STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115395	A. Building B. Wing	05/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winthrop Health and Rehabilitation	12 Chateau Drive Rome, GA 30161

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 38514 Based on observations, record review, interviews, and review of the facility policy titled, Abuse Prohibition, the facility failed to effectively address the sexually aggressive behavior of one of four residents (R#364). The facility failed to put effective interventions in place to protect three of four residents (R#17, R#55, R#42) from resident-to-resident sexual abuse. The deficient practice had the potential to affect all 61 residents residing in the facility On 04/14/2022, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator was informed of the Immediate Jeopardy (IJ) on 04/14/2022 at 7:46 PM. The noncompliance related to the immediate jeopardy was identified to have existed on 05/23/2021. The immediate jeopardy was removed on 04/17/2022. The IJ is outlined as follows: The IJ began on 05/23/2021, when R#364 was found in the room of R#17, a resident with severe cognitive impairment, with his hands under the resident's shirt on the resident's breasts. On 5/23/2021, R#17, reported to staff that she had been molested. The facility failed to put interventions in place to prevent future incidents from taking place. R#17 was subsequently sexually abused a second time by R#364 on 07/11/2021 when R#364 was found with his hands under R#17's shirt. Additional residents were sexually abused by R#364. R#55, a bedbound resident with moderate cognitive impairment, was sexually abused by R#364 on 08/27/2021, when R#364 was observed in R#55's room, with his hand under R#55's cover. R#55's brief was observed to be un-taped and folded back. On 1/21/2022, R#364 was found with his hand on the chest of R#42 another resident with severe cognitive impairment. The facility failed to address the sexually aggressive behavior of R#364 and failed to put effective interventions in place and therefore failed to protect R#17, R#55, and R#42 from resident-to-resident sexual abuse. The IJ was related to the facility's noncompliance with the program requirements, as follows: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2022

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F 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

F600: 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation (Scope/Severity [S/S]: J; F607: 42 CFR 483.12(b)(1)(4), Develop/Implement Abuse/Neglect, etc. Policies S/S: J; F608: 42 CFR 483.12(b)(5), Reporting of Reasonable Suspicion of a Crime, S/S: J; F610: 42 CFR 483.12(c)(2) (4), Alleged Violations-Investigate/Prevent/Correct S/S: J); F656: 42 CFR 483.21 - Comprehensive Resident Centered Care Plans, S/S: J; F835: 42 CFR 483.70 - Administration S/S: J.

Additionally, Substandard Quality of Care was identified with the requirements at F600: 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation (Scope/Severity [S/S]: J; F607: 42 CFR 483.12(b)(1)(4), Develop/Implement Abuse/Neglect, etc. Policies S/S: J; F608: 42 CFR 483.12(b)(5), Reporting of Reasonable Suspicion of a Crime, S/S: J; F610: 42 CFR 483.12(c)(2) (4), Alleged Violations-Investigate/Prevent/Correct S/S: J).

An Acceptable Removal Plan was received on 4/17/2022. The removal plan included placing R#364 and R#17 on one-to-one supervision, staff training, skin assessments on all residents including cognitively impaired residents and interviews with all cognitive residents regarding abuse, neglect, and sexual abuse. The survey team conducted observations, reviewed staff training records and monitoring logs, clinical record review of revised care plans, and interviews with staff and residents to verify all elements of the facility's Removal Plan were implemented. The immediacy of the Immediate Jeopardy was removed on 04/17/2022. The facility remained out of compliance at a lower scope and severity while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures governing the identification, reporting, investigation, and protection of residents from abuse, including sexual abuse

Findings include:

Review of the undated facility policy titled, Abuse Prohibition, revealed, Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm. Sexual abuse includes, but is not limited to sexual harassment, sexual coercion, or sexual assault.

1. A review of the facility's self-reported incidents revealed R#364 was the alleged perpetrator of sexual assaults upon R#17 on 05/23/2021 and 07/11/2021; R#55 on 08/27/2021; and R#42 on 01/21/2022.

A review of R#364's Face Sheet revealed the facility admitted the resident with diagnoses including cerebral infarction (stroke), vertebrobasilar artery syndrome (syndrome affecting blood supply to the brain), aphasia (comprehension and communication disorder) and chronic kidney disease.

Review of the Quarterly Minimum Data Set (MDS), dated [DATE] revealed R#364 was assessed to have a Brief Interview for Mental Status (BIMS) score of seven indicating the resident had severe cognitive impairment. This MDS documented R#364 required encouragement for transfers with setup help only needed. R#364 was assessed to be independent with locomotion off of the unit and used a wheelchair for locomotion. The resident was assessed to have no impairment to bilateral upper extremities with impairment to bilateral lower extremities.

