STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185122	A. Building B. Wing	12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Louisville Rehabilitation and Nursing	1155 Eastern Parkway Louisville, KY 40217

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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	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** 29137 Based on interview, record review and the facility's policy, it was determined the facility failed to protect three (3) of 18 (eighteen) sampled residents from abuse (Resident #69, Resident #410 and Resident #420). 1. The facility failed to protect Resident #69 and Resident #410 from sexual abuse. Staff observed Resident #69 and Resident #410 lying on the floor in Resident #69's room, with their knees touching. Resident #69 was wearing a gown, and Resident #410 had his/her pants and brief pulled down below his/her knees, with his/her genitalia exposed to Resident #69. The facility had assessed the residents as unable to consent to having sexual contact with another person. Both residents had displayed sexually inappropriate behaviors in the recent past. Resident #410 had an incident of sitting in the common area without his/her brief on, and Resident #69 had been verbally sexually inappropriate with a staff member of the opposite sex. On another occasion. Resident #69 was on the couch in the common area with his/her legs splayed apart (spread apart), and saying, Do you want some of this., to no one in particular. 2. The facility failed to protect Resident #420 from abuse. Certified Nursing Assistant (CNA) #94 was observed by Nursing Assistant (NA) #3 to poke Resident #420 on the forehead while the resident was sitting on his/her toilet. Resident #420 became upset, stood up and tried to walk towards CNA #94 and started to stumble. NA #3 then observed CNA #94 place his hands, open palmed, on Resident #420's chest and pushed the resident backwards, causing him/her to fall backwards onto the wall. Resident #420 received an abrasion to his/her back and a knot to his/her hip as a result of the fall. The facility's failure to ensure Resident #69, Resident #410 and Resident #420 were free from abuse, has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified at 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation, F600 and F609; 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F656; 42 CFR 483.70 Administration; and 42 CFR 483.75 Quality Assurance and Performance Improvement, F867, at a Scope and Severity of a J. The Immediate Jeopardy was determined to exist on 10/17/2021 and the facility was notified of the Immediate Jeopardy on 12/04/2021. In addition, Substandard Quality of Care (SQC) was identified at 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation (F600 and F609). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An acceptable removal plan was received on 12/07/2021 alleging removal of the Immediate Jeopardy on 12/08/2021. An Extended Survey and AoC validation Survey were conducted on 12/09/2021 which determined the Immediate Jeopardy had been removed on 12/08/2021, as alleged, prior to exit on 12/09/2021. The remaining non-compliance in the areas of 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation, F600 Free from Abuse and Neglect at S/S (scope and severity) of D; F609 Reporting Alleged Violations at S/S of D; 42 CFR 483.21 Comprehensive Resident Centered Care Plan; F656 Develop/Implement Comprehensive Care Plan at S/S of D; 42 CFR 483.70 Administration, F835 Administration at S/S of D; F837 Governing Body at S/S of D; and, 42 CFR 48.75 Quality Assurance and Performance Improvement, F867 QAPI/QAA Improvement Activities while the facility developed and implemented a Plan of Correction and monitored the effectiveness of the systemic changes. The findings include: Review of the facility's Abuse Policy, updated 05/02/2017, revealed the facility was to prevent resident abuse, neglect, mistreatment of residents. Continued review revealed the facility's definition of sexual abuse included such things as sexual harassment, sexual coercion or sexual assault, but was not limited to those. Per review, if a resident mistreated another resident, the resident performing the mistreatment was to be immediately separated from the other resident. Further review revealed an assessment of the resident, doing the mistreatment, was to be performed to determine the most suitable therapy, care approaches and placement, considering his/her safety, as well as the safety of other residents of the facility. Review of the facility's investigation for the alleged sexual abuse incident involving Resident #69 and Resident #410, revealed on 11/29/2021 at approximately 8:30 PM, a staff member observed Resident #69 lying fully clothed on his/her room floor, facing Resident #410. The residents' knees were touching, and the other resident had his/her pants and brief pulled below the knees with his/her genitalia exposed to Resident #69. Continued review revealed the residents were immediately separated by staff and assessed without injury noted. Record review revealed the other resident was moved to a room on the other side of the unit, closer to the Nurse's Station. Review of Resident #69's Comprehensive Care Plan, dated 09/05/2021, revealed the facility had care planned the resident for his/her behaviors with interventions which included removing Resident #69 from situations that might cause anxiety or aggression, and for staff to speak in a calm voice when attempting to deescalate his/her agitated behaviors. Continued review revealed the care plan had Foci (focus points) dated 07/23/2021, 08/24/2021 and 09/23/2021, which noted Resident #69 did not desire to have sexual contact with another person at that time. Further review of the care plan and the intervention revealed the Foci goal was to encourage Resident #69 to notify staff if he/she desired to have sexual contact with another person. Observation, on 12/02/2021 at 10:15 AM, revealed Resident #69 in the 7th floor dining room, sitting at a table in the middle of the room. The resident was with House Supervisor #1, coloring a picture. Observation, on 12/03/2021 at 10:45 AM, revealed Resident #69 was in the dining room decorating the windows with the help of Activity Aide #4. She stated however, she was unaware of why Resident #69 required the 1:1 monitoring. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Continued observation, on 12/03/2021 at 10:50 AM, revealed CNA #96 brought Resident #410 to the dining room, where Resident #69 was located, to eat his/her snack. CNA #96 sat down at a table with Resident #410 while he/she consumed the snack. Observation revealed Resident #69 continued to place stickers on the dining room windows, but stopped briefly to walk over to the table where Resident #410 was sitting. Resident #69 was observed to say something to Resident #410; however, the State Survey Agency (SSA) Surveyor was unable to hear the resident's comment. Observation at that time, revealed Resident #410 answered in response to Resident #69's comment, I am old. Additional observation revealed the Activity Aide immediately came to Resident #410's table to redirect Resident #69 back to the decorating activities. 1.(b) Review of Resident #410's clinical record revealed the facility admitted him/her on 11/19/2020 with diagnoses that included Cognitive Communication Deficit; Cerebral Infarction, Unspecified; [NAME] Matter Disease, Unspecified; Recurrent Major Depressive Disorder, Unspecified. Review of Resident #410 Comprehensive Care Plan revealed Foci dated 07/28/2021, 08/26/2021 and 09/24/2021. Further review revealed the facility assessed that Resident #410 did not have the capacity to consent to sexual activity. The goal was documented as Resident #410 would express feelings, as needed. The intervention was to allow the resident time to express his/her feelings. Review of Resident #410's Quarterly MDS Assessments dated 01/27/2021, 04/29/2021, and 07/29/2021, and the Annual MDS assessment dated [DATE], revealed the facility had assessed the resident with a BIMS score of six (6) which indicated severe cognitive impairment. Further review revealed the facility had not assessed Resident #410 to display sexually inappropriate behaviors. Observation, on 12/03/2021 at 9:46 AM, revealed Resident #410 was lying on his/her bed, with eyes open covered with a sheet. Continued observation revealed CNA #96 was sitting in a chair beside the resident's bed. Additional observation, on 12/03/2021 at 10:30 AM, revealed Resident #410 sitting in a wheelchair near the nurses' station with CNA #96 sitting nearby monitoring the resident. Interview, on 12/03/2021 at 10:35 AM with CNA #96, who was assigned to monitor Resident #410, revealed she did not know why staff were providing the 1:1 observation of Resident #410. She stated she had just taken over the 1:1 monitoring of Resident #410 that morning at shift change. Further interview revealed she had not asked the staff member she was relieving why Resident #410 required 1:1 observation, and the staff person had not provided the information to her. Unsuccessful attempts were made on 12/02/2021 and 12/03/2021 to interview Resident #69. Interview with Resident #410 on 12/03/2021 at 10:30 AM, revealed the resident was unable to recall the 11/29/2021, incident when he/she had been lying on the floor with Resident #69. Resident #410 stated he/she had a special friend of the opposite sex, but that person did not live at the facility. 31274 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview, on 12/02/2021 at 1:28 PM with Registered Nurse (RN) #11, revealed on 11/29/2021 around 8:15 PM, he started his evening medication pass. RN #11 stated he was looking for Resident #410 and started checking residents' rooms. Per interview, when he opened the door to Resident #69's room, he observed Resident #69 and Resident #410 lying on the floor facing each other. He stated Resident #69 was wearing a gown and brief. RN #11 stated Resident #410 had a shirt on; however, his/her pants and brief were pulled down below the knees, so his/her genitalia was exposed. RN #11 said Resident #410 did not act startled and stated, You caught us early, and nothing happened yet. The RN stated Resident #69 acted upset that he had opened the door and asked him why he entered the room without knocking. Continued interview revealed Resident #69 was so upset he/she tried to hit some of the nurse aides who responded to the room when the nurse called for assistance. RN #11 stated he asked the House Supervisor to assess Resident #69 and he would assess Resident #410. He stated Resident #69 had been evaluated by a psychiatric provider in the past for displaying sexually suggestive gestures and making sexually suggestive comments. Review of Resident #69's Nursing Progress Notes revealed documentation related to RN #11's comments on the resident displaying sexually suggestive gestures and making sexually suggestive comments noted on 10/17/2021 and 10/19/2021. Review of Resident #69's and Resident #410's skin assessments, dated 11/29/2021, revealed no evidence of concerns noted. Per review, the House Supervisor had completed Resident #69's skin assessment and RN #11 conducted the skin assessment for Resident #410. Telephone interview on 12/02/2021 at 1:40 PM with Certified Nursing Assistant (CNA) #92, revealed she worked on the 7th floor, which was a Dementia Unit, the evening of 11/29/2021. She stated when RN #11 called out for assistance, she went immediately to Resident #69's room. RN #11 stated when she looked in the room, Resident #69 was getting up from the floor. She stated Resident #69 was wearing a gown, and she saw a pull-up on Resident #69's bed; however, she was not sure if the resident had a brief or pull-up on or, not when she entered the room. Continued interview revealed Resident #69 acted angry and said he/she was going to hit RN #11 in the mouth because he did not knock on the door before entering the resident's room. CNA #92 stated Resident #410 was lying on the floor with his/her pants and brief below his/her knees. The CNA stated she had not heard him/her say anything to the staff who entered the room. Further interview revealed after the nursing supervisor assessed the situation, CNA #97 took Resident #410 back to his/her room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview, on 12/03/2021 at 8:41 AM with CNA #97, revealed she had been assigned to Resident #410 on the evening of 11/29/2021 when the incident occurred. She stated Resident #410 finished eating supper about 7:00 PM, so she changed the resident's brief in his/her room, and took him/her to the dining room to watch television. CNA #97 said the resident was still sitting in the dining room at approximately 7:45 PM, when she took her meal break. According to the CNA, around 8:30 PM, RN #11 asked her the whereabouts of Resident #410, and she told the RN to check in the dining room, where she last saw the resident. Per interview, RN #11 quickly returned from the dining room, stating Resident #410 was not in the dining room. The CNA stated she told the RN to check in Resident #69's room, because sometimes Resident #69 tried to assist Resident #410 by pushing him/her around in the wheelchair. Continued interview revealed she followed RN #11 to Resident #69's room and entered the room just behind the RN. CNA #97 stated RN #11 tried to get into the room, but Resident #410's wheelchair was blocking the door. She stated when RN #11 was finally able to get through the door, she entered the room and observed Resident #410 on the floor with his/her brief and pants down to his/her ankles, and Resident #69 was trying to get up from the floor. Per the CNA, Resident #69 was wearing a gown, but she was unsure if Resident #69 was wearing a brief. She stated she heard Resident #410 say that he/she and Resident #69 had not had a chance to do anything because staff came to the room too quickly. Interview revealed while taking Resident #410 back to his/her room, she asked the resident what he/she and Resident #69 were doing in the room, and his/her reply was that they had been trying to beat it up. Per CNA #97, Resident #410's comment was slang which meant the resident had been trying to have sex with Resident #69. Further interview revealed CNA #97 stated Resident #410 had told her that he/she was embarrassed by the incident. Continued interview with CNA #97 on 12/03/2021 at 8:41 AM, revealed she told RN #11 that Resident #69 was persistent about things, and that she thought Resident #69 would likely pursue a sexual encounter, more so than Resident #410. According to the CNA, when Resident #410 was in his/her wheelchair, Resident #69 tried to push him/her around. Observation, on 12/03/2021 at 9:35 AM, revealed Licensed Practical Nurse (LPN) #75 was at the medication cart near Resident #410's room. Interview with LPN #75, revealed she was an agency nurse, and this was the first day she had worked on the 7th floor. LPN #75 stated she knew Resident #69 and Resident #410 were on 1:1 (one to one) observation; however, she did not know why they were on that type of observation. Further interview revealed the night shift staff had not given her the reason, or explained why staff were providing 1:1 supervision of the residents. Interview, on 12/02/2021 at 1:57 PM with CNA #93, revealed she had been assigned to Resident #69's care on 11/29/2021, on evening shift when the incident occurred. She stated she had assisted Resident #69 in preparing for bed, and the resident's brief was changed and he/she put on a gown. CNA #93 stated the resident had laid down on his/her bed about 8:00 PM, and she covered Resident #69 with a blanket. Continued interview revealed CNA #93 left Resident #69's room to go do some of her charting, which she was doing around 8:30 PM, when she heard RN #11 and CNA #97 say they wondered how Resident #410 had gotten into Resident #69's room. CNA #93 stated she immediately went to Resident #69's room and saw Resident #410 lying on the floor in Resident #69's room, with his/her pants and brief below his/her knees, with his/her genitals exposed. CNA #93 stated she did not hear Resident #410 say anything. Further interview revealed Resident #410 required a wheelchair for mobility, and staff usually moved him/her from one place to another. However, the resident was able to self propel in the wheelchair very slowly. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview, on 12/03/2021 at 11:03 AM with House Supervisor #1, revealed Resident #69 and Resident #410 were currently under 1:1 observation, because both residents had been found lying together on the floor in Resident #69's room. She stated she thought they had been trying to engage in sex. House Supervisor #1 stated that staff that were assigned to monitor both residents should know why the residents were being monitored 1:1 in order to know how to supervise the residents to keep them, as well as other residents safe. Further interview revealed things or situations with either resident could change in the blink of an eye. She stated the assigned staff providing the monitoring had to be fully aware of why the residents were under an increased level of supervision. Interview with the facility's Interim Administrator on 12/03/2021 at 3:40 PM and again on 12/04/2021 at 4:33 PM, revealed her role was to oversee the operations of the facility. Per the Interim Administrator, no sexual abuse had occurred due to the staff providing enhanced supervision. Interview revealed the enhanced supervision being provided for Resident #69 and other residents was more frequent rounds of residents being performed by nursing staff. The Interim Administrator stated the facility had also assigned a full-time Activities person to the 7th floor (where Resident #69 resided), and more resident activities had been initiated on the 7th floor. The Interim Administrator further revealed she could only say the facility's Interdisciplinary Team (IDT) had discussed Resident #69 and Resident #410 in the IDT meetings held since she had been the Interim Administrator, which had been for three and a half (3 1/2) weeks. She additionally revealed the IDT's discussion of Resident #69 had been regarding his/her verbal and aggressive behaviors, and for Resident #410 the IDT had discussed his/her rejection of care. Review of Resident #69's Nursing Progress Notes dated 10/17/2021 through 11/29/2021, revealed the facility had placed the resident on every fifteen (15) minute checks and 1:1 supervision, for his/her verbal and/or physical aggression towards staff. Interview with the Director of Nursing, (DON) on 12/04/2021, at 5:15 PM revealed she expected residents to be care planned for inappropriate sexual behaviors with interventions documented, which would include redirection. The DON stated she was aware of the two (2) documented incidents of Resident #69 displaying inappropriate sexual behavior in October 2021, and that the resident had been placed on Risperdal medication (an antipsychotic medication). Continued interview revealed the DON did not feel there had been a facility system failure or failure in its processes in regards to the incident involving Resident #69 and Resident #410. 