 10:30am, the video was taken at 11:12 am, the notification should have been immediate and not at 1:12pm, and EMS should have been contact immediately. He said that if CR#3 arrived at the hospital at 3:12pm that was delay in treatment, and the risk was death. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 11:34am with Unit Manager, at 11:56am with ADON, 2:30pm with Wound Care Nurse, and 3:39pm with RN B who acknowledged that training was received on the topics of topics of change in condition, notifications, and resident rights. All said that a change in condition is a change outside of the resident's baseline, and a life-threatening change like respiratory distress should be reported immediately to MD or NP, RP, DON, and now administrator. All said it was never appropriate to schedule non-emergency transportation for a life-threatening change in condition, and EMS by means of 911 should be contacted immediately. All said that all none nurse nursing staff have been trained to use the stop and watch tool to report a change of condition to the nurse, the form is completed, signed by the nurse, with a copy is given to the nurse and DON. All said that a change in condition should be documented in PCC, with SBAR completed with all details, observation, assessments, notifications, transfer location, and method of transportation documented. All said the RP must be verified when at the beside, if family at beside is requesting transportation for a resident it must be confirmed by the RP, and transportation was scheduled by method provide by RP. All said that the RP/Resident have right to request transfer to hospital by which every means requested emergency or non emergency transport, and right to be notified of a change in condition. In an interview on [DATE] at 1:14pm with LVN T, she said that she received training on Changing in Condition. She said that a change in condition is a sudden onset, seizures, bleeding and any respiratory. She said that 911 is notified along with the physician, hospice, families, DON and Administrator. In an interview on [DATE] at 1:31pm with LVN U, she said that she received training on Changing in Condition. She said that change in condition that is an emergency would be cardiac issues, respiratory issue, unresponsive, shortness of breath, or seizures She said that 911 is notified along with the physician, hospice, RP, DON and Administrator. In an interview on [DATE] at 2:30pm with LVN V, she said that she received training on Changing in Condition. She said that change in condition that is an emergency would be shortness of breath. She said that 911 is notified along with the physician, RP, DON and Administrator. In an interview on [DATE] at 3:02pm with MDS Nurse, she said that she had been trained on the stop and watch tool used to notify nurses of a change in condition. She said that any change in condition should be reported to the floor nurse, DON and Administrator if necessary. She said stop and watch is being used as a tool for the staff to complete and give to the nurse to ensure they are aware of the change in condition. She said as a nurse, she would assess the resident, call physician, DON and Administrator about her findings. She said a change in condition would be updated as well in EMR(electronic medical record) and MDS. In an interview on [DATE] at 3:48pm with LVN W, she said that she received training on Changing in Condition. She said that change in condition that is an emergency would respiratory distress, shortness of breath, cardiac arrest, active or bleeding. She said that 911 is notified along with the physician, RP, DON and Administrator. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 12:05pm with the Regional QA Nurse, she said that all nursing staff have been trained on the topics as outlined in the POR. She viewed the of CR#3 dated [DATE] recorded at 11:12am. She said the person in the video was CR#3, and her breathing was in distress, she was gasping for air, and she was not aware of the video. She said that her breathing would start as shown in the video, subside, and return. She said that she was now concerned with statements provided by LVN G and the Unit Manager as to the condition of CR#3 when she transferred to the hospital. She said that if she had gone into the room and saw CR#3 breathing as shown in the video, she would have been transferred out by means of 911, MD and RP notified, and she now feels that was the reason LVN G resigned. She said that she thought that LVN did everything correctly she did not. She said that if LVN G had not resigned she would have been terminated. She said that she would need to speak with upper management about the Unit Manager to determine what disciplinary action would be taken, and she was not aware that she went to the room of CR#3. She said that the negative impact to CR#3 was death due to respiratory distress, those are things you can not play with, and CR#3 died . In an interview on [DATE] at 3:56pm with DON Z, she said that she started at the facility on [DATE], and she was being trained by the IDON and Regional QA Nurse on the facilities policy, procedures, and duties. She has worked in skilled nursing facilities since she became a nurse over eight years ago. She was made aware of IJ for Change in Condition for an alleged delay in treatment. She has received all the training identified in the POR. She said that a change in condition is a change outside of the resident's baseline, and a life-threatening change like respiratory distress should be reported immediately to MD or NP, RP, DON, and now administrator. She said it was never appropriate to schedule non-emergency transportation for a life-threatening change in condition, and EMS by means of 911 should be contacted immediately. She said that all none nurse nursing staff should have been trained to use the stop and watch tool to report a change of condition to the nurse, the form is completed, signed by the nurse, with a copy is given to the nurse and DON. She said that a change in condition should be documented in PCC, with SBAR completed with all details, observation, assessments, notifications, transfer location, and method of transportation documented. She said that RP must be verified when at the beside, if family at beside is requesting transportation for a resident it must be confirmed by the RP, and transportation was scheduled by method provide by RP. All said that the RP/Resident have right to request transfer to hospital by which every means requested emergency or non emergency transport, and right to be notified of a change in condition. She viewed the video dated [DATE] at 11:12am of CR#3. She said that although she was not familiar with the resident she could see that her breathing was labored and she was in respiratory distress. She said that if anyone went in the room around the time of the video until she would have left the facility weather it was a visitor or nursing staff, would be able to identify she was in distress. She said that if the time of the video was 11:12am, the physician was never contacted, the resident did not arrive at the hospital until 3:12pm by non-emergency transport, it was a delay in treatment. The risk to the resident would be death. An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 5:48pm [TRUNCATED]

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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** 45604 Based on observation, interviews, and record reviews, the facility failed to ensure each resident was free from abuse and neglect for 1 (CR #1) of 21 residents reviewed for abuse and neglect. -The facility failed to ensure that CR #1 was free from sexual abuse after facility staff assessed the resident to have unexplained vaginal bleeding, a sign and symptom of sexual abuse on 09/14/2024 and 09/24/2024 that resulted in CR#1 being transferred to a local hospital on 09/24/2024 with semen being found in her urine culture and acute injury found during genital exam. An Immediate Jeopardy (IJ) was identified on 9/27/2024. The IJ template was provided to the facility on [DATE] at 5:20pm. While the IJ was removed on 10/10/2024 at 3pm, the facility remained out of compliance of pattern with no actual harm and potential for more than minimal that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of their corrective systems This failure could place residents at risk of serious harm from possible abuse and neglect. Findings included: CR#1 Record review of CR#1's facesheet dated 09/26/2024, reflected that she was an [AGE] year-old female, who admitted to the facility on [DATE] with a primary diagnosis of cerebral infraction due to embolism of left middle cerebral artery (stroke). Record review of CR#1's quarterly MDS (Minimum Data Set) assessment dated [DATE] reflected a BIMS (Brief Interview for Mental Status) was not available as the resident rarely /never understood with, a staff assessment for mental status as with cognitive skills for daily decision making severely impaired. Record review of CR#1's undated comprehensive care reflected: Focus: CR#1 has impaired cognitive function and impaired thought processes AEB (as evidenced by): Rarely/never makes decisions Goal: CR#1's needs will be met, and dignity will be maintained through the next review. Intervention: Monitor/document/report PRN (as needed) any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR#1's Late Entry SBAR (Situation, Background, Assessment, and Recommendation) completed by RN B with effective date of 09/15/2024 at 6:09am reflected, this started on 09/14/2024. Since this started has stayed the same. Spotted [NAME] red blood per vagina noted on the diaper. NP AK (Nurse Practitioner), RP (Responsible Party) and ADON notified. Report endorsed to day shift nurse for follow up. Reported to NP AK on 09/14/2024 10:20 PM. Pending response from NP AK. Record review of CR#1's progress note dated 09/14/2024 at 11:23pm completed by RN B reflected, monitor resident for abnormal bruising and/or bleeding form nose gums, blood in urine or stool every shift every shift. Record review of CR#1's progress note dated 09/15/2024 at 10:05am completed by LVN D reflected, Noted no new orders from NP AK regarding vaginal bleeding, nurse reassessed resident at this time, CNA came along with nurse, no apparent blood noted in resident's diaper or vaginal area, resident denies any pain or discomfort to perineal area, denies any apparent discomfort with urination, fluids encouraged to help resident keep hydrated, resident verbalizes understanding, no apparent distress noted, will continue to monitor. Record review of CR#1's SBAR completed by RN B with effective date of 09/24/2024 05:58 am reflected, Resident noted bleeding per vaginal; thick red blood, 01 brief soaked with blood. Resident noted sitting on the floor but refused fall. Resident is AO (alert and oriented)X (times) 3, skin intact, Vital as follows, BP(blood pressure) 89/55, HR(heart rate) 122, temp(temperature) 97.8, Resp(respiration) 18, bs(blood sugar) 121. DON, NP AND RP Notified. Sending resident to hospital for follow up. EMS notified for transportation to the hospital. Pending transportation and this time, report endorsed to day shift nurse for patient follow up. Record review of CR#1's progress note dated 09/24/2024 06:15am completed by LVN D reflected, received report from off-going nurse that resident is going to hospital ER (emergency room) due to vaginal bleeding and that ambulance on the way to pick up resident as she's going to hospital for further evaluation. BP at this time=127/74, HR (Heart rare) =114,T(temperature)=97.6, RR(Respiration Rate)=18, spo2(Oxygen saturation)=97% on room air, resident laying in bed, denies any pain, headache or discomfort at this time. Record review of CR#1's progress note dated 09/24/2024 07:00am completed by LVN D reflected, Resident left facility at this time via (by way of) stretcher accompanied by 2 EMS (Emergency Medical Service) personnel, alert, denies any pain or discomfort, resident going to hospital for further evaluation of vaginal bleeding. Record review of CR#1's progress note dated 09/25/2024 08:40 pm completed by Regional QA (Quality Assurance) nurse reflected, Called resident RP an informed her of hospital urine specimen findings as reported to facility acting DON and Administrator today by SSA(State Survey Agency). RP was aware and will come to facility to meet with Administrator. Record review of CR#1's progress note dated 09/25/2024 08:50 pm completed by Regional QA (Quality Assurance) nurse reflected, Physician AL called and notified of hospital urine specimen foundlings and resident remains at the hospital. Record Review of Incident and Accident Reports found no report on CR#1 for the time frame of 09/14/2024-09/25/2024. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR#1's medical records from a local hospital, emergency room Summary reflected, admitted [DATE] with chief complaint for vaginal bleeding. Urine specimen confirmed positive for UTI (Urinary Tract Infection) and Sperm present. There was no present or active bleeding. Unable to assess if any assault had occurred. No signs of external trauma to genitalia evaluated. Recommend O/B Gyn (Obstetrician-Gynecologist) consult and SANE (Sexual Assault Nurse Examiner) Exam if concern for sexual assault. Record review of CR#1's SANE Exam dated 09/25/2024 completed by Forensic Nurse, reflected hospital requested medical forensic exam for an 83 y/o (year old) female with concerns for acute sexual assault. Genital Exam Findings with acute injury visualized and Hymenal remnants (tissue left behind after the hymen breaks). In an interview on 09/25/2024 at 8:15am with Hospital Nurse, she said that CR#1came to the emergency room [DATE], and during an examination was assessed to be bleeding in the vaginal area. She said CR#1's urine sample was found to be positive for an UTI there was a small amount of semen in the vaginal area. She said that CR#1 had a small laceration on the vaginal area indicative of abuse. She said that she did not know how long the semen had been there, but the resident was examined by an OB/GYN doctor. She said that CR#1 appeared to be afraid of male nurses. She states that the resident was in pain when touched or examined, and sometimes she refused to be cleaned in that area. In an interview and observation on 09/25/2024 at 8:50am with CR#1 at local hospital, interpreter used for Vietnamese translation. She said that she had not been touched inappropriate by a male nurse. She said that she was afraid to return to the facility. She said that staff were nice to her, and she would not continue the conversation with the interpreter. The interpreter indicated that CR#1 rambled and appeared to have a speech problem, during conversation was incoherent, an only answered yes or no questions. CR#1 was observed laying in the bed, wearing hospital gown, and her face, hands, and legs did not show any marks or bruises. In a telephone interview on 9/25/2024 at 2:44pm with RN B, she said she worked the 6pm - 6am shift PRN (as needed), and she got to work at 6:00pm on 09/14/2024. She said CR#1 was being changed, and the CNA (CNA A) told her that she noticed spotting in CR#1's brief. She said she completed a head-to-toe assessment. She said she texted the NP, called RP and ADON prior to leaving. She said when she returned the next day, the day shift nurse (LVN C) told her that there was no more blood in resident diaper. She stated on 9/24/24 the CNA (CNA E) noticed blood again in CR#1's brief. She said she completed an assessment and immediately called the IDON and was instructed to send resident to the hospital immediately then call and inform the NP. She said that there were no male staff working during her shifts. She said CR#1 walked by herself, and she has never seen her wander in other residents' room. In an Interview on 9/25/2024 at 4:00pm, with CNA A, she said on 9/14/2024 around 8:45pm, there was some blood coming from CR#1's vagina, and she alerted RN B. She said that RN B completed a head-to-toe assessment, then she text NP but never got a response. She said that the next day 9/15/2024 at 2pm, LVN D and her checked and there was no blood or discharge observed. She said there were no male nurses on the shift. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 9/25/2024 at 4:36pm with the Forensic Nurse, she said an interview was conducted with CR#1 using Vietnamese translation, she was unable to say how the semen got in the urine, and said the blood was from having a period, she was too old, and no one would want her. She said that during the examination she observed a small abrasion around the anal area. In an interview in 9/25/2024 at 6:45pm the IDON said she has worked at the facility since August 2024. She said that on 9/14/2024 it was reported that resident had blood in her brief, and the NP gave orders to monitor for further bleeding. She said on 09/24/2024 she made decision to send the resident to the hospital. She said the resident did not exhibit pain, altered mental status so they did not check for a UTI. She said she was unaware how the CR#1 got semen in her. She said the night crew were all females. She said the facility had a large Vietnamese population and visitors come in droves. In an interview on 09/25/2024 at 7:40pm with the Administrator, he said he has worked at the facility for three years and he was the abuse coordinator. He said he does not know anything about semen, there were no complaints, he had heard sexual abuse happened about 6-7 years ago, but not since he started at the facility. He said the receptionist was supposed to monitor visitors and ensure they sign in, but since COVID (coronavirus disease) it had been an open-door policy. During an entrance conference on 09/26/2024 at 1:00pm with the Administrator, IDON, and Regional QA Nurse, information was provided that CR#1 had not returned from the local hospital, the abuse coordinator was the Administrator, and the facility used the PL(Provider Letter) 18-20 for reporting guidelines on facility incidents. They said the following task were completed, notification to police, ombudsman, responsible party, physician, medical director, safety surveys, skin assessments, an initiated staff interview and in-services. Observation in 09/26/2024 at 2:00pm of CNA A entering the room [ROOM NUMBER] of CR#1 and Resident #5 for resident care, and sign posted at the door for electronic monitoring. In an effort to complete an interview on 09/26/2024 at 3:12pm with Resident #5, she was not interviewable. In an interview an observation on 09/26/2024 at 3:25pm with CNA J on the 300 hall, he said he had worked at the facility PRN for 23 months, he works shifts 6am-2pm or 2pm-10pm, and today he was working the back of 300 hall until 10pm. He said that both CR#1 and Resident#5 are roommates, speak Vietnamese, do not talk much, and Resident#5 had electronic monitoring in the room, and she does not self-ambulate. He said that CR#1 had behavior of walking from room to nurse stations to dining hall, and back to her room, does not try to leave building do to wander guard placement, or try to enter other residents' rooms. He said he not seen any male staff, residents/visitor going into the room of CR#1. He said that CR#4 in room [ROOM NUMBER] also had behavior of walking down the 300 hall, but he does not have behavior of going into other residents room, and he was easily redirected. He said he worked the following dates 9/13/2024 400 hall 6am-2pm, 9/16/2024 200 hall 6am-2pm, 9/19/2024 back of 300 hall 2pm-10pm, and 9/24/2024 back of 300 hall 2-10pm. In an effort on 09/26/2024 at 1:05pm with CR#4, he did not appear to be interviewable and did not answer questions. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 09/26/2024 at 3:50pm with CNA A, she said that she worked on the front of 300 hall, and she works 2pm-10pm. She said that both CR#1 and CR#4 have behavior of walking the 300 hall but do not go into other residents room, and both are easily redirected. She said that CR#1 had a wander guard and Resident #5 had electronic monitoring. She said that CR#1 was transferred to the hospital for vaginal bleeding, while she was not at work. She said that prior to 9/14/2024 she had no HX (history) of vaginal bleeding. She said that on 09/14/2024 on 2pm-10pm, she went to check brief of CR#1 end of shift, she saw blood in the brief, reported to RN B who assessed, RN B said that there was vaginal bleeding, and completed notifications. She said that she worked 9/24/2024 2p-10pm. She said that she had seen CR#1 with bleeding since 09/14/2024. In an interview on 09/26/2024 at 4:11pm with LVN T, she said that she worked the 6am-6pm shift, and she is assigned 300 hall. She said that CR#1 and CR#4 have behavior of walking down 300 hall, but neither resident goes into rooms of other residents. She said that Resident#5 has electronic monitoring in place, and she said that not seen male staff, residents, or visitors to enter the room of CR#1 and Resident#5. She said that during report on 09/16/2024 she was told to monitor CR#1 for vaginal bleeding. She said that she had not history of bleeding, and she had not assessed her to have bleeding. She said that CR#1 was transferred to the hospital for vaginal bleeding on 09/24/2024, she did not know the outcome, and she had not assessed her to have any injuries to the vaginal area. She said that she did not know what steps facility took to determine if assessed bleeding was abuse, but she would have thought nurse that original assessed would have reported, and she would have reported. She said that she reports everything and leave it up to management to determine if there is a concern for abuse. In an interview on 09/26/2024 at 4:29pm with LVN D, she said she worked the 6am-6pm shift and she was usually assigned 300 hall but working 400 hall on 09/26/2024. She said that CR#1 and CR#4 have behavior of walking down 300 hall, but neither resident goes into rooms of other residents. She said that Resident#5 has electronic monitoring in place, and she said that not seen male staff, residents, or visitors to enter the room of CR#1 and Resident#5. She said that during report the morning of 09/15/2024, RN B told her that CR#1 was assessed with vaginal bleeding with no injuries, contact made with on-call NP, told to monitor, and follow up with primary. She said that she monitored with no new bleeding assessed, she did not see injury, and she contacted NP AK with no new orders. She said that the morning of 09/24/2024, RN B said that CR#1 was assessed with vaginal bleeding with no injures, and contact was made with NP AK, resident was to transfer to local hospital. She said she attempted to assess and perform peri care on CR#1 before she left out, CR#1 said no, placed her hand over the brief, and was afraid to let her look. She did not know the outcome of CR#1 going to the hospital. She said that the vaginal bleeding would only be reported to the Administrator if there was concern for abuse, and no one told her that the bleeding was a concern for abuse. She did not answer when asked if vaginal bleeding was s/s of sexual abuse or not wanting to be touched was s/s of sexual abuse. She did not answer when asked if all s/s of sexual abuse should be reported when assessed the Administrator. In an effort to complete a telephone interview on 09/26/2024 at 4:47pm with the RP BH; a message was left. In an effort to complete phone interview on 09/26/2024 at 4:48pm with RP P; a message was left. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a phone interview on 09/26/2024 at 4:29pm with RN B, she said that she worked PRN, assignment varied, and usually worked 6p-6am. She said that CR#1 and CR#4 had behavior of walking down 300 hall, but neither resident goes into rooms of other residents. She said that Resident#5 had electronic monitoring in place, and she said that she had not seen male staff, residents, or visitors to enter the room of CR#1 and Resident#5. She said that on 09/14/2024 CNA A reported to her toward the end of the aide (CNA A) shift 2p-10pm, that there was blood in the resident's brief, and she assessed determine bleeding was vaginal. She said she made notifications to the primary physician on-call number, IDON, and RP. She said that there initially was no response from the physician on-call number but successful on second attempt, told to monitor, and follow up with primary physician during regular hours. She said that she gave the information in report to LVN D, who contacted NP AK, with no new orders given. She said that there was no more bleeding or spotting until the morning of 9/25/2024 at the end of her shift, and CNA E saw blood in the brief of CR#1. She said she went to assess CR#1, the brief was soaked with blood, and determined it was coming from her vagina. She called NP AK with orders to monitor. She said that she contacted the IDON who said that CR#1 need to go to the hospital because it was the second time, to call NP AK back, if no order for transfer, contact RP to see if in agreement for transfer. She said she called RP BH, who agreed to transfer, scheduled transport, and then Call NP AK with agreement. She said she never assessed CR#1 to have injury either incident. She said that she did not remember CNA E telling her CR#1 was on the floor, and she could not remember how CNA E found CR#1. She said that she did not report to the Administrator that CR#1 had vaginal bleeding because she thought the bleeding was medical and not abuse. She said that she did report to IDON both times., NP AK was aware both times, but there was not a concern for abuse. She said that she did not think of abuse, because there were no injuries, CR#1 did not say there was abuse, and CR#1 was not afraid when she assessed. She said she did not know what steps the facility took to ensure there was no abuse when bleeding started on 9/14/2024 until the transfer to hospital. She said she did not complete an incident report. In an interview on 09/26/2024 at 5:12pm with the IDON she said that she worked for the facility's corporate office as a QA Nurse, she was assigned to facilities when the DON position was vacant, she had been at the facility as the IDON since 08/07/2024, and her oversight was the [NAME] QA Nurse. She said that she had been trained, all staff trained upon and ongoing for abuse and neglect. She said that the s/s of sexual abuse could be vaginal/anal bleeding, bruising or injury to the genitals in both male/female, refusal of peri care, afraid to be touched, not want care from opposite sex staff, or s/s of STD to include discharge. She said that if a nurse saw/received information that any resident on the floor, bleeding from genitals, afraid to be touched, and refusing care, the nurse should assess, contact the physician RP, DON, and Administrator. She said that the nurse should complete progress, SBAR, and incident report. She said that the Administrator should follow policy for reporting and investigating. She said that CR#1 started to have Vaginal Bleeding on 9/14/2024 with spotting in the in brief, RN B notified the NP, RP, and her. She said that on 9/24/2024 RN B notified her that CR#1 was assessed bleeding enough to be concerns, and NP said to monitor when notified. She said that she wanted CR#1 to transfer to the hospital, and she gave RN B guidance to facilitate the transfer in which she followed. She did not learn of the outcome of CR#1's hospital transfer until notified by the SSA on 09/25/2024 around 6pm that CR#1 had UTI and semen in urine. She said that she was not aware of injury to genitals found. She said that there was a concern for sexual abuse, and she was confused as to how the urine would test positive for semen. She said she notified the Administrator after speaking to SSA. She said that none of the resident are showing behaviors of going into other rooms. She said that the Administrator has taken step to ensure safety by reporting to SSA, Law Enforcement, RP, Primary Physician, and Medical Director. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 09/26/2024 at 5:48pm with the Administrator, he said CR#1 was sent to hospital for vaginal bleeding on 9/25/2024 for vaginal bleeding. He was made aware due to SSA investigation, that semen was found in the urine of CR#1, he was not made aware of any injuries, or CR#1 to have vaginal bleeding before. He said that he was not notified that vaginal bleeding starting on 9/14/2024. In an effort to complete phone interview on 09/26/2024 at 6:05pm with NP AK; a message was left. In an interview on 09/26/2024 at 7:23pm DON AN stated she started orientation on 09/23/2024, did not finish the onboarding, and 09/26/2024 was her official first day. She said she had worked in skilled nursing facilities for [AGE] years, and she had training on abuse and neglect. She said that unexplained vaginal bleeding with no history of bleeding would be a concern, should be reported immediately, and should be investigated by the facility to rule out abuse. She said that the risk of not reporting or investigating was the abuse could continue, and without a thorough investigation residents are left unprotected an involve more residents. She said that she was not made aware of the ongoing investigation when she arrived to the facility on [DATE]. She said that that nursing staff and IDON should have notified the Administrator who is the abuse coordinator immediately after CR#1 was observed with vaginal bleeding on 09/14/2024 and 09/25/2024. She said that had not taken the necessary steps to rule out immediacy. In an effort to complete phone interview on 09/27/2024 at 8:40am with NP AK; a message was left. In an interview on 09/27/2024 at 8:40am with CNA E, she said that she worked on 09/24/2024 on the 300 hall, and she worked 10pm-6am. She said that she did an initial change of brief after the shift start, could not recall time and CR#1 was not bleeding. She said toward the end of shift right before shift change, she entered the room, CR#1 was sitting on the bed with clothing and brief on, and CR#1 pointed to brief toward the vagina. She said that blood was on pajama bottoms towards the back, that was bright red. She said that she immediately got the RN B, she came into the room, saw the blood, and she left and went to the nurse station. She said that the when the RN B returned, she said that an ambulance was called, and she wanted her to help clean her up. She said that the brief was soaked with blood, but there was no blood anywhere else. She said that the RN B assessed CR#1 head to toe with no bruising or injuries, and she said that the blood was vaginal. She said that she threw out the brief, and clothing was placed in the linen for wash. She said that completed round every two hours, she did not see anyone male staff, residents, or visitors to go in the room. She said that she did not see CR#1 leave room during her shift. She said that CR#1 did not have history of bleeding and was her first time seeing the resident with vaginal bleeding. She said did not think it was abuse because the resident did not say anything happened, she did not seem like she was in pain, or had injuries. She said that she did not see CR#1 on the floor, and she did not tell anyone she was on the floor when she found her. In an effort to complete a telephone interview on 09/27/2024 at 8:45am with the RP BH; a message was left. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a phone interview on 09/27/2024 at 9:22am with Physician AL, he said that he is the primary physician for CR#1, nursing staffed notified NP AK that CR#1 was assessed with vaginal bleeding on both 9/14/2024 and 9/25/2024, and staff were to monitor but CR#1 transferred after the second incident. He said that the [NAME] QA nurse contacted him on 09/25/2024 to inform that semen was found in the urine of the CR#1. He said that CR#1 did not have history of vaginal bleeding. He said that based on information provided sexual abuse would be highly unlikely as an initial concern without more information like trauma or injuries with the bleeding. He said that the facility should always follow their polices for abuse and neglect prevention and investigation. In a phone interview on 09/27/2024 at 9:51am with the Medical Director, she said that she was notified about CR#1, the alleged sexual abuse, and that semen was found in urine specimen while at the hospital. She said that she would not initially have concern for sexual abuse with only vaginal bleeding without any injures present for physical abuse. She said that if there were other concerns that physical or sexual abuse occurred, a resident would need to be sent for further work up and testing at the hospital. Record Review of facility policy titled Abuse, Neglect, and Exploitation Dated January 2023 read in part, Its is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written polices and procedures that prohibit and prevent abuse Definitions: Sexual Abuse is non-consensual sexual contact of any type with a resident .VII. Protection of Resident The facility will make efforts to ensure all residents are protected from physical and psychosocial harm . This was determined to be an Immediate Jeopardy (IJ) on 9/27/2024, with notification made to the Administrator, with the IDON and Regional QA Nurse present. The IJ template was provided to the Administrator on 09/27/2024 at 5:20pm. In an interview on 9/27/2024 at 5:20pm the Administrator, IDON, and Regional QA Nurse were notified of the IJ(Immediate Jeopardy), during the IJ Meeting the Regional QA Nurse said that she did not understand why the IJ was called, and there had been steps taken to keep residents safe. The IDON said that video of the 300 Hall, had provided a culprit or perpetrator identified, with CR#4 seen walking the 300 hall, corporate were unable to see if he went into to the room of CR#1, but he would be placed on 1:1 observation. In an interview on 9/28/2024 at 4:40pm with the Administrator and IDON, requested to view the video of the 300 hall. The Administrator said that the video was viewed by the corporate Compliance Officer, provided details from the video, and he did not have physical copy of the video. Observation on 10/01/2024 at 9:30am , there were 10 visitors that entered the facility and were not asked to sign in by the Receptionist. In a telephone interview on 10/02/2024 at 10:08am with RP P, she was unable to provide footage from the electronic monitor of Resident#5, system does not save footage to recall. She had not observed CR#1 to into others room, and she had no concerns for other residents to come into the room of CR#1 and Resident #5. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a phone interview on 10/01/2024 at 11:23am with NP AK, she said that notification was made 9/14/2024 and 9/24/2024 that CR#1 was assessed with vaginal bleeding. She said that she would not had an initial concern for sexual abuse with out trauma related injures like tearing or defensive injures. She said that she was not aware that semen was found in the urine culture while CR#1 was at the hospital. She said that would expect that the facility would follow their policy for reporting and investigating abuse, starting when bleeding was first assessed. In an interview on 10/02/2024 at 1:27pm with Local Police Sergeant who said that there would be no investigation as CR#1 never said that she was sexually assaulted when interviewed by the officers. In an interview on 10/02/2024 at 3:50pm at local hospital with CR#1, she responded to yes/no question only. She said nothing happened to her, she did not want to talk about, and she did not answer anymore questions. In an interview on 10/01/2024 at 3:59pm with Receptionist, she said that all visitors should sign in, she said that she did not have group volunteers sign in that morning, she should have, and it was an oversight. She said that all non staff should sign in for resident safety. In an interview on 10/02/2024 at 4:00pm with RP, who said that CR#1 will not talk about what happened, she did not have male visitors, she did not see males enter the room, or took her out on pass. She did point to a male resident seen outside of the room she said had Parkinson b/c he was shaking, but she never said he did anything to her. She said that she has decided to take CR#1 home once discharged . The following Plan of Removal(POR) submitted by the facility was accepted on 9/28/2024 at 9:14pm The plan of removal reflected the following: PLAN OF REMOVAL Name of facility: Date: F 600 - The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Problem: The facility failed to ensure that CR#1 was free from sexual abuse when presented with vaginal bleeding. CCR[sic] mains[sic] at the hospital in stable condition. The resident responsible party was immediately notified of the transfer to the hospital and the urinalysis results. The facility immediately contacted the residents attending Physician and the facility medical director of the incident and resident status. Immediate action: (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47277 Based on interview and record review the facility failed to implement their written policies and procedures that prohibit and prevent abuse for 1 (CR#1) of 21residents reviewed for reporting abuse. -The facility failed to implement their written policy of Abuse, when facility staff failed to report to the Administrator and investigate when CR #1 was assessed with vaginal bleeding on 09/14/2024 and refused perineal care (washing the genital and anal areas), requested not to be touched, and feared being touched all signs and symptoms(s/s) of sexual abuse on 09/24/2024. CR#1 was transferred to a local hospital on 9/24/2024 and semen was present in her urine sample. An Immediate Jeopardy (IJ) was identified on 9/27/2024. The IJ template was provided to the facility on [DATE] at 5:20pm. While the IJ was removed on 10/1/2024 at 5:12pm, the facility remained out of compliance pattern with no actual harm and potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of their corrective systems This deficient practices could place residents at risk for abuse, neglect, exploitation, and or mistreatment. Findings included: CR#1 Record review of CR#1's facesheet dated 09/26/2024, reflected that she was an [AGE] year-old female, who admitted to the facility on [DATE] with a primary diagnosis of cerebral infraction due to embolism of left middle cerebral artery (stroke). Record review of CR#1's quarterly MDS (Minimum Data Set) assessment dated [DATE] reflected a BIMS (Brief Interview for Mental Status) was not available as the resident rarely /never understood with, a staff assessment for mental status as with cognitive skills for daily decision making severely impaired. Record review of CR#1's undated comprehensive care reflected: Focus: CR#1 has impaired cognitive function and impaired thought processes AEB (as evidenced by): Rarely/never makes decisions Goal: CR#1's needs will be met, and dignity will be maintained through the next review. Intervention: Monitor/document/report PRN (as needed) any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR#1's Late Entry