Review of the Face Sheet for R#17 revealed the facility admitted the resident with diagnoses including Alzheimer's disease with early onset, dementia with behavioral disturbance, and delusional disorder.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the annual Minimum Data Set (MDS), dated [DATE] revealed that R#17 was assessed to have a BIMS score of four indicating the resident had severe cognitive impairment. R#17 required extensive assistance of one person for transfers and supervision of one person with locomotion on the unit and that locomotion off the unit occurred only once or twice. R#17 used a wheelchair for mobility. a. Review of a Facility Incident Report Form, dated 05/23/2021, revealed the facility initiated a report regarding abuse. The details of the incident indicated a nurse walked into R#17's room and found another resident (R#364) with his/her hands up R#17's shirt. The facility's investigation file contained the incident report, the one-page facility investigation, three witness statements, and one undated handwritten note from Social Worker (SW) FF. The statement of investigation, dated 05/27/2021, documented R#364 was found in R#17's room with his/her hands under R#17's shirt, fondling the resident's breasts. The report revealed a nurse (LPN TT) reported the incident and removed R#364 from the room. Registered Nurse (RN) CCC was then sent to interview R#17 regarding the incident. The report indicated that R#17 denied any male visitors in his/her room. The report revealed R#17 reported to Certified Nursing Assistant (CNA) AAA that a man had come to R#17's room and molested R#17. R#17 also spoke to a Licensed Practical Nurse (LPN) and stated that R#17 had told a man to get the hell out of the room, or R#17 would kick his ass. The report revealed R#364 was counseled regarding the incident and was instructed to not enter any other resident's room. The report indicated R#364 understood and that staff had been made aware if they witnessed R#364 and R#17 together, staff were to ask R#17 if the resident wanted to sit somewhere else. The report indicated the police were notified. There was a badge number on the report, but no incident number or tracking number for a police report. Review of a typed statement, dated 05/23/2021 by RN CCC, revealed that R#364 was seen rubbing R#17's leg that morning and was told by a nurse (LPN TT) to stop touching R#17 and that this was not okay. R#364 proceeded to follow R#17 around, and R#17 went to the nurses' station with tears in his/her eyes and said he/she was scared. The statement documented when RN CCC returned from lunch, staff reported that R#364 was found in R#17's room grabbing R#17's breasts. RN CCC went to talk to R#17 alone, and R#17 did not remember anyone coming into his/her room. A few minutes later, RN CCC and CNA AAA went to talk to R#17, who then reported to CNA AAA that she was molested by a guy and R#17 told him to get the hell out. The statement indicated a full body assessment was conducted by an RN and LPN and there was no bruising or redness to the chest area or abdomen. Review of a handwritten statement, dated 05/23/2021 and signed by CNA AAA, revealed the CNA went into R#17's room and asked if a man had come into the room. According to the statement, R#17 stated yes, and he molested me. CNA AAA asked the resident if the man tried to touch R#17. R#17 stated the man put his hands, down my pants and under my shirt. The resident also stated he/she told the man that he/she would kick his ass. During the survey, the surveyor attempted to contact CNA AAA via telephone; however, the CNA worked for an agency and the surveyor was unable to obtain a working number. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a handwritten statement, dated 05/23/2021 by LPN TT, revealed the nurse had witnessed R#364 stroking R#17's left upper leg. LPN TT and two different CNAs told R#364 to stop touching R#17 and that this was not appropriate. The statement documented R#364 proceeded to follow R#17 around. LPN TT stated the staff were attempting to keep a close eye on both residents' whereabouts, as R#364 was trying to pursue and isolate R#17. The statement documented that at one point R#17 was retrieved from the hall and R#17 stated she was afraid and that someone had scared her. The statement documented that LPN TT had to provide care to another resident and when she returned to where R#17 was being monitored, R#17 and R#364 were both gone. LPN TT opened the door to R#17's room and found R#364 with both hands underneath R#17's blouse, fondling both of R#17's breasts. The statement documented that R#17 was not objecting but that R#17 was not mentally capable of giving consent. The statement revealed LPN TT removed R#364 from the room. An interview on 04/17/2022 at 12:34 PM with LPN TT, when asked about the incident involving R#17 and R#364 that occurred on 05/23/2021, LPN TT stated she had directly reported the incident to the Administrator and demanded the police be notified because of how afraid R#17 was after the incident. LPN TT stated the previous Director of Nursing (DON) EEE, who was employed at the facility when this event and three other assaults by R#364 took place, did not recognize the seriousness of the incident. LPN TT stated the staff were never told if a report was filed with the state or if there were any new interventions in place for protection of R#17 and other residents, except to watch them closely. Review of an undated, untimed statement from SW FF indicated the SW asked R#17 if the resident was afraid, and R#17 said no. There was no documentation in R#17's electronic health record (EHR) regarding the sexual assault. An interview was conducted on 04/13/2022 at 1:38 PM with SW FF regarding the sexual assault of R#17 that occurred on 05/23/3021. SW FF stated the Administrator was the Abuse Coordinator, and everything was reported to her. When asked if she interviewed residents after allegations of abuse, SW FF stated she did, but that she did not document anything in the chart. SW FF stated she conducted a safety survey of other residents, and a list was provided to the Administrator. SW FF confirmed again that she did not document the information in the chart. Record review of a Nurse's Note in R#17's EHR, dated 05/23/2021 at 2:02 PM and authored by RN CCC, revealed R#17's family member was notified of the incident between the resident and another resident in R#17's room. The note did not indicate whether the Abuse Coordinator were notified. The note indicated a full body assessment was completed and that the resident's skin integrity looked normal and there was no redness on the chest or abdomen. Record review of a Nurse's Note in R#17's EHR, dated 05/24/2021 at 12:27 PM as a late entry and authored by Resident Care Coordinator (RCC) OO, indicated R#17's family was notified of the incident that occurred on 05/23/2021. The family member was made aware that staff would attempt to keep the two residents apart. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a COC [Change of Condition] - Behavior report for R#364 dated 05/23/2021, revealed the change of condition was physical aggression and that the resident was a danger to self or others. Resident has acted out sexual contact by touching and groping breast of resident after being careful to close the door to avoid exposure. The document also documented R#364 had been warned about going into female residents' rooms numerous times and had been removed several times. The report documented the resident (R#364), always slips around the other side to go into this resident's room. There were no further notes in R#364's record regarding the assault that occurred on 05/23/2022. Review of the Summary Report for R#17 indicated there were no new physician's orders following the incident on 05/23/2021. Review of the Summary Report for R#364 revealed a physician's order, dated 05/27/2021, for Zoloft (an antidepressant) 50 milligrams (mg) at bedtime for a diagnosis of depression. This medication was discontinued on 08/27/2021 and no other medications were added at that time. Record review of the EHR for R#364 revealed one Nurse's Note, dated 05/29/2021 at 2:44 PM, six days after the assault occurred. The note, which was documented by LPN TT, documented R#364 was continuing to go into a female resident's room and closing the door. On last Sunday, 5/23/2021, R#364 was found in R#17's room having inappropriate contact by having hands under the patients blouse and fondling her breast. Reported this incident and behavior, that has been observed prior, to the physical molestation to the Administrator. The note indicated LPN TT was surprised to see R#364 still having free range in the facility, considering the nature of the incident on 05/23/2021. LPN TT documented that at 2:10 PM that day (5/29/2021), the wound care nurse informed R#17's nurse that R#364 had entered R#17's room and closed the door. R#364 was removed from R#17's room, LPN TT told R#364 not to enter any rooms of female residents and close the door. R#364 cursed at LPN TT and stated he would call DON EEE. b. Review of a Facility Incident Report Form, dated 07/11/2021, revealed the facility initiated a self-report regarding abuse. The file contained the incident report, the one-page facility investigation, one witness statement, a statement from another staff member who was not a witness to the incident, an electronic mail (e-mail) from the Administrator outlining why the incident was not reported to the police, and the confirmation e-mail from the state indicating a reference number for receipt of the report. The statement of investigation, dated 07/18/2021, revealed a CNA reported to LPN PP that the CNA walked into R#364's room and found R#364 massaging the breasts of R#17. The report indicated the CNA removed R#17 from the room. R#364 was counseled regarding touching other residents inappropriately and stated he understood. The report indicated staff were notified that if they saw R#364 and R#17 together, to ask R#17 if she wanted to be removed from being around R#364. The report stated a full assessment had been conducted and no injuries were noted. Review of a typed statement, dated 07/11/2021 at 2:50 PM and signed by LPN GGG, revealed LPN GGG found R#17 in R#364's room. R#17's shirt was pulled up above the clavicles, exposing the resident's bare chest, and R#364 had both hands on R#17's breasts, massaging them. When R#364 was asked what he was doing, R#364 removed his hands, and very quickly pulled R#17's shirt down and stated, none of your business. LPN GGG removed R#17 from the room and told R#364 that he could not do that. R#364 stated, Oh yes I can. The statement documented R#17 was assisted to the other nurses' station near the resident's room, and LPN PP was informed of the incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of an email dated 7/12/2021, from the Administrator to Corporate contradicted the handwritten note written by LPN GGG (which documented that LPN GGG was the staff member that observed R#17 in R#364's room). The email indicted, in pertinent part, that a CNA found R#17 in R#364's room and that she was in no distress. The email indicated that R#17 (a severely cognitively impaired resident) probably thinks that R#364 is her husband and there is nothing that anyone can do, maybe try and keep them separated, but that would be too hard. Review of the EHR for R#17 revealed there was no documentation indicating that the resident's family, or abuse coordinator were notified of the sexual assault on 07/11/2021. There was no nurse's note or assessment found in the chart related to the 07/11/2021 incident. Review of the EHR for R#364 revealed there was no documentation regarding the sexual assault on 07/11/2021. Review of the Summary Report revealed there were no new physician's orders for R#17 related to the 07/11/2021 incident. Review of the Summary Report for R#364 indicated Seroquel (antipsychotic used to treat schizophrenia, depression, and bipolar disorder) 50 mg at bedtime was added to the resident's medications on 07/29/2021 for a diagnosis of paranoia. There were no other medications added at this time. An order to consult psychiatric services was added on 07/15/2021; however, there was no documentation to indicate R#364 received the psychiatric evaluation until 09/10/2021 after the resident had sexually assaulted R#55 on 08/27/2021. Observation on 04/12/2022 at 8:46 AM revealed R#17 sitting in his/her room, in a wheelchair. During an interview at this time, R#17 was asked what the month and year was and was unable to answer. When asked if any man had come to the residents room and touched R#17 in a way that made them uncomfortable, R#17 stated no and, I would kick their ass. Observation on 04/12/2022 at 2:38 PM revealed R#17 self-propelling on the 400 Hall between the station I and station II nurses' stations. R#17 was not seen entering any rooms or opening any doors. R#17 went to the end of the hall near station II, tested the door to the outside, turned around, and propelled back down the hall to station I. Observation on 04/12/2022 at 3:01 PM revealed R#17 self-propelling in a wheelchair on the 400 Hall between nurses' stations I and II. The surveyor observed R#17 self-propel back and forth on the hallway for 20 minutes. R#17 did not enter any rooms. Observation on 04/13/2022 at 7:57 AM revealed R#17 self-propelling their wheelchair on the 400 Hall between nurses' stations I and II. The resident did not attempt to go into any rooms, but stopped long enough to talk to a female resident sitting in the hallway near the bird cages, and then continued back down the hallway to station I. 2. Review of the Quarterly MDS dated [DATE] revealed R#364 had a BIMS score of 12 indicating the resident had moderate cognitive impairment. This MDS documented R#364 required encouragement for transfers with setup help only needed. R#364 was assessed to require encouragement with two plus person assist for locomotion off of the unit. The resident was assessed to have no impairment to bilateral upper extremities with impairment to bilateral lower extremities. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS), dated [DATE] revealed R#55 was assessed to have a BIMS score of nine indicating the resident had moderate cognitive impairment. The MDS documented R#55 required extensive assistance of two or more people for bed mobility and transfers, required limited assistance of one person for locomotion on the unit and locomotion off of the unit did not occur. R#55 used a wheelchair for mobility. R#55 was assessed to have no impairment to bilateral upper extremities but had impairment to bilateral lower extremities. Review of R#55's Face Sheet revealed the facility admitted the resident with diagnoses including vascular dementia with behavioral disturbance, major depressive disorder, history of falling, and atherosclerosis of native arteries of bilateral legs. Review of a Facility Incident Report Form, dated 08/27/2021, revealed the facility initiated a self-report regarding abuse. The file contained the incident report, a one-page facility investigation, three witness statements, one handwritten assessment, an e-mail report of the incident from DON EEE (former DON) to the Administrator, a handwritten note documenting an interview between R#55 and the Administrator, and a handwritten note documenting an interview between R#55 and Resident Care Coordinator (RCC) OO. There were no other documents provided. The statement of investigation, dated 09/02/2021, indicated that R#364 was found in R#55's room. After CNA JJJ notified LPN TT, R#55 was observed by LPN TT in bed, R#364 was in a wheelchair next to the bed with his hands under the covers. When LPN TT looked under the covers, she observed that R#55's brief had been untaped and the front of the brief folded back. LPN TT asked R#55 about the incident, and R#55 stated R#364 had not touched R#55 anywhere and better not. LPN TT stated that R#55 seemed confused. The report revealed the Administrator spoke to R#55 regarding the incident and when asked if R#364 was inappropriate, R#55 said, you mean touch me? R#55 then stated, I will let y'all know if he ever did. The investigation revealed that RCC OO spoke to R#55's family member. Former DON EEE and the Administrator counseled R#364 regarding going into another resident's room without permission and to not touch anyone inappropriately. The administrator explained to R#364 that a 30-day notice to leave the facility could be issued if there were any further occurrences. The investigation report revealed the physician and responsible party for R#364 were notified of the incident. The report revealed a conclusion that CNA JJJ's answers were inconsistent, and the facility felt there was no inappropriate behavior, that R#364 was just visiting R#55. However, review of an e-mail, dated 08/27/2021 at 1:51 PM from former DON EEE to the Administrator, documented that LPN TT brought R#364 to the DON's office and stated that R#364 was found in R#55's room with his hands under the covers. The e-mail documented that DON EEE asked R#364 why he was in R#55's room and R#364 stated R#55 needed something. DON EEE reminded R#364 that he/she had previously discussed that R#364 was not going to be going in other residents' rooms. The e-mail revealed R#364 stated he did not do anything. Then, R#364 asked DON EEE if she didn't do it? When DON EEE asked R#364 what the resident meant, R#364 stated, sex. DON EEE documented that when she had sex with an individual it was consensual and that R#364 touching other residents was not consensual. DON EEE asked R#364 if he/she had urges and if that was what all this is about? R#364 admitted yes. DON EEE then informed the resident that the facility could get with the physician to see if he can give him something. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a typed statement, dated 08/27/2021 by CNA JJJ, revealed CNA JJJ walked into R#55's room after opening the closed door. CNA JJJ saw R#364 sitting at the bedside of R#55. R#55 had her leg in the air and her brief was open. The statement indicated R#364 was touching R#55's private area. When R#364 noticed the staff member, he jumped and tried to exit the room. CNA JJJ notified LPN TT about the incident. A handwritten note was added (by the Administrator) to the bottom of the typed and signed note, that the Administrator spoke with CNA JJJ regarding the incident. The Administrator wrote that CNA JJJ was incorrect about the legs of R#55 being in the air, that the legs were under the covers, and that CNA JJJ did not see any of R#55's private areas. Review of a second typed statement by CNA JJJ was dated 08/27/2021 documented that CNA JJJ knocked on the closed door of R#55's room, then found R#364 sitting at the bedside of R#55. The statement documented R#55's legs were raised, and R#364's hands were under the covers. CNA JJJ documented that R#364 looked startled and jumped, and CNA JJJ ran to get the nurse so she could witness R#364 coming out of the room. The surveyor was unable to contact CNA JJJ for a telephone interview. The CNA worked for a staffing agency. The surveyor asked the Administrator for a contact number for CNA JJJ several times, but no phone number was provided. Review of a handwritten statement, dated 08/27/2021 and signed by LPN TT, documented that LPN TT was notified of the encounter by CNA JJJ. LPN TT, and another staff member went to R#55's room and asked the resident why R#364 was at her bedside. LPN TT documented that when they lifted the cover they discovered that R#55's brief had been untaped on the right side and was folded back exposing the resident's privates. LPN TT documented that R#55 acted confused and said, he better not touch her and that she couldn't remember. Further review revealed a handwritten assessment written by LPN TT dated 8/27/2021 that documented: Minor redness to sacrum area, dry arms/elbows, no bruising noted. Slight redness to face-dry skin. No injuries noted. Toenails need attention- very thick and overgrown. The note did not indicate whether the family or abuse coordinator were notified. An interview on 04/17/2022 at 12:34 PM with LPN TT, who stated the facility had a total disregard for the safety of the residents. She stated the staff were never told if a report was filed with the state and if there were any new interventions in place for protection of R#55 and other residents, except to watch them closely. Record review of R#55's EHR revealed a Nurse's Note, dated 08/27/2021 at 4:12 PM and authored by LPN TT. The note indicated a complete head to toe assessment was completed, and no injury or bruising was noted. There was a Daily Skilled Note, dated 08/27/2021, that made no reference to the incident. Review of the Summary Report for R#55 revealed there were no new physician's orders related to the 08/27/2021 incident. Review of the Summary Report for R#364 revealed a physician's order, dated 08/27/2021, for medroxyprogesterone (a female hormone sometimes used for treating male sexual hyperactivity by lowering testosterone levels). The directions were to administer a 150 mg per milliliter (150 mg/ml) intramuscular injection weekly on Mondays. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Psychiatric Diagnostic Evaluation, dated 09/10/2021, revealed staff reported that R#364 was impulsive and inappropriately touching female staff (there was no mention of the resident inappropriately touching other residents). The current psychotropic medications in use included sertraline (an antidepressant), mirtazapine (an antidepressant), and quetiapine (an antipsychotic). The recommendations included: - If inappropriate behaviors persist, continue medroxyprogesterone as ordered. Recommend monthly dose until stabilized. - Continue current psychotropic medications and supportive care as ordered. - Continue to monitor mood and behavior. The surveyor attempted to contact the psychiatric nurse practitioner who documented the psychiatric evaluation but was unable to reach her. An observation on 04/11/2022 at 8:08 AM revealed R#55 sitting in a wheelchair in front of nurses' station II. The resident was able to self-propel the wheelchair. Observation on 04/12/2022 at 9:46 AM revealed R#55 sitting in a wheelchair in the hallway, across from nurses' station II. An interview on 04/13/2022 at 2:10 PM with the Administrator confirmed there was no documentation of the counseling and warning of a 30-day notice for R#364 and stated, we should have documented it. When asked what medications changes were made, as indicated in the facility investigation, the Administrator stated she did not know. She also confirmed there was no documentation of the physician being notified, as stated in the facility's investigation. Observation on 04/13/2022 at 10:07 AM revealed R#55 in bed. An interview was conducted with R#55 at this time. When asked if he/she knew any man by the name of (R#364), the resident stated no. R#55 also stated he/she did not remember anyone touching them inappropriately and would not be okay with that and would not like it. The resident was unable to state the current month or year. 3. Review of the Quarterly MDS for R#364 dated 12/15/2021 revealed the resident had a BIMS score of 11 indicating the resident was assessed to have moderate cognitive impairment. The MDS documented that R#364 was independent with transferring and with locomotion on and off the unit and used a wheelchair for locomotion. No behavioral symptoms were indicated on the MDS. Review of a Quarterly Minimum Data Set (MDS), for R#42 dated 11/16/2021 revealed that a BIMS assessment was not conducted for R#42 as the resident was rarely or never understood and was severely impaired in cognitive skills for daily decision-making. The resident was totally dependent for bed mobility and locomotion on the unit and required extensive assistance of two or more people with transfers. Locomotion off the unit occurred only once or twice. The resident was assessed to have no impairment to bilateral upper extremity with impairment to bilateral lower extremities. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R#42's Face Sheet revealed the facility admitted the resident with diagnoses including Alzheimer's disease with late onset, need for assistance with personal care, other signs and symptoms involving emotional state, and pseudobulbar affect (disorder of the nervous system that causes inappropriate laughing or crying). Review of the Facility Incident Report Form, dated 01/21/2022, revealed the facility initiated a self-report regarding resident-to-resident abuse. The date of the incident was 01/20/2022. The file contained the incident report, the one-page facility investigation, and two witness statements. There were no other documents provided. The facility investigation, dated 01/28/2022, revealed that a nurse reported to former DON EEE that R#364 was seen with his hand on the outside of the shirt of R#42, near the breast area. Review of a handwritten statement, dated 01/20/2022 and signed by LPN KKK, revealed R#364 was observed with his/her hand on R#42's chest. The report documented that R#364 was in his/her wheelchair beside R#42. There were no injuries. The surveyor attempted to obtain a phone number for LPN KKK as well as the identity of the other witness, but LPN KKK was no longer employed by the facility, and the surveyor was unable to obtain contact information. Review of a handwritten statement, dated 01/20/2021 at 7:35 PM, did not legibly identify the witness' title, and the Administrator did not recognize the name on the statement. The statement indicated LPN KKK separated R#364 and R#42. The statement also indicated that R#42 was not crying and was not in distress. Record review of the Summary Report revealed there were no new physician's orders for Resident #42 related to the 01/21/2022 incident. Record review of the Summary Report for R#364 also revealed there were no new orders related to the 01/21/2022 incident. The only new orders for R#364 on 01/21/2022 were for a treatment to the left lower leg and an antibiotic to treat cellulitis to the left lower leg. Observation on 04/11/2022 at 8:05 AM revealed R#42 was in the hallway at nurses' station II, in a recliner. Observation on 04/12/2022 at 9:55 AM revealed R#42 was in the hallway, next to nurses' station II, in a recliner. The resident was nonverbal, other than moans and grunts. Observation on 04/12/22 at 4:07 PM revealed R#364 was in their room, sitting in a wheelchair. The door to the room was closed. Observation on 04/13/2022 at 8:04 AM revealed R#364 was in their room, sitting in his/her wheelchair. Observation on 04/13/2022 at 10:02 AM revealed R#364 was in their