42857 2. Review of the facility's policy titled, Abuse Prevention Program, updated 05/02/2017, revealed each resident was to receive care and services in a person-centered environment in which all individuals were treated as human beings. Per review, the facility defined abuse as the willful infliction of injury resulting in physical harm, pain, mental anguish, or deprivation by an individual, including a caretaker. Further review revealed physical abuse was defined as a willful act against a resident by another resident or staff, to include shoving. (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 facility's policy titled, Dignity, undated, revealed residents were to have all aspects of their dignity maintained by staff regardless of the resident's cognitive level or ability to realize or understand what was being said or done by others. Continued review revealed staff was to always be polite and respectful to residents, and not carry on long conversations with each other about their personal issues unrelated to the resident, as that could make the resident feel ignored and hurt his/her feelings. Review of Resident #420's medical record revealed the facility admitted the resident on 09/05/2021, with diagnoses that included Intellectual Disabilities, Lack of Coordination, Abnormalities of Gait and Mobility, Developmental Disorder of Scholastic Skills, Altered Mental Status, and Weakness. Review of the facility's Pre-Admission Screening and Resident Review (PASRR), dated 09/02/2021, revealed Resident #420 had an unsteady balance related to his/her diagnosis of weakness. Per review, Resident #420 had an adaptive behavior noted of an eight (8) year, five (5) month old. Continued review revealed Resident #420 had a history of being verbally aggressive with caregivers when things did not go his/her way. The facility assessed the resident as noncompliant at times. Further review revealed Resident #420's Intelligent Quotient (IQ) was noted to range from forty-two (42) to sixty (60) which indicated a moderate degree of cognitive limitation. Review of Resident #420's Admission Minimum Data Set (MDS) Assessment, dated 09/12/2021, revealed the facility had assessed the resident with a Brief Interview for Mental Status (BIMS) score of ten (10) which indicated moderate cognitive impairment. Further review revealed the facility had not assessed Resident #420 to have behaviors. Review of Resident #420's Comprehensive Care Plan (CCP), dated 09/30/2021, revealed the facility had care planned the resident for intellectual impairment and exhibiting temper fits when limits were set with food and drink intake related to his/her dietary restrictions and changes in his/her routine or a planned activity. Continued review revealed Resident #420 had a history of fabricating or embellishing the truth and attention seeking behaviors. Resident #420's interventions included: for staff to assist the resident with reality orientation when episodes of fantasy/fabrications interfered with his/her well-being. Per review, Resident #420 liked associating with others such as celebrities and characters on television or in movies. The care plan revealed Resident #420 enjoyed conversing with staff in the common area of the unit, or interacting one-on-one with staff. Further review revealed staff were to validate Resident #420's concerns; however, they were to set limits with the resident's negative behavior. Review of the facility's Incident Report, dated 11/26/2021 timed at 12:54 PM, revealed Nurse Aid (NA) #3 reported she witnessed CNA #94 place his finger on Resident #420's forehead and push the resident's head backwards. Continued review revealed in response, Resident #420 stood up and started walking towards CNA #94 and was attempting to hit the CNA. Per review, NA #3 then witnessed CNA #94 place the palms of his hands on Resident #420's chest and push him/her backwards. Resident #420 fell which resulted in a red abrasion to his/her back. Continued review revealed later on a raised area was observed to the resident's hip. Record review revealed witness statements were obtained and all parties involved in the incident were suspended after the incident had been reported to facility management. Per review of the Incident Report, Resident #420 reported injuring his/her back at the time of the fall. Further review revealed when Resident #420 was using the restroom CNA #94 played a prank on him/her and made him/her fall against the wall. Additional review revealed when Resident #420 walked to the shower room after using the restroom, he/she noticed a big thing on his/her right hip. (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 Resident #420's Progress Note, dated 11/25/2021 at 5:51 PM, revealed a Change in Condition had been completed. Continued review of the Progress Note revealed an abrasion and bruising was noted on the resident's mid and left lower back. Further review of the Progress Note revealed staff notified the Nurse Practitioner, and a new order was received for triple antibiotic ointment (TAO) to the abrasion and to continue to monitor the area of bruising. Record review revealed an X-Ray Report, dated 11/25/2021, which was obtained after the incident. Resident #420 received an x-ray to his/her right hip for swelling and pain; however, there was no obvious fracture observed. Continued record review revealed another X-Ray Report dated 11/29/2021, and an Ultrasound (US) report documented a subcutaneous solid lesion which might represent a hematoma. Further review revealed a recommendation for Resident #420 to have a Computed Tomography (CT) scan performed. Review of Resident #420's medical record revealed a CT scan was scheduled for 12/07/2021. Observations of Resident #420 on 12/02/2021 at 1:52 PM and 12/02/2021 at 8:45 AM, revealed the resident sitting up in his/her wheelchair. Observation of Resident #420's back revealed no evidence of an abrasion to the resident's back. When asked if the State Survey Agency (SSA) Surveyor could observe his/her right hip, Resident #420 declined to allow the observation. Interview with Resident #420, at the time of observation, revealed after breakfast on 11/25/2021, CNA #43 and NA #3 assisted him/her to go use the restroom. Continued interview revealed Resident #420 had been sitting on the commode when CNA #94 came into his/her room. The resident stood up and tried to practice karate on CNA #94. Per interview, that was when Resident #420 lost his/her balance and fell against the wall causing an injury to his/her back. Further interview revealed Resident #420 noticed the injury to his/her hip on the way to the shower room and the nurse had been notified. Interview with NA #3, on 12/02/2021 at 3:40 PM, revealed she was in training to start CNA classes and had only worked at the facility for two (2) weeks. Per interview, she was training with CNA #43 and they were assigned to Resident #420 on 11/25/2021. She stated 11/25/2021 was Resident #420's shower day and after the resident's breakfast, she and CNA #43 assisted Resident #420 to the restroom with his/her walker. She stated they assisted the resident to the commode, where he/she sat down. According to NA #3, after the resident used the restroom, she and CNA #43 were going to assist Resident #420 to the shower room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Continued interview revealed while Resident #420 was using the toilet in the restroom, CNA #94 walked into the room and went straight to the resident and poked him/her in the forehead causing his/her head to move backward. NA #3 stated Resident #420 became upset and raised up off the commode and used his/her walker to move forward toward CNA #94. She stated Resident #420 let go of his/her walker and attempted to hit CNA #94 and became unsteady and started to stumble. Per NA #3, CNA #94 then placed his hands, palms opened, on Resident #420's chest near his/her shoulders and pushed the resident backwards. Interview revealed she and CNA #43 observed Resident #420 fall backwards and make contact with the floor. She stated at that time, CNA #43 lifted Resident #420's shirt and noticed red scratches on the resident's back. She stated she told CNA #94 to come and look at what he had done. Further interview revealed CNA #94 immediately left the room. She and CNA #43 got Resident #420 off the floor (without notifying the nurse to come and assess the resident) and continued to take him/her to the shower room. NA #3 stated after entering the shower room with Resident #420, CNA #43 left to get the nurse. She stated LPN #38 entered the shower room and asked Resident #420 what happened, and the resident responded, (CNA #94) pushed me. NA #3 further revealed while completing the resident's shower, she noticed a knot on Resident #420's hip and notified LPN #38. Additionally, she stated LPN #38 stated he would call and get an order for an x-ray of Resident #420's hip. Continued interview revealed she was in training and hadn't yet started her CNA classes. She stated she had only worked about 8 shifts in the facility before the incident. She stated she was shaken up after the incident because she had never seen anything like that before. NA #3 stated she did not report it until she went home and spoke to her mother, who was a CNA. An additional interview with NA #3, on 12/04/2021 at 10:09 AM, revealed she had been educated and knew she should report any allegations of abuse immediately; however, she was not sure who she was to report the allegations of abuse to. She further revealed Resident #420 had reported the incident to the nurse, after the incident on 11/25/2021, while he/she was in the shower room. Interview with CNA #94, on 12/02/2021 at 2:52 PM, revealed on the morning of 11/25/2021, he entered Resident #420's room and was speaking to CNA #43 and NA #3 while Resident #420 was using the restroom. Per interview, CNA #43 left the resident's room to prepare for his/her shower. Interview revealed he and Resident #420 had an ongoing joke about Resident #420's twin brother. He stated he was joking with Resident #420 about it when the resident stood up from the commode and started to come toward CNA #94. Continued interview revealed Resident #420 became unsteady and started to stumble. CNA #94 stated he grabbed Resident #420's walker while NA #3 grabbed Resident #420's elbow to help stabilize him/her. An additional interview with CNA #94, on 12/04/2021 at 9:24 AM, revealed he had received abuse training at the facility. Continued interview revealed he was aware of the different types of abuse and he knew that any allegation of abuse needed to be reported immediately to his supervisor. CNA #94 stated he knew he could also report any allegation of abuse to the Director of Nursing (DON). (continued on next page)

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Landmark of Louisville Rehabilitation and Nursing	1155 Eastern Parkway Louisville, KY 40217

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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	Interview with LPN #38, on 12/04/2021 at 12:05 PM, revealed CNA #43 notified him that Resident #420 had fallen against the wall in his/her room. LPN #38 stated he noticed the abrasion on Resident #420's back and asked what happened, but none of the staff answered. According to LPN #38, he assumed the abrasion was where staff transferred Resident #420 onto the shower chair. Continued interview revealed after the resident's shower, staff brought Resident #420 to the nurse's station as usual to sit there. LPN #38 stated at that time, Resident #420 told him that he/she had been pushed by CNA #94. Interview revealed because of Resident #420's past history of making up stories about people he/she was aggravated with the LPN put the resident's statement in the back of his mind. Further interview revealed LPN #38 ultimately forgot about the incident reported by Resident #420 that he/she was pushed by CNA #94. He further stated Resident #420 stayed at the area near the nurse's station for the duration of his shift and he had not witnessed any other interactions between CNA #94 and Resident #420. Additionally, LPN #38 stated he had recently been educated on abuse and knew that any abuse allegations needed to be reported immediately to his supervisor but, he failed to report this incident regarding Resident #420. Interview with the DON, on 12/04/2021 at 5:20 PM, revealed upon knowledge of the allegation of abuse reported by the resident and staff member, the facility had immediately suspended all parties involved and initiated an investigation. Continued interview revealed she was notified on 11/25/2021 at approximately 4:30 PM of the allegation by NA #3, after the NA had finished her shift for the day; however, the incident had occurred that morning after breakfast per interview. Per interview, after the notification of alleged abuse, the facility implemented the Guardian Angel Rounds which required managers to round on the units at a specific time and gather any resident complaints, concerns and/or grievances and report any resident complaints, concerns or grievances to her. She revealed she called every shift, floor to floor every day, and monitored residents' documentation every day for anything suspicious (i.e., sudden onset of extreme pain) which could potentially identify a concern for the facility. Further interview revealed she expected staff to ensure residents were kept safe and to report any allegations of abuse immediately. Interview with the Administrator, on 12/04/2021 at 4:34 PM, revealed the abuse investigation was initiated immediately o [TRUNCATED]

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42857 Based on interview, record review and facility policy review it was determined the facility failed to ensure staff reported alleged violations and potential abuse of one (1) of eighteen (18) sampled residents (Resident #420). Nurse Aid (NA) #3 witnessed Certified Nursing Assistant (CNA) #94 poke Resident #420 in the forehead while the resident was sitting on the toilet. Resident #420 became agitated at CNA #94, and started to walk toward the CNA, becoming unsteady on his/her feet. NA #3 observed CNA #94 place his open hands on Resident #420's chest, pushing the resident backwards. Resident #420 fell and sustained an abrasion to his/her back. NA #3 told CNA #94, See what you did. Even though NA #3 witnessed the incident, she failed to report it until her shift ended and she went home, approximately six (6) hours later. Resident #420 told Licensed Practical Nurse (LPN) #38 that CNA #94 pushed him/her, which resulted in a fall. However, LPN #38 did not report the incident as he did not believe the incident was abuse of Resident #420. The facility's failure to ensure staff reported alleged violations and potential abuse, has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified at 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation, F600 and F609; 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F656; 42 CFR 483.70 Administration; and, 42 CFR 483.75 Quality Assurance and Performance Improvement, F867, all at a Scope and Severity of a J. The Immediate Jeopardy was determined to exist on 10/17/2021. The facility was notified of the Immediate Jeopardy on 12/04/2021. In addition, Substandard Quality of Care (SQC) was identified at 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation (F600 and F609). An acceptable removal plan was received on 12/07/2021 alleging removal of the Immediate Jeopardy on 12/08/2021. An Extended Survey and AoC/removal plan validation survey were concluded on 12/09/2021 which determined the Immediate Jeopardy had been removed on 12/08/2021, as alleged, prior to exit on 12/09/2021. The remaining non-compliance in the areas of 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation, F600 Free from Abuse and Neglect at S/S (scope and severity) of D; F609 Reporting Alleged Violations at S/S of D; 42 CFR 483.21 Comprehensive Resident Centered Care Plan; F656 Develop/Implement Comprehensive Care Plan at S/S of D; 42 CFR 483.70 Administration, F835 Administration at S/S of D; F837 Governing Body at S/S of D; and, 42 CFR 48.75 Quality Assurance and Performance Improvement, F867 QAPI/QAA Improvement Activities while the facility developed and implemented a Plan of Correction and monitored the effectiveness of the systemic changes. The findings include: (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Abuse Prevention Program, updated 05/02/2017, revealed nursing staff were responsible for reporting the appearance of bruises, lacerations, or other abnormalities on residents as the injuries occurred. Further review revealed after being notified of the residents' injuries, the Nursing Supervisor was responsible for assessing the resident, reviewing the documentation, and reporting the resident's injuries to the Administrator or designee. Per review, if the injury was related to suspected abuse, staff were to separate the alleged perpetrator from other residents, ensure all other