SBAR (Situation, Background, Assessment, and Recommendation) completed by RN B with effective date of 09/15/2024 at 6:09am reflected, this started on 09/14/2024. Since this started has stayed the same. Spotted [NAME] red blood per vagina noted on the diaper. NP AK (Nurse Practitioner), RP (Responsible Party) and ADON notified. Report endorsed to day shift nurse for follow up. Reported to NP AK on 09/14/2024 10:20 PM. Pending response from NP AK. Record review of CR#1's progress note dated 09/14/2024 at 11:23pm completed by RN B reflected, monitor resident for abnormal bruising and/or bleeding form nose gums, blood in urine or stool every shift every shift. Record review of CR#1's progress note dated 09/15/2024 at 10:05am completed by LVN D reflected, Noted no new orders from NP AK regarding vaginal bleeding, nurse reassessed resident at this time, CNA came along with nurse, no apparent blood noted in resident's diaper or vaginal area, resident denies any pain or discomfort to perineal area, denies any apparent discomfort with urination, fluids encouraged to help resident keep hydrated, resident verbalizes understanding, no apparent distress noted, will continue to monitor. Record review of CR#1's SBAR completed by RN B with effective date of 09/24/2024 05:58 am reflected, Resident noted bleeding per vaginal; thick red blood, 01 brief soaked with blood. Resident noted sitting on the floor but refused fall. Resident is AO (alert and oriented)X (times) 3, skin intact, Vital as follows, BP(blood pressure) 89/55, HR(heart rate) 122, temp(temperature) 97.8, Resp(respiration) 18, bs(blood sugar) 121. DON, NP AND RP Notified. Sending resident to hospital for follow up. EMS notified for transportation to the hospital. Pending transportation and this time, report endorsed to day shift nurse for patient follow up. Record review of CR#1's progress note dated 09/24/2024 06:15am completed by LVN D reflected, received report from off-going nurse that resident is going to hospital ER (emergency room) due to vaginal bleeding and that ambulance on the way to pick up resident as she's going to hospital for further evaluation. BP at this time=127/74, HR (Heart rare) =114,T(temperature)=97.6, RR(Respiration Rate)=18, spo2(Oxygen saturation)=97% on room air, resident laying in bed, denies any pain, headache or discomfort at this time. Record review of CR#1's progress note dated 09/24/2024 07:00am completed by LVN D reflected, Resident left facility at this time via (by way of) stretcher accompanied by 2 EMS (Emergency Medical Service) personnel, alert, denies any pain or discomfort, resident going to hospital for further evaluation of vaginal bleeding. Record review of CR#1's progress note dated 09/25/2024 08:40 pm completed by Regional QA (Quality Assurance) nurse reflected, Called resident RP an informed her of hospital urine specimen findings as reported to facility acting DON and Administrator today by SSA(State Survey Agency). RP was aware and will come to facility to meet with Administrator. Record review of CR#1's progress note dated 09/25/2024 08:50 pm completed by Regional QA (Quality Assurance) nurse reflected, Physician AL called and notified of hospital urine specimen foundlings and resident remains at the hospital. Record Review of Incident and Accident Reports found no report on CR#1 for the time frame of 09/14/2024-09/25/2024. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR#1's medical records from a local hospital, emergency room Summary reflected, admitted [DATE] with chief complaint for vaginal bleeding. Urine specimen confirmed positive for UTI (Urinary Tract Infection) and Sperm present. There was no present or active bleeding. Unable to assess if any assault had occurred. No signs of external trauma to genitalia evaluated. Recommend O/B Gyn (Obstetrician-Gynecologist) consult and SANE (Sexual Assault Nurse Examiner) Exam if concern for sexual assault. Record review of CR#1's SANE Exam dated 09/25/2024 completed by Forensic Nurse, reflected hospital requested medical forensic exam for an 83 y/o (year old) female with concerns for acute sexual assault. Genital Exam Findings with acute injury visualized and Hymenal remnants (tissue left behind after the hymen breaks). In an interview on 09/25/2024 at 8:15am with Hospital Nurse, she said that CR#1came to the emergency room [DATE], and during an examination was assessed to be bleeding in the vaginal area. She said CR#1's urine sample was found to be positive for an UTI there was a small amount of semen in the vaginal area. She said that CR#1 had a small laceration on the vaginal area indicative of abuse. She said that she did not know how long the semen had been there, but the resident was examined by an OB/GYN doctor. She said that CR#1 appeared to be afraid of male nurses. She states that the resident was in pain when touched or examined, and sometimes she refused to be cleaned in that area. In an interview and observation on 09/25/2024 at 8:50am with CR#1 at local hospital, interpreter used for Vietnamese translation. She said that she had not been touched inappropriate by a male nurse. She said that she was afraid to return to the facility. She said that staff were nice to her, and she would not continue the conversation with the interpreter. The interpreter indicated that CR#1 rambled and appeared to have a speech problem, during conversation was incoherent, an only answered yes or no questions. CR#1 was observed laying in the bed, wearing hospital gown, and her face, hands, and legs did not show any marks or bruises. In a telephone interview on 9/25/2024 at 2:44pm with RN B, she said she worked the 6pm - 6am shift PRN (as needed), and she got to work at 6:00pm on 09/14/2024. She said CR#1 was being changed, and the CNA (CNA A) told her that she noticed spotting in CR#1's brief. She said she completed a head-to-toe assessment. She said she texted the NP, called RP and ADON prior to leaving. She said when she returned the next day, the day shift nurse (LVN C) told her that there was no more blood in resident diaper. She stated on 9/24/24 the CNA (CNA E) noticed blood again in CR#1's brief. She said she completed an assessment and immediately called the IDON and was instructed to send resident to the hospital immediately then call and inform the NP. She said that there were no male staff working during her shifts. She said CR#1 walked by herself, and she has never seen her wander in other residents' room. In an Interview on 9/25/2024 at 4:00pm, with CNA A, she said on 9/14/2024 around 8:45pm, there was some blood coming from CR#1's vagina, and she alerted RN B. She said that RN B completed a head-to-toe assessment, then she text NP but never got a response. She said that the next day 9/15/2024 at 2pm, LVN D and her checked and there was no blood or discharge observed. She said there were no male nurses on the shift. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 9/25/2024 at 4:36pm with the Forensic Nurse, she said an interview was conducted with CR#1 using Vietnamese translation, she was unable to say how the semen got in the urine, and said the blood was from having a period, she was too old, and no one would want her. She said that during the examination she observed a small abrasion around the anal area. In an interview in 9/25/2024 at 6:45pm the IDON said she has worked at the facility since August 2024. She said that on 9/14/2024 it was reported that resident had blood in her brief, and the NP gave orders to monitor for further bleeding. She said on 09/24/2024 she made decision to send the resident to the hospital. She said the resident did not exhibit pain, altered mental status so they did not check for a UTI. She said she was unaware how the CR#1 got semen in her. She said the night crew were all females. She said the facility had a large Vietnamese population and visitors come in droves. In an interview on 09/25/2024 at 7:40pm with the Administrator, he said he has worked at the facility for three years and he was the abuse coordinator. He said he does not know anything about semen, there were no complaints, he had heard sexual abuse happened about 6-7 years ago, but not since he started at the facility. He said the receptionist was supposed to monitor visitors and ensure they sign in, but since COVID (coronavirus disease) it had been an open-door policy. During an entrance conference on 09/26/2024 at 1:00pm with the Administrator, IDON, and Regional QA Nurse, information was provided that CR#1 had not returned from the local hospital, the abuse coordinator was the Administrator, and the facility used the PL(Provider Letter) 18-20 for reporting guidelines on facility incidents. They said the following task were completed, notification to police, ombudsman, responsible party, physician, medical director, safety surveys, skin assessments, an initiated staff interview and in-services. Observation in 09/26/2024 at 2:00pm of CNA A entering the room [ROOM NUMBER] of CR#1 and Resident #5 for resident care, and sign posted at the door for electronic monitoring. In an effort to complete an interview on 09/26/2024 at 3:12pm with Resident #5, she was not interviewable. In an interview an observation on 09/26/2024 at 3:25pm with CNA J on the 300 hall, he said he had worked at the facility PRN for 23 months, he works shifts 6am-2pm or 2pm-10pm, and today he was working the back of 300 hall until 10pm. He said that both CR#1 and Resident#5 are roommates, speak Vietnamese, do not talk much, and Resident#5 had electronic monitoring in the room, and she does not self-ambulate. He said that CR#1 had behavior of walking from room to nurse stations to dining hall, and back to her room, does not try to leave building do to wander guard placement, or try to enter other residents' rooms. He said he not seen any male staff, residents/visitor going into the room of CR#1. He said that CR#4 in room [ROOM NUMBER] also had behavior of walking down the 300 hall, but he does not have behavior of going into other residents room, and he was easily redirected. He said he worked the following dates 9/13/2024 400 hall 6am-2pm, 9/16/2024 200 hall 6am-2pm, 9/19/2024 back of 300 hall 2pm-10pm, and 9/24/2024 back of 300 hall 2-10pm. He said that no one had interviewed him or asked him to write a witness statement as part of investigation involving CR#1. In an effort on 09/26/2024 at 1:05pm with CR#4, he did not appear to be interviewable and did not answer questions. (continued on next page)

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	676381	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Houston Rehabilitation and Healthcare Center	13428 Bissonnet Houston, TX 77083

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 09/26/2024 at 3:50pm with CNA A, she said that she worked on the front of 300 hall, and she works 2pm-10pm. She said that both CR#1 and CR#4 have behavior of walking the 300 hall but do not go into other residents room, and both are easily redirected. She said that CR#1 had a wander guard and Resident #5 had electronic monitoring. She said that CR#1 was transferred to the hospital for vaginal bleeding, while she was not at work. She said that prior to 9/14/2024 she had no HX (history) of vaginal bleeding. She said that on 09/14/2024 on 2pm-10pm, she went to check brief of CR#1 end of shift, she saw blood in the brief, reported to RN B who assessed, RN B said that there was vaginal bleeding, and completed notifications. She said that she worked 9/24/2024 2p-10pm. She said that she had seen CR#1 with bleeding since 09/14/2024. She said that she had not been interview by anyone as part of investigation involving CR#1 or asked to write statement. She said that she did not think to report CR#1 vaginal bleeding on 09/14/2024, she did not know if RN B had reported, and maybe she should have reported In an interview on 09/26/2024 at 4:11pm with LVN T, she said that she worked the 6am-6pm shift, and she is assigned 300 hall. She said that CR#1 and CR#4 have behavior of walking down 300 hall, but neither resident goes into rooms of other residents. She said that Resident#5 has electronic monitoring in place, and she said that not seen male staff, residents, or visitors to enter the room of CR#1 and Resident#5. She said that during report on 09/16/2024 she was told to monitor CR#1 for vaginal bleeding. She said that she had not history of bleeding, and she had not assessed her to have bleeding. She said that CR#1 was transferred to the hospital for vaginal bleeding on 09/24/2024, she did not know the outcome, and she had not assessed her to have any injuries to the vaginal area. She said that she did not know what steps facility took to determine if assessed bleeding was abuse, but she would have thought nurse that original assessed would have reported, and she would have reported. She said that she reports everything and leave it up to management to determine if there is a concern for abuse. She said that she had not been interviewed or asked to a write statement. In an interview on 09/26/2024 at 4:29pm with LVN D, she said she worked the 6am-6pm shift and she was usually assigned 300 hall but working 400 hall on 09/26/2024. She said that CR#1 and CR#4 have behavior of walking down 300 hall, but neither resident goes into rooms of other residents. She said that Resident#5 has electronic monitoring in place, and she said that not seen male staff, residents, or visitors to enter the room of CR#1 and Resident#5. She said that during report the morning of 09/15/2024, RN B told her that CR#1 was assessed with vaginal bleeding with no injuries, contact made with on-call NP, told to monitor, and follow up with primary. She said that she monitored with no new bleeding assessed, she did not see injury, and she contacted NP AK with no new orders. She said that the morning of 09/24/2024, RN B said that CR#1 was assessed with vaginal bleeding with no injures, and contact was made with NP AK, resident was to transfer to local hospital. She said she attempted to assess and perform peri care on CR#1 before she left out, CR#1 said no, placed her hand over the brief, and was afraid to let her look. She did not know the outcome of CR#1 going to the hospital. She said that the vaginal bleeding would only be reported to the Administrator if there was concern for abuse, and no one told her that the bleeding was a concern for abuse. She did not answer when asked if vaginal bleeding was s/s of sexual abuse or not wanting to be touched was s/s of sexual abuse. She did not answer when asked if all s/s of sexual abuse should be reported when assessed the Administrator. She said she had not been interviewed or asked to write a witness statement after either incident. In an effort to complete a telephone interview on 09/26/2024 at 4:47pm with the RP BH; a message was left. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an effort to complete phone interview on 09/26/2024 at 4:48pm with RP P; a message was left. In a phone interview on 09/26/2024 at 4:29pm with RN B, she said that she worked PRN, assignment varied, and usually worked 6p-6am. She said that CR#1 and CR#4 had behavior of walking down 300 hall, but neither resident goes into rooms of other residents. She said that Resident#5 had electronic monitoring in place, and she said that she had not seen male staff, residents, or visitors to enter the room of CR#1 and Resident#5. She said that on 09/14/2024 CNA A reported to her toward the end of the aide (CNA A) shift 2p-10pm, that there was blood in the resident's brief, and she assessed determine bleeding was vaginal. She said she made notifications to the primary physician on-call number, IDON, and RP. She said that there initially was no response from the physician on-call number but successful on second attempt, told to monitor, and follow up with primary physician during regular hours. She said that she gave the information in report to LVN D, who contacted NP AK, with no new orders given. She said that there was no more bleeding or spotting until the morning of 9/25/2024 at the end of her shift, and CNA E saw blood in the brief of CR#1. She said she went to assess CR#1, the brief was soaked with blood, and determined it was coming from her vagina. She called NP AK with orders to monitor. She said that she contacted the IDON who said that CR#1 need to go to the hospital because it was the second time, to call NP AK back, if no order for transfer, contact RP to see if in agreement for transfer. She said she called RP BH, who agreed to transfer, scheduled transport, and then Call NP AK with agreement. She said she never assessed CR#1 to have injury either incident. She said that she did not remember CNA E telling her CR#1 was on the floor, and she could not remember how CNA E found CR#1. She said that she did not report to the Administrator that CR#1 had vaginal bleeding because she thought the bleeding was medical and not abuse. She said that she did report to IDON both times., NP AK was aware both times, but there was not a concern for abuse. She said that she did not think of abuse, because there were no injuries, CR#1 did not say there was abuse, and CR#1 was not afraid when she assessed. She said she did not know what steps the facility took to ensure there was no abuse when bleeding started on 9/14/2024 until the transfer to hospital. She said she did not complete an incident report. She said she had not been interviewed or asked to write statement. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 09/26/2024 at 5:12pm with the IDON she said that she worked for the facility's corporate office as a QA Nurse, she was assigned to facilities when the DON position was vacant, she had been at the facility as the IDON since 08/07/2024, and her oversight was the [NAME] QA Nurse. She said that she had been trained, all staff trained upon and ongoing for abuse and neglect. She said that the s/s of sexual abuse could be vaginal/anal bleeding, bruising or injury to the genitals in both male/female, refusal of peri care, afraid to be touched, not want care from opposite sex staff, or s/s of STD to include discharge. She said that all abuse should be reported to the Administrator/Abuse Coordinator immediately. She said that if a nurse saw/received information that any resident on the floor, bleeding from genitals, afraid to be touched, and refusing care, the nurse should assess, contact the physician RP, DON, and Administrator. She said that the nurse should complete progress, SBAR, and incident report. She said that the Administrator should follow policy for reporting and investigating. She said that the risk of not reporting or investigating is residents could be unsafe or abuse could continue. She said that CR#1 started to have Vaginal Bleeding on 9/14/2024 with spotting in the in brief, RN B notified the NP, RP, and her. She said that on 9/24/2024 RN B notified her that CR#1 was assessed bleeding enough to be concerns, and NP said to monitor when notified. She said that she wanted CR#1 to transfer to the hospital, and she gave RN B guidance to facilitate the transfer in which she followed. She did not learn of the outcome of CR#1's hospital transfer until notified by the SSA on 09/25/2024 around 6pm that CR#1 had UTI and semen in urine. She said that she was not aware of injury to genitals found. She said that there was a concern for sexual abuse, and she was confused as to how the urine would test positive for semen. She said she notified the Administrator after speaking to SSA. She said that none of the resident are showing behaviors of going into other rooms. She said that the Administrator has taken step to ensure safety by reporting to SSA, Law Enforcement, RP, Primary Physician, and Medical Director. In an interview on 09/26/2024 at 5:37pm with the Social Worker, he said that he works Monday-Friday from 8am-5pm. He said that there was an on going investigation involving CR#1, who assessed with vaginal bleeding, transferred to the hospital, and semen was found in her urine. He had not been interviewed as part of the investigation or asked to write a witness statement. He said that he had been asked to complete safety survey's on the 300 Hall, he complete interviews with English speaking female residents on the hall, with no abuse/neglect disclosed, and CNA A went with him. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 09/26/2024 at 5:48pm with the Administrator, he said that he had been trained on Abuse and Neglect, he was able to list types, provide s/s of sexual abuse, vaginal/anal bleeding, bruising or injury to the genitals in both male/female, could refuse care, be afraid to be touched or not want care from opposite sex staff. He said that the risk of not reporting or investigating abuse is that it could continue. He said that CR#1 was sent to hospital for vaginal bleeding on 9/25/2024 for vaginal bleeding. He was made aware due to SSA investigation, that semen was found in the urine of CR#1, he was not made aware of any injuries, or CR#1 to have vaginal bleeding before. He said that he had completed the following tasks as part of his investigation, self report completed, notification to the police, RP, physician, and Medical Director notified, increased monitoring in place, inservice for abuse and neglect initiated, resident interviews completed of all females on 300 hall, reviewed nursing department staff schedules with no male staff that worked during the time of the incident, hallway cameras for 300 hall being viewed by corporate IT was ongoing from 9/24/2024 until resident was transferred. He said that skins assessments were started on 09/26/2024 on 300 hall with female residents. He said he did not know why the assessments delayed, did not include all residents. He said that staff interviews were ongoing, but did not answer when asked if they had already been started. He said that he did not have direct care staff complete witness statements, he had not reviewed visitor log. He said no male staff had been suspended or suspected. He did not answer when asked if he thoroughly reviewed the schedules for all clinical male staff working during the time resident was observed with vaginal bleeding. He said that he was not notified that vaginal bleeding starting on 9/14/2024, and did not answer if he would have initiated investigation if he were aware. He did not answer when asked if staff to include IDON should have notified him as the abuse coordinator when bleeding was observed for both incidents. He said that he was not aware that CNA J worked the day prior to the initial bleeding being assessed, and multiple shifts since CR#1 transferred to the hospital to include assessment on the 300 hall. He was made aware of concern that facility self-report evidence was requested at entrance, there had been no evidence provided, and he provided no answer as to why. In an effort to complete phone interview on 09/26/2024 at 6:05pm with NP AK; a message was left. In an interview on 09/26/2024 with CNA A and LVN T, they stated they were not asked to increased monitoring on the hall, and they round every two hours as normal. In an interview on 09/26/2024 at 7:00pm during the end of day meeting with the Administrator, Regional QA Nurse, IDON, and DON AN with a list of concerns provided. The concerns provided were self-reported investigation evidence was requested at entrance not received, multiple interviews with direct staff that had not been interviewed or provide witness statements, Social Worker only interview English speaking residents for safety surveyors, multiple staff to include IDON were aware of vaginal bleeding on 09/14/2024 and 09/24/2024, and had not reported to the Administrator, CNA J who worked 9/13/2024, and multiple dates between 9/14/2024 and 9/24/2024 scheduled to work all though he had not been interview or asked to provide statement, no efforts to exclude male residents, visitors, or staff as perpetrators, no efforts to request electronic monitor of Resident#5 RP P, skin assessment were not initiated until after SSA entrance on 09/26/2024, with the skin assessments completed to include female residents on 300 hall, and staff denial that they were asked to increase monitoring. DON AN asked whose license would be referred if there was an IJ called. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 09/26/2024 at 7:23pm DON AN stated she started orientation on 09/23/2024, did not finish the onboarding, and 09/26/2024 was her official first day. She said she had worked in skilled nursing facilities for [AGE] years, and she had training on abuse and neglect. She said that unexplained vaginal bleeding with no history of bleeding would be a concern, should be reported immediately, and should be investigated by the facility to rule out abuse. She said that the risk of not reporting or investigating was the abuse could continue, and without a thorough investigation residents are left unprotected an involve more residents. She said that she was not made aware of the ongoing investigation when she arrived to the facility on [DATE]. She said that that nursing staff and IDON should have notified the Administrator who is the abuse coordinator immediately after CR#1 was observed with vaginal bleeding on 09/14/2024 and 09/25/2024. She said that had not taken the necessary steps to rule out immediacy. In an effort to complete phone interview on 09/27/2024 at 8:40am with NP AK; a message was left. In an interview on 09/27/2024 at 8:40am with CNA E, she said that she worked on 09/24/2024 on the 300 hall, and she worked 10pm-6am. She said that she did an initial change of brief after the shift start, could not recall time and CR#1 was not bleeding. She said toward the end of shift right before shift change, she entered the room, CR#1 was sitting on the bed with clothing and brief on, and CR#1 pointed to brief toward the vagina. She said that blood was on pajama bottoms towards the back, that was bright red. She said that she immediately got the RN B, she came into the room, saw the blood, and she left and went to the nurse station. She said that the when the RN B returned, she said that an ambulance was called, and she wanted her to help clean her up. She said that the brief was soaked with blood, but there was no blood anywhere else. She said that the RN B assessed CR#1 head to toe with no bruising or injuries, and she said that the blood was vaginal. She said that she threw out the brief, and clothing was placed in the linen for wash. She said that completed round every two hours, she did not see anyone male staff, residents, or visitors to go in the room. She said that she did not see CR#1 leave room during her shift. She said that CR#1 did not have history of bleeding and was her first time seeing the resident with vaginal bleeding. She said did not think it was abuse because the resident did not say anything happened, she did not seem like she was in pain, or had injuries. She said that she did not see CR#1 on the floor, and she did not tell anyone she was on the floor when she found her. She said that she had not been interviewed or asked to write a witness statement. She said that she had not been asked to increase rounds. In an effort to complete a telephone interview on 09/27/2024 at 8:45am with the RP BH; a message was left. In a phone interview on 09/27/2024 at 9:22am with Physician AL, he said that he is the primary physician for CR#1, nursing staffed notified NP AK that CR#1 was assessed with vaginal bleeding on both 9/14/2024 and 9/25/2024, and staff were to monitor but CR#1 transferred after the second incident. He said that the [NAME] QA nurse contacted him on 09/25/2024 to inform that semen was found in the urine of the CR#1. He said that CR#1 did not have history of vaginal bleeding. He said that based on information provided sexual abuse would be highly unlikely as an initial concern without more information like trauma or injuries with the bleeding. He said that the facility should always follow their polices for abuse and neglect prevention and investigation. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a phone interview on 09/27/2024 at 9:51am with the Medical Director, she said that she was notified about CR#1, the alleged sexual abuse, and that semen was found in urine specimen while at the hospital. She said that she would not initially have concern for sexual abuse with only vaginal bleeding without any injures present for physical abuse. She said that if there were other concerns that physical or sexual abuse occurred, a resident would need to be sent for further work up and testing at the hospital. Record review of Long-Term Care Regulatory Provider Letter (PL) 2024-14 Replaces, PL 2019-17, Date Issued: August 29, 2024, Title: Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Other Incidents that a Nursing Facility (NF) Must Report to the Health and Human Services Commission (HHSC) reflected in part, 2.1 Incidents that a NF Must Report to HHSC A NF must report to CII the following types of incidents, in accordance with applicable state and federal requirements: Abuse, Neglect, Exploitation, Death due to unusual circumstances, A missing resident, Misappropriation, Drug theft, and Suspicious injuries of unknown source, Fire, Emergency situations that pose a threat to resident health and safety, and Communicable disease situations that are an unusual or abnormal event that poses a threat to resident health and safety. 2.4 Reportable Incidents and Timeframe . Do Report: abuse (with or without serious bodily injury), an incident that results in serious bodily injury and that involves any of the following: neglect, exploitation, mistreatment, injuries of unknown source, Misappropriation of resident property .When to Report Immediately, but not later than two hours after the incident occurs or is suspected Attachment 1: Definitions and Examples of ANE (Abuse and Neglect)and other Reportable Incidents . Abuse: HHSC rules define abuse as: The negligent or willful infliction of injury, unreasonable confinement, intimidation, or punishment with resu [TRUNCATED]

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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** 45604 Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not 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 of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 (CR#1) out of 21 residents reviewed for reporting. 1. CNA A, RN B, and IDON failed to report to the facilities Abuse Coordinator when CR#1 was assessed with unexplained vaginal bleeding a sign and symptom(s/s) of sexual abuse on 09/14/2024. 2. CNA C, RN B, and IDON failed to report to the facilities Abuse Coordinator when CR#1 was assessed with unexplained vaginal bleeding s/s of sexual abuse on 09/24/2024. CR#1 was transferred to a local hospital on 9/24/2024 and semen was present in her urine sample. 3. LVN D failed to report to the facilities Abuse Coordinator when CR#1 was assessed with unexplained vaginal bleeding on 09/24/2024, refused perineal care (washing the genital and anal areas), requested not to be touched, and feared of being touched all s/s of sexual abuse on 09/25/2024. CR#1 was transferred to a local hospital on 9/24/2024 and semen was present in her urine sample. An Immediate Jeopardy (IJ) was identified on 9/27/2024. The IJ template was provided to the facility on [DATE] at 5:20pm. While the IJ was removed on 10/1/2024 at 5:12pm, the facility remained out of compliance of pattern with no actual harm and potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of their corrective systems This deficient practices could place residents at risk for abuse, neglect, exploitation, and or mistreatment. Findings included: CR#1 Record review of CR#1's facesheet dated 09/26/2024, reflected that she was an [AGE] year-old female, who admitted to the facility on [DATE] with a primary diagnosis of cerebral infraction due to embolism of left middle cerebral artery (stroke). Record review of CR#1's quarterly MDS (Minimum Data Set) assessment dated [DATE] reflected a BIMS (Brief Interview for Mental Status) was not available as the resident rarely /never understood with, a staff assessment for mental status as with cognitive skills for daily decision making severely impaired. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR#1's undated comprehensive care reflected: Focus: CR#1 has impaired cognitive function and impaired thought processes AEB (as evidenced by): Rarely/never makes decisions Goal: CR#1's needs will be met, and dignity will be maintained through the next review. Intervention: Monitor/document/report PRN (as needed) any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Record review of CR#1's Late Entry SBAR (Situation, Background, Assessment, and Recommendation) completed by RN B with effective date of 09/15/2024 at 6:09am reflected, this started on 09/14/2024. Since this started has stayed the same. Spotted [NAME] red blood per vagina noted on the diaper. NP AK (Nurse Practitioner), RP (Responsible Party) and ADON notified. Report endorsed to day shift nurse for follow up. Reported to NP AK on 09/14/2024 10:20 PM. Pending response from NP AK. Record review of CR#1's progress note dated 09/14/2024 at 11:23pm completed by RN B reflected, monitor resident for abnormal bruising and/or bleeding form nose gums, blood in urine or stool every shift every shift. Record review of CR#1's progress note dated 09/15/2024 at 10:05am completed by LVN D reflected, Noted no new orders from NP AK regarding vaginal bleeding, nurse reassessed resident at this time, CNA came along with nurse, no apparent blood noted in resident's diaper or vaginal area, resident denies any pain or discomfort to perineal area, denies any apparent discomfort with urination, fluids encouraged to help resident keep hydrated, resident verbalizes understanding, no apparent distress noted, will continue to monitor. Record review of CR#1's SBAR completed by RN B with effective date of 09/24/2024 05:58 am reflected, Resident noted bleeding per vaginal; thick red blood, 01 brief soaked with blood. Resident noted sitting on the floor but refused fall. Resident is AO (alert and oriented)X (times) 3, skin intact, Vital as follows, BP(blood pressure) 89/55, HR(heart rate) 122, temp(temperature) 97.8, Resp(respiration) 18, bs(blood sugar) 121. DON, NP AND RP Notified. Sending resident to hospital for follow up. EMS notified for transportation to the hospital. Pending transportation and this time, report endorsed to day shift nurse for patient follow up. Record review of CR#1's progress note dated 09/24/2024 06:15am completed by LVN D reflected, received report from off-going nurse that resident is going to hospital ER (emergency room) due to vaginal bleeding and that ambulance on the way to pick up resident as she's going to hospital for further evaluation. BP at this time=127/74, HR (Heart rare) =114,T(temperature)=97.6, RR(Respiration Rate)=18, spo2(Oxygen saturation)=97% on room air, resident laying in bed, denies any pain, headache or discomfort at this time. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR#1's progress note dated 09/24/2024 07:00am completed by LVN D reflected, Resident left facility at this time via (by way of) stretcher accompanied by 2 EMS (Emergency Medical Service) personnel, alert, denies any pain or discomfort, resident going to hospital for further evaluation of vaginal bleeding. Record review of CR#1's progress note dated 09/25/2024 08:40 pm completed by Regional QA (Quality Assurance) nurse reflected, Called resident RP an informed her of hospital urine specimen findings as reported to facility acting DON and Administrator today by SSA(State Survey Agency). RP was aware and will come to facility to meet with Administrator. Record review of CR#1's progress note dated 09/25/2024 08:50 pm completed by Regional QA (Quality Assurance) nurse reflected, Physician AL called and notified of hospital urine specimen foundlings and resident remains at the hospital. Record Review of Incident and Accident Reports found no report on CR#1 for the time frame of 09/14/2024-09/25/2024. Record review of CR#1's medical records from a local hospital, emergency room Summary reflected, admitted [DATE] with chief complaint for vaginal bleeding. Urine specimen confirmed positive for UTI (Urinary Tract Infection) and Sperm present. There was no present or active bleeding. Unable to assess if any assault had occurred. No signs of external trauma to genitalia evaluated. Recommend O/B Gyn (Obstetrician-Gynecologist) consult and SANE (Sexual Assault Nurse Examiner) Exam if concern for sexual assault. Record review of CR#1's SANE Exam dated 09/25/2024 completed by Forensic Nurse, reflected hospital requested medical forensic exam for an 83 y/o (year old) female with concerns for acute sexual assault. Genital Exam Findings with acute injury visualized and Hymenal remnants (tissue left behind after the hymen breaks). In an interview on 09/25/2024 at 8:15am with Hospital Nurse, she said that CR#1came to the emergency room [DATE], and during an examination was assessed to be bleeding in the vaginal area. She said CR#1's urine sample was found to be positive for an UTI there was a small amount of semen in the vaginal area. She said that CR#1 had a small laceration on the vaginal area indicative of abuse. She said that she did not know how long the semen had been there, but the resident was examined by an OB/GYN doctor. She said that CR#1 appeared to be afraid of male nurses. She states that the resident was in pain when touched or examined, and sometimes she refused to be cleaned in that area. In an interview and observation on 09/25/2024 at 8:50am with CR#1 at local hospital, interpreter used for Vietnamese translation. She said that she had not been touched inappropriate by a male nurse. She said that she was afraid to return to the facility. She said that staff were nice to her, and she would not continue the conversation with the interpreter. The interpreter indicated that CR#1 rambled and appeared to have a speech problem, during conversation was incoherent, an only answered yes or no questions. CR#1 was observed laying in the bed, wearing hospital gown, and her face, hands, and legs did not show any marks or bruises. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of evidence provided by the facility reflected, that facility staff completed questionnaires that they had not noticed anything suspicious in the facility, had not seen CR#1 out of her room or male staff or residents near the room of CR#1. Record review of evidence provided by the facility reflected, that the facility did not have witness statements or interviews with direct care staff that provided care to CR#1 on the incident dates of 09/14/2024 and 09/24/2024. In an interview on 09/29/2024 from 7:45pm to 8:15pm with 2:00pm -10:00pm shift aides (CNA A , CNA AO , CNA AP, and CNA AQ, who were acknowledge being trained on Abuse Neglect Policy to include typed of abuse highlighting sexual abuse, sign and symptoms of sexual abuse that included vaginal bleeding, refusing care, and fear of being touched, all abuse must reported to the administrator who was the abuse coordinator, and reported immediately. In a telephone interview on 09/30/2024 at 6:10am with CNA AR and with LVN AS at 6:20am, LVN AS could be heard providing the answers to CNA AR in effort determined if their training on abuse and neglect was satisfactory. In an interview on 09/30/2024 at 12pm with HR Director, she said that DON AN did not report to work on 09/27/2024 and was terminated. She said that she had been trained on Abuse Neglect Policy, she was not able to provide the type of abuse, or the sign and symptoms of sexual abuse. In an interview on 09/30/2024 from 12:45p.m. to 6:32p.m. with staff on all shifts (Laundry Aide AU, Housekeeper AV, Floor Technician AW, Housekeeper AX, CNA H, Restorative Aide, CNA L, CNA K , CNA, CNA N, PTA, Cook, Dietary Aide, Dietary Aide, LVN T, LVN V, CNA A , Staffing Coordinator, CNA AZ, LVN AJ, CNA, and MA R) who acknowledged being trained on Abuse Neglect Policy to include typed of abuse highlighting sexual abuse, sign and symptoms of sexual abuse that included vaginal bleeding, refusing care, and fear of being touched, all abuse must reported to the administrator who was the abuse coordinator, and reported immediately. All acknowledged being trained on Residents Rights Policy to include the right to be free of abuse and neglect, and Redirection of Residents with Wandering Behaviors immediately to nurse, MD, DON, and Administrator. In an interview on 10/01/2024 at 12pm with the HR Director, who acknowledged being trained on Abuse Neglect Policy to include typed of abuse highlighting sexual abuse, sign and symptoms of sexual abuse that included vaginal bleeding, refusing care, and fear of being touched, all abuse must reported to the administrator who was the abuse coordinator, and reported immediately. She acknowledged being trained on Residents Rights Policy to include the right to be free of abuse and neglect, and Redir [TRUNCATED]