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38514 Based on interview, record review, document review, and review of facility policies titled, Reporting and Investigating Abuse, and Abuse Prohibition - Screening, Hiring and Training Practices, the facility failed to develop and/or implement the protection, reporting, training components of their abuse for three of four (R#17, R#42, R#55) residents reviewed for sexual abuse. On 04/14/2022, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator was informed of the Immediate Jeopardy (IJ) on 04/14/2022 at 7:46 PM. The noncompliance related to the immediate jeopardy was identified to have existed on 05/23/2021. The immediate jeopardy was removed on 04/17/2022. The IJ is outlined as follows: The IJ began on 05/23/2021, when R#364 was found in the room of R#17, a resident with severe cognitive impairment, with his hands under the resident's shirt on the resident's breasts. On 5/23/2021, R#17, reported to staff that she had been molested. The facility failed to put interventions in place to prevent future incidents from taking place. R#17 was subsequently sexually abused a second time by R#364 on 07/11/2021 when R#364 was found with his hands under R#17's shirt. Additional residents were sexually abused by R#364. R#55, a bedbound resident with moderate cognitive impairment, was sexually abused by R#364 on 08/27/2021, when R#364 was observed in R#55's room, with his hand under R#55's cover. R#55's brief was observed to be un-taped and folded back. On 1/21/2022, R#364 was found with his hand on the chest of R#42 another resident with severe cognitive impairment. The facility failed to address the sexually aggressive behavior of R#364 and failed to put effective interventions in place and therefore failed to protect R#17, R#55, and R#42 from resident-to-resident sexual abuse. The IJ was related to the facility's noncompliance with the program requirements, as follows: F600: 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation (Scope/Severity [S/S]: J; F607: 42 CFR 483.12(b)(1)(4), Develop/Implement Abuse/Neglect, etc. Policies S/S: J; F608: 42 CFR 483.12(b)(5), Reporting of Reasonable Suspicion of a Crime, S/S: J; F610: 42 CFR 483.12(c)(2) (4), Alleged Violations-Investigate/Prevent/Correct S/S: J); F656: 42 CFR 483.21 - Comprehensive Resident Centered Care Plans, S/S: J; F835: 42 CFR 483.70 - Administration S/S: J. Additionally, Substandard Quality of Care was identified with the requirements at F600: 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation (Scope/Severity [S/S]: J; F607: 42 CFR 483.12(b)(1)(4), Develop/Implement Abuse/Neglect, etc. Policies S/S: J; F608: 42 CFR 483.12(b)(5), Reporting of Reasonable Suspicion of a Crime, S/S: J; F610: 42 CFR 483.12(c)(2) (4), Alleged Violations-Investigate/Prevent/Correct S/S: J). (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An Acceptable Removal Plan was received on 4/17/2022. The removal plan included placing R#364 and R#17 on one-to-one supervision, staff training, skin assessments on all residents including cognitively impaired residents and interviews with all cognitive residents regarding abuse, neglect, and sexual abuse. The survey team conducted observations, reviewed staff training records and monitoring logs, clinical record review of revised care plans, and interviews with staff and residents to verify all elements of the facility's Removal Plan were implemented. The immediacy of the Immediate Jeopardy was removed on 04/17/2022. The facility remained out of compliance at a lower scope and severity while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures governing the identification, reporting, investigation, and protection of residents from abuse, including sexual abuse Findings include: Review of the undated facility policy titled, Reporting and Investigating Abuse revealed, Intent: It is the intent of this center to establish standards of practice for investigation and reporting abuse, neglect, mistreatment, exploitation, and misappropriation of property. Reporting: Once a complaint or situation is identified involving alleged mistreatment, neglect, or abuse, including injuries of unknown source and/or misappropriation of patient property and is reported to the Administrator, the incident will be immediately reported (within 2 hours) to the State. The Administrator or designee will take immediate action to prevent further potential violations while the alleged violation is being investigated. Within two hours, contact the local Police Department if there is reasonable cause to believe abuse or suspicion of a crime has occurred, to begin investigation. The section of the policy for protection of residents from further abuse only addressed measures to be taken if the alleged perpetrator was a staff member and indicated, The center will take all measures to provide emotional support and reassurance following reporting of suspected abuse and follow-up care as needed. Review of the undated facility policy titled, Abuse Prohibition - Screening, Hiring and Training Practices revealed, New and existing associates will receive training that includes: Activities that constitute abuse, neglect, misappropriation of resident property, and exploitation; Procedures for reporting abuse, neglect, misappropriation of resident property, and exploitation; Preventing abuse, neglect, misappropriation of resident property, and exploitation, including injuries of unknown origin; and Dementia management. A review of the facility's self-reported incidents revealed R#364 was the alleged perpetrator of sexual assaults upon R#17 on 05/23/2021 and 07/11/2021; R#55 on 08/27/2021; and R#42 on 01/21/2022. 1. A review of R#364's Face Sheet revealed the facility admitted the resident with diagnoses including cerebral infarction (stroke), vertebrobasilar artery syndrome (syndrome affecting blood supply to the brain), aphasia (comprehension and communication disorder) and chronic kidney disease. Review of the Quarterly Minimum Data Set (MDS), dated [DATE] revealed R#364 was assessed to have a Brief Interview for Mental Status (BIMS) score of seven indicating the resident had severe cognitive impairment. Review of the Quarterly MDS dated [DATE] revealed R#364 had a BIMS score of 12 indicating the resident had moderate cognitive impairment. Quarterly MDS dated [DATE] revealed the resident had a BIMS score of 11 again indicating the resident was assessed to have moderate cognitive impairment. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R#17's Face Sheet revealed the facility admitted the resident with diagnoses including Alzheimer's disease with early onset, dementia with behavioral disturbance, and delusional disorder. Review of the annual Minimum Data Set (MDS), dated [DATE] revealed that R#17 was assessed to have a BIMS score of four indicating the resident had severe cognitive impairment. 1a. Review of a Facility Incident Report Form, dated 05/23/2021, revealed the facility initiated a report regarding abuse. The details of the incident indicated a nurse walked into R#17's room and found R#364 with his/her hands up R#17's shirt. The report indicated the police were notified. There was a badge number on the report, but no incident number or tracking number for a police report. There was no further indication of any measures taken by the facility to protect R#17 and other residents from further potential abuse by R#364. Review of a typed statement, dated 05/23/2021 by RN CCC, and CNA AAA went to talk to R#17, who reported being molested to CNA AAA. Record review of the EHR for R#364 revealed one Nurse's Note, dated 05/29/2021 at 2:44 PM, six days after the assault occurred. The note, which was documented by LPN TT, revealed R#364 was continuing to go into a resident's room and closing the door. The note indicated LPN TT was surprised to see R#364 still having free range in the facility, considering the nature of the incident on 05/23/2021. An interview was conducted on 04/13/2022 at 2:10 PM with the Administrator when asked for the police report for the incident on 05/23/2021, and the Administrator stated no report number was provided, only a badge number. 1b. Review of a Facility Incident Report Form, dated 07/11/2021, revealed the facility initiated a self-report regarding abuse. Review of a typed statement, dated 07/11/2021 at 2:50 PM and signed by LPN GGG, revealed the nurse found R#17 in R#364's room. The shirt of R#17 (a severely cognitively impaired resident) was pulled up above the clavicles, exposing the bare chest, and R#364 had both hands on R#17's breasts, massaging them. Review of the Summary Report revealed an order dated 07/15/2021 to consult psychiatric services for R#364; however, there was no documentation to indicate R#364 received the psychiatric evaluation until 09/10/2021, after R#364 assaulted R#55 on 08/27/2021. During an interview on 04/15/2022 at 11:40 AM, RCC OO confirmed there were no nurse's notes regarding the sexual assault on 07/11/2022 in R#17's chart. RCC OO confirmed a full body assessment for any injury related to the 07/11/2022 incident was not completed for R#17, and there was no documentation indicating whether the incident had been reported to the physician or the abuse coordinator. 2. Review of R#55's Face Sheet revealed the facility admitted the resident with diagnoses including vascular dementia with behavioral disturbance, major depressive disorder, history of falling, and atherosclerosis of native arteries of bilateral legs. Review of the quarterly Minimum Data Set (MDS), dated [DATE] revealed R#55 was assessed to have a BIMS score of nine indicating the resident had moderate cognitive impairment. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Facility Incident Report Form, dated 08/27/2021, revealed the facility initiated a self-report regarding abuse. The statement of investigation, dated 09/02/2021, indicated that R#364 was found in R#55's room. There was no documentation regarding any further measures taken to protect R#55 or other residents from further potential abuse by R#364. 3. Review of the Face Sheet for R#42 revealed the facility admitted the resident with diagnoses including Alzheimer's disease with late onset, need for assistance with personal care, other signs and symptoms involving emotional state, and pseudobulbar affect (disorder of the nervous system that causes inappropriate laughing or crying). Review of a Quarterly Minimum Data Set (MDS), dated [DATE] revealed that a BIMS assessment was not conducted for R#42 as the resident was rarely or never understood and was severely impaired in cognitive skills for daily decision-making. Review of the Facility Incident Report Form, dated 01/21/2022, revealed the facility initiated a self-report regarding resident-to-resident abuse. The date of the incident was 01/20/2022. The facility investigation dated 01/28/2022 revealed that a nurse reported to former DON EEE that R#364 was seen with their hand on the outside of the shirt of R#42, near the breast area. There was no documentation of any further measures to protect R#42 and other facility residents from further potential abuse by R#364. There was no documentation any other residents were interviewed or assessed to determine if they may have experienced or witnessed sexual abuse by R#364. Review of the EHR for R#42 revealed there was no nurse's note regarding the incident on 01/21/2022. An interview on 04/12/2022 at 4:08 PM with LPN MMM, who stated R#364 was spoiled by former DON EEE and was permitted to, basically get away with murder. LPN MMM confirmed R#364 had been sexually inappropriate with female staff members as well as female residents. LPN MMM, brought their concerns to DON EEE, the DON did not address the concerns and blew them off. An interview on 04/12/2022 at 4:17 PM with RN NNN regarding the alleged sexual abuse perpetrated by R#364. When asked if the staff had been given any instruction on how to protect the female residents and staff from R#364's sexually inappropriate behaviors, RN NNN stated the only instruction staff had received was to redirect R#364. An interview on 04/13/2022 at 8:07 AM with CNA RRR regarding R#364' sexual behaviors. CNA RRR confirmed the staff was not in-serviced regarding any interventions to protect other residents from sexual assault by R#364, but that staff tried to keep R#364 separated from R#17 and monitor them. A telephone interview was conducted on 04/13/2022 at 4:15 PM with former DON EEE. DON EEE revealed when asked about her recollection of any incidents surrounding R#364 and sexual assault of any residents at the facility, DON EEE stated she was able to recall a few. When asked if any in-services were conducted after the two incidents involving R#17, DON EEE stated she felt there were, and the in-service would be in the paper documents. When asked if there were any in-services or training provided to the staff regarding that incident on interventions to prevent further sexual assault, DON EEE stated there may have been a paper in-service training but was not able to recall if any training was done. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on 04/14/2022 at 9:07 AM with Medical Director HHH, who was also the attending physician for R#364, R#17, R#55 and R#42. When asked what interventions could be helpful to protect vulnerable female residents from sexual abuse, Medical Director HHH stated to monitor R#364 closely and try to keep him/her away from female residents. In each of the four documented incidents of sexual assault allegedly perpetrated by R#364, there was no documentation to indicate interviews were conducted with other residents to determine if they had been abused or had witnessed abuse by R#364. There was no documentation to indicate that staff were provided with education and clear instructions on how to protect the victims and other facility residents from further sexual abuse, nor on how to monitor and provide emotional support and follow-up care to the victims of sexual assault, as per the facility's abuse policy and procedures. During the interview with Administrator on 04/13/2022 at 2:10 PM, the Administrator was asked for the facility's abuse prohibition policies. Administrator AA provided three separate policies. The first policy titled Abuse Prohibition, covered definitions of abuse, how to identify possible abuse, and prevention of abuse. The second policy titled Abuse Prohibition - Screening, Hiring and Training Practices, covered training and hiring practices at the facility. The third policy titled, Reporting and Investigating Abuse, covered reporting, investigation, protection, and confidentiality. The policy regarding protection did not include provision of an immediate response to protect the resident from physical and psychosocial harm during an investigation. The policy also did not include examination of the victim, including a physical and psychological examination of the resident. The facility policy did not include staffing or room changes or increased supervision of the resident. When asked what the facility policy was for investigating an allegation of abuse or neglect, the Administrator stated the facility would report the incident, complete the investigation, and send it to the state. When asked about the facility's policy for protecting residents from further potential abuse, the Administrator stated the facility would suspend an alleged staff perpetrator until the investigation was completed and would terminate the staff member if the complaint was substantiated by the state. The Administrator stated the facility would protect residents by not telling staff who made an accusation and by separating the residents if there was abuse between two residents. She stated the facility would have the physician intervene when needed. None of the policies addressed protection of residents from further potential abuse when the alleged perpetrator was another facility resident. Further interview revealed the Administrator confirmed no additional abuse/neglect in-services were provided to the staff after the incidents occurred and no new interventions were put in place for resident protection after the incidents involving R#364. Cross refer F600 17141

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38514 Based on observations, record review, staff and family interviews, and review of facility policies titled, Reporting and Investigating Abuse, the facility failed to ensure allegations of sexual abuse were thoroughly investigated and failed to implement protective measures to prevent further incidences of sexual abuse for three of four (R#17, R#55, R#42) residents reviewed for sexual abuse. On 04/14/2022, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator was informed of the Immediate Jeopardy (IJ) on 04/14/2022 at 7:46 PM. The noncompliance related to the immediate jeopardy was identified to have existed on 05/23/2021. The immediate jeopardy was removed on 04/17/2022. The IJ is outlined as follows: The IJ began on 05/23/2021, when R#364 was found in the room of R#17, a resident with severe cognitive impairment, with his hands under the resident's shirt on the resident's breasts. On 5/23/2021, R#17, reported to staff that she had been molested. The facility failed to put interventions in place to prevent future incidents from taking place. R#17 was subsequently sexually abused a second time by R#364 on 07/11/2021 when R#364 was found with his hands under R#17's shirt. Additional residents were sexually abused by R#364. R#55, a bedbound resident with moderate cognitive impairment, was sexually abused by R#364 on 08/27/2021, when R#364 was observed in R#55's room, with his hand under R#55's cover. R#55's brief was observed to be un-taped and folded back. On 1/21/2022, R#364 was found with his hand on the chest of R#42 another resident with severe cognitive impairment. The facility failed to address the sexually aggressive behavior of R#364 and failed to put effective interventions in place and therefore failed to protect R#17, R#55, and R#42 from resident-to-resident sexual abuse. The IJ was related to the facility's noncompliance with the program requirements, as follows: F600: 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation (Scope/Severity [S/S]: J; F607: 42 CFR 483.12(b)(1)(4), Develop/Implement Abuse/Neglect, etc. Policies S/S: J; F608: 42 CFR 483.12(b)(5), Reporting of Reasonable Suspicion of a Crime, S/S: J; F610: 42 CFR 483.12(c)(2) (4), Alleged Violations-Investigate/Prevent/Correct S/S: J); F656: 42 CFR 483.21 - Comprehensive Resident Centered Care Plans, S/S: J; F835: 42 CFR 483.70 - Administration S/S: J. Additionally, Substandard Quality of Care was identified with the requirements at F600: 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation (Scope/Severity [S/S]: J; F607: 42 CFR 483.12(b)(1)(4), Develop/Implement Abuse/Neglect, etc. Policies S/S: J; F608: 42 CFR 483.12(b)(5), Reporting of Reasonable Suspicion of a Crime, S/S: J; F610: 42 CFR 483.12(c)(2) (4), Alleged Violations-Investigate/Prevent/Correct S/S: J). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winthrop Health and Rehabilitation	12 Chateau Drive Rome, GA 30161