residents' safety, notify their nurse or supervisor immediately, and notify the Administrator or Director of Nursing (DON) or the person in charge of the facility at the time. Continued review revealed staff members suspected of abuse of a resident, or misconduct were to immediately be barred from any further contact with the residents. Record review revealed the staff person suspected of abuse was also to be suspended from duty pending the outcome of the facility's investigation, prosecution, or disciplinary action against the employee. Per policy review, the Administrator or designee was to notify the State Agencies, and Law Enforcement Officials of alleged or suspected resident abuse or neglect incidents immediately after being informed of such incidents. Review of the facility's policy titled, Abuse Reporting, updated 05/02/2017, revealed the facility would not tolerate resident abuse or mistreatment by anyone, including its staff members. The policy stated all personnel were to promptly report any incident or suspected incident of resident abuse and could do so without fear of retaliation or retribution from the facility or other staff. Continued review revealed staff, who observed an incident of resident abuse, were to immediately report such incidents to the Charge Nurse, regardless of the time lapse since the incident occurred. Per review, the Charge Nurse was to immediately examine the residents(s) involved in the incident, and immediately report the incident to the Administrator or his/her designee. Review of Resident #420's clinical record revealed the facility admitted the resident on 09/05/2021, with diagnoses that included, Abnormalities of Gait and Mobility, Weakness, Lack of Coordination, Intellectual Disabilities, Developmental disorder of Scholastic Skills, and Altered Mental Status. Review of the facility's Pre-Admission Screening and Resident Review (PASRR), dated 09/02/2021, revealed Resident #420 had adaptive behavior of an eight (8) year, five (5) month old. The resident's unsteady balance was related to his/her weakness. Additional review revealed Resident #420 was noted to have an Intelligent Quotient (IQ) ranging from forty-two (42) to sixty (60) which indicated a moderate degree of cognitive limitation. Review of the Admission Minimum Data Set (MDS), dated [DATE], revealed the facility assessed Resident #420 with a Brief Interview of Mental Status (BIMS) score of ten (10) out of fifteen (15) which indicated the resident had moderate cognitive impairment. Review of Resident #420's Comprehensive Care Plan (CCP), dated 09/30/2021, revealed the facility had noted the resident had a history of fabricating/embellishing the truth and attention seeking behaviors. The care plan interventions included for staff to assist Resident #420 with reality orientation when he/she experienced episodes of fantasy/fabrications that interfered with the resident's well-being. Continued review revealed staff were to validate Resident #420's concerns. However, they were to set limits with the resident's negative behaviors. Resident #420 enjoyed sitting in the common area of the unit and conversing with staff, or having one-to-one (1:1) interactions with staff. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's Incident Report, dated 11/26/2021 and timed at 12:54 PM, revealed NA #3 reported on 11/25/2021, that she had witnessed CNA #94 place his finger on Resident #420's forehead and push the resident's head backwards, while the resident was sitting on the toilet. Per review, the incident occurred sometime between breakfast and lunch. Continued review revealed Resident #420 stood up from the toilet, and began to walk towards CNA #94, attempting to hit the CNA for pushing his/her head back. The Incident Report stated NA #3 then observed CNA #94 place the palms of his hands on Resident #420's chest and push the resident backwards causing the resident to fall to the floor. Record review revealed Resident #420 obtained a red abrasion to his/her back; and, was later assessed to have a raised area to his/her hip. Further review revealed witness statements were obtained and later, all parties involved were suspended after the incident had been reported to the facility management. Review of the facility's timeline for the 11/25/2021 incident revealed NA #3 had not reported the incident of alleged abuse of Resident #420 until after her shift was over on that date (which was after 3:00 PM). Continued review revealed facility management was not made aware of the incident on 11/25/2021 until 4:36 PM. Review of the facility's interview with Resident #420, on 11/25/2021 at 6:38 PM, after the incident had been reported, revealed CNA #94 Kinda played a prank or joke on me and made me fall and injure my back. Interview with NA #3, on 12/02/2021 at 3:40 PM, revealed she had observed CNA #94 enter Resident #420's room while the resident was sitting on the toilet in his/her restroom on 11/25/2021, sometime between breakfast and lunch. NA #3 stated she observed CNA #94 poke Resident #420 on the forehead which caused the resident's head to go backwards. She stated Resident #420 became upset and stood up trying to move towards CNA #94 to hit the CNA and the resident started to stumble. Per interview, at that time, CNA #94 placed his opened hands on Resident #420's upper chest area near his/her shoulders and pushed the resident backwards causing him/her to fall down. According to NA #3, after the incident she and CNA #43 took Resident #420 to the shower room and Licensed Practical Nurse (LPN) #38 also entered the shower room. Further interview revealed Resident #420 notified LPN #38 that CNA #94 had pushed him/her down which caused the resident to scratch his/her back. NA #3 stated she ultimately decided to notify the facility of the incident after her shift ended at 3:00 PM, and she had gone home. She stated she had been educated to report incidents; however, she did not known to whom she was to report them to. Record review revealed no documented evidence the facility's management was immediately notified of the alleged abuse after the incident, as per the policy. Interviews with NA #3, LPN #38, and CNA #94 revealed CNA #94, the alleged perpetrator, continued to work on the unit near Resident #420 and provided care for other residents living on that unit. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LPN #38 on 12/04/2021 at 12:05 PM, revealed CNA #43 notified him that Resident #420 had fallen against the wall. He stated when he saw Resident #420, after he had been notified, the resident was already in the shower chair in the shower room. LPN #38 stated he had observed the abrasion on Resident #420's back and asked the resident what had happened. However, the resident did not answer. LPN #38 stated he assumed the resident's abrasion was from the transfer from his/her wheelchair to the shower chair. Continued interview revealed it wasn't until after Resident #420's shower, when the resident was brought to the nurse's station, that Resident #420 reported CNA #94 pushed him/her. Further interview revealed he did not report what Resident #420 told him as potential abuse at that time. The LPN stated he ultimately forgot to report the incident due to the resident's past history of embellishing/fabricating the truth. Interview further revealed in hindsight he should have reported the allegation of abuse immediately. LPN #38 stated he had received the abuse education provided by the facility, and knew he should have reported the incident immediately. However, he had not done so. Interview with the Director of Nursing (DON), on 12/04/2021 at 5:20 PM, revealed she expected all staff to report any allegation of abuse immediately. She stated when the facility became aware of the allegation, all parties were suspended immediately and an investigation was started. The DON stated she did not feel that failure to report had been a failure on the facility's part, as she felt the staff members involved in the incident had not followed their training and the facility's policies and procedures. Continued interview revealed the staff members involved in the incident were no longer employed at the facility. Further interview revealed it was NA #3's perception that CNA 94 pushed Resident #420 down. Interview with the Administrator, on 12/04/2021 at 4:34 PM, revealed an abuse investigation had immediately been initiated once the facility was notified of the abuse allegations. Per interview, she did not believe the incident had been a failure on the part of the facility regarding the late reporting, as the facility had reported the allegation once the management team had been notified. She stated she believed it was a failure on the part of the staff. Interview revealed all the staff involved in the incident had received the abuse education provided, including reporting, on a weekly basis, if not more. The Administrator stated all those staff had been educated; however, they still had not reported the incident immediately as required, and that was the reason the facility ultimately determined they needed to fire those staff. The facility took the following actions to remove the Immediate Jeopardy (IJ): 1. The abuse allegation regarding Resident #420 was reported to the appropriate agencies as soon as the facility became aware of the incident. 2. A skin assessment and pain assessment were completed for Resident #420 on 11/25/2021 with a new treatment order per the physician. 3. Social Services (SS) followed and monitored Resident #420 for three (3) days following the incident. 4. The involved staff were terminated from the facility at the close of the investigation. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. Event calls were held on 11/25/2021, 11/26/2021, 11/27/2021 and 11/28/2021. The facility held an Ad Hoc QAPI meeting on 11/29/2021 with the IDT to review the allegations and interventions. Follow up calls were held on 11/30/2021, 12/02/2021, and 12/05/2021. 6. The facility began interviews and skin assessments on all residents on 11/25/2021. These were completed on 11/29/2021. 7. The Administrator was responsible to ensure all reportable events were reported. 8. The facility developed a twenty-four (24) hour supervision schedule beginning 12/06/2021 to ensure better reporting of potential allegations of abuse. 9. Abuse education was started on 12/05/2021, and was completed by the Nurse Management Team. 10. The facility reported all nursing notes were being reviewed in the Clinical Quality Indicators (CQI) meetings. 11. The facility placed Resident #69 on one-on-one (1:1) supervision on 11/29/2021. 12. Social Services (SS) monitored Resident #69 for three (3) days. 13. The facility's contracted Provider Services assessed Resident #69 on 11/30/2021 to determine his/her cognitive ability to consent to sexual conduct. 14. Resident #69 was assessed by psychiatric (psych) services on 12/03/2021 with a follow up on 12/06/21021. 15. Resident #69's care plan was reviewed and updated by the Interdisciplinary Team (IDT) on 11/24/2021, 11/29/2021, 11/30/2021, and 12/01/2021 with added interventions. 16. Resident #69 was reviewed weekly in the Behavior Meetings. 17. Resident #410 was placed on 1:1 supervision on 11/29/2021. 18. SS monitored Resident #410 for three (3) days. 19. Resident #410 was assessed by psych services on 12/03/2021 with a follow up on 12/06/2021. 20. Resident #410's care plan was reviewed and updated by the IDT on 11/29/2021, 11/23/2021 and 12/03/2021. 21. Resident #410 was being reviewed weekly in the Behavior Meetings. 22. Resident #410 was moved to a different room on 11/30/2021 and to a different unit on 12/03/2021 to decrease the risk of reoccurring events. 23. IDT reviewed Resident #410 on 12/03/2021 and determined it was safe to decrease the 1:1 supervision to every fifteen (15) minute checks. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	24. The facility held an Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting and event calls on 12/01/2021. Follow up event calls were conducted on 11/30/2021, 12/02/2021 and 12/05/2021 with the RDO, RNC, Governing Body, Administrator and DON regarding Resident #69 and Resident #410. 25. Any new, continuing, or worsening behaviors will be reviewed daily during the Clinical Quality Indicators (CQI) Meeting. 26. On 12/06/2021, all residents with a documented history of sexual behaviors were reviewed by the IDT and care plans were updated to increase safety. 27. The SS Department will assess the resident's desire to have sexual contact upon admission or readmission to the facility. 28. Abuse education was started on 12/05/2021, and was completed by the Nurse Management Team. 29. The SS Director began audits of four (4) resident charts daily beginning 12/05/2021, with residents who had known behaviors. 30. The audits will be reviewed daily by the RDO or RNC. 31. The audits reviewed by the RDO or RNC will be presented to the QAPI committee. 32. The RDO or RNC will attend the QAPI meetings weekly for four (4) weeks, then monthly for three (3) months. The State Survey Agency (SSA) validated the facility took the following actions: 1. Review of the Long-Term Care - Self Reported Incident, dated 12/02/2021, revealed the facility notified the proper State Agencies on 11/25/2021. 2. Review of the Pain Review, dated 11/25/2021 and Skin Check, dated 11/25/2021, revealed a licensed nurse completed assessments with a small abrasion noted to Resident #420's back. Continued review revealed a new order for Triple Antibiotic Ointment was obtained on 11/25/2021, per the provider. Unsuccessful attempts were made on 12/09/2021 at 12:45 PM and 1:30 PM, to contact the Licensed Nurse who obtained the order. 3. Record review revealed the SS Director monitored Resident #420 for three (3) days on 11/26/2021, 11/29/2021 and 11/30/2021 after the incident for any signs or symptoms of distress with no concerns noted. Interview with the SS Director, on 12/09/2021 at 12:54 PM revealed she monitored Resident #420 for three (3) days for concerns of sadness, any changes from baseline, lack of participation in activities, and any change from his/her normal daily activities. Continued interview revealed no concerns had been identified. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Personnel record review revealed CNA #94, LPN #38, NA #3, and CNA #43 were terminated on 12/03/2021, following the outcome of the investigation. 5. Review of the facility's QAPI Meeting Minutes, dated 11/29/2021 revealed the IDT held a meeting to discuss the incident and allegation. Continued review revealed event calls were held regarding the incident involving Resident #420 on 11/25/2021, 11/26/2021, 11/27/2021, 11/28/2021, 11/30/82021, 12/02/2021, and 12/05/2021. Interview with the RDO, on 12/09/2021 at 3:13 PM, revealed she participated in the Ad Hoc QAPI meeting with follow up event calls regarding Resident #420. They discussed the incident and to keep the team updated on the investigation. They also brainstormed on the type of action plan that was needed. Interview with the RNC, on 12/09/2021 at 3:04 PM, revealed he participated in the Ad Hoc QAPI meeting and the follow up event calls regarding the incident involving Resident #420. Continued interview revealed, we are updated on the investigation and tried to determine the root cause of the incident. Per interview, suggestions had been given to the facility and to determine what else could be completed to ensure the right procedures were being followed. Interview with a representative of the facility's Governing Body, on 12/09/2021 at 3:41 PM, revealed the Governing Body members had been present for the Ad Hoc QAPI meeting and follow up event calls. He stated the event calls were placed regarding identified concerns, any serious reportable events. Per interview, we evaluated all the facts, ensured interviews were completed, discussed resident assessments and interventions. He further revealed during the event calls, there was also discussion of whether there was a need for improvement and if a concern was identified it became part of the QAPI process. Interview with the DON, on 12/09/2021 at 2:05 PM, revealed she had been a part of the Ad Hoc QAPI meetings and event calls. She stated during the meetings and event calls, the event was discussed. She stated they attempted to determine what led up to the incident and what the plan would be after the event occurred. Interview with the Administrator, on 12/09/2021 at 2:43 PM, revealed she had been a part of the Ad Hoc QAPI and event calls. Continued interview revealed the team discussed the allegations regarding Resident #420 and what had been reported to the facility. She stated the facts of the event were discussed, along with ensuring that the necessary reporting occurred and where the facility went from there. 6. Record review revealed the facility completed interviews or skin assessments on all present residents for any concerns of possible abuse. No concerns were identified. 7. Interview with the Administrator, on 12/09/2021 at 2:43 PM, revealed she would report any abuse allegation if the DON did not. Continued interview revealed she would notify the appropriate State Agencies. She stated the DON or ADON would complete the initial incident report and keep her updated on the investigation, she would advise if needed. Per interview, she would ensure the five (5) day report was completed and sent to the reporting agencies timely. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Louisville Rehabilitation and Nursing	1155 Eastern Parkway Louisville, KY 40217