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	676381	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Houston Rehabilitation and Healthcare Center	13428 Bissonnet Houston, TX 77083

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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** 45604 Based on observation, interview, and record review, the facility failed to have evidence that all alleged violations of abuse or mistreatment were thoroughly investigated and prevent further potential abuse or mistreatment while the investigation was in progress for 1 of 21 residents (CR#1) reviewed for abuse. 1. The Administrator, who was the facility's abuse coordinator and was responsible for investigating and reporting abuse incidents, failed to thoroughly investigate and report when CR#1 was assessed with unexplained vaginal bleeding on 09/14/2024, refused perineal care (washing the genital and anal areas), requested not to be touched, and feared being touched all signs and symptoms (s/s) of sexual abuse on 09/24/2024. CR#1 was transferred to a local hospital on 9/24/2024 and semen was present in her urine sample. 2. The Administrator, who was the facility's abuse coordinator and was responsible for investigating and reporting abuse incidents, failed thoroughly investigate and accurately report an allegation of abuse, when allegations were made that CR #3's was abused by the Hired Sitter on 07/13/2024. An Immediate Jeopardy (IJ) was identified on 9/27/2024. The IJ template was provided to the facility on [DATE] at 5:20pm. While the IJ was removed on 10/8/2024 at 3:43pm, the facility remained out of compliance of pattern with no actual harm and potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of their corrective systems These failures could place residents involved in abuse incidents at risk of continued abuse, further injury, pain, and physical and emotional distress. Findings included: CR#1 Record review of CR#1's facesheet dated 09/26/2024, reflected that she was an [AGE] year-old female, who admitted to the facility on [DATE] with a primary diagnosis of cerebral infraction due to embolism of left middle cerebral artery (stroke). Record review of CR#1's quarterly MDS (Minimum Data Set) assessment dated [DATE] reflected a BIMS (Brief Interview for Mental Status) was not available as the resident rarely /never understood with, a staff assessment for mental status as with cognitive skills for daily decision making severely impaired. Record review of CR#1's undated comprehensive care reflected: Focus: CR#1 has impaired cognitive function and impaired thought processes AEB (as evidenced by): Rarely/never makes decisions Goal: CR#1's needs will be met, and dignity will be maintained through the next review. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR#1's progress note dated 09/25/2024 08:50 pm completed by Regional QA (Quality Assurance) nurse reflected, Physician AL called and notified of hospital urine specimen foundlings and resident remains at the hospital. Record Review of Incident and Accident Reports found no report on CR#1 for the time frame of 09/14/2024-09/25/2024. Record review of CR#1's medical records from a local hospital, emergency room Summary reflected, admitted [DATE] with chief complaint for vaginal bleeding. Urine specimen confirmed positive for UTI (Urinary Tract Infection) and Sperm present. There was no present or active bleeding. Unable to assess if any assault had occurred. No signs of external trauma to genitalia evaluated. Recommend O/B Gyn (Obstetrician-Gynecologist) consult and SANE (Sexual Assault Nurse Examiner) Exam if concern for sexual assault. Record review of CR#1's SANE Exam dated 09/25/2024 completed by Forensic Nurse, reflected hospital requested medical forensic exam for an 83 y/o (year old) female with concerns for acute sexual assault. Genital Exam Findings with acute injury visualized and Hymenal remnants (tissue left behind after the hymen breaks). In an interview on 09/25/2024 at 8:15am with Hospital Nurse, she said that CR#1 came to the emergency room [DATE], and during an examination was assessed to be bleeding in the vaginal area. She said CR#1's urine sample was found to be positive for an UTI there was a small amount of semen in the vaginal area. She said that CR#1 had a small laceration on the vaginal area indicative of abuse. She said that she did not know how long the semen had been there, but the resident was examined by an OB/GYN doctor. She said that CR#2 appeared to be afraid of male nurses. She states that the resident is in pain when touched or examined, and sometimes she refuses to be cleaned in that area. In an interview and observation on 09/25/2024 at 8:50am with CR#1 at local hospital, interpreter used for Vietnamese translation. She said that she had not been touched inappropriate by a male nurse. She said that she was afraid to return to the facility. She said that staff were nice to her, and she would not continue the conversation with the interpreter. The interpreter indicated that CR#1 rambled and appeared to have a speech problem, during conversation was incoherent, an only answered yes or no questions. CR#1 was observed laying in the bed, wearing hospital gown, and her face, hands, and legs did not show any marks or bruises. In an interview on 9/25/2024 at 4:36pm with the Forensic Nurse, she said that an interview was conducted with CR#1 using Vietnamese translation, she was unable to say how the semen got in the urine, and said the blood was from having a period, she was too old, and no one would want her. She said that during the examination she observed a small abrasion around the anal area. In an interview in 9/25/2024 at 6:45pm with IDON, and she has worked at the facility since August 2024. She said that on 9/14/2024 it was reported that resident had blood in her brief, and the NP gave orders to monitor for further bleeding. She said that on 09/24/2024 she made decision to send the resident to the hospital. She said that the resident did not exhibit pain, altered mental status so they did not check for a UTI. She said that she was unaware how the CR#1 got semen in her. She said that the night crew were all females. She said that the facility had a large Vietnamese population and visitors come in droves. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 09/25/2024 at 7:40pm with the Administrator, he said that he has worked at the facility for three years and he was the abuse coordinator. He said that he does not know anything about semen, there were no complaints, he had heard sexual abuse happened about 6-7 years ago, but not since he started at the facility. He said that the receptionist was supposed to monitor visitors and ensure they sign in, but since COVID (coronavirus disease) it had been an open-door policy. During an entrance conference on 09/26/2024 at 1:00pm with the Administrator, IDON, and Regional QA Nurse, information was provided that that CR#1 had not returned from the local hospital, the abuse coordinator was the Administrator. They all stated that after they were made aware that it was suspected that CR#1 was sexually abused on 09/25/2024, notification to police, ombudsman, responsible party, physician, medical director, safety surveys, skin assessments, an initiated staff interview and in-services. Observation in 09/26/2024 at 2:00pm of the room [ROOM NUMBER] of CR#1 and Resident #5 with sign posted at the door for electronic monitoring. In an interview an observation on 09/26/2024 at 3:25pm with CNA J on the 300 hall, he said he had worked at the facility PRN for 23 months, he works shifts 6am-2pm or 2pm-10pm, and today he was working the back of 300 hall until 10pm. He said that both CR#1 and Resident#5 are roommates, speak Vietnamese, do not talk much, and Resident#5 had electronic monitoring in the room, and she does not self-ambulate. He said that CR#1 had behavior of walking from room to nurse stations to dining hall, and back to her room, does not try to leave building do to wander guard placement, or try to enter other residents' rooms. He said he not seen any male staff, residents/visitor going into the room of CR#1. He said that CR#4 in room [ROOM NUMBER] also had behavior of walking down the 300 hall, but he does not have behavior of going into other residents room, and he was easily redirected. He said he worked the following dates 9/13/2024 400 hall 6am-2pm, 9/16/2024 200 hall 6am-2pm, 9/19/2024 back of 300 hall 2pm-10pm, and 9/24/2024 back of 300 hall 2-10pm. He said that no one had interviewed him or asked him to write a witness statement as part of investigation involving CR#1. In an interview on 09/26/2024 at 3:50pm with CNA A, she said that she worked on the front of 300 hall, and she works 2pm-10pm. She said that both CR#1 and CR#4 have behavior of walking the 300 hall but do not go into other residents room, and both are easily redirected. She said that CR#1 had a wander guard and Resident #5 had electronic monitoring. She said that CR#1 was transferred to the hospital for vaginal bleeding, while she was not at work. She said that prior to 9/14/2024 she had no HX (history) of vaginal bleeding. She said that on 09/14/2024 on 2pm-10pm, she went to check brief of CR#1 end of shift, she saw blood in the brief, reported to RN B who assessed, RN B said that there was vaginal bleeding, and completed notifications. She said that she worked 9/24/2024 2p-10pm. She said that she had seen CR#1 with bleeding since 09/14/2024. She said that she did not think to report CR#1 vaginal bleeding on 09/14/2024, she did not know if RN B had reported, and maybe she should have reported. She said that she had not been interview by anyone as part of investigation involving CR#1 or asked to write statement. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 09/26/2024 at 4:11pm with LVN T, she said that she worked the 6am-6pm shift, and she is assigned 300 hall. She said that CR#1 and CR#4 have behavior of walking down 300 hall, but neither resident goes into rooms of other residents. She said that Resident#5 has electronic monitoring in place, and she said that not seen male staff, residents, or visitors to enter the room of CR#1 and Resident#5. She said that during report on 09/16/2024 she was told to monitor CR#1 for vaginal bleeding. She said that she had not history of bleeding, and she had not assessed her to have bleeding. She said that CR#1 was transferred to the hospital for vaginal bleeding on 09/24/2024, she did not know the outcome, and she had not assessed her to have any injuries to the vaginal area. She said that she did not know what steps facility took to determine if assessed bleeding was abuse, but she would have thought nurse that original assessed would have reported, and she would have reported. She said that she had not been interviewed or asked to a write statement. In an interview on 09/26/2024 at 4:29pm with LVN D, she said she worked the 6am-6pm shift and she was usually assigned 300 hall but working 400 hall on 09/26/2024. She said that CR#1 and CR#4 have behavior of walking down 300 hall, but neither resident goes into rooms of other residents. She said that Resident#5 has electronic monitoring in place, and she said that not seen male staff, residents, or visitors to enter the room of CR#1 and Resident#5. She said that during report the morning of 09/15/2024, RN B told her that CR#1 was assessed with vaginal bleeding with no injuries, contact made with on-call NP, told to monitor, and follow up with primary. She said that she monitored with no new bleeding assessed, she did not see injury, and she contacted NP AK with no new orders. She said that the morning of 09/24/2024, RN B said that CR#1 was assessed with vaginal bleeding with no injures, and contact was made with NP AK, resident was to transfer to local hospital. She said she attempted to assess and perform peri care on CR#1 before she left out, CR#1 said no, placed her hand over the brief, and was afraid to let her look. She did not know the outcome of CR#1 going to the hospital. She said that the vaginal bleeding would only be reported to the Administrator if there was concern for abuse, and no one told her that the bleeding was a concern for abuse. She did not answer when asked if vaginal bleeding was s/s of sexual abuse or not wanting to be touched was s/s of sexual abuse. She did not answer when asked if all s/s of sexual abuse should be reported when assessed the Administrator. She said she had not been interviewed or asked to write a witness statement after either incident. In an effort to complete a telephone interview on 09/26/2024 at 4:47pm with the RP BH; a message was left. In an effort to complete phone interview on 09/26/2024 at 4:48pm with RP P; a message was left. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a phone interview on 09/26/2024 at 4:29pm with RN B, she said that she worked PRN, assignment varied, and usually worked 6p-6am. She said that CR#1 and CR#4 had behavior of walking down 300 hall, but neither resident goes into rooms of other residents. She said that Resident#5 had electronic monitoring in place, and she said that she had not seen male staff, residents, or visitors to enter the room of CR#1 and Resident#5. She said that on 09/14/2024 CNA A reported to her toward the end of the aide (CNA A) shift 2p-10pm, that there was blood in the resident's brief, and she assessed determine bleeding was vaginal. She said she made notifications to the primary physician on-call number, IDON, and RP. She said that there initially was no response from the physician on-call number but successful on second attempt, told to monitor, and follow up with primary physician during regular hours. She said that there was no more bleeding or spotting until the morning of 9/25/2024 at the end of her shift, and CNA E saw blood in the brief of CR#1. She said she went to assess CR#1, the brief was soaked with blood, and determined it was coming from her vagina. She called NP AK with orders to monitor. She said that she contacted the IDON who said that CR#1 need to go to the hospital because it was the second time, to call NP AK back, if no order for transfer, contact RP to see if in agreement for transfer. She said she called RP BH, who agreed to transfer, scheduled transport, and then Call NP AK with agreement. She said she never assessed CR#1 to have injury either incident. She said that she did not remember CNA E telling her CR#1 was on the floor, and she could not remember how CNA E found CR#1. She said that she did not report to the Administrator that CR#1 had vaginal bleeding because she thought the bleeding was medical and not abuse. She said that she did report to IDON both times., NP AK was aware both times, but there was not a concern for abuse. She said that she did not think of abuse, because there were no injuries, CR#1 did not say there was abuse, and CR#1 was not afraid when she assessed. She said she did not know what steps the facility took to ensure there was no abuse when bleeding started on 9/14/2024 until the transfer to hospital. She said she did not complete an incident report. She said she had not been interviewed or asked to write statement. In an interview on 09/26/2024 at 5:12pm with the IDON she said that she worked for the facility's corporate office as a QA Nurse, she was assigned to facilities when the DON position was vacant, she had been at the facility as the IDON since 08/07/2024, and her oversight was the [NAME] QA Nurse. She said that she had been trained, all staff trained upon and ongoing for abuse and neglect. She said that the s/s of sexual abuse could be vaginal/anal bleeding, bruising or injury to the genitals in both male/female, refusal of peri care, afraid to be touched, not want care from opposite sex staff, or s/s of STD to include discharge. She said that all abuse should be reported to the Administrator/Abuse Coordinator immediately. She said that if a nurse saw/received information that any resident on the floor, bleeding from genitals, afraid to be touched, and refusing care, the nurse should assess, contact the physician RP, DON, and Administrator. She said that the Administrator should follow policy for reporting and investigating. She said that the risk of not reporting or investigating was residents could be unsafe or abuse could continue. She said that CR#1 started to have Vaginal Bleeding on 9/14/2024 with spotting in the in brief, RN B notified the NP, RP, and her. She said that on 9/24/2024 RN B notified her that CR#1 was assessed bleeding enough to be concerns, and NP said to monitor when notified. She said that she wanted CR#1 to transfer to the hospital, and she gave RN B guidance to facilitate the transfer in which she followed. She said she did not learn of the outcome of CR#1's hospital transfer until notified by the SSA on 09/25/2024 around 6pm that CR#1 had UTI and semen in urine. She said that she was not aware of injury to genitals found. She said that there was a concern for sexual abuse, and she was confused as to how the urine would test positive for semen. She said she notified the Administrator after speaking to SSA. She said that the Administrator has taken step to ensure safety by reporting to SSA, Law Enforcement, RP, Primary Physician, and Medical Director. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 09/26/2024 at 7:00pm during the end of day meeting with the Administrator, Regional QA Nurse, IDON, and DON AN with a list of concerns provided. The concerns provided were self-reported investigation evidence was requested at entrance not received, multiple interviews with direct staff that had not been interviewed or provide witness statements, Social Worker only interview English speaking residents for safety surveyors, multiple staff to include IDON were aware of vaginal bleeding on 09/14/2024 and 09/24/2024, and had not reported to the Administrator, CNA J who worked 9/13/2024, and multiple dates between 9/14/2024 and 9/24/2024 scheduled to work all though he had not been interview or asked to provide statement, no efforts to exclude male residents, visitors, or staff as perpetrators, no efforts to request electronic monitor of Resident#5 RP P, skin assessment were not initiated until after SSA entrance on 09/26/2024, with the skin assessments completed to include female residents on 300 hall, and staff denial that they were asked to increase monitoring. DON AN asked whose license would be referred if there was an IJ called. In an interview on 09/26/2024 at 7:23pm DON AN stated she started orientation on 09/23/2024, did not finish the onboarding, and 09/26/2024 was her official first day. She said she had worked in skilled nursing facilities for [AGE] years, and she had training on abuse and neglect. She said that unexplained vaginal bleeding with no history of bleeding would be a concern, should be reported immediately, and should be investigated by the facility to rule out abuse. She said that the risk of not reporting or investigating was the abuse could continue, and without a thorough investigation residents are left unprotected an involve more residents. She said that she was not made aware of the ongoing investigation when she arrived to the facility on [DATE]. She said that that nursing staff and IDON should have notified the Administrator who is the abuse coordinator immediately after CR#1 was observed with vaginal bleeding on 09/14/2024 and 09/25/2024. She said that had not taken the necessary steps to rule out immediacy. In an effort to complete phone interview on 09/27/2024 at 8:40am with NP AK; a message was left. In an interview on 09/27/2024 at 8:40am with CNA E, she said that she worked on 09/24/2024 on the 300 hall, and she worked 10pm-6am. She said that she did an initial change of brief after the shift start, could not recall time and CR#1 was not bleeding. She said toward the end of shift right before shift change, she entered the room, CR#1 was sitting on the bed with clothing and brief on, and CR#1 pointed to brief toward the vagina. She said that blood was on pajama bottoms towards the back, that was bright red. She said that she immediately got the RN B, she came into the room, saw the blood, and she left and went to the nurse station. She said that the when the RN B returned, she said that an ambulance was called, and she wanted her to help clean her up. She said that the brief was soaked with blood, but there was no blood anywhere else. She said that the RN B assessed CR#1 head to toe with no bruising or injuries, and she said that the blood was vaginal. She said that she threw out the brief, and clothing was placed in the linen for wash. She said that completed round every two hours, she did not see anyone male staff, residents, or visitors to go in the room. She said that she did not see CR#1 leave room during her shift. She said that CR#1 did not have history of bleeding and was her first time seeing the resident with vaginal bleeding. She said did not think it was abuse because the resident did not say anything happened, she did not seem like she was in pain, or had injuries. She said that she did not see CR#1 on the floor, and she did not tell anyone she was on the floor when she found her. She said that she had not been interviewed or asked to write a witness statement. She said that she had not been asked to increase rounds. In an effort to complete a telephone interview on 09/27/2024 at 8:45am with the RP BH; a message was left. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a phone interview on 09/27/2024 at 9:22am with Physician AL, he said that he is the primary physician for CR#1, nursing staffed notified NP AK that CR#1 was assessed with vaginal bleeding on both 9/14/2024 and 9/25/2024, and staff were to monitor but CR#1 transferred after the second incident. He said that the [NAME] QA nurse contacted him on 09/25/2024 to inform that semen was found in the urine of the CR#1. He said that CR#1 did not have history of vaginal bleeding. He said that based on information provided sexual abuse would be highly unlikely as an initial concern without more information like trauma or injuries with the bleeding. He said that the facility should always follow their polices for abuse and neglect prevention and investigation. In a phone interview on 09/27/2024 at 9:51am with the Medical Director, she said that she was notified about CR#1, the alleged sexual abuse, and that semen was found in urine specimen while at the hospital. She said that she would not initially have concern for sexual abuse with only vaginal bleeding without any injures present for physical abuse. She said that if there were other concerns that physical or sexual abuse occurred, a resident would need to be sent for further work up and testing at the hospital. Record Review of facility policy titled Abuse, Neglect, and Exploitation Dated January 2023 read in part, Its is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written polices and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriate of resident property. Statement: All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. VI. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or repo1ts of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence); 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 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. 7. All allegations are thoroughly investigated. The administrator initiates investigations . 9. The administrator provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation. 13. The individual conducting the investigation as a minimum: a. reviews the documentation and evidence; e. interviews any witnesses to the incident . h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; i.interviews the resident's roommate, family members, and visitors . reviews all events leading up to the alleged incident; and . 14. The following guidelines are used when conducting interviews: Witness statements are obtained in writing, signed and dated. The witness may write his/her statement, or the investigator may obtain a statement VII. Protection of Resident The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: C. Increased supervision of alleged victim and residents; . This was determined to be an Immediate Jeopardy (IJ) on 9/27/2024, with notification made to the Administrator, with the IDON and Regional QA Nurse present. The IJ template was provided to the Administrator on 09/27/2024 at 5:20pm. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45604 Based on observation, interview, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 2 (CR #2 and CR#3) out of 21 residents reviewed for quality of care in that: 1. LVN F failed to notify the hospice nurse, Non-Emergency Medical Service (EMS), and local hospital that CR#2 required assessment for sexual abuse after being observed with vaginal bleeding a sign and symptom of sexual abuse. CR#2 arrived at the hospital on [DATE] at 7:52am and had not been assessed for the concern for sexual abuse at 11:19am. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE]at 10:26am. While the IJ was removed on [DATE] at 3pm, the facility remained out of compliance at a pattern with no actual harm and potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of their corrective systems. 2. The facility failed to arrange emergency transportation to a local hospital when CR#3 was in respiratory distress on [DATE] at 10:30am, CR#3 arrived at the local hospital at 3:12pm by means of non-emergency contracted transportation. An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 5:48pm. While the IJ was removed on [DATE] 4:25 pm at , the facility remained out of compliance at a pattern with no actual harm and potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of their corrective systems. These failures could expose residents to delayed treatment, worsening of condition, low quality of care, hospitalization , and death. Findings included: Record review of CR#2's face sheet dated [DATE], reflected she was an [AGE] year-old female, who admitted to the facility on [DATE] on hospice with a primary diagnosis of traumatic subdural hemorrhage (brain bleed after a head injury). Record review of CR#2's undated comprehensive care reflected: Focus: CR#2 is on hospice services. DX (diagnosis): Acute Respiratory Failure. Call hospice first for any change in condition. Goal: Dignity will be maintained and the resident will be kept comfortable and pain free with in one hour of (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	intervention through the next review. Intervention: Assist with ADL's (Activities of Daily Living) and provide comfort measures as needed. Ensure Advanced Directives are in place per resident and responsible party request. Monitor for decreased appetite, weight loss, skin break down, n\v(nausea and vomiting), etc(et cetera-report to Hospice. Monitor for s\s(sign and symptom) of increased pain, discomfort-give meds(medication)\tx's(treatment) monitor for relief. Focus: CR#2 has a pressure ulcer (Stage 4) to (Sacrum) d/t(do to): Poor Nutritional Status, Moisture/Incontinence and Immobility and is at risk for further skin breakdown. Goal: The wound(s) will show improvement during the review period with therapeutic interventions. Interventions: Air Mattress as indicated and ordered. Assess for pain and treat as indicated especially if pain is noticed before treatment. Assess wound for improvement during each treatment and report to the MD if the wound is declining. Notify MD(Medical Doctor) and RP(Responsible Party) of changes in condition as appropriate. Practice good hygiene. Treatment as ordered. Weekly skin assessment. Record review of CR#2's admission MDS (Minimum Data Set) assessment dated [DATE] reflected a BIMS(Brief Interview for Mental Status) was not available as the resident rarely /never understood with severely impaired cognitive skills for daily decision making. Record review of CR#2's progress note completed on [DATE] at 8:00am by LVN F read in part, During routine peri care, writer with CNA E assigned to resident, noted vaginal bleeding, noted also some clots. No signs and symptoms of distress at this time. No visible swelling, bruising, redness noted. Soiled brief and other beddings gathered and preserved. Vitals taken : BP(blood pressure) ,d+[DATE], P(pulse) 101, R(Respiration) 20, TEMP(temperature) 97.5, 89% on collar trach(tracheostomy) of 28% SPO2(Oxygen saturation). DON(IDON), Hospice Nurse, Physician, and NP(nurse practitioner) called. CR#2 and 2 EMS personnel exit the facility at 0726hrs. Record review of CR#'2 SBAR(Situation, Background, Assessment, and Recommendation) dated [DATE] completed by LVN F reflected notification to the RP completed 5:40am of being transferred to the hospital. Record review of CR#2's transfer/discharge report dated [DATE] did not list a chief complaint o reason for transfer. Record review of CR#2's contracted EMS run report dated [DATE] reflected a reason for transport for vaginal bleeding evaluation with no information that the bleeding could be related to sexual abuse. The transport started at 7:39am, and CR#2 arrived to the hospital at 7:49am. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR#2's hospital medical records dated [DATE] with admission time at 7:54am reflected a chief complaint for vaginal bleeding with no information that the bleeding could be related to sexual abuse. Re-evaluation Progress Note read in part, .update; I was notified that the state was visiting the ER, because of this patient's presentation, and they were concerned about possible sexual assault .Afterwards, I spoke with representative from the state, who asked me several questions regarding the patients presentation, and whether or not we suspect that this is a sexual assault or not. I am unsure whether or not there is any sexual assault component to this case, as the patient's bleeding could be from their sacral ulcer, rather than the vagina, but it is unclear. A pelvic ultrasound, shows no adnexal masses, no peritoneal free fluid, and no visualized uterus and ovaries. Upon our examination, there was no signs of any obvious vaginal trauma such as vaginal laceration. Time of re-eval 11:15am.Records reflected a discharge date of [DATE]. Record review of CR#2'sprogress note dated [DATE] an completed by Regional QA(Quality Assurance) Nurse reflected notification was made to the hospice service and RP to inform of a suspicion of sexual abuse suspected with vaginal bleeding. In an interview on [DATE] at 9:45am with the Administrator, he said that an investigation had been indicated and report made to State Survey Agency (SSA) after a resident (CR#2) was observed that morning between 4:00 am-5:00am with vaginal bleeding. He said that the resident(CR#2)was sent to the hospital for exam, treatment, and to confirm if the bleeding was due to a sexual assault. In an interview on [DATE] at 10:45am with RN AA at a local hospital, she confirmed that CR#2 was in the emergency room (ER) for vaginal bleeding, with no information about a concern for sexual assault. She said that the Emergency Department (ED) should have notified her upon arrival, no one had, and she should no to ensure resident safety while in the hospital. She said that she had to ensure her management was aware, notification for law enforcement, and if a SANE exam was needed. In an interview on [DATE] at 11:17am with RN AB at a local hospital, she said that CR#2 arrived at the hospital with a chief complaint of vaginal bleeding, was assessed, and will be discharged . She said that the bleeding was most likely due to pressure ulcer stage 3 on the sacrum, CR#2 was not actively bleeding, and would not be admitted . She said that CR#2 arrived at the hospital by means of contracted Emergency Medical Service (EMS). She said that Emergency Medical Technician (EMT) or the facility did not provide information that there was concern for abuse, neglect, or sexual abuse. She said that there were no concerns on labs completed for the presence of semen in the urine, but there were no labs completed for sexual transmitted disease (STD). She said that she did not see signs of sexual assault upon the initial physical exam. She said that facility should have informed, if EMT was aware they should have informed, information was needed upon arrival to make an accurate assessment determine if sexual abuse was the cause of the vaginal bleeding, or the presence of STD. Observation on [DATE] at 11:17am while completing interview with RN AB, a Physician (Physician AC)could be seen in the room of CR#2 speaking with the facilities Marketing Director. Observation of the Marketing Director with her cellular phone on speaker with someone from facility speaking too. Observation of the Physician AC providing details that CR#2 would be discharged , and the Marketing Director left the hospital. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 11:19am with Physician AC at a local hospital, he said that EMT or facility provided details that there was a concern that CR#2 bleeding could be due to sexual assault upon arrival. He said that he should have been provided with the information when CR#2 arrived, for him take the appropriate steps to conclude if there was a concern sexual assault. He said that he was just learning of this concern from the hospitals Quality Assurance Department. He said that CR#2's urine sample did not have semen present, there were no concern on the pelvic exam or ultrasound for concern of assault. He said that there were no labs for STD screening, and if he had known upon arrival would have ordered. He said that he was unsure if CR#2 would be admitted , that would depend on additional labs, and contact was needed with the family of CR#2. He said that the person from the facility (Marketing Director) came to check status of CR#2, determine if she was being admitted or discharging back to the facility, and she did not provide details that there was a concern for sexual assault. Observation on [DATE] at 11:20am of CR#2 at the local hospital revealed CR#2 was not interviewable and was sleeping. In an effort to complete a phone interview on [DATE] at 1:12pm with LVN F a message was left. In a phone interview on [DATE]:14pm with CNA E, she that she worked from 10pm -6am starting the night of [DATE]. She said that at 4:50am LVN F, and her went to change the brief on CR#2, and she saw blood clots in her brief. LVN F assessed to see where the blood was coming from, blood started pouring out, but she (CNA E) could not tell where the blood was coming from, and LVN F never said where it was coming from. She said that she thought LVN F reported the information to the family, physician, IDON, and Administrator. She said that the nurse tried to contact hospice. She said that CR#2 was transferred to the hospital to see why she was bleeding and determine if it had to do with abuse. She said that she thought everyone knew there could be abuse, and the hospital had to know to determine if abuse happened or not. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record Review of facility policy titled Notification of Changes Dated [DATE] read in part, The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistently with his or her authority, the resident's representative when there is a change requiring notification .Circumstances requiring notification include: 2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: a. life-threatening conditions, .4. A transfer or discharge of the resident from the facility . Record Review of facility policy titled Transfer and Discharge(including AMA Dated [DATE] read in part, It is the policy of this facility to permit each resident to remain in the facility, and not initiate transfer or discharge for the resident from the facility except in limited circumstances .10. For a transfer to another provider, for any reason, the following information must be provided to the receiving provider: d. All other information necessary to meet the resident's needs, which includes, but may not be limited to: i. resident status, including baseline and current mental, behavioral, and functional status, reason for transfer. Record Review of facility policy titled Provision of Quality Care Dated February 2023 read in part, Based on comprehensive assessments, the facility will ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive person-centered care plans, and the residents' choices. Policy Explanation and Compliance Guidelines: 1. Each resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being. This was determined to be an Immediate Jeopardy (IJ) on [DATE]. The IJ template was provided to the facility on [DATE] at 10:26am. The following Plan of Removal(POR) submitted by the facility was accepted on [DATE] 8:11am. The plan of removal reflected the following: PLAN OF REMOVAL Name of facility: Date: [DATE] F 684 - The facility will ensure that residents receive treatment and care in accordance with professional standards of practice. Problem: The facility failed to notify the hospice nurse, EMS, and hospital staff that Resident#2 needed to be assessed for sexual abuse after she was observed with suspected vaginal bleeding. On [DATE] Resident #2, was assessed and transferred out to the hospital for further evaluation and returned to the facility with a new order for vibramycin x10 days for wound infection. The residents' care was resumed under hospice and the expired due to end of life complications on [DATE] at 0742am. Immediate action: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	13. On [DATE] the DON/Designee initiated in-service with the facility licensed nurses on Transfer/discharged Report. This report is printed out by the nurse/designee, the nurse then writes the reason for transfer at the bottom of the page and turns it into EMS who is to submit to the hospital. Ongoing Projected completion [DATE]. Any staff member not present or in service on [DATE] and [DATE] will not be allowed to assume their duties until in-serviced. Ongoing In-service will be completed by DON/ADON/WC NURSE/or weekend nurse supervisor, until all staff, weekend, prn, and agency staff in completed. Monitoring 14. On [DATE] The DON/designee began a questionnaire to validate the effectiveness of the training. The questionnaire is conducted with facility licensed nurses. Immediate re-education will be completed by the DNS/designee if any staff is unable to answer appropriately to the questions on the questionnaire. Staff will not be allowed to work until after completion of the questionnaire. Projected completion [DATE]. 