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An Acceptable Removal Plan was received on 4/17/2022. The removal plan included placing R#364 and R#17 on one-to-one supervision, staff training, skin assessments on all residents including cognitively impaired residents and interviews with all cognitive residents regarding abuse, neglect, and sexual abuse. The survey team conducted observations, reviewed staff training records and monitoring logs, clinical record review of revised care plans, and interviews with staff and residents to verify all elements of the facility's Removal Plan were implemented. The immediacy of the Immediate Jeopardy was removed on 04/17/2022. The facility remained out of compliance at a lower scope and severity while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures governing the identification, reporting, investigation, and protection of residents from abuse, including sexual abuse Findings include: Review of the undated facility policy titled, Reporting and Investigating Abuse revealed, Intent: It is the intent of this center to establish standards of practice for investigation and reporting abuse, neglect, mistreatment, exploitation, and misappropriation of property. The Administrator or designee will take immediate action to prevent further potential violations while the alleged violation is being investigated. The section of the policy for protection of residents from further abuse only addressed measures to be taken if the alleged perpetrator was a staff member. In addition, the investigative section of the policy did not address conducting an investigation of resident to resident abuse. A review of R#364's Face Sheet revealed the facility admitted the resident with diagnoses including cerebral infarction (stroke), vertebrobasilar artery syndrome (syndrome affecting blood supply to the brain), aphasia (comprehension and communication disorder) and chronic kidney disease. Review of the Quarterly Minimum Data Set (MDS), dated [DATE] revealed R#364 was assessed to have a Brief Interview for Mental Status (BIMS) score of seven indicating the resident had severe cognitive impairment. Review of the Quarterly MDS dated [DATE] revealed R#364 had a BIMS score of 12 indicating the resident had moderate cognitive impairment. Quarterly MDS dated [DATE] revealed the resident had a BIMS score of 11 again indicating the resident was assessed to have moderate cognitive impairment. 1. Review of R#17's Face Sheet revealed the facility admitted the resident with diagnoses including Alzheimer's disease with early onset, dementia with behavioral disturbance, and delusional disorder. Review of the annual Minimum Data Set (MDS), dated [DATE] revealed that R#17 was assessed to have a BIMS score of four indicating the resident had severe cognitive impairment. R#17 required extensive assistance of one person for transfers and supervision of one person with locomotion on the unit and that locomotion off the unit occurred only once or twice. R#17 used a wheelchair for mobility. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1.a. Review of a COC [Change of Condition] - Behavior report, dated 05/23/2021, for R#364 revealed the resident had sexual contact, which included touching and groping the breast of a female resident, after being careful to close the door to avoid exposure. The document also revealed R#364 had been warned about going into female residents' rooms numerous times and had been removed several times. The report indicated the resident, always slips around the other side to go into this resident's room. Review of a Facility Incident Report Form, dated 05/23/2021, revealed the facility initiated a report regarding abuse. The details of the incident indicated a nurse walked into R#17's room and found another resident with his hands up R#17's shirt. The facility's investigation file contained the incident report, a one-page facility investigation, three witness statements, and one undated handwritten note from SW FF. The statement of investigation dated 05/27/21 indicated that R#364 was found in R#17's room with his hands under R#17's shirt, fondling the resident's breasts. The report revealed a nurse reported the incident and removed R#364 from the room. RN CCC interviewed R#17 regarding the incident and the resident denied any male visitors in her room. The report revealed R#17 reported to CNA AAA that a man had come to her room and molested her. R#17 also told an LPN that she had told a man to get the hell out of the room, or she would kick his ass. The report revealed that R#364 was counseled regarding the incident and was instructed not to enter any other resident's room. The report indicated R#364 understood and that staff had been made aware if they witnessed R#364 and R#17 together, they were to ask R#17 if she wanted to sit somewhere else. There was no documented evidence the facility interviewed R#364, or any other facility residents about their treatment at the facility and no documented evidence the facility assessed R#17's psychosocial well-being. In addition, there was no documented evidence any action was taken to protect Resident #17 or other facility residents from further potential abuse. Review of a handwritten statement, dated 05/23/2021 by LPN TT, revealed the nurse had witnessed R#364 stroking R#17's left upper leg. LPN TT and two different CNAs told R#364 to stop touching R#17 and that this was not appropriate. The statement documented R#364 proceeded to follow R#17 around. LPN TT stated the staff were attempting to keep a close eye on both residents' whereabouts, as R#364 was trying to pursue and isolate R#17. The statement documented that at one point R#17 was retrieved from the hall and R#17 stated she was afraid and that someone had scared her. The statement documented that LPN TT had to provide care to another residents and when she returned to where R#17 was being monitored, R#17 and R#364 were both gone. LPN TT opened the door to R#17's room and found R#364 with both hands underneath R#17's blouse, fondling both of R#17's breasts. The statement documented that R#17 was not objecting but that R#17 was not mentally capable of giving consent. The statement revealed LPN TT removed R#364 from the room. An interview conducted on 04/13/2022 at 1:38 PM with SW FF revealed she interviewed residents after allegations of abuse, but did not document anything in the chart. According to SW FF, she conducted a safety survey of other residents, and a list was provided to the Administrator. However, SW FF confirmed there was no documentation of the interviews. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 04/15/2022 at 11:40 AM, RCC OO confirmed that a nurse's note was in the EHR for R#17 regarding the sexual assault and that it addressed a skin assessment but nothing about the resident's emotional state. When asked what the procedure was after an allegation of sexual abuse, RCC OO stated a full head to toe assessment should be done. An incident report should be completed, and a nurse's note should be documented to include notification of the family, physician, and Administrator; and a description of the incident. When asked what time the incident occurred on 05/23/2021, RCC OO stated she did not know, because there was no documentation regarding when the incident occurred. RCC OO also confirmed a full body assessment was not completed for R#17, and there was no documentation indicating whether the incident was reported to the abuse coordinator. RCC OO also confirmed there was no documentation in R#364's chart referencing the sexual assault. An interview was conducted on 04/13/2022 at 2:10 PM with the Administrator. The surveyor asked for the police report for the incident on 05/23/2021, and the Administrator stated no report number was provided, only a badge number. When asked where the assessment of R#17 was located, the Administrator stated it should be in the chart. The Administrator stated the facility conducted a skin assessment and that the skin assessment was possibly considered a full assessment. The Administrator stated he/she did not know the exact time the incident occurred or what was covered when R#364 was counseled, but the notes should be in the chart. The Administrator stated she was not sure when SW FF spoke to R#17 or where this was documented. An interview with LPN TT on 04/17/2022 at 12:34 PM revealed the facility had total disregard for the safety of the residents, especially R#17. LPN TT stated former Director of Nursing (DON) EEE, who was employed at the facility when this event occurred did not recognize the seriousness of the incident. 1.b. Review of a Facility Incident Report Form, dated 07/11/2021, revealed a CNA walked into R#364's room and found R#364 massaging the breasts of R#17. The report indicated the CNA removed R#17 from the room. R#364 was counseled regarding touching other residents inappropriately and the resident stated understanding. The report indicated staff were notified that if they saw R#364 and R#17 together, to ask R#17 if the resident wanted to be removed from being around R#364. The report stated a full assessment had been conducted and no injuries were noted. Review of a typed statement, dated 07/11/2021 at 2:50 PM and signed by LPN GGG, revealed the nurse found R#17 in R#364's room. R#17's shirt was pulled up above the resident's clavicles, exposing the bare chest, and R#364 had both hands on R#17's breasts, massaging them. When R#364 was asked what he was doing, R#364 removed his/her hands, pulled R#17's shirt down and stated, None of your business. LPN GGG removed R#17 from the room and told R#364 that he could not do that. R#364 replied, Oh yes I can. The statement indicated R#17 was assisted to the other nurses' station near his room, and the nurse informed LPN PP of the incident. Further review of the Facility Incident Report Form, dated 07/11/2021 revealed no documented evidence the facility obtained a witness statement from any CNA, specifically the CNA who initially found R#17 in R#364's room. Further review revealed no evidence the facility interviewed R#364 regarding the incident, nor any other facility residents about their treatment at the facility. According to the investigation, a full skin assessment of R#17 was conducted, and no injuries were noted; however, a review of the resident's electronic health record revealed no documented evidence the facility assessed R#17's physical or psychosocial status. In addition, there was no documented evidence any action was taken to protect Resident #17 or other facility residents from further potential abuse. (continued on next page)

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F 0610

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Review of a handwritten statement, dated 07/11/2021 at 2:50 PM and signed by LPN PP, revealed LPN PP was not a witness to the actual incident, but that LPN GGG brought R#17 back to the side of the building where R#17's room was located.

Review of an email dated 7/12/2021, from the Administrator to Corporate contradicted the handwritten note written by LPN GGG (which documented that LPN GGG was the staff member that observed R#17 in R#364's room). The email indicted, in pertinent part, that a CNA found R#17 in R#364's room and that she was in no distress. The email indicated that R#17 (a severely cognitively impaired resident) probably thinks that R#364 is her husband and there is nothing that anyone can do, maybe try and keep them separated, but that would be too hard. The email also documented that the incident was reported (to the State) however, it was not reported to the police since there was no crime committed.

The surveyor attempted to contact LPN PP for a telephone interview; however, LPN PP was an agency nurse, and the surveyor was unable to obtain a working phone number.

There was no witness statement from any CNA attached to the investigation.

An interview was conducted on 04/13/2022 at 2:10 PM with Administrator. When asked why the sexual abuse on 07/11/2021 was not reported to the police, the Administrator stated he/she did not report all incidents and that it depended on the circumstances of each incident. The Administrator stated he/she reported the incident on 05/23/2021 because R#17 had used the word molested.

During an interview on 04/15/2022 at 11:40 AM, RCC OO confirmed there were no nurse's notes regarding the sexual assault on 07/11/2022 in R#17's chart. When asked what time this incident occurred, RCC OO stated he/she did not know, because there was no documentation regarding what time the incident occurred. RCC OO confirmed a full body assessment was not completed for R#17, and there was no documentation indicating whether the incident had been reported to the physician or the abuse coordinator. RCC OO also confirmed there was no documentation in R#364's chart regarding the sexual assault.

2. Review of a Facility Incident Report Form, dated 08/27/2021, revealed the facility initiated a self-report regarding abuse. According to the statement of investigation, dated 09/02/2021, R#364 was found in R#55's room. Certified Nursing Assistant (CNA) JJJ alerted Licensed Practical Nurse (LPN) TT and LPN TT observed R#55 in bed with the resident's legs elevated. R#364 was in a wheelchair next to the bed with his hands under the covers. When LPN TT looked under the covers, the tape strips on R#55's brief were undone and the front of the brief was folded back.

Review of R#55's Face Sheet revealed the facility admitted the resident on 11/21/2019 with diagnoses including vascular dementia with behavioral disturbance, major depressive disorder, history of falling, and atherosclerosis of native arteries of bilateral legs.

Review of the quarterly Minimum Data Set (MDS), dated [DATE] revealed R#55 was assessed to have a BIMS score of nine indicating the resident had moderate cognitive impairment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of an e-mail, dated 08/27/2021 at 1:51 PM from former Director of Nursing (DON) EEE to Administrator, revealed that LPN TT brought R#364 to the DON's office and stated that R#364 was found in R#55's room with his hands under the covers. The e-mail indicated the DON asked R#364 why he was in R#55's room and R#364 stated R#55 needed something. The DON reminded R#364 that they had previously discussed that R#364 was not going to be going in other residents' rooms. The e-mail revealed R#364 stated he did not do anything, then asked the DON if she didn't do it. When the DON asked R#364 what he meant, R#364 stated, sex. DON EEE indicated she asked R#364 if he had urges and if that was what all this is about. R#364 admitted yes. DON EEE then informed the resident she would consult the physician to see if something could be ordered. Review of a handwritten statement, dated 08/27/2021 and signed by LPN TT, documented that LPN TT was notified of the encounter by CNA JJJ. LPN TT, and another staff member went to R#55's room and asked the resident why R#364 was at her bedside. LPN TT documented that when they lifted the cover they discovered that R#55's brief had been untaped on the right side and was folded back exposing the resident's privates. LPN TT documented that R#44 acted confused and said, he better not touch her and that she couldn't remember. Review of a Facility Incident Report Form, dated 08/27/2021, and the statement of investigation, dated 09/02/2021, revealed the Former DON EEE and the Administrator counseled R#364 regarding going into another resident's room without permission and to not touch anyone inappropriately. The Administrator explained to R#364 that a 30-day notice to leave the facility could be issued if there were any further occurrences. There was no documented evidence when considering whether the allegation was substantiated that the facility considered what LPN TT observed when she went into R#55's nor the conversation the resident had with DON EEE. In addition, there was no documented evidence the facility implemented interventions to monitor R#364's behavior to prevent further potential abuse. An interview was conducted on 04/13/2022 at 2:10 PM with the Administrator when asked about the assessments that the investigation stated were completed, the Administrator stated assessments should be in the chart. The Administrator confirmed there was no documentation regarding counseling or the possible 30-day notice, stated we should have documented it. During an interview on 04/15/2022 at 11:40 AM, RCC OO confirmed that there was one nurse's note in the EHR for R#55 regarding the sexual assault. The note did not include the time this incident occurred, who had been notified, nor the description of the incident. RCC OO stated there should have been notes with this information. RCC OO also confirmed there was no documentation in R#364's chart describing the sexual assault that occurred on 08/27/2021. 3. Review of the Facility Incident Report Form, dated 01/21/2022, revealed the facility initiated a self-report regarding resident-to-resident abuse. The date of the incident was 01/20/2022. The facility investigation, dated 01/28/2022, revealed that a nurse reported to former Director of Nursing (DON) EEE that R#364 was seen with his hand on the outside of the shirt of R#42, near the breast area. Review of R#42's Face Sheet revealed the facility admitted the resident with diagnoses including Alzheimer's disease with late onset, need for assistance with personal care, other signs and symptoms involving emotional state, and pseudobulbar affect (disorder of the nervous system that causes inappropriate laughing or crying). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Winthrop Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 12 Chateau Drive Rome, GA 30161	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Quarterly Minimum Data Set (MDS), dated [DATE] revealed that a BIMS assessment was not conducted for R#42 as the resident was rarely or never understood and was severely impaired in cognitive skills for daily decision-making. Review of a handwritten statement dated 01/20/2022 and signed by Licensed Practical Nurse (LPN) KKK revealed R#364 was observed with his hand on R#42's chest. The report indicated R#364 was in his wheelchair beside R#42. There were no injuries. The surveyor attempted to obtain a phone number for LPN KKK as well as the identity of the other witness, but LPN KKK was no longer employed by the facility, and the surveyor was unable to obtain contact information. Review of a handwritten statement, dated 01/20/2021 at 7:35 PM, did not legibly identify the witness' title, and the Administrator did not recognize the name on the statement. The statement indicated LPN KKK separated R#364 and R#42. The statement also indicated R#42 was not crying and was not in distress. Review of the Electronic Health Record (her) for R#42 revealed there was no nurse's note regarding the incident on 01/20/2022. The record did indicate a skin assessment was completed on 01/21/2022. There was no documentation in the chart indicating what time the incident occurred, or details of the incident. Record review of a Summary Report for R#42 and R#364 revealed there were no new physician's orders related to the incident. During an interview on 04/15/2022 at 11:40 AM, Resident Care Coordinator (RCC) OO confirmed there was no nurse's note in the EHR for R#42 or R#364 regarding the incident. An interview was conducted with the Family of R#42 on 04/13/2022 at 10:17 AM. The Family indicated the facility did not explain any processes or interventions that would be put into place to protect R#42. Continued review of the Facility Incident Report Form, dated 01/21/2022, the report indicated a full head to toe assessment had been completed and that R#364 was counseled that he could not touch other residents inappropriately. R#364 stated he understood. The nurse practitioner was informed of the incident and added a medication for R#364's behavior. The investigation indicated staff was made aware of the situation and staff were to report if they saw R#364 being inappropriate with another resident. There was no documented evidence the facility implemented any action to monitor R# 364's behavior to prevent further potential abuse. An interview was conducted on 04/13/2022 at 2:10 PM with Administrator revealed the Administrator could not speak to how staff were made aware of the incident and should report inappropriate behavior and stated he/she did not know if there was any documentation that it occurred. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview was conducted on 04/13/2022 at 4:15 PM with former DON EEE. DON EEE stated when asked if she felt R#17 was afraid and crying, as indicated by the witnesses after the encounter on 05/23/2021, DON EEE stated, I don't think [R#17] was fearful. DON EEE stated regarding R#42, she felt R#364 was just comforting R#42 and did not put his hands under her shirt. Further interview with DON EEE revealed she felt the witness was incorrect regarding R#55 and R#364. She stated she did not feel R#55 would be able to lift her legs in the air. DON EEE stated to prevent further potential abuse staff would keep R#364 in eyesight, place him at the nurse's station, and monitor. Cross refer F600 17141