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. Interview with the DON, on 12/09/2021 at 2:50 PM, revealed managers had been delegated to complete rounds during the off-business hours and the rounding sheets were reviewed every morning and evening. 9. Review of the staff list revealed permanent staff, agency, and therapy staff completed education regarding the abuse policy, behaviors, with the opportunity for question and answer along with a posttest that required a 100% pass rate. Continued review revealed staff who had not yet received the education had not worked since 12/08/2021. Those staff had to complete the education prior to being allowed to work. Interview with the Activity Aide, on 12/09/2021 at 1:28 PM, revealed she had received the education on abuse and reporting. The education included to whom to report abuse allegations to, and when to report it. Continued interview revealed she received education regarding behaviors in residents; the importance of reporting new or worsening behaviors; and, to ensure that residents were kept safe. Further interview revealed she had also completed care plan education which stated the importance of updating a resident's care plan if there was a resident change. She stated there was post test that she completed. Interview with Laundry Aide #2, on 12/09/2021 at 1:12 PM, revealed she had been educated on abuse training and the importance of reporting anything suspicious to the nurse or supervisor. Continued interview revealed she received education regarding resident behaviors. If any behaviors were identified she was to report them to a nurse or supervisor. Additionally, she revealed she completed a posttest after receiving the education. Interview with the Dietary Aide, on 12/09/2021 at 1:18 PM, revealed he had received abuse training regarding reporting any abuse allegations immediately. Per interview, he had also received education related to if you observed harm to a resident, or a resident reported something to you to ensure that was reported. Continued interview revealed if behaviors were noted as new, continuing or worsening to report them to a nurse. He further revealed a post test had been completed. Interview with CNA #26, on 12/09/2021 at 1:43 PM, revealed she completed abuse training on the different types of abuse, and the importance of reporting abuse immediately to the supervisor and to ensure residents were safe. Continued interview revealed she received education on resident behaviors regarding the importance of reporting any new or continuing behaviors. Further interview revealed she received care plan education on the importance of using the care plan. Additionally, she revealed she completed a post test. Interview with CNA #51, on 12/09/2021 at 1:33 PM revealed she completed abuse training and the importance of reporting it immediately. Per interview, she had received behavior education regarding using the binders on the units to report any new, worsening, or continuing behaviors and to ensure all behaviors were charted. Further interview revealed if there was a resident change, that change needed to be reflected in the resident's care plan. She stated a post test had been completed. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Certified Medication Technician (CMT) #4, on 12/09/2021 at 1:59 PM, revealed she completed abuse training regarding reporting immediately and the signs of potential abuse (i.e., suspicious bruising). Continued interview revealed she received education on residents' behaviors. She stated there was a binder on each unit with residents who had behaviors that could be used to understand triggers and different interventions to use to address those behaviors. Further interview revealed she received education about residents' care plans and the importance of updating the care plan with any changes to ensure residents were receiving the proper care. She completed a post test. Interview with LPN #42, on 12/09/2021 at 2:02 PM, revealed she received abuse training regarding how to identify abuse and when and whom to report it to and ensure the residents were kept safe. Continued interview revealed regarding behaviors, if staff noticed a change in the resident's behaviors they were to report it to the nurse immediately. Per interview, staff were to ensure any behaviors were care planned and documented. Further interview revealed she received education regarding the use of the resident's care plan, how to use it and the importance of following the care plan. She completed a post test. Interview with LPN #43, on 12/09/2021 at 1:04 PM, revealed she received education regarding reporting abuse immediately, and ensuring that any new or worsening behaviors were reported and documented, along with why the care plans were important to follow. Further interview revealed a post test had been included with the education provided. Interview with LPN #50, on 12/09/2021 at 1:24 PM, revealed she completed abuse training regarding what to do immediately when an allegation was made and whom to report it to. Continued interview revealed any behaviors were to be reported to the supervisor and documented along with updating the care plan with any resident changes. Interview with RN #5, on 12/09/2021 at 1:51 PM, revealed she received education regarding who, when and what to report regarding abuse allegations. Continued interview revealed she received training on residents' behaviors, and the use of the binders on each unit. Per interview, she had received training to notify the nurse if there was any new behaviors or worsening behaviors noted. Further interview revealed she completed care plan education regarding the importance of updating the care plan if there was a change in the resident. She further revealed she had completed a post test. Interview with the Nurse Management Team (Director of Clinical Services, DON, RDO, Staff Development Coordinator, RNC, and ADON), on 12/09/2021 at 2:11 PM, revealed staff education had been completed in small groups, through 1:1 training, or telephonically with staff members who all had completed the post test. Continued interview revealed staff were educated on abuse, Governing Body, care planning, reporting abuse, reporting falls, incidents and abuse allegations timely. Further interview revealed care plans were discussed with the importance of the care plans being resident centered. Interview further revealed the importance of a resident having appropriate care plans in place, and ensuring they were followed was also discussed. 10. Interview with the CQI staff, which included the Administrator, DON, Assistant DON, Unit Managers, Minimum Data Set (MDS) Coordinator, SS Director, Activity Director, Dietary Manager, Rehab Manager, Medical Director, and the RDO on 12/09/2021 at 2:25 PM, revealed they reviewed all Nurses' Progress Notes every day during the morning clinical meeting for anything abnormal, for any behaviors, and/or potential abuse concerns. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11. Record review revealed the facility placed Resident #69 on 1:1 supervision on 11/29/2021 which continued through 12/08/2021. No concerns were identified. 12. Record review revealed the SS Director completed monitoring for Resident #69 for three (3) days on 11/30/2021, 12/01/2021, and 12/02/202. There were no concerns of psychosocial distress noted. Interview with the SS Director, on 12/09/2021 at 12:54 PM, revealed she had monitored Resident #69 for three (3) days for any concerns of sadness, any changes from baseline, lack of participation in activities, and any change from his/her normal daily activities. Continued interview revealed no concerns had been identified. 13. Record review revealed contracted provider services assessed Resident #69 on 11/30/2021 and determined Resident #69 was not capable of giving informed consent regarding consensual sexual activity. Per review, no new orders had been received at that time. 14. Record review revealed psych services assessed Resident #69 on 12/03/2021 and 12/06/2021 with new orders for a new medication to be started. 15. Review of the Comprehensive Care Plan revealed Resident #69's care plan had been updated on 11/24/2021, 11/29/2021, 11/30/2021, and 12/01/2021 with interventions that included: placing a bright sign on his/her door to assist the resident in identifying his/her correct room; 1:1 observation; residents to be separated; and pain and skin assessments to be completed. Continued review revealed additional interventions included: Social Services to observe for psychosocial distress; evaluations to be completed by the contracted provider services; psych services to follow; and the IDT had determined Resident #69 did not have the cognitive capacity to consent to sexual activity. Interview with the IDT members which included, but were not limited to, the Administrator, DON, ADON, Unit Managers, MDS Coordinator, SS Director, Activity Director, Dietary Manager, Rehab Manager, Medical Director and the RDO, on 12/09/2021 at 2:25 PM revealed they had reviewed Resident #69's care plan. They reviewed the care plan to ensure proper interventions were in place to help monitor the resident's behaviors and maintain safety for him/her and other residents. 16. Review of the Behavior Meeting Agenda revealed Resident #69 was reviewed in the weekly behavior meetings. The most recent meeting was held on 12/02/2021. Interview was conducted with the Behavior Meeting Members which included, but was not limited to, the Administrator, DON, ADON, Unit Managers, MDS Coordinator, SS Director, Activity Director, Dietary Manager, Rehab Manager, Medical Director and the RDO on 12/09/2021 at 2:25 PM. Further interview revealed that during the meetings, they reviewed residents for any concerns regarding verbal aggression, physical aggression, refusal of medications, sexual behaviors, any abnormal behaviors and anything which affected the resident or other residents. 17. Record review revealed Resident #410 was placed on 1:1 supervision on 11/29/2021 through 12/03/2021, with no concerns noted. 18. Record review revealed the SS Director observed Resident #410 for three (3) days on 11/30/2021, 12/01/2021 and 12/02/2021 with no concerns of psychosocial distress noted. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the SS Director, on 12/09/2021 at 12:54 PM, revealed she monitored Resident #410 for three (3) days for concerns of sadness, any changes from baseline, lack of participation in activities, and any change from his/her normal daily activities. Continued interview revealed no concerns had been identified. 19. Record review revealed Resident #410 was seen by psych services on 12/03/2021 with a follow up visit on 12/06/2021, and no new orders received. 20. Review of the Comprehensive Care Plan (CCP) revealed the IDT reviewed and updated Resident #410's care plan on 11/29/2021, 11/30/2021 and 12/03/2021 with interventions that included 1:1 staff observation; residents were separated; skin and pain assessments completed; moved the resident's room to a more visible location near the nurse's station. Continued review revealed further interventions which included: SS was to follow for signs [TRUNCATED]

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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. 29137 Based on interview, record review, and review of the facility's documents, it was determined the facility failed to develop and implement the Comprehensive Person-Centered Care Plan for one (1) of eighteen (18) sampled residents (Resident #69). Review of Resident #69's Comprehensive Care Plan revealed the resident expressed no desire to have sexual contact with another person, after assessments on 07/27/2021, 08/24/2021 and 09/23/2021. The interventions included: for staff to encourage Resident #69 to notify them if he/she had the desire to have sexual contact with another person. Review of the Progress Notes for Resident #69 dated 10/17/2021 and 10/19/2021 revealed the resident made sexual statements to male staff, and sat with his/her legs spread in a common area encouraging staff to come and get some. However, review of Resident #69's Comprehensive Care Plan revealed these behaviors were not identified and addressed in the care plan. On 11/29/2021, at approximately 8:30 PM, a staff person observed Resident #69 lying on the floor in his/her room facing another resident. The other resident, (Resident #410) had his/her pants and adult brief pulled down below the knees and his/her genitalia was exposed to Resident #69. The facility's failure to ensure Resident #69's Comprehensive Person-Centered Care Plan was developed and implemented has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified at 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation, F600 and F609; 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F656; 42 CFR 483.70 Administration; and, 42 CFR 483.75 Quality Assurance and Performance Improvement, F0867, at a Scope and Severity of a J. The Immediate Jeopardy was determined to exist on 10/17/2021. The facility was notified of the Immediate Jeopardy on 12/04/2021. In addition, Substandard Quality of Care (SQC) was identified at 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation (F600 and F609). An acceptable removal plan was received on 12/07/2021 alleging removal of the Immediate Jeopardy on 12/08/2021. An Extended Survey and Removal Plan Validation Survey were conducted on 12/09/2021 which determined the Immediate Jeopardy had been removed on 12/08/2021, as alleged, prior to exit on 12/09/2021. The remaining non-compliance in the areas of 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation, F600 Free from Abuse and Neglect at S/S (scope and severity) of D; F609 Reporting Alleged Violations at S/S of D; 42 CFR 483.21 Comprehensive Resident Centered Care Plan; F656 Develop/Implement Comprehensive Care Plan at S/S of D; 42 CFR 483.70 Administration, F835 Administration at S/S of D; F837 Governing Body at S/S of D; and, 42 CFR 48.75 Quality Assurance and Performance Improvement, F867 QAPI/QAA Improvement Activities while the facility developed and implemented a Plan of Correction and monitored the effectiveness of the systemic changes. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The findings include: Review of the facility's document titled, 4.7 The RAI{Resident Assessment Instrument} and Care Planning, undated, revealed a good assessment was the starting point for good clinical problem solving and decision making and ultimately for the creation of a sound care plan. Per review, the care plan should be reviewed and revised on an ongoing basis to ensure interventions were effective and to reflect changes in the resident and the care he/she was receiving. Review of Resident #69's clinical record revealed the facility admitted the resident, on 02/13/2019, with diagnoses that included Alzheimer's Disease with Late Onset, Other Symbolic Dysfunctions, Dementia with Behavioral Disturbances, Anxiety Disorder, and Psychotic Disorder with Delusions. Review of Resident #69's Annual Minimum Data Set (MDS) Assessment, dated 11/08/2021, revealed Resident #69 was assessed as having a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated the resident was moderately cognitively impaired. Per review, Resident #69 was not assessed as having physical behaviors which included hitting, grabbing or displaying sexually inappropriate behavior. Review of Resident #69's Progress Notes revealed a note dated 10/17/2021 at 2:54 AM, which stated the resident made inappropriate sexual statements to staff. Review of a Progress Note dated 10/19/2021 at 4:12 PM, revealed Resident #69 had been sitting (dressed) in the common area of the unit, with his/her legs spread open, encouraging staff to come and get it. Further review of the 10/19/2021 Progress Note revealed Resident #69 was also telling male employees he/she wanted to grab their junk. Review of Resident #69's Comprehensive Care Plan (CCP), dated 09/05/2021 revealed the facility had care planned the resident for behaviors with interventions which included: removing Resident #69 from situations that might cause anxiety or aggression; staff to speak to the resident in a calm voice when attempting to deescalate agitated behaviors. Continued review of the CCP revealed a Focus on Resident #69's care plans dated 07/23/2021, 08/24/2021 and 09/23/2021, which noted the resident did not desire to have sexual contact with another person at that time. The goal stated Resident #69 would notify staff if he/she desired to have sexual contact with another person. However, there was no evidence the facility developed interventions to address Resident #69's comments and behaviors documented in the 10/17/2021 and 10/19/2021 Progress Notes. Review of the facility's investigation revealed on 11/29/2021 at approximately 8:30 PM, a staff member had observed Resident #69 lying on the floor in his/her room floor, with another resident facing Resident #69. Per review, Resident #69 was fully clothed; however, the other resident had his/her pants and brief pulled below the knees (exposing his/her genitalia to Resident #69). Continued review revealed the staff member observed that the two (2) residents' knees were touching. Staff immediately separated the residents and both residents were assessed without injuries noted. Further review revealed the other resident (Resident #410), present in Resident #69's room at the time of the incident, was moved to a room on the other side of the unit, closer to the Nurse's Station. The Surveyor attempted to interview Resident #69; however, all attempts were unsuccessful. (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 Resident #410's clinical record revealed the facility had assessed the resident to have a BIMS score of six (6) which was indicative of severe cognitive impairment. Interview on 12/03/2021 at 10:30 AM, with Resident #410 revealed the resident was unable to remember anything about Monday night (11/29/2021, the date of the incident). Interview with RN #11, on 12/02/2021 at 8:37 AM, via phone, revealed he had been performing his medication pass around 8:15 PM. RN #11 stated he had not seen Resident #410 sitting in the common area where he/she had been previously. He stated when he went to look for Resident #410, he noted that Resident #69's room door was closed. Per interview, he knocked on Resident #69's door, and entered his/her room where he observed Resident #410 lying on the floor with his/her brief and pants down to the ankles and his/her genitals exposed to Resident #69. Further interview revealed Resident #69 was wearing a gown and brief. He stated Resident #69 was upset with him (RN #11) for being in his/her room. Interview with the facility's Interim Administrator on 12/03/2021 at 3:40 PM and again on 12/04/2021 at 4:33 PM, revealed overseeing the facility's operations was her role as Administrator. The Interim Administrator stated regarding the care planning issues identified, she had no clinical background and was unable to speak to those issues. She stated she could only say Resident #69 and Resident #410 had been discussed in the facility's Interdisciplinary Team (IDT) meetings ever since she had become the Interim Administrator. She stated they discussed Resident #69 related to his/her verbal and aggressive behaviors and Resident #410 for his/her rejection of care. According to the Interim Administrator, she was aware of Resident #69's previous sexually inappropriate behavior. Interview revealed residents could be placed on every fifteen (15) minute checks or 1:1 supervision by nursing staff using their nursing judgement without a Physician's order. Interview with the Director of Nursing, (DON) on 12/04/2021, at 5:15 PM, revealed she expected any resident's inappropriate behaviors to be care planned with interventions documented and staff were to implement the interventions. Continued interview revealed the DON felt there had been no failure in the facility's current system or processes, or in the care planning of interventions for Resident #69. Per interview, the DON stated it was not feasible for the facility to keep a constant eye on all residents with behaviors. The DON stated she felt staff had been following Resident #69's care plan interventions at the time of the incident. However, the facility had assessed the residents to be unable to give consent for sexual contact with another person, and had been care planned to have no desire for sexual contact with others. The facility took the following actions to remove the Immediate Jeopardy (IJ): 1. The abuse allegation regarding Resident #420 was reported to the appropriate agencies as soon as the facility became aware of the incident. 