STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185127	A. Building B. Wing	02/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Centre for Health & Rehabilitation	642 North Third Street Danville, KY 40422

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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** 42932 Based on interview, record review, and facility policy review, it was determined the facility failed to ensure four (4) of thirty-five (35) sampled residents (Resident #10, Resident #67, Resident #174, and Resident #175), who were all cognitively impaired and lacked the capacity to consent to sexual relations, were protected from sexual abuse. In addition, it was determined the facility failed to protect two (2) of six (6) sampled residents (Resident #37 and Resident #174) from physical abuse. 1.Review of the facility's investigation documentation revealed on 12/06/2021, Resident #174 and Resident #10 were found by staff in Resident #10's room. Both residents were observed to have their pants down to mid-thigh, and Resident #10 had his/her hand on Resident #174's thigh. Resident #10 was placed on one (1) to one (1) supervision; however, the facility failed to ensure Resident #174 was provided increased supervision for his/her safety and the safety of other residents. 2. Review of the facility's investigation documentation revealed on 12/27/2021, revealed Resident #174 was involved in a second (2nd) allegation of abuse. Resident #174 was found by staff in Resident #175's room. Per the allegation, Resident #174 was found behind the door in Resident #175's room with his/her clothing disheveled and Resident #175 was lying on the bed pulling at the waist of his/her pants. Review of the residents ' medical record and interviews with staff revealed the facility failed to provide increased supervision for the residents, to ensure their safety, as well as, the safety of other residents. 3. Review of the facility's investigation documentation and interview with facility staff revealed on 01/15/2022, Resident #175 was observed in a second (2nd) sexual abuse allegation. Resident #67 was found in Resident #175's room actively engaged in sexual intercourse. Per record review, there was no documented evidence the facility provided increased monitoring and/or supervision to ensure the safety of Resident #175 and other residents. 4. In addition, on 12/21/2021, Resident #174 wandered into Resident #37's room. Staff found Resident #174 with water on his/her face and observed Resident #37 holding an empty cup. Staff also observed both residents pulling each other's hair, and immediately separated the residents. Resident #37 was placed on one (1) on one (1) monitoring following the incident and referred to psych for evaluation. However, the facility failed to provide increased supervision and monitoring for Resident #174, of whom had a history of wandering into other residents ' rooms. (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	The facility's failure to ensure residents 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 on 02/12/2022 and determined to exist on 12/06/2021 at 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation (F600, F607, and F610), 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F657), and 42 CFR 483.70 Administration (F835). The facility was notified of the Immediate Jeopardy on 02/12/2022. An acceptable Immediate Jeopardy removal plan was received on 02/22/2022, which alleged removal of the Immediate Jeopardy on 02/19/2022. The State Survey Agency determined the Immediate Jeopardy was removed as alleged on 02/19/2022, prior to exit on 02/24/2022, which lowered the scope and severity (s/s) to D at 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation, (F600, F607 and F610) 483.21 Comprehensive Resident Centered Care Plans (F657) and 42 CFR 483.70 Administration (F835), while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility ' s policy titled, Abuse, Neglect and Misappropriation of Property, dated 05/08/2019, revealed it was the facility's intention to prevent the occurrence of abuse, neglect, exploitation, injuries of unknown origin and misappropriation of resident property. Continued review revealed the facility intended to assure all alleged violations of federal and state laws which involved abuse, neglect, exploitation, injuries of unknown origin and misappropriation of resident property were investigated. Review revealed all alleged violations were to be reported immediately to the facility Administrator, State Survey Agency, and other state and local agencies in accordance with federal and state law. The policy review revealed abuse included physical, mental, verbal and sexual abuse, and included deprivation by a caretaker of goods and services that were necessary to attain or maintain physical, mental and psychosocial well-being. Further review revealed sexual abuse included, but was not limited to, any physical contact with a resident's body that was not reasonably related to appropriate provision of ordered care or services. In addition, review revealed the policy presumed all abuse, as defined in the policy caused physical harm, pain or mental anguish to any resident, even if he or she did not understand the incident. 