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F 0656

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

38514

Based on observations, interviews, record review, document review, and review of the facility policy titled, Patient's Plan of Care, the facility failed to ensure person-centered, comprehensive care plans were developed to meet the safety and psychological needs of four of 16 (R#364, R#17, R#42 and R#55) whose care plans were reviewed. Specifically, the facility failed to ensure the comprehensive care plan for R#364 addressed the resident's sexually abusive behaviors to prevent further sexual abuse of other facility residents; and the comprehensive care plans for R#17, R#42, and R#55 failed to address protective measures and the necessary care, assessments and monitoring related to having been sexually assaulted by R#364.

On 04/14/2022, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents.

The facility's Administrator was informed of the Immediate Jeopardy (IJ) on 04/14/2022 at 7:46 PM. The noncompliance related to the immediate jeopardy was identified to have existed on 05/23/2021. The immediate jeopardy was removed on 04/17/2022.

The IJ is outlined as follows:

The IJ began on 05/23/2021, when R#364 was found in the room of R#17, a resident with severe cognitive impairment, with his hands under the resident's shirt on the resident's breasts. On 5/23/2021, R#17, reported to staff that she had been molested. The facility failed to put interventions in place to prevent future incidents from taking place. R#17 was subsequently sexually abused a second time by R#364 on 07/11/2021 when R#364 was found with his hands under R#17's shirt. Additional residents were sexually abused by R#364. R#55, a bedbound resident with moderate cognitive impairment, was sexually abused by R#364 on 08/27/2021, when R#364 was observed in R#55's room, with his hand under R#55's cover. R#55's brief was observed to be un-taped and folded back. On 1/21/2022, R#364 was found with his hand on the chest of R#42 another resident with severe cognitive impairment. The facility failed to address the sexually aggressive behavior of R#364 and failed to put effective interventions in place and therefore failed to protect R#17, R#55, and R#42 from resident-to-resident sexual abuse.

The IJ was related to the facility's noncompliance with the program requirements, as follows:

F600: 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation (Scope/Severity [S/S]: J; F607: 42 CFR 483.12(b)(1)(4), Develop/Implement Abuse/Neglect, etc. Policies S/S: J; F608: 42 CFR 483.12(b)(5), Reporting of Reasonable Suspicion of a Crime, S/S: J; F610: 42 CFR 483.12(c)(2) (4), Alleged Violations-Investigate/Prevent/Correct S/S: J); F656: 42 CFR 483.21 - Comprehensive Resident Centered Care Plans, S/S: J; F835: 42 CFR 483.70 - Administration S/S: J.

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NAME OF PROVIDER OR SUPPLIER Winthrop Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 12 Chateau Drive Rome, GA 30161	

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Additionally, Substandard Quality of Care was identified with the requirements at F600: 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation (Scope/Severity [S/S]: J; F607: 42 CFR 483.12(b)(1)(4), Develop/Implement Abuse/Neglect, etc. Policies S/S: J; F608: 42 CFR 483.12(b)(5), Reporting of Reasonable Suspicion of a Crime, S/S: J; F610: 42 CFR 483.12(c)(2) (4), Alleged Violations-Investigate/Prevent/Correct S/S: J). An Acceptable Removal Plan was received on 4/17/2022. The removal plan included placing R#364 and R#17 on one-to-one supervision, staff training, skin assessments on all residents including cognitively impaired residents and interviews with all cognitive residents regarding abuse, neglect, and sexual abuse. The survey team conducted observations, reviewed staff training records and monitoring logs, clinical record review of revised care plans, and interviews with staff and residents to verify all elements of the facility's Removal Plan were implemented. The immediacy of the Immediate Jeopardy was removed on 04/17/2022. The facility remained out of compliance at a lower scope and severity while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures governing the identification, reporting, investigation, and protection of residents from abuse, including sexual abuse Findings include: Review of the undated facility policy, titled, Patient's Plan of Care, indicated, Intent: Each patient will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the patient's medical, physical, mental, and psychosocial needs. Guideline: A comprehensive care plan should be developed within 7 days after completion of the comprehensive MDS [Minimum Data Set] assessment. When developing the comprehensive care plan, facility staff should use the MDS to assess the patient's clinical condition, cognitive and functional status, and use of services. The patient's care plan should be reviewed after each MDS assessment and revised based on changing goals, preferences and needs of the patient and in response to current interventions. The comprehensive care plan should also be updated as ongoing clinical assessments identify changes. A review of the facility's self-reported incidents revealed R#364 was the alleged perpetrator of sexual assaults upon R#17 on 05/23/2021 and 07/11/2021; R#55 on 08/27/2021; and R#42 on 01/21/2022. 1. A review of R#364's Face Sheet revealed the facility admitted the resident with diagnoses including cerebral infarction (stroke), vertebrobasilar artery syndrome (syndrome affecting blood supply to the brain), aphasia (comprehension and communication disorder) and chronic kidney disease. Review of R#17's Face Sheet revealed the facility admitted the resident with diagnoses including Alzheimer's disease with early onset, dementia with behavioral disturbance, and delusional disorder. a. Review of a handwritten statement, dated 05/23/2021 by LPN TT, revealed in pertinent part, LPN TT opened the door to R#17's room and found R#364 with both hands underneath R#17's blouse, fondling both of R#17's breasts. The statement documented that R#17 was not objecting but that R#17 was not mentally capable of giving consent. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. Review of a typed statement, dated 07/11/2021 at 2:50 PM and signed by LPN GGG, revealed the nurse found R#17 in R#364's room. R#17's shirt was pulled up above the clavicles, exposing the bare chest, and R#364 had both hands on R#17's breasts, massaging them. Review of the Care Plan, updated 01/27/2022, revealed R#364 had behaviors as evidenced by pacing, wandering, verbal aggression and inappropriate sexual behaviors. Interventions included: - Assess patterns of behavior with behavior monitoring. - Be an active listener. - Allow for expression of feelings without censure. - Communicate face to face. - Involve in activities based on the resident's preferences and cognitive functioning. - Redirect patient as needed. - Use medication for short periods in the lowest possible dosage. Review of the Care Plan, updated 01/13/2022, revealed R#17 was at risk for behaviors related to psychosocial factors and Alzheimer's disease, as evidenced by wandering and restlessness. Interventions included: - Conduct behavior assessment as needed. - Provide activities of choice to reduce frustration and dependence on others. - Remove patient from stressful situations. - Be an active listener, allow for expression of feelings without censure. Review of the care plans for R#364 revealed there was no care plan developed regarding his sexual behaviors which contributed to the sexual assault against R#17. No prevention interventions were implemented to prevent future sexual assaults. Review of the care plans for R#17 revealed there was no care plan developed following the sexual assault to address protection from further assaults or monitoring of psychological harm. 2. Review of R#55's Face Sheet revealed the facility admitted the resident with diagnoses including vascular dementia with behavioral disturbance, major depressive disorder, history of falling, and atherosclerosis of native arteries of bilateral legs. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Facility Incident Report Form, dated 08/27/2021, revealed the statement of investigation, dated 09/02/2021, indicated that R#364 was found in R#55's room. After CNA JJJ notified LPN TT, R#55 was observed by LPN TT in bed, with legs elevated. R#364 was in a wheelchair next to the bed with his hands under the covers. When LPN TT looked under the covers, R#55's brief had the tape strips undone and the front of the brief folded back. LPN TT asked R#55 about the incident, and R#55 stated R#364 had not touched R#55 anywhere and better not. Review of the Care Plan, updated 03/24/2022, revealed R#55 had a cognitive deficit related to a diagnosis of vascular dementia, as evidenced by poor decision-making, a short-term memory problem, and impulsive behavior. Interventions included: - Explain all procedures and treatments. - Monitor labs. - Assess for pain. - Observe for any changes or decline in cognitive status. Review of the Care Plan, updated 04/22/2021, revealed R#55 had behaviors, as evidenced by impulsiveness, verbal aggression, disrobing, hitting at staff during attempts to provide care, agitation, delusions, and a history of cussing at others. The interventions included: - Conduct behavior assessment as needed. - Provide activities of choice. - Redirect as needed, enjoys talking about past, children, and work life. - Remove from stressful situations. Review of the care plans for R#364 revealed there was no care plan developed regarding his sexual behaviors which contributed to the sexual assault against R#55. No prevention interventions were implemented to prevent future sexual assaults. Review of the care plans for R#55 revealed there was no care plan developed following the sexual assault to address protection from further assaults or monitoring of psychological harm. 3. Review of R#42's Face Sheet revealed the facility admitted the resident with diagnoses including Alzheimer's disease with late onset, need for assistance with personal care, other signs and symptoms involving emotional state, and pseudobulbar affect (disorder of the nervous system that causes inappropriate laughing or crying). Review of the Facility Incident Report Form, dated 01/21/2022, revealed the facility initiated a self-report regarding resident-to-resident abuse. The date of the incident was 01/20/2022. revealed that a nurse reported to former DON EEE that R#364 was seen with his hand on the outside of the shirt of R#42, near the breast area. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Care Plan, dated 03/10/2022 revealed R#42 had cognitive impairment related to dementia and delirium, as evidenced by short and long-term memory problems and severely impaired decision-making. Interventions included explaining all procedures and treatments, allowing ample time to absorb and respond to information, and providing a consistent routine. Review of the care plans for R#364 revealed there was no care plan developed regarding his sexual behaviors which contributed to the sexual assault against R#42. No prevention interventions were implemented to prevent future sexual assaults. Review of the care plans for R#364 revealed there was no care plan developed following the sexual assault to address protection from further assaults or monitoring of psychological harm. An interview was conducted on 04/12/2022 at 4:08 PM with LPN MMM, LPN MMM confirmed R#364 had been sexually inappropriate with female staff members as well as female residents. During an interview on 04/13/2022 at 2:10 PM, Administrator stated R#364's inappropriate behavior should be addressed in the care plan and updated. As of 04/14/2022 at 11:00 AM, the care plan for R#364 did not address the history of sexual assaults against other facility residents. R364's care plan did not contain interventions to prevent R#364 from sexually assaulting other residents. The care plans for R#17, R#42 and R#55 did not address protection from further assaults or monitoring for psychological harm related to the assaults. An interview was conducted with RN LLL on 04/14/2022 at 11:08 AM. RN LLL stated all nurses played a part in care planning. RN LLL confirmed there were no care plans developed for R#364's sexual assaults or for protection for R#17, R#42, and R#55. RN LLL stated the care plans did not have the proper interventions. An interview was conducted with the Administrator on 04/14/2022 at 1:19 PM revealed the care plans should be updated annually, quarterly and with significant changes. She indicated care plans should tell the story of the resident. The Administrator agreed the care plans for R#364, R#17, R#42 and R#55 should have been updated. On 04/14/2022 at 1:50 PM, an interview was conducted with the current DON (DON CC) regarding care plans. DON CC stated care plans were to be developed on admission and should be person-centered. DON CC indicated care plans should be reviewed after events and updated. On 04/15/2022 at 11:40 AM, Resident Care Coordinator (RCC) OO was interviewed regarding the care plans of R#364, R#17, R#42, and R#55. RCC OO stated the care plans should be updated or a new care plan should be developed and that she would expect there to be interventions in place to protect residents. Cross refer F600 17141 46194