2. A skin assessment and pain assessment were completed for Resident #420 on 11/25/2021. A new treatment was ordered. 3. Social Services (SS) followed and monitored Resident #420 for three (3) days following the incident. 4. The involved staff were terminated from the facility at the close of the investigation. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. Event calls were held on 11/25/2021, 11/26/2021, 11/27/2021 and 11/28/2021. The facility held an Ad Hoc QAPI meeting on 11/29/2021 with the IDT to review the allegations and interventions. Follow up calls were held on 11/30/2021, 12/02/2021, and 12/05/2021. 6. The facility began interviews and skin assessments to determine any potential abuse allegation or suspected abuse. The interview and assessments were started on 11/25/2021 and all were completed on 11/29/2021. 7. The Administrator was responsible to ensure all reportable events were reported. 8. The facility developed a twenty-four (24) hour supervision schedule beginning 12/06/2021 to ensure better reporting of potential allegations of abuse. 9. Education was started on 12/05/2021, and was completed by the Nurse Management Team. 10. The facility reported all nursing notes were being reviewed in the Clinical Quality Indicators (CQI) meetings. 11. The facility placed Resident #69 on one-on-one (1:1) staff supervision on 11/29/2021 for increased supervision. 12. Social Services (SS) monitored Resident #69 for three (3) days. 13. The facility's contracted medical services provider assessed Resident #69 on 11/30/2021 to determine his/her cognitive ability to consent to sexual contact. 14. Resident #69 was assessed by psychiatric (psych) services on 12/03/2021 with a follow up on 12/06/21021. 15. Resident #69's care plan was reviewed and updated by the Interdisciplinary Team (IDT) on 11/24/2021, 11/29/2021, 11/30/2021, and 12/01/2021 with added interventions. 16. Resident #69 was being reviewed weekly in the Behavior Meetings. 17. Resident #410 was placed on 1:1 supervision on 11/29/2021. 18. SS monitored Resident #410 for three (3) days. 19. Resident #410 was assessed by psych services on 12/03/2021 with a follow up assessment on 12/06/2021. 20. Resident #410's care plan was reviewed and updated by the IDT on 11/29/2021, 11/23/2021 and 12/03/2021. 21. Resident #410 was being reviewed weekly in the Behavior Meetings. 22. Resident #410 was moved to a different room on 11/30/2021 and to a different unit on 12/03/2021 to decrease the risk of reoccurring events. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	23. IDT reviewed Resident #410 on 12/03/2021 and determined it was safe to decrease his/her 1:1 supervision to every fifteen (15) minute checks. 24. The facility held an Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting and event calls on 12/01/2021 with follow up event calls on 11/30/2021, 12/02/2021 and 12/05/2021 with the RDO, RNC, Governing Body, Administrator and DON regarding Resident #69 and Resident #410. 25. Any new, continuing, or worsening behaviors will be reviewed daily during the Clinical Quality Indicators (CQI) Meeting. 26. On 12/06/2021, all residents with a documented history of sexual behaviors were reviewed by the IDT. Care plans were updated to increase safety. 27. The SS Department will assess the resident's desire to have sexual contact upon admission or readmission to the facility. 28. Staff education was started on 12/05/2021, and completed by the Nurse Management Team. 29. The SS Director began audits of four (4) residents' charts daily beginning 12/05/2021. Residents with known behaviors were audited. 30. The audits will be reviewed daily by the RDO or RNC. 31. The audits reviewed by the RDO or RNC will be presented to the QAPI committee. 32. The RDO or RNC will attend the QAPI meetings weekly for four (4) weeks, then monthly for three (3) months. The State Survey Agency (SSA) validated the facility took the following actions: 1. Review of the Long-Term Care - Self Reported Incident, dated 12/02/2021, revealed the facility notified the proper State Agencies on 11/25/2021. 2. Review of the Pain Review, dated 11/25/2021 and Skin Check, dated 11/25/2021, revealed a licensed nurse completed assessments with a small abrasion noted to Resident #420's back. Continued review revealed a new order for Triple Antibiotic Ointment was obtained on 11/25/2021, per the provider. Unsuccessful attempts were made to contact the Licensed Nurse, who obtained the order, on 12/09/2021 at 12:45 PM and 1:30 PM. 3. Record review revealed the SS Director monitored Resident #420 for three (3) days on 11/26/2021, 11/29/2021 and 11/30/2021 after the incident for any signs or symptoms of distress with no concerns noted. Interview with the SS Director, on 12/09/2021 at 12:54 PM revealed she monitored Resident #420 for three (3) days for concerns of sadness, any changes from baseline, lack of participation in activities, and any change from his/her normal daily activities. Continued interview revealed no concerns had been identified. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Personnel record review revealed CNA #94, LPN #38, NA #3, and CNA #43 were terminated on 12/03/2021, following the outcome of the investigation. 5. Review of the facility's QAPI Meeting Minutes, dated 11/29/2021, revealed the IDT held a meeting to discuss the incident and allegation. Continued review revealed event calls were held regarding the incident involving Resident #420 on 11/25/2021, 11/26/2021, 11/27/2021, 11/28/2021, 11/30/82021, 12/02/2021, and 12/05/2021. Interview with the RDO, on 12/09/2021 at 3:13 PM, revealed she participated in the Ad Hoc QAPI meeting with follow up event calls regarding Resident #420, to discuss the incident and to keep the team updated on the investigation, and to brainstorm on the type of action plan needed. Interview with the RNC, on 12/09/2021 at 3:04 PM, revealed he participated in the Ad Hoc QAPI meeting and the follow up event calls regarding the incident involving Resident #420. The RNC stated, We are updated on the investigation and tried to determine the root cause of the incident. Per interview, suggestions had been given to the facility to determine what else could be completed to ensure the right procedures were being followed. Interview with a representative of the facility's Governing Body, on 12/09/2021 at 3:41 PM, revealed the Governing Body members had been present for the Ad Hoc QAPI meeting and follow up event calls. He stated the event calls were placed regarding identified concerns, any serious reportable events. Per interview, we evaluated all the facts, ensured interviews were completed, discussed resident assessments and interventions. He further revealed during the event calls, there was also discussion of whether there was a need for improvement and if a concern was identified it became part of the QAPI process. Interview with the DON, on 12/09/2021 at 2:05 PM, revealed she had been a part of the Ad Hoc QAPI meetings and event calls. She stated during the meetings and event calls the event was discussed; attempted to determine what led up to the incident; and, what the plan would be after the event occurred. Interview with the Administrator, on 12/09/2021 at 2:43 PM, revealed she had been a part of the Ad Hoc QAPI and event calls. Continued interview revealed the team discussed the allegations regarding Resident #420 and what had been reported to the facility. Per interview, the facts of the event were discussed, along with ensuring the necessary reporting occurred and where the facility went from there. 6. Record review revealed the facility completed interviews or skin assessments on all present residents for any concerns of possible abuse. 7. Interview with the Administrator, on 12/09/2021 at 2:43 PM, revealed she would report any abuse allegation if the DON did not. Continued interview revealed she would notify the appropriate State Agencies. She stated the DON or ADON would complete the initial incident report and keep her updated on the investigation, she would advise if needed. Per interview, she would ensure the five (5) days was completed and sent to the reporting agencies timely. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. Interview with the DON, on 12/09/2021 at 2:50 PM, revealed managers had been delegated to complete rounds during the off-business hours and the rounding sheet were reviewed every morning and evening. 9. Review of the staff list revealed permanent staff, agency, and therapy staff completed education regarding the abuse policy, behaviors, with the opportunity for question and answer along with a posttest that required a 100% pass rate. Continued review revealed staff who had not yet received the education were staff that had not worked since 12/08/2021 and those staff had to complete the education prior to being allowed to work. Interview with the Activity Aide, on 12/09/2021 at 1:28 PM, revealed she had received the education about abuse regarding reporting, whom to report abuse allegations to, and when to report it. Continued interview revealed she received education regarding resident behaviors, and the importance of reporting new or worsening behaviors and to ensure that residents were kept safe. Further interview revealed she had also completed care plan education which stated the importance of updating a resident's care plan if there was a resident change and a post test had been completed. Interview with Laundry Aide #2, on 12/09/2021 at 1:12 PM, revealed she had been educated on abuse training and the importance of reporting anything suspicious to the nurse or supervisor. Continued interview revealed she received education regarding; if resident behaviors were identified to who to report them to, a nurse or supervisor. Additionally, she revealed she completed a posttest after receiving the education. Interview with the Dietary Aide, on 12/09/2021 at 1:18 PM, revealed he had received abuse training regarding reporting any abuse allegations immediately. Per interview, he had also received education related to if you observed harm to a resident, or a resident reported something to you to ensure that was reported. Continued interview revealed if behaviors were noted as new, continuing or worsening to report them to a nurse. He further revealed a post test had been completed. Interview with CNA #26, on 12/09/2021 at 1:43 PM, revealed she completed abuse training on the different types of abuse, and the importance of reporting abuse immediately to the supervisor and ensure residents were safe. Continued interview revealed she received education on resident behaviors regarding the importance of reporting any new or continuing behaviors. Further interview revealed she received care plan education on the importance of using the care plan. Additionally, she revealed she completed a post test. Interview with CNA #51, on 12/09/2021 at 1:33 PM revealed she completed abuse training and the importance of reporting it immediately. Per interview, she had received behavior education regarding using the binders on the units to report any new, worsening, or continuing behaviors and ensure all behaviors were charted. Further interview revealed if there was a resident change, that change needed to be reflected in the resident's care plan. Additionally, she stated a post test had been completed. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Certified Medication Technician (CMT) #4, on 12/09/2021 at 1:59 PM, revealed she completed abuse training regarding reporting it immediately and the signs of potential abuse (i.e., suspicious bruising). Continued interview revealed she received education on residents' behaviors and there was a binder on each unit with residents, who had behaviors that could be used to understand triggers and different interventions to use to address those behaviors. Further interview revealed she received education about residents' care plans and the importance of updating the care plan with any changes to ensure residents were receiving the proper care. She revealed she completed a post test. Interview with LPN #42, on 12/09/2021 at 2:02 PM, revealed she received abuse training regarding how to identify abuse and when and who to report it to and ensure the residents were kept safe. Continued interview revealed regarding behaviors, if staff noticed a change in the resident's behaviors, they were to report it to the nurse immediately. Per interview, staff were to ensure any behaviors were care planned and documented. Further interview revealed she received education regarding the use of the resident's care plan, how to use it and the importance of following the care plan. Additionally, she revealed a post test had been completed. Interview with LPN #43, on 12/09/2021 at 1:04 PM, revealed she received education regarding reporting abuse immediately, and ensuring that any new or worsening behaviors were reported and documented. She also received education along with why the care plans were important to follow. Further interview revealed a post test had been included with the education provided. Interview with LPN #50, on 12/09/2021 at 1:24 PM, revealed she completed abuse training regarding what to do immediately when an allegation was made and to whom to report it to. Continued interview revealed any behaviors were to be reported to the supervisor and documented along with updating the care plan with any resident changes. Interview with RN #5, on 12/09/2021 at 1:51 PM, revealed she received education regarding who, when and what to report regarding abuse allegations. Continued interview revealed she received training on residents' behavior, and the use of the binders on each unit. Per interview, she had received training to notify the nurse if there were any new behaviors or worsening behaviors noted. Further interview revealed she completed care plan education regarding the importance of updating the care plan if there was a change in the resident. She further stated she had completed a post test. Interview with the Nurse Management Team (Director of Clinical Services, DON, RDO, Staff Development Coordinator, RNC and ADON), on 12/09/2021 at 2:11 PM, revealed staff education had been completed in small groups, through 1:1 training, or telephonically with staff members who all had completed the post test. Continued interview revealed staff were educated on abuse, Governing Body, care planning, reporting abuse, reporting falls, incidents and abuse allegations timely. Further interview revealed care plans were discussed with the importance of the care plans being patient/resident centered. Interview further revealed the importance of a resident having appropriate care plans in place, and ensuring they were followed was also discussed. 10. Interview with the CQI staff which included, but not been limited to the Administrator, DON, Assistant DON, Unit Managers, Minimum Data Set (MDS) Coordinator, SS Director, Activity Director, Dietary Manager, Rehab Manager, Medical Director, and the RDO on 12/09/2021 at 2:25 PM, revealed they reviewed all Nurses' Progress Notes every day during the morning clinical meeting for anything abnormal, for any behaviors, and/or potential abuse concerns. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11. Record review revealed the facility placed Resident #69 on 1:1 supervision on 11/29/2021, which continued through 12/08/2021. No concerns were identified. 12. Record review revealed the SS Director completed monitoring for Resident #69 on 11/30/2021, 12/01/2021, and 12/02/2021. No concerns of psychosocial distress were noted. Interview with the SS Director, on 12/09/2021 at 12:54 PM, revealed she had monitored Resident #69 for three (3) days for any concerns of sadness, any changes from baseline, lack of participation in activities, and any change from his/her normal daily activities. Continued interview revealed no concerns had been identified. 13. Record review revealed the facility's contracted medical services provider assessed Resident #69 on 11/30/2021 and determined Resident #69 was not capable of giving informed consent regarding consensual sexual activity. Per review, no new orders had been received at that time. 14. Record review revealed psych services assessed Resident #69 on 12/03/2021 and 12/06/2021 with new orders for a new medication to be started. 