15. An impromptu QAPI meeting was conducted with the facility's Medical Director on [DATE] to notify of the potential for non-compliance and the action plan implemented for approval. Plan approved on [DATE]. The Plan of Removal was confirmed for the IJ by monitoring from [DATE] through [DATE] as follows: Record review of the in-services provided as supporting evidence did not outline steps the nursing staff should take when a resident was transferred to the hospital for suspicion of abuse to ensure that all notification were made and the hospital received information upon arrival to the hospital. In an interview on [DATE] at 1:36pm with the IDON, she recanted her original statements that she did tell Hospice Nurse AD that there was a concern for sexual abuse. She said that skin assessment were completed by the ADON, Wound Care Nurse, and Unit Manager, and there were no issues identified. She said that all nursing staff were trained by either the Administrator, IDON, and Regional QA Nurse with a steps to when transferring a resident to the hospital when there is a suspicion of abuse, neglect, to include sexual abuse, along with who should be notified. She said that the nurse should complete the following steps; If a resident is assessed with any of the s/s of abuse to include sexual abuse. 1. Secure the area that resident was found and room until law enforcement arrives. 2. Secure items that can be used as evidence, secure in bio hazard bag and in the DON office. 3. Notify the Primary MD/NP/On call service, RP, and hospice if appropriate to disclose the change condition and that there was s/s of sexual abuse, and requesting order to send to the ER for treatment and rule out sexual abuse. 4. Notify the RP and hospice if appropriate to disclose the change of condition was a s/s of sexual abuse, and transfer to ER was for treatment and to rule out sexual abuse (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	5. Notify both the Abuse Coordinator/designee or compliance hotline posted throughout facility there is concern for abuse, neglect, or sexual abuse. Follow guidance provided. 6. Notify DON so that confirmation is made that all previous steps were completed. 7. Notify emergency or non emergency transportation dispatcher, and EMT upon arrival that there was suspension that the s/s could be abuse or sexual abuse o confirm/unconfirm sexual assault or abuse. 8. Complete three transfer/discharge summary ensure that the s/s was listed under chief complaint and there was suspension of abuse or sexual abuse. There should be two provided to the EMT upon arrival, one for EMT, one for the hospital, and one for the facility. 9. Notify the hospital triage/charge nurse prior to residents arrival of suspension that s/s could be abuse or sexual abuse if non emergency transportation is utilized. 10. Document in progress note and complete SBAR. In an interview on [DATE] at 2:34pm with the Administrator, he said that he was trained by the IDON and Regional QA Nurse on the steps the nursing staff should complete when there was suspicion of abuse to include sexual abuse and transferring to the hospital. He said that he assisted with training staff once his training was completed. He said that the step-by-step training was not provided with evidence to support the POR, and he was not able to recall the step trained own. He said that he did not know how he trained the nursing staff on the process if he did not know the steps. In an interview on [DATE] at 2:53pm with the Unit Manager, she said that she assisted with completing skin assessments of the residents with no new issues identified. She said that she was trained since the IJ was called but she could not remember the topic. In an interview on [DATE] at 3:00pm with the ADON, she said that she assisted with completing skin assessments of the residents with no new issues identified. She said that she was trained since the IJ was called but she could not remember the topic. In an interview on [DATE] at 3:10pm with the Regional QA Nurse, with the Administrator and IDON present. She said that the POR was accepted without a step-by-step process, and she was not aware of what the step by step process the IDON would have trained the staff on. She agreed to provide the step-by-step process as outlined by the IDON, 1:1 training would be completed with the Administrator, ADON, and Unit Manager by the IDON, and any nursing staff that could not successfully account the steps would be re-trained. In an interview on [DATE] at 3:34pm with the Wound Care Nurse, she said that she assisted with completing skin assessments of the residents with no new issues identified. She said that she was trained since the IJ was called but she could not remember the topic. In an interview on [DATE] with nursing staff on the 6:00am-6:00pm, LVN U at 3:48pm, LVN T at 4:05pm; at LVN V at 4:23pm, and MDS Coordinator at 4:32pm who were all knowledgeable on the Step by Step process that should be taken when there was suspicion of abuse to include sexual abuse and the resident was transferred to the hospital as detailed by the IDON. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 10:28am with the Administrator, he said that he received a 1:1 training with the Regional QA Nurse on [DATE], and he was knowledgeable on the Step by Step process that should be taken when there was suspicion of abuse to include sexual abuse and the resident was transferred to the hospital as detailed by the IDON. He said that the risk of not completing the steps was prevent future abuse from happening, CR#2 could have been discharged from the hospital without proper assessment if the abuse did or did not occur, and hospice was a part of the care team and privilege to information the same as the physician. He said that LVN F did not ensure that hospice was aware or that hospital was aware upon arrival, when she should have. In an interview on [DATE] at 11:00an with the ADON, she said that she received a 1:1 training with the Regional QA Nurse on [DATE], and she was knowledgeable on the Step by Step process that should be taken when there was suspicion of abuse to include sexual abuse and the resident was transferred to the hospital as detailed by the IDON. She said that the risk of not completing the steps was prevent future abuse from happening, CR#2 could have been discharged from the hospital without proper assessment if the abuse did or did not occur, and hospice was a part of the care team and privilege to information the same as the physician. She said that LVN F did not ensure that hospice was aware or that hospital was aware upon arrival, when she should have. In a phone interview on [DATE] at 11:23am with Hospice AH, she said that she was the primary hospice nurse for CR#2, and CR#2 started to transition on [DATE], and she expired on [DATE]. She said that Hospice Nurse AD was contacted when CR#2 was assessed with vaginal bleeding, and she was not told there was concern f [TRUNCATED]

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 45604 Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles in locked compartments for 1 of 3 medication carts reviewed for storage of drugs. LVN AJ failed to ensure a medication cart was locked and supervised when reviewed for storage of drugs, when she left the 100/400 hall cart unlocked while asleep. This failure could place residents at risk for drug diversion, drug overdose, and accidental or intentional administration to a resident, which could lead to deterioration of general health. Findings include: Observation and Interview on 10/05/204/2024 at 4:10am with LVN AJ, who was observed asleep at a desk on the 400 hall with 100/400 hall medication cart unlocked. Observation of LVN AJ to be asleep for approximately 5 minutes, and LVN AJ had to be awaken. LVN AJ to walked to the medication cart and proceeded to lock it. She said that it was very important to keep the medication cart locked, and if a resident had opened the cart, they could have taken medication, which is detrimental to their health. In an interview on 10/07/2024 at 10am with the IDON, she said that LVN AJ had been terminated for sleeping with the medication cart being unlocked. She said that the medication cart had to be locked when it was not in use. She said that anyone who was not authorized could take medications to include residents. She said that if a resident took unprescribed medication it was possible for an adverse reaction depending on the type of medication. In an interview on 10/10/2024 at 2:00pm with the Medical Director, said the medication cart should be locked at all times when not in use. She said that a resident could get a medications, it could cause a potential risk of adverse reaction if a resident took inappropriate medication. In an interview on 10/25/2024 at 2:59pm with the Consultant Pharmacist, he said that he was notified by the IDON that a medication was unlocked and nursed observed to be asleep. He said that he completed an inservices, he checked carts to ensure locks functioned, and that no medications were missing. He said that he completed a medication pass with no concerns. He said that the medication carts should be locked when it was not in direct line of sight. He said that this would prevent anyone to include residents from getting into the cart and taking medications that are not for them. He said that the risk is adverse reaction or harm if a resident took medication not prescribed. He said he believed the nurse was terminated, because the cart was unlocked and not in direct line of sight since she was sleeping. Record review of employee discipline notice for LVN AJ dated 10/05/2024 with type of disciplinary action of termination for conduct of employee observed sleeping while on shift, and employee cart left unsecured. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of facility policy titled Medication Storage Dated May 2023 read in part, Policy: It is the policy of the this facility to ensure all medication hosed on our premises will be stored in the pharmacy and/or medication rooms according to manufacturer's recommendation and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture, control, segregation, and security. Policy Explanation ad compliance Guidelines 1. General Guidelines: a. All drugs and biological will be stored in locked compartments (i.e., medications carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls ,

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F 0835 Level of Harm - Minimal harm or potential for 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** 45604 Based on observations, interviews, and record reviews, the facility failed to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain highest practicable physical, mental, and psychosocial well-being of each resident for 2 of 21 residents (CR#1 and CR#3) reviewed for administration. 1. The Administrator, who was the facility's abuse coordinator and was responsible for investigating and reporting abuse incidents, failed to thoroughly investigate and accurately report an allegation of sexual abuse, when CR #1 was assessed with signs and symptoms of sexual abuse on 09/14/2024 for vaginal bleeding an on 09/24/2024 for refused perineal care (washing the genital and anal areas), requested not to be touched, and feared being touched. CR#1 was transferred to a local hospital on 9/24/2024 and semen was present in her urine sample. 2. The Administrator, who was the facility's abuse coordinator and was responsible for investigating and reporting abuse incidents, failed thoroughly investigate and accurately report an allegation of abuse, when allegations were made that CR #3's was abused by the Hired Sitter on 07/13/2024. These failures could place residents who are involved in abuse incidents at risk for continued abuse, or further injury, pain, physical and emotional distress. Findings included: CR#1 Record review of CR#1's face sheet dated 09/26/2024, reflected that she was an [AGE] year-old female, who admitted to the facility on [DATE] with a primary diagnoses of cerebral infraction due to embolism of left middle cerebral artery(stroke Record review of CR#1's quarterly MDS assessment dated [DATE] reflected a BIMS(Brief Interview for Mental Status) was not available as the resident rarely /never understood with severely impaired cognitive skills for daily decision making. Record review of CR#1's undated comprehensive care reflected: Focus: CR#1 has impaired cognitive function and impaired thought processes AEB (as evidenced by): Rarely/never makes decisions Goal: CR#1's needs will be met and dignity will maintained through the next review. Intervention: Monitor/document/report PRN(as needed) any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of CR#1's Late Entry SBAR(Situation, Background, Assessment, and Recommendation) completed by RN B with effective date of 09/15/2024 at 6:09am reflected, This started on 09/14/2024. Since this started has stayed the same. Spotted [NAME] red blood per vagina noted on the diaper. NP AK (Nurse Practitioner), RP(Responsible Party) and ADON notified. Report endorsed to day shift nurse for follow up. Reported to NP on 09/14/2024 10:20 PM. Pending response from NP. Record review of CR#1's progress note dated 09/14/2024 at 11:23pm completed by RN B reflected, Monitor resident for abnormal bruising and/or bleeding from nose gums, blood in urine or stool every shift every shift. Record review of CR#1's progress note dated 09/15/2024 at 10:05am completed by LVN D reflected, Noted no new orders from NP regarding vaginal bleeding, nurse reassessed resident at this time, CNA came along with nurse, no apparent blood noted in resident's diaper or vaginal area, resident denies any pain or discomfort to perineal area, denies any apparent discomfort with urination, fluids encouraged to help resident keep hydrated, resident verbalizes understanding, no apparent distress noted, will continue to monitor. Record review of CR#1's SBAR completed by RN B with effective date of 09/24/2024 05:58 reflected, Resident noted bleeding per vaginal; thick red blood, 01 brief soaked with blood. Resident noted sitting on the floor but refused fall. Resident is AO(alert and oriented)X (times) 3, skin intact, Vital as follows, BP(blood pressure) 89/55, HR(heart rate) 122, temp(temperature) 97.8, Resp(respiration) 18, bs(blood sugar) 121. DON, NP AND RP Notified. Sending resident to hospital for follow up. EMS notified for transportation to the hospital. Pending transportation and this time, report endorsed to day shift nurse for patient follow up. Record review of CR#1's progress note dated 09/24/2024 06:15am completed by LVN D reflected, Received report from off-going nurse that resident is going to hospital ER(emergency room) due to vaginal bleeding and that ambulance on the way to pick up resident as she's going to hospital for further evaluation. BP at this time=127/74, HR(Heart rare)=114,T(temperature)=97.6, RR(Respiration Rate)=18, spo2(Oxygen saturation)=97% on room air, resident laying in bed, denies any pain, headache or discomfort at this time. Record review of CR#1's progress note dated 09/24/2024 07:00am completed by LVN D reflected, Resident left facility at this time via (by way of) stretcher accompanied by 2 EMS(Emergency Medical Service) personnel, alert, denies any pain or discomfort, resident going to hospital for further evaluation of vaginal bleeding. Record review of CR#1's progress note dated 09/25/2024 08:40 pm completed by Regional QA (Quality Assurance) nurse reflected, Called resident RP an informed her of hospital urine specimen findings as reported to facility acting DON and Administrator today by SSA(State Survey Agency). RP was aware and will come to facility to meet with Administrator. Record review of CR#1's progress note dated 09/25/2024 08:50 pm completed by Regional QA (Quality Assurance) nurse reflected, Physician AL called and notified of hospital urine specimen findings and resident remains at the hospital. Record Review of Incident and Accident Reports found no report on CR#1 for the time frame of 09/14/2024-09/25/2024. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of CR#1's medical records from a local hospital, emergency room Summary reflected, admitted [DATE] with chief complaint for vaginal bleeding. Urine specimen confirmed positive for UTI (Urinary Tract Infection) and Sperm present. There was no present or active bleeding. Unable to assess if any assault had occurred. No signs of external trauma to genitalia evaluated. Recommend O/B Gyn (Obstetrician-Gynecologist) consult and SANE (Sexual Assault Nurse Examiner) Exam if concern for sexual assault. Record review of CR#1's SANE Exam dated 09/25/2024 completed by Forensic Nurse, reflected hospital requested medical forensic exam for an 83 y/o(year old) female with concerns for acute sexual assault. Genital Exam Findings with acute injury visualized and Hymenal remnants (tissue left behind after the hymen breaks). CR#3 Record review of CR#3's face sheet dated 10/14/2024, reflected she was a [AGE] year-old female, who admitted to the facility on [DATE] with a primary diagnoses of mild unspecified dementia with secondary diagnosis of down syndrome(genetic condition effecting brain development), hypothyroidism(underactive thyroid), generalized anxiety disorder, and unspecified convulsions(uncontrolled shaking. Record review of CR#3's quarterly MDS (Minimum Data Set) assessment dated [DATE] reflected a BIMS(Brief Interview for Mental Status) was not available as the resident rarely /never understood with severely impaired cognitive skills for daily decision making. Record review of CR#3's undated comprehensive care reflected: Focus: CR#3 has history of Seizures and is at risk for Injury. Goal: Resident will be free from Seizure Activity until the next review Intervention: Call MD and family for s/s of antiseizure medication toxicity. Document/notify family and MD to notify of any seizures. Ensure direct care staff are aware of residents history of Seizure Activity. Give medications per order, monitor labs--report abnormals to M.D. If a seizure occurs, protect from injury-do not restrain, turn to side, loosen tight clothing, etc, take vital signs-inform M.D. and R.P. Labs per MD order. Make resident comfortable after seizure activity. Monitor for efficacy and adverse consequences, abdominal pain, anorexia nausea, dermatologic reactions, blood dyscrasias. Monitor for warning signs-prior to seizure activity. Record review CR#3's of electronic medical records did not reflect progress notes or skin assessment completed by LVN V on 07/13/2024. Record review of CR#3's skin assessment dated [DATE] completed by LVN G reflected, Right hand (back): Light green circle bruising to right hand about 2 inches. Right knee (front): 2 inch long scraped to right knee. Pink in color. Healing. Record review of CR#3'selectronic medical records did not reflect progress notes completed by LVN G on 07/15/2024. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of SSA reporting database did not reflected that a Provider Investigation Report (PIR) was submitted in the month of July of 2024 to involve CR#3. In an interview on 09/25/2024 at 8:15am with Hospital Nurse, she said that CR#1came to the emergency room [DATE], and during an examination was assessed to be bleeding in the vaginal area. She said CR#1's urine sample was found to be positive for an UTI there was a small amount of semen in the vaginal area. She said that CR#1 had a small laceration on the vaginal area indicative of abuse. In an interview and observation on 09/25/2024 at 8:50am with CR#1 at local hospital, interpreter used for Vietnamese translation. She said that she had not been touched inappropriate by a male nurse. She said that she was afraid to return to the facility. She said that staff were nice to her, and she would not continue the conversation with the interpreter. The interpreter indicated that CR#1 rambled and appeared to have a speech problem, during conversation was incoherent, an only answered yes or no questions. CR#1 was observed laying in the bed, wearing hospital gown, and her face, hands, and legs did not show any marks or bruises. In an interview on 9/25/2024 at 4:36pm with the Forensic Nurse, she said that an interview was conducted with CR#1 using Vietnamese translation, she was unable to say how the semen got in the urine, and said the blood was from having a period, she was too old, and no one would want her. She said that during the examination she observed a small abrasion around the anal area. In an interview on 9/25/2024 at 6:45pm with the IDON, she has worked at the facility since August 2024. She said that on 9/14/2024 it was reported to her that CR#1 had blood in her brief, and the NP gave orders to monitor for further bleeding. She said that on 09/24/2024 she made decision to send the resident to the hospital. She was not aware that CR#1 urine specimen tested positive semen. In an interview on 09/25/2024 at 7:40pm with the Administrator, he said that he has worked at the facility for three years and he was the abuse coordinator. He said that he does not know anything about semen. During an entrance conference on 09/26/2024 at 1:00pm with the Administrator, IDON, and Regional QA Nurse, information was provided that that the abuse coordinator was the Administrator. They all stated that after they were made aware that it was suspected that CR#1 was sexually abused on 09/25/2024, notification to police, ombudsman, responsible party, physician, medical director, safety surveys, skin assessments, an initiated staff interview and in-services. Observation in 09/26/2024 at 2:00pm of CNA A entering the room of CR#1 and Resident #5 for resident care, and sign posted at the door for electronic monitoring. In an effort to complete an interview on 09/26/2024 at 3:12pm with Resident #5, she was not interviewable. In an interview an observation on 09/26/2024 at 3:25pm with CNA J on the 300 hall, he said that he has worked at the facility PRN for 23 months, he works shifts 6am-2pm or 2pm-10pm, and today he was working the back of 300 hall until 10pm. He said that no one had interviewed him or asked him to write a witness statement as part of investigation involving CR#1. He said that he worked the following dates 9/13/2024 400 hall 6am-2pm, 9/16/2024 200 hall 6am-2pm, 9/19/2024 back of 300 hall 2pm-10pm, and 9/24/2024 back of 300 hall 2-10pm. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Houston Rehabilitation and Healthcare Center	13428 Bissonnet Houston, TX 77083

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of staff scheduled to confirm CNA J worked9/13/2024 400 hall 6am-2pm, 9/16/2024 200 hall 6am-2pm, 9/19/2024 back of 300 hall 2pm-10pm, and 9/24/2024 back of 300 hall 2-10pm. In an interview on 09/26/2024 at 3:50pm with CNA A, she said that she worked on the front of 300 hall, and she works 2pm-10pm. He had been trained on abuse and neglect, he listed types, and said s/s(sign and symptom) of sexual abuse could be vaginal/anal bleeding, or injury to the genitals in both male/female residents. He said that all abuse and neglect is reported the Administrator/Abuse coordinator immediately. She said that CR#1 was transferred to the hospital for vaginal bleeding, while she was not at work. She said that prior to 9/14/2024 she had no history of vaginal bleeding. She said that on 09/14/2024 on 2pm-10pm, she went to check brief of CR#1 end of shift, she saw blood in the brief, reported to RN B who assessed, RN B said that there was vaginal bleeding, and completed notifications. She said that she had not been interview by anyone as part of investigation involving CR#1 or asked to write statement. She said that she did not think to report CR#1 vaginal bleeding on 09/14/2024, , she did not know if RN B had reported, and maybe she should have reported. In an interview on 09/26/2024 at 4:11pm with LVN T, she said that she works the 6am-6pm shift and she is assigned 300 hall. She said that she had been trained on abuse and neglect, she listed types, and said s/s of sexual abuse could be vaginal/anal bleeding, or injury to the genitals in both male/female residents. She said that all abuse and neglect is reported the Administrator/Abuse coordinator immediately. She said that during report on 09/16/2024 she was told to monitor CR#1 for vaginal bleeding. She said that she had not history of bleeding, and she had not assessed her to have bleeding. She said that CR#1 was transferred to the hospital for vaginal bleeding on 09/24/2024, she did not know the outcome, and she had not assessed her to have any injuries to the vaginal area. She said that she did not know what steps facility took to determine if assessed bleeding was abuse, but she would have thought nurse that original assessed would have reported, and she would have reported. She said that she had not been interviewed or asked to a write statement. In an interview on 09/26/2024 at 4:29pm with LVN D, she said that she works the 6am-6pm shift and she is usually assigned 300 hall but working 400 hall that day. She said that she had been trained on abuse and neglect, she listed types, and said s/s of sexual abuse could be vaginal/anal bleeding, or injury to the genitals in both male/female residents. She said that all abuse and neglect is reported the Administrator/Abuse coordinator immediately. She said that during report the morning of 09/15/2024, RN B told her that CR#1 was assessed with vaginal bleeding with no injuries, contact made with on-call NP, told to monitor, and follow up with primary. She said that the morning of 09/24/2024, RN B said that CR#1 was assessed with vaginal bleeding with no injures, and contact was made with NP AK, resident was to transfer to local hospital. She said that she attempted to assess and perform peri care on CR#1 before she left out, CR#1 said no, placed her hand over the brief, and was afraid to let her look. She said that she did not know if RNB had reported to Administrator, but she had not reported. She said she had not been interviewed or asked to write a witness statement after either incident. In an effort to complete phone interview on 09/26/2024 at 4:47pm with the RP BH; a message was left. In an effort to complete phone interview on 09/26/2024 at 4:48pm with RP P; a message was left. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/26/2024 at 5:37pm with the Social Worker, he said that he works Monday-Friday from 8am-5pm. He said that he had been trained on Abuse and Neglect, he was able to list types, provide s/s of sexual abuse, he had not seen abuse, if he had would report immediately to the Administrator, and if not reported the abuse could continue or happened to more residents. He said that there was an on going investigation involving CR#1, who assessed with vaginal bleeding, transferred to the hospital, and semen was found in her urine. He had not been interviewed as part of the investigation or asked to write a witness statement. He said that he had been asked to complete safety survey's on the 300 Hall, he complete interviews with English speaking female residents on the hall, with no abuse/neglect disclosed. , In an interview on 09/26/2024 at 5:48pm with the Administrator, he said that he had been trained on Abuse and Neglect, he was able to list types, provide s/s of sexual abuse, vaginal/anal bleeding, bruising or injury to the genitals in both male/female, could refuse care, be afraid to be touched or not want care from opposite sex staff. He said that the risk of not reporting or investigating abuse was that it could continue. He said that CR#1 was sent to hospital for vaginal bleeding on 9/24/2024. He was made aware due to SSA investigation on 09/25/2024, that semen was found in the urine of CR#1, he was not made aware of any injuries, or CR#1 to have vaginal bleeding before. He said that he had completed the following tasks as part of his investigation after he was notified in 09/25/2024, self report completed, notification to the police, RP, physician, and Medical Director notified, increased monitoring in place, inservice for abuse and neglect initiated, resident interviews completed of all females on 300 hall, reviewed nursing department staff schedules with no male staff that worked during the time of the incident, hallway cameras for 300 hall being viewed by corporate IT was ongoing from 9/24/2024 until resident was transferred. He said that skins assessments were started on 09/26/2024 on 300 hall with female residents. He said he did not know why the assessments delayed, did not include all residents. He said that staff interviews were ongoing, but did not answer when asked if they had already been started. He said that he did not have direct care staff complete witness statements, he had not reviewed visitor log. He said no male staff had been suspended or suspected. He did not answer when asked if he thoroughly reviewed the schedules for all clinical male staff working during the time resident was observed with vaginal bleeding. He said that he was not notified that vaginal bleeding starting on 9/14/2024, and did not answer if he would have initiated investigation if he were aware. He did not answer when asked if staff to include IDON should have notified him as the abuse coordinator when bleeding was observed for both incidents. He said that he was not aware that CNA J worked the day prior to the initial bleeding being assessed, and multiple shifts since CR#1 transferred to the hospital to include assessment on the 300 hall. He was made aware of concern that facility self report evidence was requested at entrance, there had been no evidence provided, and he provided no answer as to why. In an interview on 09/26/2024 at 5:40pm with CNA A and LVN T, who said that they had not been asked to increased monitoring on the hall, and they round every two hours as normal. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/26/2024 at 7:00pm during the end of day meeting with the Administrator, Regional QA Nurse, IDON, and DON AN with a list of concerns provided. The concerns provided were self-reported investigation evidence was requested at entrance not received, multiple interviews with direct staff that had not been interviewed or provide witness statements, Social Worker only interview English speaking residents for safety surveyors, multiple staff to include IDON were aware of vaginal bleeding on 09/14/2024 and 09/24/2024, and had not reported to the Administrator, CNA J who worked 9/13/2024, and multiple dates between 9/14/2024 and 9/24/2024 scheduled to work all though he had not been interview or asked to provide statement, no efforts to exclude male residents, visitors, or staff as perpetrators, no efforts to request electronic monitor of Resident#5, skin assessment were not initiated until after SSA entrance on 09/26/2024, with the skin assessments completed to include female residents on 300 hall, and staff denial that they were asked to increase monitoring. In an interview on 09/26/2024 at 7:23pm with DON AN, she started orientation on 09/23/2024, did not finish onboard, and 09/26/2024 was her official first day. She said that she had worked in skilled nursing facilities for [AGE] years, and she had training on abuse and neglect. She said that un explained vaginal bleeding with no history of bleeding would be a concern, should be reported immediately, and should be investigated by the facility to rule out abuse. She said that the risk of not reporting or investigating was the abuse could continue, and without a thorough investigation residents are left unprotected an involve more residents. She said that she was not made aware of the on going investigation when she arrived to the facility on [DATE]. She said that that nursing staff and IDON should have notified the Administrator who is the abuse coordinator immediately after CR#1 was observed with vaginal bleeding on 09/14/2024 and 09/25/2024. She said that had not taken the necessary steps to rule out immediacy. In an interview on 09/27/2024 at 8:40am with CNA E, she said that she worked on 09/24/2024 on the 300 hall, and she worked 10pm-6am. She said that she had been trained on abuse and neglect, she listed types, and said s/s of sexual abuse could be vaginal/anal bleeding, injury to the genitals in both male/female, fear, refusing care especially from the sex of who may hurt them, or not wanting to be touched at all. She said that abuse should be reported immediately to the administrator who is the abuse coordinator. She said toward the end of shift right before shift change, she entered the room, CR#1 was sitting on the bed with clothing and brief on, and CR#1 pointed to brief toward the vagina. She said that blood was on pajama bottoms towards the back, that was bright red. She said that she immediately got the RN B, she came into the room, saw the blood, and she left and went to the nurse station. She said that when the RN B returned she said that an ambulance was called, and she wanted her to help clean her up. She said that the brief was soaked with blood, but there was no blood anywhere else. She said that the RN B assessed CR#1 head to toe with no bruising or injuries, and she said that the blood was vaginal. She said that she threw out the brief, and clothing was placed in the linen for wash. She said that she did not report because she thought RN B did, and she did not think it was abuse because the resident did not say anything happened, she did not seem like she was in pain, or injuries. She said that she had not been interviewed or asked to write a witness statement. She said that she had not been asked to increase rounds. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a phone interview on 09/27/2024 at 9:22am with Physician AL, he said that he was the primary physician for CR#1, nursing staffed notified NP AK that CR#1 was assessed with vaginal bleeding on both 9/14/2024 and 9/25/2024. He said that the [NAME] QA nurse contacted him on 09/25/2024 to inform that semen was found in the urine of the CR#1. He said that based on information provided sexual abuse would be highly unlikely as an initial concern without more information like trauma or injuries with the bleeding. He said that the facility should always follow their polices for abuse and neglect prevention and investigation. In a phone interview on 09/27/2024 at 9:51am with the Medical Director, she said that she was notified about CR#1, the alleged sexual abuse, and that semen was found in urine specimen while at the hospital. She said that she was told an investigation was initiated, with steps taken to pull employee schedules for males staff, interviews with staff assigned to resident, and residents interviews. She said that she would not initially have concern for sexual abuse with only vaginal bleeding without any injures present for physical abuse. She said that if there were other concerns that physical or sexual abuse occurred, a resident would need to be sent for further work up and testing at the hospital. She said that the facility should follow there abuse policy for reporting, to include completion of a thorough investigation from the time vaginal bleeding started due to current status of CR#1. She said that if the facility does not follow the policy or investigation thoroughly there was potential the incident could happened again. In an interview on 9/27/2024 at 5:20pm with the Administrator, IDON, and Regional QA Nurse, the Regional QA Nurse said that there had been steps taken to keep residents safe. The IDON said that video of the 300 Hall, had provided a culprit or perpetrator identified, with CR#4 seen walking the 300 hall, corporate were unable to see if he went into to the room of CR#1, but he would be placed on 1:1 observation. Record review of evidence provided by the facility reflected, that the facility did not immediately initiate skin assessments on 09/25/2024, and the skin assessments were initiated on 09/26/2024 after 1:00pm and completed on 09/26/2024. Record review of evidence provided by the facility reflected, that the facility did not immediately assess male residents who could ambulate, the assessments started after entrance on 09/26/2024, and CR#4 was placed on 1:1 supervision until 09/26/2024 8:15pm. Record review of evidence provided by the facility reflected, that the facility, initiated life safety interviews with on 9/26/2024 with English speaking females on the 300 hall, and the remaining residential population was initiated and completed on 09/27/2024 with no new issues identified. Record review of evidence provided by the facility reflected, that the facility did not have witness statements or interviews with direct care staff that provided care to CR#1 on the incident dates of 09/14/2024 and 09/24/2024. Record review of evidence provided by the facility reflected, that the facility had surveillance videos of a male resident(CR#4) wondered outside the CR#1's room and suspect, based on footage, the resident(CR#4) went into the victims' (CR#1)room, and CR#4 was seen in the room for an undetermined length of time in multiple occasions. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and Record Review on 10/01/2024 at 10:17am with Administrator of video from the computer of the Administrator of 300 hall starting 09/23/2024 at 4:18am 8:36pm that did show CR#4 enter the room of CR#1. He said that was all the footage provided to him by IT at that time. In a phone interview on 10/01/2024 at 11:23am with NP AK, she said that notification was made 9/14/2024 and 9/24/2024 that CR#1 was assessed with vaginal bleeding. She said that she would not had an initial concern for sexual abuse without trauma related injures like tearing or defensive injures. She said that she was not aware that semen was found in the urine culture while CR#1 was at the hospital. She said that would expect that the facility wou [TRUNCATED]