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20958 Based on observations, record review, interviews, and review of the facility policy titled, Patient's Plan of Care, the facility failed to ensure care plans were revised to include residents' current care needs for one of 26 (R#2) sampled residents whose care plans were reviewed. Specifically, the facility failed to ensure the care plan for toileting was revised after R#2 became more independent with toileting. Findings include: Review of the facility's undated policy, titled, Patient's Plan of Care, indicated, The patient's care plan should be reviewed after each MDS [Minimum Data Set] assessment and revised based on changing goals, preferences and needs of the patient and in response to current interventions. The comprehensive care plan should also be updated as ongoing clinical assessments identify changes. All members of the care plan team will participate in the development, review, and revision of care plan. 1. Review of the Face Sheet for R#2 revealed the facility admitted the resident on 12/10/2021 with diagnoses including hypertensive chronic kidney disease, type two diabetes mellitus, unsteadiness on feet, and muscle weakness. Review of the admission Minimum Data Set (MDS), dated [DATE], revealed R#2 was readmitted from the hospital on 12/28/2021. The resident's Brief Interview for Mental Status (BIMS) score was 12, which indicated the resident's cognition was moderately impaired. The MDS also indicated the resident did not transfer between surfaces or walk in his room. The resident was totally dependent on two or more staff members for toilet use and was occasionally incontinent of bladder but always continent of bowel. A review of the Care Plan, dated 01/10/2022, revealed the resident had a self-care deficit related to needing assistance with toileting and hygiene. The interventions included assisting the resident with activities of daily living (ADLs) as needed and providing cues as needed. Review of the Care Plan, updated 01/24/2022, revealed the resident was incontinent of urine as evidenced by being always incontinent of bowel and bladder. The interventions included checking the resident frequently and assisting with toileting as needed, keeping the call light within reach and reminding the resident to call for assistance, and providing perineal care (peri-care) after each incontinent episode. The interventions were dated 01/10/2022. Review of the Care Plan, updated 01/24/2022, revealed the resident had limited mobility as evidenced by an unsteady gait and the need for assistance with moving from a sitting to lying position in bed, toilet transfers, and transfers from the bed to the chair. The interventions included providing the appropriate level of assistance to promote the resident's safety, providing cues as needed, and referring to therapy as indicated. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 04/11/2022 at 2:07 PM, R#2 was in his room, sitting in a wheelchair and propelling it around the room independently. The resident stated he was able to use the bathroom independently. During an interview on 04/14/2022 at 1:54 PM, Registered Nurse (RN) JJ, the MDS Coordinator, revealed R#2's care plan was last reviewed on 03/31/2022. RN JJ stated the care plans were working care plans and that the nurses assigned to care for the resident should have revised the care plan. RN JJ stated R#2 used to be more lethargic and had more falls, but the resident had received therapy and become stronger and returned to his baseline. RN JJ stated R#2 no longer needed frequent checks and changes for incontinence and that the care plan should have been revised. She stated R#2 had only had one incontinent episode in the last month. On 04/14/2022 at 1:48 PM, the current Director of Nursing (DON) was interviewed regarding R#2's care plan. The DON reported R#2 had improved and was not as incontinent as he had been. The DON indicated she had not been doing the care plans, but that it should have been revised. 46194 17141

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07157 Based on observation, interview, and record review the facility failed to ensure one of two residents (R#44), reviewed for activities of daily living (ADLs), received necessary services to maintain grooming and personal hygiene. Specifically, the facility failed to provide nail care for R#44. Findings include: A review of R#44's admission Minimum Data Set (MDS), dated [DATE], revealed the resident had diagnoses that included dementia and diabetes. A review of the Brief Interview for Mental Status (BIMS) revealed the resident had a score of seven, indicating severely impaired cognition. Further, the MDS indicated R#44 required extensive assistance of one staff person for personal hygiene and was totally dependent on two staff for bathing. A review of R#44's Care Plan, updated on 03/08/2022, revealed the facility identified the resident had decreased mobility and a self-care deficit with an intervention to assist the resident with ADLs as needed. On 04/11/2022 at 12:00 PM, R#44 was observed seated at the nurses' station. At 12:02 PM on 04/11/2022, the resident was observed with long, jagged, dirty fingernails. R#44's ring finger on the right hand also had a brown substance on the fingernail. Observation and interview with R#44 on 04/12/2022 at 4:50 PM revealed the resident was in the bed with the covers up. The resident stated a bath had been provided. Observation of the resident's fingernails revealed the resident's nails had been trimmed since the 04/11/2022 observation; however, the resident had a dark colored substance underneath the nails. On 04/13/2022 at 11:54 AM, R#44 was observed with clean fingernails on the left hand, but on the right hand there was a brown substance underneath the fingernails. During an interview on 04/14/2022 at 10:14 AM, Certified Nursing Assistant (CNA)/bath aide QQ indicated a podiatrist provided residents' nail care and activities staff sometimes provided manicures. CNA QQ stated she cleaned the resident's hands with a washcloth and tried to clean under the nails. Continued interview with CNA QQ on 04/14/2022 at 11:48 AM revealed R#44 was independent with handwashing but needed assistance with clipping the fingernails. The CNA stated she tried to clean underneath the nails of R#44 with a washcloth. CNA QQ stated the facility did not have manicure kits or sticks to clean residents' nails. On 04/14/2022 at 6:28 PM, Interim Director of Nursing (DON) BB and Current DON CC were interviewed about nail care for dependent residents. DON BB stated facility CNAs could trim residents' fingernails and stated the facility had nail clippers and manicure kits to clean fingernails. An interview with the Administrator on 04/14/2022 at 7:20 PM revealed resident nail care was expected to be completed as part of personal hygiene care. 17141

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 46194 Based on observations, interviews, record review, and review of a facility policy titled, Restorative the facility failed to ensure one of 14 (R#34), residents reviewed who required a restorative nursing program, received restorative nursing services in accordance with R#34's Nursing Restorative Care Program. Findings include: A review of an undated facility policy titled Restorative revealed the intent of the policy was To provide nursing interventions that promote the patient's ability to adapt and adjust to living as independently and as safely as possible. When clinically appropriate, these interventions may be captured in a formalized restorative nursing care plan overseen by Restorative Nursing Supervisor(s). PURPOSE To provide a formalized restorative care plan to be implemented by appropriately trained staff and overseen by a restorative nursing supervisor. A review of the Face Sheet for R#34 revealed the resident had diagnoses which included traumatic hemothorax, plural effusion, congestive heart failure, fracture, and muscle weakness. A review of the quarterly Minimum Data Set (MDS) for R#34 dated 03/22/2022 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The resident's MDS revealed R#34 required extensive assistance of two staff for transfers, bed mobility, and bathing and noted the resident utilized a wheelchair as a mobility device. The MDS indicated R#34 had no limitations in range of motion. According to the MDS, the resident participated in therapy three of the last seven days and the most recent therapy regimen ended 03/22/2022. A review of an Occupational Therapy Discharge Summary dated 03/22/2022 and a Physical Therapy Discharge Summary dated 03/23/2022, revealed R#34 was discharged from therapy related to the resident meeting maximum potential. The summaries indicated the resident was discharged to a skilled nursing restorative program. Review of the Nursing Restorative Care Program for R#34, dated 03/22/2022, revealed the facility developed a plan of care to provide daily range of motion (ROM) to the resident's upper body. The resident's goals were to maintain/improve adequate active range of motion (AROM) of both upper extremities to allow daily participation in mobility and other functional activities, and to decrease the risk of injury. According to the restorative program, the facility developed three intervention/approaches: 1. Provide adequate AROM of both upper extremities. 2. Perform light resistance upper extremity exercises with a number one dumbbell (such as raising arms up and down and to the side; bicep curls; shoulder rolls; overhead reaching exercises; elbow and wrist bending; and as far as is comfortable, straightening exercises). 3. Perform moderate resistance upper extremity exercises with a red TheraBand or number two dumbbell (such as raising arms up and down and to the side as far as is comfortable, bicep curls, shoulder rolls, overhead reaching exercises, elbow and wrist bending and straightening exercises). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/13/2022 at 2:08 PM, with Physical Therapy Assistant (PTA) VV, the Director of Rehabilitation (Rehab), stated the therapy department developed a restorative nursing program for some residents when discharged from therapy. The PTA stated R#34 was on an upper body restorative program for upper body maintenance. According to PTA VV, restorative nursing should be provided to the resident once per day every day of the week. A review of R#34's Nursing Restorative Care Program for March 2022 revealed that, from 03/22/2022 through 03/31/2022, the facility provided 45 minutes of restorative nursing services on six of the ten days. No restorative nursing services were provided on four days (03/24/2022 -03/27/2022). Review of R#34's April 2022 Nursing Restorative Care Program revealed that, from 04/01/2022 through 04/12/2022, the facility provided 15 minutes of restorative care on nine of 12 days but did not provide any restorative care on three of 12 days (Sunday 04/03/2022; Saturday 04/09/2022; and Sunday 04/10/2022). Observation and interview with R#34 on 04/11/2022 at 11:18 AM revealed the resident was lying in bed. R#34 stated he/she could not walk well since falling at home. R#34 stated therapy discharged him/her about three weeks prior because the resident was not responding to therapy. During an observation and interview with R#34 on 04/13/2022 at 11:46 AM, the resident was observed sitting in a wheelchair in the resident's room. The resident stated staff had not been providing exercise for about three weeks. An interview with CNA XX on 04/13/2022 at 2:23 PM, revealed her job assignments included obtaining resident vital signs and weights, providing incontinence care, and assisting residents with eating. CNA XX stated today was the first time she was asked to provide restorative nursing services to residents. The CNA stated the facility provided a list of residents who needed restorative services, but did not provide details about the exercise program for each resident. CNA XX stated R#34's restorative program would include moving the arms. According to the CNA, she would not be providing restorative therapy to R#34 that day. Further interview revealed the CNA had not received any training from therapy or restorative nursing regarding R#34's program. According to the CNA, the restorative program used walkers and gait belts, but did not provide access to weights. Observation with the CNA of the Restorative assignment list revealed R#34's name was listed and under the restorative section was ROM - upper body. No details were provided regarding the resident's specific restorative program. During an interview on 04/13/2022 at 10:36 AM, Restorative Nurse PP revealed activities staff had started doing ROM exercises with the residents who required restorative nursing. She stated CNAs were still assisting residents with restorative ambulation and at times the facility had enough CNAs to complete other restorative interventions. During an interview on 04/13/2022 at 2:26 PM, Restorative Nurse PP stated if a resident participated in ROM exercises with activities staff, the restorative nurse documented that restorative ROM and stretching were provided. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/13/2022 at 4:19 PM, Restorative Nurse PP revealed that, even though the restorative nurse documented that all three of R#34's Nursing Restorative Care Program interventions were provided, the facility only provided AROM for a total of 15 minutes. Restorative Nurse PP confirmed she only listed what AROM exercises residents required on the Restorative assignment sheet for CNAs. According to the Restorative Nurse, if there were blanks on the Nursing Restorative Care Program, restorative nursing had not been provided. During an interview on 04/13/2022 at 2:15 PM, Activities Assistant WW revealed activities staff provided morning stretch for residents at 9:30 AM. Per Activities Assistant WW, the activity consisted of exercises that restorative nursing gave them to complete with residents in the restorative program. The activities assistant stated the stretches were to limber up the residents' muscles and consisted of things like rolling the wrists and rolling the shoulders. Per Activities Assistant WW, the activity was a 15-minute program during which everyone did the same exercises, noting it was not individualized to each resident. According to the activities assistant, R#34 had never attended the morning stretch activity. During an interview on 04/14/2022 at 11:05 AM, with the Interim Director of Nursing (DON BB) stated restorative nursing was required to perform maintenance restorative services to prevent resident decline. DON BB stated that, according to the Resident Assessment Instrument guidelines, the facility had to complete two areas of restorative nursing for 15 minutes a day, six days a week. She stated the therapy department worked with the nursing department by teaching them a walking program and going over established goals for the residents. During an interview on 04/14/2022 at 7:27 PM, Administrator stated the expectation was for the restorative nursing program to be in place and to be implemented. However, the Administrator stated she knew there had been problems with the restorative program being implemented.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07157 Based on observations, interviews, record review, and review of the facility policy titled, Skilled Inpatient Services - Accident Investigation Guidelines, the facility failed to conduct comprehensive investigations and root cause analyses to determine the cause of falls to prevent future falls for two of five sampled residents [R#44 and R#37] reviewed for accidents. Findings include: A review of a facility policy titled, Skilled Inpatient Services - Accident Investigation Guidelines, copyrighted in 2020, revealed that accidents or incidents occurring on this center's premises should be investigated as part of the safety management program. The policy further indicated an investigation should be conducted as soon after an accident as possible, that facts should be gathered while an accident was fresh in the minds of those involved, and the accident investigator should focus on understanding the root causes of the accident. 1. Review of a Face Sheet for R#44 revealed diagnoses that included dementia and generalized muscle weakness. Review of the 02/28/2022 admission Minimum Data Set (MDS) for R#44 revealed a Brief Interview for Mental Status (BIMS) score of seven, indicating severely impaired cognition. The MDS indicated R#44 needed extensive assistance for bed mobility, was not steady when moving from a seated to a standing position, and was not steady during surface-to-surface transfers. The MDS further indicated R#44 required substantial/maximum assistance with rolling left to right and was dependent upon staff for going from a seated position to a standing position. The MDS also identified that R#44 had no fractures related to falls in the six months prior to admission, had a fall in the last month prior to admission, and indicated the resident had a fall in the last two to six months prior to admission. Review of the Care Plan for R#44, most recently dated 03/27/2022, revealed a Care Area/Problem of Fall Risk related to a fall in the past month, incontinence, and an unsteady gait. The interventions listed on the plan were to assist the resident with activities of daily living (ADLs) and mobility (dated 02/04/2022), keep personal items in reach (02/04/2022), remind the resident to call instead of yell when needing assistance (dated 02/04/2022), utilize Broda(R) (a chair offering tilt, recline, and leg rest adjustments) Chair (dated 03/03/2022), and to utilize bed bolsters and maintain the bed in a low position (dated 04/06/2022). Review of an undated certified nursing assistant (CNA) care card, referred to as POCS, which provided instruction for caregiving, revealed the POCS listed care approaches for R#44's care. In a section for Bed Mobility, caution and high risk for falls were noted with special equipment listed as pillows, air mattress, wedges, and grippy socks and safety interventions listed as place mat beside bed and bed in low position. A review of the Nurse Note documents revealed R#44 experienced three falls in the past two months on 03/02/2022, 04/01/2022, and 04/06/2022. Per the notes: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winthrop Health and Rehabilitation	12 Chateau Drive Rome, GA 30161

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 03/02/2022, R#44 fell forward out of a wheelchair and received a bruise to the left forehead and a skin tear to the left elbow. -On 04/01/2022, the nurse note revealed R#44 was found on the floor rolled in covers and next to the bed. R#44 complained of pain to the left shoulder and an x-ray was ordered. -On 04/06/2022, R#44 was found on the floor with the side of his/her face on the floor and legs on the bed. It was determined the resident was sitting up in bed in an upright position after therapy. R#44 was assessed to have redness to the side of the face. The resident indicated the bottom portion of the bed was elevated prior to the fall. A review of an Event - Initial Note v3.0, with a record date of 03/02/2022, revealed R#44 fell on [DATE] at 2:00 PM in his/her room while in a wheelchair. Per the note, the resident was leaning over the wheelchair and fell to the floor, face forward. The note indicated injuries sustained included a bruise not subdural and a skin tear to the left elbow. The note identified that a reclining back wheelchair was added to help prevent falls when the resident was leaning over in the wheelchair. A review of the Event - Initial Note v3.0 with a record date of 04/01/2022 indicated R#44 rolled out of bed. Per the note, the resident was found with redness and pain in the left arm and shoulder, for which an x-ray was ordered. The note identified that a mat on the right side of the bed was implemented to keep R#44 from sustaining injury if the resident rolled out of bed again. A review of R#44's mobile imaging Patient Report, dated 04/01/2022, revealed there were no acute fracture lines visible. A review of a Progress Note documented by Nurse Practitioner (NP) LL, dated 04/05/2022, revealed R#44 had a fall on 04/01/2022 with an x-ray of the left arm and shoulder ordered due to complaints of pain. Per the note, the x-ray was negative for any acute fracture. A review of the Event Initial Note v3.0 with a record date of 04/06/2022 revealed R#44 rolled out of bed on 04/06/2022 at 1:00 PM. Per the note, a nurse observed R#44 on the floor with the side of the face on the floor and legs on the bed. The nurse identified redness to the side of R#44's face. It was documented that the resident was able to move all extremities. Per the note, the resident reported he/she was sitting up in bed in an upright position after therapy and the bottom of the bed was elevated. It was documented that R#44 was alert with confusion at times. On 04/11/2022 at 12:02 PM, R#44 was observed to have a faded green bruise on the left temporal area of the head and a faded green bruise on the back side of the left upper arm. The resident was asked about the bruises and said that the bruises were a result of the fall out of the bed to the floor or that someone had run into R#44 hitting R#44 in the head. On 04/12/2022 at 4:50 PM, R#44 was observed in a low air loss mattress bed. On 04/12/2022 at 11:45 PM, R#44 was observed in a low air loss mattress bed with the bed in a low position, the call light in reach. (continued on next page)

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

An interview with Certified Nursing Assistant (CNA) MM on 04/13/2022 at 10:58 AM revealed she had worked with R#44 previously. CNA MM was asked about fall prevention instructions for R#44 and stated the instructions were in the computer on the POCS, with fall prevention measures in red.