15. Review of the Comprehensive Care Plan revealed Resident #69's care plan had been updated on 11/24/2021, 11/29/2021, 11/30/2021, and 12/01/2021 with interventions that included: placing bright sign on his/her door to assist the resident in identifying his/her correct room:1:1 observation; residents to be separated; and, pain and skin assessments were completed. Continued review revealed additional interventions included: Social Services to observe for psychosocial distress; evaluations to be completed by the facility's contracted medical services provider; psych services to follow; and the IDT had determined Resident #69 did not have the cognitive capacity to consent to sexual activity. Interview with the IDT members which included, but were not limited to, the Administrator, DON, ADON, Unit Managers, MDS Coordinator, SS Director, Activity Director, Dietary Manager, Rehab Manager, Medical Director and the RDO, on 12/09/2021 at 2:25 PM revealed they had reviewed Resident #69's care plan. The review included to ensure proper interventions were in place to help monitor the resident's behaviors and maintain safety for him/her and other residents. 16. Review of the Behavior Meeting Agenda revealed Resident #69 was being reviewed in the weekly behavior meetings, the most recent being 12/02/2021. Interview with the Behavior Meeting Members which included; but was not limited to the Administrator, DON, ADON, Unit Managers, MDS Coordinator, SS Director, Activity Director, Dietary Manager, Rehab Manager, Medical Director and the RDO on 12/09/2021 at 2:25 PM, revealed during the meetings they reviewed residents for any concerns regarding verbal aggression, physical aggression, refusal of medications, sexual behaviors, any abnormal behaviors and anything which affected the resident or other residents. 17. Record review revealed Resident #410 was placed on 1:1 supervision on 11/29/2021 through 12/03/2021 with no concerns noted. 18. Record review revealed the SS Director observed Resident #410 for three (3) days on 11/30/2021, 12/01/2021 and 12/02/2021 with no concerns of psychosocial distress noted. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the SS Director, on 12/09/2021 at 12:54 PM, revealed she monitored Resident #410 for three (3) days for concerns of sadness, any changes from baseline, lack of participation in activities, and any change from his/her normal daily activities. Continued interview revealed no concerns had been identified. 19. Record review revealed Resident #410 was seen by psych services on 12/03/2021 with a follow up visit on 12/06/2021, and no new orders received. 20. Review of the Comprehensive Care Plan (CCP) revealed the IDT reviewed and updated Resident #410's care plan on 11/29/2021, 11/30/2021 and 12/03/2021 with interventions that included 1:1 staff observation; residents were separated; skin and pain assessments completed; moved the resident's room to a more visible location near the nurse's station. Continued review revealed further interventions which included: SS was to follow for signs and symptoms of psychosocial distress; gather information on past falls, and attempt to determine the root cause of the fall and to anticipate and intervene to prevent recurrence. Interview with the Behavior Meeting Members which included but was not limited to; the Administrator, DON, ADON, Unit Managers, MDS Coordinator, SS Director, Activity Director, Dietary Manager, Rehab Manager, Medical Director and the RDO on 12/09/2021 at 2:25 PM, revealed they had reviewed Resident #410's care plan. The review included to ensure proper interventions were in place to help monitor the resident's behaviors and maintain safety for him/her and other residents. 21. Review of the Behavior Meeting Agenda revealed Resident #410 was discussed and monitored weekly in the Behavior meetings. The most recent meeting was on 12/02/2021. Interview with the Behavior Meeting Members revealed during the meetings they were reviewing residents for any concerns regarding verbal aggression, physical aggression, refusal of medications, sexual behaviors, any abnormal behaviors and anything which affected the resident or other residents. 22. Review of the facility's Census List revealed Resident #410 had been moved to a different room on 11/30/2021 and to a different unit on 12/03/2021. 23. Record review revealed on 12/03/2021, the IDT determined to relocate Resident #410 to a different unit. 1:1 supervision would be discontinued when the resident was settled into the new room; seen by psych services; and, the resident had not been displaying sexual behaviors over the last five (5) days of 1:1 monitoring. Record review revealed every fifteen (15) minute checks were completed for Resident #410 on 10/08/2021 through 12/04/2021 continuing through the current review. Interview with the IDT members, on 12/09/2021 at 2:25 PM revealed when Resident #410 was moved to another unit, he/she adapted well to the new environment with no concerns identified. The team reviewed the residents prior to determining the 1:1 supervision was no longer needed 24. Review of the QAPI Meeting Minutes, dated 12/01/2021 revealed the members were not limited to, the RDO, RNC, Governing Body members, Administrator and DON. Further review revealed an Ad Hoc QAPI meeting had been held regarding Resident #69 and Resident #410. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the RDO, on 12/09/2021 at 3:13 PM, revealed she participated in the Ad Hoc QAPI meeting with follow up event calls regarding Resident #410 and Resident #69 to discuss the incident. Per interview, the meeting and event calls had been to keep the team updated on the investigation, and to brainstorm on the type of action plan needed if indicated. Interview with the RNC, on 12/09/2021 at 3:04 PM, revealed he participated in the Ad Hoc QAPI meeting and follow up event calls for the involved residents. Continued interview revealed during the meeting and event calls they were updated on the facility's investigation and tried to determine the root cause of the incident. Further interview revealed the QAPI members gave the facility suggestions, helped determine what else could be completed and to ensure the right [TRUNCATED]

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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. 28707 Based on interview, record review, review of the facility's policy, and review of the facility's Plan of Correction (PoCs) for the 07/03/2021 Recertification Survey and the 12/06/2019 Recertification Survey, it was determined the facility failed to have an effective Administration responsible for establishing and implementing policies regarding management and operation of the facility. The facility was re-cited at F-600, F-609, and F-656. Review of the 12/06/2019 Recertification Survey revealed the facility was cited at 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation (F-600) at a Scope and Severity of an E; and, at 42 CFR 483.21 Comprehensive Resident Centered Care Plans (F-656) at a Scope and Severity of a G. Review of the 07/03/2021, Recertification Survey, revealed the facility was again cited at 42 CFR Freedom from Abuse, Neglect and Exploitation (F-600); and 42 CFR 483.21 Comprehensive Resident Centered Care Plans (F-656) both at a Scope and Severity of a J. As those were repeat deficiencies, the State Survey Agency (SSA) additionally cited 42 CFR 483.70 Administration (F-835 and F-837) and 42 CFR 483.75 Quality Assurance and Performance Improvement (F-867) all at a Scope and Severity of a J, The facility was also cited at 42 CFR Freedom from Abuse, Neglect, and Exploitation (F-609) at a Scope and Severity of a J. Interview and record review revealed the facility failed to ensure residents were free from abuse; residents' behaviors were addressed; and residents' care plans were developed and implemented per the facility's PoCs. In addition, the facility failed to ensure all allegation of abuse were reported timely. 1. Record review revealed Resident #69 exhibited sexual behaviors directed towards staff on 10/17/2021 and 10/19/2021; however, there was no documented evidence the facility developed and implemented a care plan to address the behaviors. Review of the facility's investigation for an alleged sexual abuse incident involving Resident #69 and Resident #410, revealed on 11/29/2021 at approximately 8:30 PM, a staff member observed Resident #69 lying fully clothed on his/her room floor. The residents' knees were touching, and the other resident had his/her pants and brief pulled below the knees with his/her genitalia exposed to Resident #69. Continued review revealed the residents were immediately separated by staff and assessed without injury noted. 2. Per interview, the facility failed to protect Resident #420 from abuse. Certified Nursing Assistant (CNA) #94 was observed by Nursing Assistant (NA) #3 to poke Resident #420 on the forehead while the resident was sitting on his/her toilet. Resident #420 became upset, stood up and tried to walk towards CNA #94 and started to stumble. NA #3 then observed CNA #94 place his hands, open palmed, on Resident #420's chest and pushed the resident backwards, causing him/her to fall backwards onto the wall. Resident #420 received an abrasion to his/her back and a knot to his/her hip as a result of the fall. NA #3 failed to immediately report the allegation and waited until after her shift (approximately six hours). LPN #38 failed to report the allegation when Resident #420 reported the incident to LPN #38. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's failure to have an effective system to ensure the Administrator used it's resources in a manner to ensure responsible for establishing and implementing policies regarding the management and operation of the facility has caused or is likely to cause serious injury, harm, impairment, or death to residents. Immediate Jeopardy (IJ) was identified at 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation, F-600 and F-609; 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F-656; 42 CFR 483.70 Administration; and, 42 CFR 483.75 Quality Assurance and Performance Improvement, F-867, all at a Scope and Severity of a J. The Immediate Jeopardy was determined to exist on 10/17/2021 and the facility was notified of the Immediate Jeopardy on 12/04/2021. In addition, Substandard Quality of Care (SQC) was identified at 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation (F-600 and F-609). An acceptable removal plan was received on 12/07/2021 alleging removal of the Immediate Jeopardy on 12/08/2021. An Extended Survey and Immediate Jeopardy removal survey conducted on 12/09/2021 determined the Immediate Jeopardy had been removed on 12/08/2021, as alleged, prior to exit on 12/09/2021. The remaining non-compliance in the areas of 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation, F-600 Free from Abuse and Neglect at S/S (Scope and Severity) of D; F-609 Reporting Alleged Violations at S/S of D; 42 CFR 483.21 Comprehensive Resident Centered Care Plan; F-656 Develop/Implement Comprehensive Care Plan at S/S of D; 42 CFR 483.70 Administration, F-835 Administration at S/S of D; F-837 Governing Body at S/S of D; and, 42 CFR 48.75 Quality Assurance and Performance Improvement, F-867 QAPI/QAA Improvement Activities while the facility developed and implemented a Plan of Correction and monitored the effectiveness of the systemic changes. The findings include: Review of the facility's Administrator Job Description, not dated, revealed the Administrator led and directed the overall operation of the facility in accordance with residents' needs, federal and state government regulations, and company policies/procedures to maintain quality of care for all residents. Per review, the Administrator worked with facility management staff and consultants in planning all aspects of the facility's operations. Further review revealed the Administrator monitored each department's activities, evaluated their performance, and monitored the operations of all facility departments. Further review revealed the Administrator ensured the facility appropriately utilized its consultants and other support resources. The Job Description revealed the Administrator was to maintain a working knowledge of all governmental regulations and ensured the facility was compliant with those regulations. In addition, the Administrator was to have an understanding of and ensure compliance of all rules regarding residents' rights. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's Director of Nursing (DON) Job Description, not dated, revealed the DON, under the supervision of the Administrator, had authority, responsibility, and accountability for the functions, activities, and training of all nursing services staff. Review revealed the DON was responsible for the overall management of resident care twenty-four (24) hours a day, seven (7) days a week. Per review, the DON was to conduct periodic reviews of residents' care plans to ensure they were interdisciplinary and were updated daily by the charge nurse as changes occurred. Further review revealed the DON was to review all resident accidents and incidents (A/I) daily and develop an appropriate plan to prevent future accidents and incidents. In addition, the Job Description revealed the DON was to ensure he/she was aware of Resident Abuse Reporting Law, ensure all nursing staff understood the Law, and ensure compliance with it was maintained. Review of the facility's Plan of Correction for the Recertification Survey, dated 07/03/2021, under F-600 revealed all staff were inserviced beginning 06/21/2021 on the facility's abuse policy. Per the PoC, residents with new, continuing, or worsening behaviors would be reviewed in the weekly behavior meeting. Continued review revealed the Behavior Tracking Tool All Staff Usage was initiated on 09/10/2021, to report new, continuing and worsening behaviors to the IDT. Per the PoC all new, continuing and worsening behaviors would be reviewed in the morning CQI meeting and care planned interventions updated as needed. Continued review revealed residents with increased behaviors and/or a history of aggression to staff or other residents, would be reviewed weekly in the Behavior Meeting beginning 09/10/2021. Care plan and treatment regimens would be adjusted as needed. The Social Services Director would report to the QAPI committee weekly a summary of the weekly behavior meeting. If any patterns were identified, an Action Plan would be written and monitored weekly by the Administrator until resolved. Review of the facility's Plan of Correction for Recertification Survey, dated 07/03/2021, under F-609 revealed education was conducted on 09/03/2021 and completed on 09/10/2021 for all staff. Per the PoC, the education included the facility's abuse policy focusing on what abuse was, reporting allegations and suspected abuse/neglect, who to report abuse and what to report. Per the PoC, auditing would be completed and presented to the QAPI Committee weekly for review and recommendations until desired threshold of 100% compliance was met for three (3) consecutive months. If any patterns were identified, an Action Plan would be written and monitored weekly by the Administrator until resolved. Review of the facility's Plan of Correction for the Recertification Survey, dated 07/03/2021, under F-656, revealed residents with increased behaviors were to be reviewed weekly in Behavior Meetings, with care plans adjusted as needed to include nursing interventions. This information was to be reported to the QAPI committee weekly. Review of the facility's Plan of Correction for Recertification Survey dated 12/09/2019, under F-600 revealed an inservice for all staff including agency was held 01/16/2020 through 02/05/2020. Continued review revealed the education presented included the facility's abuse policy, resident rights (to include the right to be free from abuse in any form), Care Planning for residents with behaviors to include redirection and supervision. 1. Clinical record review revealed the facility admitted Resident #69 on 02/13/2019, with diagnoses that included Dementia with Behavioral Disturbances, Alzheimer's Disease with Late Onset, Psychotic Disorder with Delusions, and Anxiety Disorder. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Annual Minimum Data Set (MDS) Assessment, dated 11/08/2021, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated moderate cognitive impairment. Continued review revealed the facility assessed Resident #69 as having verbal behaviors exhibited one to three (1-3) days which had significantly impacted his/her care, disrupted the privacy of other residents and impacted the living environment within the facility. Further review revealed Resident #69 had not been assessed as having behaviors that included hitting, grabbing or sexually inappropriate acting out. Review of Resident #69's Comprehensive Care Plan (CCP), dated 09/05/2021 revealed the facility had care planned the resident for behaviors with interventions which included: removing Resident #69 from situations that might cause anxiety or aggression; staff to speak to the resident in a calm voice when attempting to deescalate agitated behaviors. Review of Resident #69's Behavior Note, dated 10/17/2021 at 2:54 AM, revealed the resident had been combative and had inappropriate sexual behaviors. Continued review revealed the resident was sexually aggressive to male employees. However, there was no documented evidence a care plan was developed and implemented for this behavior, per the PoC. Continued review of Resident #69's Behavior Notes, dated 10/19/2021 at 4:12 PM, revealed the resident was sitting on the couch in the common area and stated he/she wanted to grab the employee's junk. Continued review revealed Resident #69's legs were spread open and he/she was telling staff come and get it. Per the note, the resident was mainly making the statements towards male staff and became more agitated with redirection; however, there was no documented evidence a care plan was developed and implemented for this behavior, per the PoC. Continued review of the CCP revealed a Focus on Resident #69's care plan dated 07/23/2021, 08/24/2021 and 09/23/2021, which noted the resident did not desire to have sexual contact with another person at that time. The goal stated Resident #69 would notify staff if he/she desired to have sexual contact with another person. However, there was no documented evidence the facility developed interventions to address Resident #69's comments and behaviors documented in the 10/17/2021 and 10/19/2021 Progress Notes. Interview with Registered Nurse (RN) #11 on 12/02/2021 at 1:28 PM, revealed on 11/29/2021 around 8:15 PM, he was performing the medication pass, and was looking for Resident #410, who had previously been sitting in his/her wheelchair in the dining area. RN #11 started checking for Resident #410 in other residents' rooms. Continued interview revealed when he checked Resident #69's room, he observed Resident #69 lying on the floor facing Resident #410, who had his/her pants and brief pulled down below the knees with his/her genitals exposed to Resident #69. Per RN #11, the residents were separated and assessed after the incident. Further interview revealed Resident #69 had previously displayed sexually suggestive gestures and comments which had been inappropriate, and the resident had been evaluated by a psychiatric provider. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Review of Resident #420's medical record revealed the facility admitted the resident on 09/05/2021, with diagnoses that included Intellectual Disabilities, Lack of Coordination, Abnormalities of Gait and Mobility, Developmental Disorder of Scholastic Skills, Altered Mental Status, and Weakness. Review of Resident #420's Admission Minimum Data Set (MDS) Assessment, dated 09/12/2021, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of ten (10) which indicated moderate cognitive impairment. Further review revealed the facility had not assessed Resident #420 to have behaviors. Review of the facility's, Pre-Admission Screening and Resident Review (PASRR), dated 09/02/2021, revealed Resident #420 had an unsteady balance related to his/her diagnosis of weakness. Per review, Resident #420 had an adaptive behavior noted of an eight (8) year, five (5) month old. Continued review revealed Resident #420 had a history of being verbally aggressive with caregivers when things did not go his/her way. The facility assessed the resident as noncompliant at times. Further review revealed Resident #420's Intelligent Quotient (IQ) was noted to range from forty-two (42) to sixty (60) which indicated a moderate degree of cognitive limitation. Interview with NA #3, on 12/02/21 at 3:40 PM, revealed on 11/25/2021, she had observed CNA #94 enter Resident #420's room while the resident was sitting on the toilet in his/her restroom. NA #3 stated she observed CNA #94 poke Resident #420 on the forehead which caused the resident's head to go backwards. She stated Resident #420 became upset and stood up trying to move towards CNA #94 to hit the CNA and the resident started to stumble. Per interview, at that time, CNA #94 placed his opened hands on Resident #420's upper chest area near his/her shoulders and pushed the resident backwards causing him/her to fall down. Further interview revealed Resident #420 notified LPN #38 that CNA #94 had pushed him/her down which caused the resident to scratch his/her back. NA #3 stated she ultimately decided to notify the facility of the incident after her shift ended at 3:00 PM, and she had gone home, approximately six (6) hours after the incident. She stated she had been educated to report incidents; however, she did not known to whom she was to report them to. Interview with LPN #38, on 12/04/2021 at 12:05 PM, revealed after the resident's shower, Resident #420 reported to him that CNA #94 pushed him/her. Further interview revealed he did not report what Resident #420 told him as potential abuse at that time. The LPN stated he ultimately forgot to report the incident due to the resident's past history of embellishing/fabricating the truth. LPN #38 stated he had received the abuse education provided by the facility, and knew he should have reported the incident immediately. However, he had not done so. Interview with the Director of Nursing (DON) on 12/04/2021 at 5:19 PM, revealed she did not feel there had been a failure in the facility's Administration. Per interview, Resident #69 had no prior sexual behaviors directed toward other residents, so there was no failure in care planning for the residents, prior to the 11/29/2021 facility self-reported sexual abuse allegation. Continued interview revealed the incident involving Resident #420, on 11/25/2021, which staff initially failed to report, revealed the facility terminated the staff involved as they were trained on reporting, which had been part of the facility's previous POC. The DON stated once administration became aware of the allegation, they had responded appropriately. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the facility's Interim Administrator on 12/03/2021 at 3:40 PM, and again on 12/04/2021 at 4:33 PM, revealed her role was to oversee the operations of the facility. She revealed she had assisted in formulating a Plan of Correction for the previous deficient practice cited. Per interview, the Interim Administrator had been performing the auditing from the facility's prior Plan of Correction. Per interview, her job was to conduct some of the audits and ensure other audits were being conducted properly. She revealed she had taken it upon herself to oversee the facility's staff education process, because she felt there was room for improvement, as the staff had been re-educated multiple times. In reference to the 11/29/2021 facility reported sexual abuse allegation involving Resident #69 and Resident #420, she stated she did not believe there had been a failure on the facility's part which resulted in sexual abuse. Continued interview revealed no sexual abuse had occurred due to the enhanced supervision provided by facility staff. Per interview, the enhanced supervision the facility had provided for Resident #69 and other residents was nursing staff making more frequent resident rounds, assigning a full-time Activities staff person to the 7th floor (where Resident #69 resided), and initiation of more activities for the residents on that floor. According to the Interim Administrator, as she had no clinical background, she could not speak to the care planning issues identified. She said she could only say both Resident #69 and Resident #410 had been discussed in the Interdisciplinary Team (IDT) meetings during the three and a half (3 1/2) weeks she had been the Interim Administrator. Interview revealed the discussion in the IDT meetings for both residents centered around Resident #69's aggressive and verbal behaviors, and Resident #420's rejection of care. Regarding the facility reported physical abuse allegation involving Resident #420, the Interim Administrator said the facility had followed its plan of correction by terminating staff who failed to report suspected abuse. Interview with the Regional Director of Operations (RDO) on 12/04/2021 at 5:55 PM, revealed the Administrator's job was to make sure the facility's PoC was implemented as written, and audits were conducted per the PoC. The RDO revealed the Administrator was to ensure any patterns identified in the audits were examined, and plans were being put into place, as needed, to address any issues identified. Per interview, a great deal of time was spent by the facility to ensure staff understood abuse reporting, what to report, when to report, and who to report incidents to. She stated per the PoC, staff who failed to report incidents were subject to disciplinary action. Continued interview revealed as there had been a failure on staff's part to report the incident involving Resident #410, the decision was made to terminate that staff person. Further, she stated the person currently in the Administrator role, was managing things in the facility effectively. Interview with the Regional [NAME] President (RVP) on 12/04/2021 at 6:58 PM, revealed the RDO oversaw the Administrator and his/her job duties. Per interview, he received daily follow-up regarding the facility from the RDO and was a participant in the facility calls on Tuesdays and Thursdays. He stated he took ownership of any decisions, and if the facility fell short, he took responsibility for it and saw that it was corrected. (refer to F-600, F-609 and F-656) 42857 The facility took the following actions to remove the Immediate Jeopardy (IJ): (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. The RDO was to review all resources available, and the Administrator and IDT were to ensure resources were available and utilized. The RDO would monitor weekly for four (4) weeks, then monthly for three (3) months. The RDO or the Registered Nurse Consultant (RNC) was to be present in the facility seven (7) days a week until compliance was met. The RDO or RNC was to update the RVP until compliance was achieved. 2. The Administrator and the Interdisciplinary Team Members (IDT) were educated on the resources available for the facility. The State Survey Agency (SSA) validated the facility took the following actions: 1. Interview with the RDO, on 12/09/2021 at 3:13 PM, revealed she reviewed all resources available for the facility with the Administrator and IDT. She revealed she was monitoring to ensure all resources were utilized. Per interview, she was present in the facility seven (7) days a week, and had been providing daily updates to the RVP to ensure continuing compliance was being met. 2. Interview with the IDT, on 12/09/2021 at 2:43 PM, verified the completion of an in-service regarding available resources for the facility. Review of the facility's documentation revealed the IDT, which included the Administrator, had received the in-service education on resources available for the facility. Interview with the IDT (which included the Administrator, DON, Assistant DON, Unit Managers, Minimum Data Set (MDS) Coordinator, Social Services (SS) Director, Activity Director, Dietary Manager, Rehabilitation (Rehab) Manager, Medical Director, and the RDO, on 12/09/2021 at 2:25 PM, revealed they had received in-service education on the resources available to the facility to ensure compliance was maintained.

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 28707 Based on interview, record review, review of the facility's policy and previous Plans of Correction (POCs) for the 12/06/2019 and the 07/03/2021 Recertification Surveys, it was determined the facility failed to have an effective Governing Body responsible for establishing policies and ensuring the implementation of the policies regarding the management and operation of the facility. The facility failed to maintain substantial compliance, in the areas of 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation (F600 and F609); and, 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F656). Review of the 12/06/2019 Recertification Survey revealed the facility was cited at 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation (F600) at a Scope and Severity of an E; and, at 42 CFR 483.21 Comprehensive Resident Centered Care Plans (F656) at a Scope and Severity of a G. Review of the 07/03/2021, Recertification Survey, revealed the facility was again cited at 42 CFR Freedom from Abuse, Neglect and Exploitation (F600); and 42 CFR 483.21 Comprehensive Resident Centered Care Plans (F656) both at a Scope and Severity of a J. As those were repeat deficiencies, the State Survey Agency (SSA) additionally cited 42 CFR 483.70 Administration (F835 and F837) and 42 CFR 483.75 Quality Assurance and Performance Improvement (F867) all at a Scope and Severity of a J, The facility was also cited at 42 CFR Freedom from Abuse, Neglect, and Exploitation (F609) at a Scope and Severity of a J. The facility's failure to provide an effective Governing Body responsible for establishing and implementing policies regarding the management and operation of the facility has caused or is likely to cause serious injury, harm, impairment, or death to residents. Immediate Jeopardy was identified on 12/04/2021 and was determined to exist on 10/17/2021, at 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation (F600) (F609), 42 CFR 483.21 Comprehensive Resident Centered Care Plans (F656), 42 CFR 483.70 Administration (F835) (F837) and 42 CFR 483.75 Quality Assurance and Performance Improvement (F867) all at a Scope and Severity of a J. The facility was notified of the Immediate Jeopardy on 12/04/2021. In addition, Substandard Quality of Care (SQC) was identified in 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation (F600 and F609). An acceptable removal plan was received on 12/07/2021 alleging removal of the Immediate Jeopardy on 12/08/2021. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An Extended Survey and Immediate Jeopardy Removal Validation Survey were concluded on 12/09/2021 which determined the Immediate Jeopardy had been removed on 12/08/2021, as alleged, prior to exit on 12/09/2021. The remaining non-compliance in the areas of 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation, F600 Free from Abuse and Neglect at S/S (scope and severity) of D; F609 Reporting Alleged Violations at S/S of D; 42 CFR 483.21 Comprehensive Resident Centered Care Plan; F656 Develop/Implement Comprehensive Care Plan at S/S of D; 42 CFR 483.70 Administration, F835 Administration at S/S of D; F837 Governing Body at S/S of D; and, 42 CFR 48.75 Quality Assurance and Performance Improvement, F867 QAPI/QAA Improvement Activities while the facility developed and implemented a Plan of Correction and monitored the effectiveness of the systemic changes. The findings include: Governing Body policy requested - none received Review of the facility's Plan of Correction for the Recertification Survey, dated 07/03/2021, under F-600 revealed all staff were inserviced beginning 06/21/2021 on the facility's abuse policy. Per the PoC, residents with new, continuing, or worsening behaviors would be reviewed in the weekly behavior meeting. Continued review revealed the Behavior Tracking Tool All Staff Usage was initiated on 09/10/2021, to report new, continuing and worsening behaviors to the IDT. Per the PoC all new, continuing and worsening behaviors would be reviewed in the morning CQI meeting and care planned interventions updated as needed. Continued review revealed residents with increased behaviors and/or a history of aggression to staff or other residents, would be reviewed weekly in the Behavior Meeting beginning 09/10/2021. Care plan and treatment regimens would be adjusted as needed. The Social Services Director would report to the QAPI committee weekly a summary of the weekly behavior meeting. If any patterns were identified, an Action Plan would be written and monitored weekly by the Administrator until resolved. Review of the facility's Plan of Correction for Recertification Survey, dated 07/03/2021, under F-609 revealed education was conducted on 09/03/2021 and completed on 09/10/2021 for all staff. Per the PoC, the education included the facility's abuse policy focusing on what abuse was, reporting allegations and suspected abuse/neglect, who to report abuse and what to report. Per the PoC, auditing would be completed and presented to the QAPI Committee weekly for review and recommendations until desired threshold of 100% compliance was met for three (3) consecutive months. If any patterns were identified, an Action Plan would be written and monitored weekly by the Administrator until resolved. Review of the facility's Plan of Correction for the Recertification Survey, dated 07/03/2021, under F-656, revealed residents with increased behaviors were to be reviewed weekly in Behavior Meetings, with care plans adjusted as needed to include nursing interventions. This information was to be reported to the QAPI committee weekly. Review of the facility's Plan of Correction for Recertification Survey dated 12/09/2019, under F-600 revealed an inservice for all staff including agency was held 01/16/2020 through 02/05/2020. Continued review revealed the education presented included the facility's abuse policy, resident rights (to include the right to be free from abuse in any form), Care Planning for residents with behaviors to include redirection and supervision. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Review of Resident #69's Behavioral Notes revealed Resident #69 exhibited sexual behaviors directed towards staff on 10/17/2021 and 10/19/2021; however, there was no documented evidence the facility developed and implemented a care plan to address the behaviors, per the facility's PoC. Review of the facility's investigation for an alleged sexual abuse incident involving Resident #69 and Resident #410, revealed on 11/29/2021 at approximately 8:30 PM, a staff member observed Resident #69 lying fully clothed on his/her room floor. Per the report, the residents' knees were touching, and Resident #410 had his/her pants and brief pulled below the knees with his/her genitalia exposed to Resident #69. Continued review revealed the residents were immediately separated by staff and assessed without injury noted. 