1.Review of the facility's Incident Report dated 12/06/2021, revealed Kentucky Medication Aide (KMA) #1 responded to Resident #10's call light. Review revealed upon entering the room KMA #1 observed Resident #174 lying on the bed with pants pulled down to thighs, and Resident #10 seated at the head of the bed, feet on floor with his/her pants pulled down to his/her knees. Continued review revealed Resident #10 had been observed to have his/her hand on Resident #174's thigh. Further review revealed both residents were immediately separated, and a head to toe skin assessment was conducted of both residents. The Incident Report further revealed no injuries were found on either resident, and neither resident was able to recall the incident. In addition, review revealed Resident #10 was placed on one (1) to one (1) monitoring. Review of Resident #174's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses of Unspecified Dementia with Behavioral disturbance; Dysphagia; and Wandering. Continued review revealed Resident #174 was discharged home with his/her spouse as a planned discharge on 12/28/2021. (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 Admission Minimum Data Set (MDS) Assessment, dated 11/05/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of one (1) out of fifteen (15), which indicated Resident #174 was severely cognitively impaired. Continued review of the Admission MDS Assessment revealed Resident #174 had been assessed to have behaviors that put the resident at risk of physical illness or injury. Further review of the MDS Assessment revealed Resident #174 had experienced behaviors that significantly interfered with the resident's care and wandering behaviors which significantly intruded on the privacy or activities of others on one (1) to three (3) occasions during the assessment period. Review of Resident #174's Comprehensive Care Plan, dated 10/29/2021, revealed the facility had noted a problem area of wandering with interventions that included to administer medications as ordered and observe for effectiveness of the medications; intervene as needed to protect the rights and safety of others; and approach in a calm manner. Further review revealed additional interventions which included for staff to divert the resident's attention, remove him/her from situations as necessary, and take to the resident to another location as needed. Review of the Care Plan further revealed a goal for the resident not to harm self or others secondary to his/her behaviors. In addition, review of the Care Plan revealed no documented revisions had been made to Resident #174's care plan following the incident which occurred on 12/06/2021, involving Resident #10. Review of Resident #174's Psychiatric Progress Note, dated 12/07/2021, revealed the resident had been referred for an acute psychiatric visit related to inappropriate sexual behaviors with other residents, aggression, and insomnia. Further review revealed Resident #174 had recently exhibited more aggressive behaviors and was wandering into other residents' rooms. Review of Resident #174's Physician Orders revealed an order for Zoloft 25 milligram (,) given by mouth every evening, initiated on 12/08/2021, for anxiety and insomnia. Behavior monitoring records for Resident #174 for after the incident on 12/06/2021 were requested; however, the facility did not provide any behavior monitoring records for the resident for after 12/06/2021. Review of Resident #10's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses of Dementia with Behavioral Disturbance; Wandering; and COPD. Review of the Quarterly MDS Assessment, dated 11/18/2021, for Resident #10, revealed the facility assessed the resident with a BIMS score of three (3), which indicated severe cognitive impairment. Continued review of Resident #10's Minimum Data Set (MDS) Assessment revealed the facility assessed the resident as having no presence of physical, verbal or other behavioral symptoms during the assessment period. Review of Resident #10's Comprehensive Care Plan, dated 05/03/2021, revealed the facility had identified a problem area for wandering and sexually inappropriate behavior. Continued review of the wandering problem area revealed interventions which included target behavior monitoring for sexually inappropriate behaviors each shift; monitoring the resident's interaction with other residents and report inappropriate behaviors. Further review revealed the interventions also included for staff to administer Resident #10's medications as per order; perform every fifteen (15) minute checks of the resident; and obtain a psychiatric (psych) consult as needed. Review further revealed a goal for Resident #10 not to harm self or others secondary to his/her behaviors. (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 #10's physician orders revealed an order, dated 12/06/2021, for Viibryd 10 mg tablet by mouth every day for seven (7) days which was to start on 12/07/2021 and end on 12/13/2021. Further review of the physician ' s orders revealed an order, dated 12/13/2021, to begin Paxil 10 mg by mouth daily for Anxiety on 12/14/2021. Review of Resident #10's Behavior Monitoring sheets revealed the resident had been placed on one (1) to one (1) monitoring beginning 12/06/2021. Continued review revealed Resident #10 remained on the one (1) to one (1) monitoring during the course of the survey with no further incidents. Review of Resident #10's Psychiatric Progress Note, dated 12/07/2021, revealed the resident had been referred related to recent sexually inappropriate behaviors, increased anxiety and for evaluation of possible pharmacological intervention to aid with the sexually inappropriate behaviors and Anxiety. Continued review revealed a recommendation for a gradual taper and dose reduction of Viibryd (antidepressant medication used to treat Major Depressive Disorder) 20 milligram (mg) daily. Further review