On 04/14/2022 at 2:56 PM, an interview with Licensed Practical Nurse (LPN) PP was conducted regarding post-fall investigations conducted for R#44. LPN PP stated she was the Quality Assurance Performance Improvement (QAPI) nurse and referred to QAPI documentation during the interview. The LPN stated that, per the review of the 03/02/2022 fall, R#44 had a bruise and a skin tear to the left arm, noting R#44 was in a standard wheelchair at the time of the fall, which was changed to a Broda chair post-fall. LPN PP stated additional investigative information for the fall on 04/01/2022 at 3:15 PM was not on the QAPI form because she was the involved nurse. LPN PP stated she did not collect any additional information for QAPI documentation for the fall on 04/01/2022, including speaking to the direct care staff who put R#44 into the bed before the fall. LPN PP stated when investigating the fall on 04/06/2022 at 1:00 PM, she spoke to the cart LPN about the fall. LPN PP stated she did not speak with the direct care staff who put R#44 to bed and did not know what type of mattress was on the bed.

On 04/14/2022 at 6:28 PM, an interview with the current Director of Nursing (DON) and Interim DON (DON BB) was conducted. The current DON stated she was usually notified in the morning meeting of residents who had sustained falls, noting those falls were discussed in the morning meetings. When asked about the expectation of the QAPI nurse, the current DON stated the QAPI nurse oversaw all falls, making sure everything was in place, which included documentation and discussion of the falls in the morning meeting. The DON stated she discussed falls in QAPI and did whatever she could do to prevent falls. The DON stated the QAPI nurse should conduct a root cause analysis for every fall and should be documenting investigative actions in fall notes or nursing notes. The DON stated it must be part of the investigation to speak to staff who cared for a resident prior to a fall.

46194

2. Review of a Face Sheet revealed R#37 had diagnoses that included non-traumatic brain dysfunction, congestive heart failure, dementia, and bipolar disease, schizophrenia.

Review of a 02/24/2022 quarterly Minimum Data Set (MDS) for R#37 revealed a Brief Interview for Mental Status (BIMS) score of eight, indicating moderately impaired cognition. The MDS further revealed R#37 was dependent on staff for transfers, bed mobility, and toilet use. The MDS indicated R#37 used a wheelchair as a mobility device.

Review of Nurses Note for R#37 revealed the resident had falls on 02/26/2022 and 04/10/2022. A Nurses Note for 04/10/2022 also identified that R#37 had a fall on 04/09/2022 at 10:00 PM; however, there was no Nurses Note regarding the fall on 04/09/2022.

A review of an Event - Initial Note v3.0, dated 02/26/2022 at 6:21 PM, revealed the resident had a fall in her room and was found under the bed. Further review of the note revealed R#37 stated in her interview she rolled over out of the bed. There was no injury documented. Per the note, R#37 was sent to emergency room (ER) for evaluation. The documented interventions put into place included providing more frequent checks, keeping the call light and other items needed in reach.

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

A review of an Event - Initial Note v3.0, dated 04/09/2022 at 10:00 PM, revealed R#37 had a fall in her room. The note indicated a certified nurse aide (CNA) noticed the resident on the floor during rounds. Per the note, interventions put into place were placing the bed in a low position and the call light within reach. There was no provided documentation of an investigation for this fall.

A review of an Event Follow-Up V2.0, dated 04/10/2022, revealed R#37 rolled from the bed and landed on her stomach, bumping her head. The document contained follow-up documentation for the 04/09/2022 fall, but there was no Event - Initial Note for the fall that occurred on 04/10/2022.

A review of a Resident's Consolidated Order document, dated 04/10/2022, revealed R#37 was sent to the ER at the family's request due to the resident falling twice in twenty-four hours.

A review of a Nurses Note for R#37, dated 04/10/2022, revealed the resident came back from the ER with no injures from the fall and no abnormal labs.

On 04/11/2022 at 11:47 AM, observations were made of R#37 and the resident's room. R#37 stated she experienced two falls the prior weekend. R#37 stated she fell to the floor in her room during both falls.

Review of an Event Initial Note v3.0, dated 04/11/2022 at 9:00 PM, revealed R#37 had a fall and was observed sitting on the left side of her bed on the floor with her back against the bed. No injuries were documented. Per the note, the resident verbalized she just wanted to get up. The note indicated the resident was put back to bed, which was in the lowest position with the call light within reach. It was documented staff would continue to monitor the resident. Interventions put into place were documented as bed in a low position, call light within reach, and needed or desired items in easy reach. There was no provided documentation of an investigation into the cause of the fall.

On 04/11/2022 at 1:48 PM, R#37's family member was interviewed. The family member stated the resident had a fall on the previous Saturday and Sunday. The family member stated that staff from the facility called about both of the falls, but was unable to provide a name of the staff who notified them.

Review of a Nurses Note, dated 04/11/2022 at 7:52 PM, revealed the family requested R#37 be sent to the ER due to three falls in three days. Per the note, R#37 left the facility via ambulance at 10:15 p.m. and was admitted to the hospital. R#37 did not return to the facility during the survey.

During an interview on 04/12/2022 at 2:21 PM, Licensed Practical Nurse (LPN) KK stated the process for a resident who had fallen included assessment of the resident for injuries and an initial fall report documented by staff. Per LPN KK, when writing up a fall report, staff provided a brief scenario of what happened, noting staff then reviewed the care plan to come up with new fall prevention interventions. LPN KK stated staff updated the CNAs' plan of care, so staff knew what had changed. LPN KK noted staff conducted event follow-up charting for three days, noting when the nurse filled out the initial event, the nurse clicked on any new intervention, which flowed over to a quality assurance and performance improvement (QAPI) event note. LPN KK stated the fall nurse (LPN PP) then reviewed the fall and made sure the interventions were appropriate to the circumstances of the fall. LPN KK stated she was not sure what happened with R#37's fall, but noted the resident went to the hospital and was identified to be a danger to themself or others. She stated she was not aware of R#37 having any other falls.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/12/2022 at 3:09 PM, CNA SS stated the nursing staff usually informed CNAs which residents were at risk for falls. She stated when R#37's fall happened last night, a resident came to her and notified her that R#37 was on the floor. CNA SS stated she asked the resident what happened, and the resident told her she just slid down to the floor. During an interview 04/12/2022 at 11:45 PM, LPN UU stated that, on 04/11/2022, R#37's roommate approached and told staff R#37 had fallen. LPN UU stated the resident was sitting on the left side of bed, which was in its lowest position with the resident sitting on the floor. LPN UU stated the resident stated she was trying to get into her chair. She said the resident slid down and out of the left side of the bed. She stated staff were required to fill out an initial event report, which requested fall prevention interventions. LPN UU stated regarding the fall on 04/09/2022, LPN UU noted the resident was found on the floor on the right side of the bed. Per LPN UU, a fall prevention intervention was to keep her eyes on R#37 during neurological checks. LPN UU stated staff communicated events from one shift to another through reports, noting she had no report that the resident had another fall on 04/10/2022. During an interview on 04/13/2022 at 10:00 AM, LPN TT stated R#37 had an unwitnessed fall Sunday morning 04/10/2022. She stated as staff were passing trays the aide said she found the resident on the floor face down. She stated she did an assessment on the resident and immediately called the family. She stated the family said the resident had another fall that night. She stated the family said this was two falls within 24 hours. LPN TT stated the resident had fallen on 04/10/2022 from the bed. She stated she did the initial report. She stated the initial report would go to the administrator and DON and they would be looking at it and going over the details of it. She stated if she would have had the clinical report from the previous fall, she would have known the resident fell . She stated the night nurse did not do an initial event. During an interview on 04/13/2022 at 8:48 AM, LPN PP stated when she arrived at the facility in the mornings, she looked at a dashboard for falls from the previous night, then read about the associated event, including the nurse's resident assessment. LPN PP stated if she had any questions about the event, she called the nurse and/or spoke to the resident. LPN PP stated she documented on the QAPI Tool, explaining it was essentially the same document as the Initial Note, except for the addition of new interventions formulated after talking to staff and/or the resident. LPN PP stated she was new to this and was still learning. LPN PP noted post-fall follow-up occurred for 72 hours, to include an assessment regarding whether an intervention was successful. If an intervention was not successful, LPN PP described that we go back and assess the situation to see if we can put another intervention in place. LPN PP stated R#37 experienced falls on 02/26/2022, 04/09/2022, and 04/11/2022, but failed to mention the fall on 04/10/2022, noting she was only finding the falls on 02/26/2022, 04/09/2022 and 04/11/2022. LPN PP stated nothing was documented on 04/10/2022 about the resident having had a fall, noting she first heard about that fall while talking to R#37's family member. During a follow up interview on 04/14/2022 at 8:22 AM, LPN PP stated she managed the QAPI report, but knew nothing about root cause analyses. A review of the QAPI reports revealed no evidence falls were investigated to find the root cause of the falls. The review revealed the QAPI reports contained the same information the initial fall assessments provided. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/14/2022 at 6:38 PM, the Interim DON (DON BB) stated she was usually notified of falls by staff during morning meetings. She stated staff discussed all falls during the morning meeting. DON BB noted staff should put a fall intervention in place, assess the environment to see what caused the fall, put a patient-specific fall prevention intervention in place, document neurological checks, and discuss the event with the next shift and management. She stated the expectation of the fall nurse was to make sure appropriate interventions were in place, document and discuss falls, oversee the presentation of falls at QAPI meetings, oversee all the falls in the building, and help prevent resident falls. She stated the fall/QAPI nurse should be conducting a root cause analysis for every fall and documenting the analysis in a nursing note. The DON BB stated fall data should be shared at QAPI and morning meetings. During an interview on 04/14/2022 at 7:13 PM, Administrator stated that, when a resident fell , staff were to document an initial event note, document a follow-up note, and conduct a root cause analysis, noting a nurse should investigate the where and why of a fall to attempt to identify intervention(s) to prevent further falls. Post survey interview on 5/9/2022 at 9:27 a.m. regarding R#37 spoke with Temporary Interim DON DD revealed that R#37 was sent to emergency room and was admitted to the hospital on 4/11/2022. Medical Records for hospitalization were requested. Record review of an acute care hospital history and physical for R#37 dated 4/11/2022 revealed the resident had a history of schizophrenia and bipolar disorder with dementia. According to the emergency department report, the resident was sent from the nursing home because she was saying that the people in the nursing home was going to burn her home and kill her. Note renal failure and urinary tract infection. Resident may benefit from psychiatric consultation. Record review of a Progress Note dated 4/15/2022 documented by FNP-C, in pertinent part, revealed that R#37 was readmitted to the facility after a recent hospitalization after multiple falls, increased hallucinations in the facility. R#37 was treated for a urinary tract infection (UTI) workup negative otherwise. Her (R#37's) altered mental status was contributed to acute encephalopathy from UTI. She had an episode of urine retention requiring straight cath (catherization); however, it spontaneously resolved. All medications were reviewed. Previous medications were discussed with the physician and restarted. Diagnoses and Assessment included acute encephalopathy resolved. Hospital discharge follow-up, Bipolar disorder, in partial remission, UTI, frequent falls. Post survey interview, and review of the medical records for R#37 on 5/16/2022 at 11:26 a.m. with Interim DON BB and Interim DON DD revealed that R#37 was admitted to the hospital on 4/11/2022 after a fall. The resident's diagnoses for this hospitalization included altered mental status secondary to a UTI. The resident was diagnosed to have a UTI on 4/12/2022. DON BB stated that the resident did not have any injuries related to falls and that the reason the resident had three falls was because of the altered mental status related to the UTI. 17141