2. Per interview, the facility failed to protect Resident #420 from abuse. Certified Nursing Assistant (CNA) #94 was observed by Nursing Assistant (NA) #3 to poke Resident #420 on the forehead while the resident was sitting on his/her toilet. Resident #420 became upset, stood up and tried to walk towards CNA #94 and started to stumble. NA #3 then observed CNA #94 place his hands, open palmed, on Resident #420's chest and pushed the resident backwards, causing him/her to fall backwards onto the wall. Resident #420 received an abrasion to his/her back and a knot to his/her hip as a result of the fall. NA #3 failed to immediately report the allegation and waited until after her shift (approximately six hours). LPN #38 failed to report the allegation when Resident #420 reported the incident to LPN #38. Interview, on 12/02/2021 at 1:34 PM with the facility's Minimum Data Set (MDS) Director, revealed facility management was on phone calls with Corporate staff all the time. She stated any time there was an unusual occurrence, such as a reportable event (defined as any event required to be reported to the SSA), the Governing Body would review the incident information before it was sent to the State Survey Agency. Interview with the DON on 12/02/2021 at 2:58 PM, revealed the RDO had audit tools for the previous PoC and was responsible for ensuring all the audits performed were in compliance. The DON said to ensure the audits were performed as required, she called the facility on shifts when she was not present, and instructed a staff person to go floor to floor, asking staff members the abuse prevention questions, and they were to report the results of the staff interviews to her. The DON said, specific to former citations of F600 and F609, the facility was monitoring the newly admitted and readmitted residents to determine their preference regarding sexual desire, and the capacity to consent. Further interview revealed protecting residents was a part of the facility's abuse policy, and if an event (incident) occurred, the facility immediately initiated an investigation, which was was the case for the currently cited incidents. Interview with the Regional Nurse Consultant (RNC) on 12/04/2021 at 6:38 PM, revealed the Governing Body, and Regional [NAME] President (RVP), had been to the facility on and off and there were conference calls with the CEO and CNO. He revealed the Governing Body was kept aware of what was going on in the facility. Per interview, the Governing Body had been on several event (reportable incidents per the RNC) calls, as well as, the normal Tuesday and Thursday calls held every week where the progress of the previous POC had been reviewed. The RNC stated the abuse allegation involving Resident #420, and the sexual abuse allegation involving Resident #69 and Resident #410, cases of event calls to discuss the incidents, he and the members of the Governing Body had been on those calls. Further interview revealed the RVP was always on all those phone calls, and the facility's CNO and CEO, who were also a part of the Governing Body, were on some of the phone calls as well. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the facility's Regional Director of Operations (RDO) on 12/02/2021 at 2:24 PM and again on 12/04/2021 at 5:55 PM, revealed Corporate had shifted from weekly reviews with the Administrator to twice weekly phone calls with the Administrator and other facility staff which included the Director of Nursing (DON), Regional Nurse Consultant (RNC) Regional [NAME] President (RVP), and at times, with the Chief Nursing Officer (CNO) and Chief Executive Officer (CEO). Per interview, the RNC was stationed at the facility full time as a resource. She stated during phone calls, the Corporate and facility staff reviewed where the facility was with their PoC, and any new concerns were discussed, along with any need for additional resources. Continued interview revealed the Governing Body was kept informed about what the facility was doing, with event phone calls which were related to incidents that were reportable to the State Survey Agency. The RDO stated the event calls were in addition to the normal phone calls the facility held with the Governing Body on Tuesdays and Thursdays every week. Per interview, education on abuse and reporting was provided on more than one occasion for three (3) of the four (4) staff involved in the physical abuse allegation involving Resident #420. The RDO revealed they were trained to report and failed to do so. Further interview revealed the facility spent a lot of time ensuring staff understood the reporting process, such as, how to report, what to report, and when to report incidents. Continued interview revealed she wasn't sure what the issue with Resident #69's care plan was. She believed appropriate interventions were in place for the 10/17/21 and 10/19/21 incidents involving staff, and stated Resident #69 had no history of sexual behavior in more than a year. She stated Resident #69 had not expressed wanting to have sex, and she did not feel there had been a failure to develop or implement new interventions due to behaviors on 10/17/21 and 10/19/21. Interview with the RVP on 12/04/2021 at 6:58 PM, revealed the Administrator reported directly to the RDO, who was considered part of the Governing Body. Per interview, the RVP followed up with the RDO daily. He revealed he had been kept informed on what was going on at the facility and was responsible for the facility, as well as, other facilities in his region. Per the RVP, he was perplexed as to why the State Survey Agency team was considering the identified concerns at the Immediate Jeopardy (IJ) level, and did not perceive the facility had done anything wrong. Further interview revealed the RVP said he did not feel the concerns were at the IJ level due to the increased vigilance at the facility and improvements in residents' care. 42857 The facility took the following actions to remove the Immediate Jeopardy (IJ): 1. The RNC and/or the RDO were to provide seven (7) days a week coverage. 2. Daily updates would be provided to the RVP daily by the RNC or RDP until compliance was achieved. The Governing Body, RDO or RNC were to report back to the Governing Body weekly to ensure progress was being made towards compliance. 3. The facility's Governing Body was to be represented and involved in the QAPI process. 4. Audit results were to be presented to the QAPI Committee weekly until compliance was met. The State Survey Agency (SSA) validated the facility took the following actions: (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Interview with the RDO, on 12/09/2021 at 3:13 PM revealed she and/or the RNC would be in the facility, seven (7) days a week until compliance was achieved. 2. Interview with the RDO, on 12/09/2021 at 3:13 PM, revealed she was notifying the Regional [NAME] President (RVP) through daily updates at that time and when the facility decided compliance had been maintained they would make the determination to change to twice weekly updates. Interview with the RVP, on 12/09/2021 at 3:41 PM, revealed he had been receiving updates from the RDO or RNC daily at that time. He revealed during the telephone calls they discussed any events of the day; the percentages of the staff education completed; whether any additional resources were needed; the outside firm's focus areas and it's progress; and the general progress of the facility on its Plan of Correction and status. 3. Interview with the Governing Body Representative, on 12/09/2021 at 3:41 PM, revealed he was participating in the facility's QAPI meetings daily. Per interview, prior to the current jeopardy notices, he had been participating twice weekly in the QAPI meetings, and participating in the event calls. He further revealed he would continue to participate as listed now in the facility's Immediate Jeopardy removal plan. 4. Interview on 12/09/2021 at 2:25 PM, with the QAPI Committee members (which included the Administrator, Director of Nursing (DON), Assistant DON, Unit Managers, Minimum Data Set (MDS) Coordinator, Social Services (SS) Director, Activity Director, Dietary Manager, Rehab Manager, Medical Director, and the RDO, revealed the QAPI Committee was reviewing the results of all the facility's audits weekly and had not identified any concerns at the time of the interview. Further interview revealed however, if concerns were identified, the team would discuss the concerns and generate a plan to address them.

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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 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 28707 Based on observation, interview, record review, and facility policy review, it was determined the facility failed to have an effective process in place to address system failures through regularly scheduled Quality Assurance Performance Improvement (QAPI) meetings. The facility failed to identify quality of care deficiencies and failed to take actions aimed at performance improvement to ensure improvements were realized and sustained. Repeated deficient practice was cited at 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation (F600 and F609); and 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F656). The same deficiencies were cited during the 07/03/2021 Recertification Survey. Review of the Plan of Correction for the Abbreviated Survey dated 07/03/2021 revealed data collected in the weekly QAPI meetings would be reviewed, as well as the minutes of the meeting, where areas of concern that required an Action Plan or a PIP (Performance Improvement Plan) were decided upon. Per review any written Action Plan or PIP would be reviewed for appropriateness and accuracy and progress towards the end goal, with any concerns to be addressed. Further review revealed the alleged compliance date was 09/18/2021. However, record review revealed the facility failed to ensure residents were free from abuse; failed to report allegations of abuse to the State Survey Agency (SSA) within two (2) hours of the alleged violation; failed to ensure resident care plans were developed; and, failed to ensure the facility was effectively managed with an quality assurance program to maintain substantial compliance. (Refer to F600, F609, and F656). The facility's failure to provide an effective Quality Assurance Performance Improvement (QAPI) Program responsible for planning, developing, implementing, and maintaining an effective, comprehensive, and data driven program in accordance with Federal Guidelines focused on indications of outcomes in the facility has caused or is likely to cause serious injury, harm, impairment, or death to residents. Immediate Jeopardy (IJ) was identified at 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation, F600 and F609; 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F656; 42 CFR 483.70 Administration, F835 and F837; and, 42 CFR 483.75 Quality Assurance and Performance Improvement all at a Scope and Severity of a J. The Immediate Jeopardy was determined to exist on 10/17/2021. The facility was notified of the Immediate Jeopardy on 12/04/2021. Additionally, Substandard Quality of Care (SQC) was identified in 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation (F600 and F609). An acceptable removal plan was received on 12/07/2021 alleging removal of the Immediate Jeopardy on 12/08/2021. (continued on next page)

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	185122	A. Building B. Wing	12/09/2021

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview, on 12/02/2021 at 11:37 AM, with the Assistant Director of Nursing (ADON), who had previously been the Staff Development Coordinator (SDC), revealed she attended the facility's QAPI meetings which were held on Thursdays. Per interview, the QAPI meetings were held to discuss identified deficiencies that were being worked on through the auditing process. In addition, she stated the facility had also implemented weekly behavior meetings with social services and the IDT, during which all residents' behaviors were discussed. Further interview revealed she had assisted with the audits from the previous POC regarding new resident admissions and readmissions of residents. The ADON stated she had audited to ensure residents Brief Interview for Mental Status (BIMS) score had been assessed; the question regarding whether a resident desired sexual contact had been asked; and, that the residents' care plans reflected their response with interventions in place. Interview with the facility's Activities Director on 12/02/2021 at 2:11 PM, revealed she attended the weekly QAPI meetings as a result of the previous POC. She stated there were corporate people on voice call during the meetings. The Activities Director stated resident behaviors were discussed during the meetings, and that helped them to come up with interventions for the residents. Further interview revealed the solutions discussed in the QAPI meetings were pretty much working. However, she was not a part of the facility's auditing process. Interview with the DON on 12/02/2021 at 2:58 PM, revealed she had attended the weekly QAPI meetings as part of the previous POC. Per interview, she participated in discussion of the audits conducted, and if issues were identified she assisted with how to correct them. The DON stated the QAPI meetings were now a lot more in depth than they had been in the past, with much greater information on what had been identified, and what the facility was doing to correct the identified issues. Interview on 12/04/2021 at 5:19 PM, revealed the DON stated that to her knowledge, there had been no indications of previous sexual desire by either Resident #69 or Resident #410. She stated she felt there had been no failure on the facility's part regarding the incident involving those residents. The DON stated she did not think there was a failure regarding reporting the incident in which Resident #420 was allegedly abused by staff. Further interview revealed the facility had provided staff training as per the previous POC. However, four [4] staff failed to follow that education regarding the reporting of incidents; and, three [3] of those staff failed to immediately report potential abuse of a resident. In addition, two [2] residents that the facility assessed as unable to give consent for sexual contact were not provided the supervision necessary to keep them safe. The DON stated the staff involved failed to follow the training they received. As a result, they were terminated from employment. Interview with the facility's Regional Nurse Consultant (RNC) on 12/02/2021 at 3:22 PM, revealed he attended the weekly QAPI meetings. He stated the audits being managed by the Administrator were reviewed to determine if they were being completed as per the previous POC, and anything that needed to be discussed was discussed. According to the RNC, staff in the QAPI meetings had gone through to ensure everyone was educated on abuse as required. He stated there had been extensive abuse education for all staff working in the building. Further interview revealed, any issues which arose during the facility's IDT meetings were often discussed in ad-hoc QAPI meetings, and then reviewed again in the monthly QAPI meetings. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 12/04/2021 at 6:38 PM, revealed the RNC stated he made suggestions and recommendations and encouraged the use of his recommendations regarding the previous POC. He stated he had helped provide some of the staff education on abuse and different things like that. Interview revealed the facility had educated staff on reporting incidents in a timely manner, and immediately if abuse was suspected. Continued interview revealed staff were trained to report incidents to an immediate supervisor, Administrator, and DON. Per the RNC, the immediate supervisor was to report the incident to the DON and Administrator per the education. Further interview revealed if staff felt their immediate supervisor was not doing what needed to be done, they were to follow the facility's chain of command and report the incident to the DON or Administrator. He further revealed the Administrator was to adhere to maintaining the facility's QAPI meetings, and ensuring all pieces and parts of identified concerns/issues were followed up on. Interview with the facility's Interim Administrator on 12/03/2021 at 3:40 PM and again on 12/04/2021 at 4:33 PM, revealed her role was to oversee the operations of the facility. According to the Interim Administrator, she had provided assistance in developing the facility's previous Plan of Correction (POC). Continued interview revealed she had been performing and overseeing the auditing indicated on the facility's previous POC. The Interim Administrator revealed she had taken it upon herself to supervise the staff education process for the facility as there was room for improvement with the staff having been re-educated multiple times. Additional interview revealed she could not answer 100% what the facility's process was regarding care planning. She stated both Resident #69 and Resident #410 had been reviewed weekly in the facility's behavior meeting. Per interview, the facility had been reviewing Resident #69 for his/her aggressive behaviors, and Resident #410 for his/her rejection of care. According to the Interim Administrator, she was aware of Resident #69's previous sexually inappropriate behavior. Interview on 12/04/2021 at 5:55 PM, with the Regional Director of Operations (RDO) revealed there had been no failure in the facility's QA process. She stated ad-hoc QAPI meetings had been occurring for the 11/29/2021 abuse incident involving Resident #69 and Resident #410 and, also for the incident involving Resident #420. She stated the action plans had been put into place for both incidents, and the facility had followed their previous POC as written. Interview with the Regional [NAME] President (RVP) on 12/04/2021 at 6:58 PM, revealed he had been participating in the facility's QAPI meeting reviews and discussions. He stated he had been ensuring the facility had the necessary resources on site to address any needs. He revealed he had been on follow up calls with the facility on Tuesdays and Thursdays, and was in daily contact with the RDO, who participated in the QAPI reviews with the facility's team. 42857 The facility took the following actions to remove the Immediate Jeopardy (IJ): 1. On 12/07/2021, the QAPI Committee and Medical Director reviewed and approved the facility's standardized agenda. 2. The QAPI Committee was in-serviced by the RDO on the revised QAPI plan. (continued on next page)

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