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 36105 Based on record review, observations, interviews, and review of facility procedural guidelines titled, Pharmacy Services Medication Administration-General and Pharmacy Services Discontinued Medications, the facility failed to ensure a medication error rate less than 5%. There were three errors out of 36 opportunities, resulting in a medication error rate of 8.33% involving (R#4 and R#35). Specifically, the facility failed to ensure R#4 received an ordered antibiotic ointment for the eyes; and failed to ensure that R#35 was not administered a discontinued beta-blocker and was administered the correct dose of a supplement. Findings include: A review of a facility procedural guideline titled, Pharmacy Services Medication Administration-General, copyrighted in 2019, revealed, The joint responsibility of the center and the pharmacy is to ensure accurate medication administration .At the end of each medication pass, the person administering the medications reviews the MAR [medication administration record] to ascertain that all necessary doses were administered and all administered doses were documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications. A review of a facility procedural guideline titled, Pharmacy Services Discontinued Medications, copyrighted in 2019, revealed, Discontinued medications packaged in the compliance packaging must be handled by the nurse promptly to prevent administration on the next scheduled time. The nurse shall indicate on the remaining strip packs which medication is discontinued by highlighting the medication on the package, or by writing 'DC'd' [discontinued] by the medication name on the pack. The nurse shall pull the discontinued medication pill in the corner of the package and staple it in such a manner as to segregate the DC'd medication from the remaining active medications in the pack. Upon completion of the med [medication] pass, the nurse shall place the pack with the discontinued medication in the locked secure area designated for destruction. 1. A review of the Resident's Consolidated Order, for R#4 revealed an order dated 03/03/2022 directing staff to apply erythromycin (antibiotic) 5 mg (milligrams)/gram (0.5%) eye ointment to both eyes one time per day. Observation of medication administration on 04/13/2022 at 7:33 AM revealed Licensed Practical Nurse (LPN) KK failed to administer R#4's erythromycin eye ointment according to physician orders recorded in the MAR. During an interview on 04/13/2022 at 10:45 AM, LPN KK stated she missed the order for R#4's erythromycin eye ointment. During an interview on 04/13/2022 at 11:53 AM, Interim Director of Nursing (DON BB) confirmed R#4's erythromycin eye ointment was due at 9:00 AM, noting it was apparent LPN KK did not know she missed the dose until notified of the omission by the surveyor, stating, It's a medication error. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of R#35's Order Group Report (Medications) document revealed staff were to discontinue administering carvedilol, a beta-blocker prescribed for R#35 due to tachycardia (a faster than normal heart rate) on 04/12/2022. Per the Order Group Report, the carvedilol had been dosed at 6.25 milligrams (mg) and was previously ordered to be administered orally using one tablet daily. A review of R#35's eMAR (electronic medication administration record), with a record date of 04/01/2022 through 04/13/2022, revealed staff were to administer vitamin D 2000 International Units (IU)/50 micrograms (mcg) using two 1000 IU/25 mcg tablets (to equal 2000 IU/50 mcg) orally one time per day for a diagnosis of vitamin D deficiency with a start date of 04/13/2022. A previous eMAR entry, which Licensed Practical Nurse (LPN) KK was operating under during the time of medication pass, revealed staff were to administer 2000 IU/50 mcg of vitamin D3 to R#35 orally one time per day using one tablet with a start date of 02/21/2022 and an end date of 04/13/2022. Observation of medication administration on 04/13/2022 at 8:07 AM revealed LPN KK administered a dose of carvedilol 6.25 mg to R#35, which had been discontinued the previous day on 04/12/2022. Further observation revealed LPN KK also administered 25 mcg of vitamin D3 to R#35 instead of the ordered dose of 50 mcg. During an interview on 04/13/2022 at 10:48 AM, LPN KK confirmed there was not a current order for R#35 to receive carvedilol according to the eMAR and located a Physician's Telephone RBVO [read back verbal order] Order, which directed staff to discontinue R#35's carvedilol on 04/12/2022. LPN KK stated the carvedilol was included in the pharmacy pack for that morning (a pharmacy pack contained all doses of pharmacy-supplied medications for a specific timeframe in one bag with the medications listed and described on the bag). LPN KK stated that, typically when a medication was discontinued, a nurse marked through the medication and stapled the pharmacy pack closed so the medication would not be used. LPN KK stated she was not told in report that the carvedilol had been discontinued. LPN KK stated, I usually check the bag [pharmacy pack] compared with the MAR; it was a mistake on my part. At 10:57 AM, LPN KK confirmed she gave R#35 the wrong dose of vitamin D3, noting she administered 25 mcg instead of 50 mcg as ordered. During an interview on 04/13/2022 at 11:53 AM, Interim Director of Nursing (DON BB) stated that, when R#35's carvedilol was discontinued, staff should have called the pharmacy to have a new pharmacy pack sent, which would not have contained the carvedilol. Regarding the carvedilol, DON BB stated, I would absolutely expect [staff] to hold it and not give it and noted that the issue appeared to be that the nurse gave the medications in the pharmacy package without looking at the eMAR. DON BB stated she recommended staff hold the pharmacy package, check each medication against the MAR, and then put a check mark on the pharmacy package. DON BB confirmed LPN KK made a medication error. Regarding the vitamin D3 administration observation, DON BB confirmed a medication error was made. During an interview on 04/14/2022 at 11:26 AM, the Administrator stated her expectation was for there to be no medication errors. 17141

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26764 Based on interviews, record review, and review of the facility policy titled, Description of Facility Services the facility failed to ensure one of one residents (R#36) sampled for dental care received dental care as needed. Specifically, the facility failed to ensure a referral or examination occurred for R#36 to address ill-fitting dentures. Findings include: A review of the facility policy titled, Description of Facility Services, updated in July of 2018, revealed The center offers .dental care at the center. If the patient so chooses, these examinations can be scheduled. A review of a Skilled Inpatient Services facility policy subtitled Referrals, with a copyright date of 2020, revealed Patient/Social Services should coordinate all patient referrals. A review of a Face Sheet revealed the facility admitted R#36 on 08/05/2021 with diagnoses including protein calorie malnutrition, adult failure to thrive, and osteoarthritis. A review of a quarterly Minimum Data Set (MDS), dated [DATE], revealed R#36 scored 15 during a Brief Interview for Mental Status (BIMS), indicating the resident was cognitively intact. Further review of the MDS revealed R#36 required extensive assistance with bed mobility, dressing, eating, and personal hygiene. The assessment noted R#36 had broken or loosely fitting full or partial dentures. A review of MDS assessments completed since the resident's admission revealed the resident had broken or loosely fitting full or partial dentures per a quarterly assessment dated [DATE] and a quarterly assessment dated [DATE] and that the resident was assessed to have no natural teeth or tooth fragments per an admission assessment dated [DATE]. A review of a Notice of Decision, dated 10/15/2021, revealed that R#36 had been determined eligible for medical assistance benefits effective in the beginning of September 2021. During an interview with R#36 on 04/11/2022 at 11:53 AM, the resident stated her current bottom dentures did not fit and were no longer worn. R#36 stated her diet was now chopped meats, but she preferred regular textured foods. On 04/14/2022 at 10:09 AM, Certified Nursing Assistant (CNA) DD stated there was a top denture but the bottom denture did not fit. CNA DD thought bottom dentures would be a benefit for the resident and had mentioned it to a nurse when she provided care for R#36. On 04/14/2022 at 12:01 PM, Social Worker (SW) FF stated that R#36 got services through Medicaid now, noting it might be possible to get dentures for R#36. R#36 was interviewed on 04/14/2022 at 1:53 PM and stated she would like to get new bottom dentures to help chew/eat better. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winthrop Health and Rehabilitation	12 Chateau Drive Rome, GA 30161

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint interview with the Current Director of Nursing (DON CC) and the Interim DON (DON BB) on 04/15/2022 at 7:16 PM, DON BB stated that R#36 had ill-fitting dentures, including the top denture, noting it appeared that the resident's mouth had shrunk. DON BB and the DON CC each stated they were not aware that R#36 was concerned about her dentures. The DON stated he/she would expect to see a dental consultation occur as soon as possible for any resident who had concerns about their dentures. The Administrator was interviewed on 04/15/2022 at 8:41 PM and stated her expectation was for facility staff to attempt to obtain dentures for any resident who had a problem with chewing or eating, noting such a resident should be referred to the dental practice. 17141

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 38514 Based on observations, record review, review of the Facility's Job Title: Administrator and the Facility's Job Title: Director of Nursing Services Administration failed to ensure residents were free from resident-to-resident sexual abuse, failed to develop and implement policies and procedures to prohibit abuse, failed to develop policies and procedures to ensure reasonable suspicion of a crime against any resident was reported to local law enforcement, failed to ensure all alleged incidents of sexual abuse were thoroughly investigated and immediate protective measures were put into place, failed to ensure person-centered, comprehensive care plans were developed to meet the safety and psychological needs. The failed practice had the potential to affect all 61 residents residing in the facility. On 04/14/2022, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator was informed of the Immediate Jeopardy (IJ) on 04/14/2022 at 7:46 PM. The noncompliance related to the immediate jeopardy was identified to have existed on 05/23/2021. The immediate jeopardy was removed on 04/17/2022. The IJ is outlined as follows: The IJ began on 05/23/2021, when R#364 was found in the room of R#17, a resident with severe cognitive impairment, with his hands under the resident's shirt on the resident's breasts. On 5/23/2021, R#17, reported to staff that she had been molested. The facility failed to put interventions in place to prevent future incidents from taking place. R#17 was subsequently sexually abused a second time by R#364 on 07/11/2021 when R#364 was found with his hands under R#17's shirt. Additional residents were sexually abused by R#364. R#55, a bedbound resident with moderate cognitive impairment, was sexually abused by R#364 on 08/27/2021, when R#364 was observed in R#55's room, with his hand under R#55's cover. R#55's brief was observed to be un-taped and folded back. On 1/21/2022, R#364 was found with his hand on the chest of R#42 another resident with severe cognitive impairment. The facility failed to address the sexually aggressive behavior of R#364 and failed to put effective interventions in place and therefore failed to protect R#17, R#55, and R#42 from resident-to-resident sexual abuse. The IJ was related to the facility's noncompliance with the program requirements, as follows: F600: 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation (Scope/Severity [S/S]: J; F607: 42 CFR 483.12(b)(1)(4), Develop/Implement Abuse/Neglect, etc. Policies S/S: J; F608: 42 CFR 483.12(b)(5), Reporting of Reasonable Suspicion of a Crime, S/S: J; F610: 42 CFR 483.12(c)(2) (4), Alleged Violations-Investigate/Prevent/Correct S/S: J); F656: 42 CFR 483.21 - Comprehensive Resident Centered Care Plans, S/S: J; F835: 42 CFR 483.70 - Administration S/S: J. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Additionally, Substandard Quality of Care was identified with the requirements at F600: 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation (Scope/Severity [S/S]: J; F607: 42 CFR 483.12(b)(1)(4), Develop/Implement Abuse/Neglect, etc. Policies S/S: J; F608: 42 CFR 483.12(b)(5), Reporting of Reasonable Suspicion of a Crime, S/S: J; F610: 42 CFR 483.12(c)(2) (4), Alleged Violations-Investigate/Prevent/Correct S/S: J). An Acceptable Removal Plan was received on 4/17/2022. The removal plan included placing R#364 and R#17 on one-to-one supervision, staff training, skin assessments on all residents including cognitively impaired residents and interviews with all cognitive residents regarding abuse, neglect, and sexual abuse. The survey team conducted observations, reviewed staff training records and monitoring logs, clinical record review of revised care plans, and interviews with staff and residents to verify all elements of the facility's Removal Plan were implemented. The immediacy of the Immediate Jeopardy was removed on 04/17/2022. The facility remained out of compliance at a lower scope and severity while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures governing the identification, reporting, investigation, and protection of residents from abuse, including sexual abuse Findings include: A review of the facility's, Job Title: Administrator, revealed the Administrator was to direct the day-to-day functions of the nursing center in accordance with current federal, state, and local regulations that govern long-term care centers. The essential regulatory included that the Administrator was responsible for procedural guidelines relative to the prevention and reporting of patient abuse. A review of the facility's, Job Title: Director of Nursing Services, revealed the Director of Nursing (DON) was to plan, organize, develop, and direct the overall operation of the nursing service department in accordance with current federal, state, and local regulations. The essential clinical services functions included that the DON was responsible for directing, evaluating and supervising patient care and initiating corrective action as necessary; honoring patient's rights to fair and equitable treatment, self-determination, and privacy; and assuming responsibility for procedural guidelines relative to the prevention and reporting of patient abuse. A review of the facility's self-reported incidents revealed R#364 was the alleged perpetrator of sexual assaults upon R#17 on 05/23/2021 and 07/11/2021; R#55 on 08/27/2021; and R#42 on 01/21/2022. 1. Administration failed to put effective interventions in place to protect three of four residents (R#17, R#55, R#42) from resident-to-resident sexual abuse. Cross refer F600 2. Administration failed to develop and/or implement the protection, reporting, training components of their abuse for three of four (R#17, R#42, R#55) residents reviewed for sexual abuse. Cross refer F607 (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Administration failed to ensure allegations of sexual abuse were reported to the police for three of four (R#17, R#55 R#42) reviewed for sexual abuse. Cross refer F608 4. Administration failed to ensure allegations of sexual abuse were thoroughly investigated and failed to implement protective measures to prevent further incidences of sexual abuse for three of four (R#17, R#55, R#42) residents. Cross refer F610 5. Administration failed to ensure person-centered, comprehensive care plans were developed to meet the safety and psychological needs of four of 16 (R#364, R#17, R#42 and R#55) whose care plans were reviewed. Cross refer F656 An interview on 4/13/2022 at 7:46 AM with RN LLL when asked what education staff had received regarding protecting other residents from sexual assault/abuse from R#364, RN LLL stated she was told to separate R#364 from the female residents and monitor R#364. An interview on 04/13/2022 at 7:52 AM with Housekeeper QQQ revealed that she had not ever been in-serviced on what to do regarding sexual abuse. An interview on 04/13/2022 at 2:10 PM with the Administrator when asked why the allegations of sexual abuse for R#17 that occurred on 7/11/2021, for R#55, which occurred on 08/27/2021, and for R#42 which occurred on 1/21/2022 were not reported to the police, the Administrator stated she did not report all incidents, that it depended on each incident. When asked how staff were made aware of the sexual assaults, in the facility's investigation, the Administrator stated she did not know and did not know if there was any documentation of that. A telephone interview on 04/13/2022 at 4:15 PM with former DON EEE revealed she had worked at the facility for approximately two years and left the job about two months ago. When asked about her recollection of any incidents surrounding R#364 and sexual assault with any female residents at the facility, DON EEE stated she was able to recall a few. When asked if there were any in-services or training provided to the staff regarding that incident on interventions to prevent further sexual assault, DON EEE stated there may have been a paper in-service training but was not able to recall if any training was done. When asked about the sexual assault on R#55 by R#364, When asked what interventions or controls had been put into place to protect other female residents from sexual abuse from R#364, DON EEE stated staff would keep R#364 in eyesight, place them at the nurse's station and monitor. DON EEE was asked what procedure was to be followed, after an allegation of sexual abuse. DON EEE stated the physician would be notified either by her or a member of the management team, and this would be documented in the resident's record. DON EEE stated the SW would speak to other residents regarding safety, and those forms would be kept in the Administrator's office. DON EEE did not indicate the incidents should be reported to local law enforcement. An interview on 04/17/2022 at 12:34 PM with LPN TT stated the facility had previously had a total disregard for the safety of the residents. (continued on next page)

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