revealed to reduce the Viibryd to 10 mg daily, and eventually discontinue the medication after seven (7) days, then initiate Paxil (antidepressant medication and also used to treat Anxiety) 10 mg by mouth daily. Observation of Resident #10 on 02/08/2022 at 12:40 PM, revealed the resident seated in the dining area interacting appropriately with other residents and a one (1) on one (1) staff member present with him/her. Observation of Resident #10, on 02/10/2022 at 10:34 AM, revealed the resident lying on the bed with eyes closed, and a one (1) on one (1) staff member present in the room. Review of the facility's investigation documentation for the 12/06/2021 incident involving Resident #10 and Resident #174, revealed the investigation concluded on 12/10/2021. Continued review revealed the facility did not substantiate sexual abuse had occurred as there had been no intent due to both residents having a diagnosis of Dementia and BIMS scores below eight (8). Further review revealed sexual abuse was not substantiated additionally because Resident #10 had his/her hand on Resident #174's thigh, with no other touching observed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Kentucky Medication Aide (KMA) #1, on 02/09/2022 at 9:35 AM, revealed she had been working when the incident occurred between Resident #174 and Resident #10 on 12/06/2021. KMA #1 stated she had been charting at the nurse's station when Resident #10's call light began going off, and she went to answer it. Per KMA #1, when she entered Resident #10's room through the closed door she observed the privacy curtain was also closed. Continued interview revealed she pulled the curtain back, and walked to the foot of the bed where she observed Resident #10 sitting at the head of the bed sitting upright with his /her feet on the floor, and his/her pants down to mid-thigh. KMA #1 stated she also observed Resident #174 with his/her pants down to mid-thigh, and Resident #10's hand had been on Resident #174's thigh. KMA #1 revealed she immediately separated the residents, and notified her charge nurse, Registered Nurse (RN) #2. Interview revealed RN #2 then notified the Administrator and Director of Nursing (DON) about the incident. She stated Resident #174 had not had wandering tendencies and had not had any incidents of sexually inappropriate behaviors prior to the incident with Resident #10 on 12/06/2021. KMA #1 revealed Resident #174 had been taken to his/her own room, and Resident #10 was placed on one (1) to one (1) monitoring immediately following the incident. Further interview revealed she was unsure of any specific interventions put in place for Resident #174 following that incident. KMA #1 further revealed, when asked if she had been trained on identifying and reporting abuse and management of residents with behaviors, she stated yes, she had been trained on abuse and management of behaviors. In addition, she revealed staff attempted to redirect residents if they were having behaviors and would attempt to engage them in an activity or conversation. She additionally revealed residents experiencing behaviors might also be placed on one (1) to (1) monitoring. Interview with State Registered Nurse Aide (SRNA) #6, on 02/10/2022 at 11:00 AM, revealed she had been working on 12/06/2021, when the incident occurred between Resident #174 and Resident #10. She stated she had not observed any inappropriate sexual behaviors or inappropriate touching with either resident during the time she provided care prior to 12/06/2021. SRNA #6 revealed she had been on break at the time the incident occurred. Continued interview revealed Resident #10 had been placed on one (1) to one (1) monitoring immediately after the incident on 12/06/2021. She stated Resident #174 frequently wandered into other residents' rooms, and staff would redirect him/her from the other resident's room. SRNA #6 revealed; however, she was unable to recall any specific interventions in place for Resident #174 following the incident involving Resident #10. Further interview revealed when asked if she had been trained on abuse, she stated yes, she had received abuse training and would report any potential abuse of a resident immediately to the charge nurse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Unit Manager, on 02/09/2022 at 2:44 PM, revealed she was aware of the incident involving Resident #174 and Resident #10, that occurred on 12/06/2021. She stated Resident #10 had been placed on one (1) to one (1) monitoring on 12/06/2021, when the incident occurred. Continued interview revealed Resident #10 was still on the one (1) on one (1) monitoring by staff; however, she could not recall any specific interventions that were put in place for Resident #174 following the incident on 12/06/2021. The Unit Manager stated neither resident had a history of any incidents prior to 12/06/2021. Interview revealed when an incident occurred on the unit it was discussed in the morning clinical meeting, Monday through Friday, and resident care plans and interventions were reviewed. The Unit Manager revealed attendees of the morning clinical meeting were the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers, Administrator, Social Worker, and MDS Nurse. She stated, regarding the incident on 12/06/2021 involving Resident #174, that Resident #10 had been discussed in the morning clinical meeting. Further interview revealed Resident #174 and his/her behaviors had also been discussed in the morning clinical meeting; however, she did not recall any specific interventions having been implemented for Resident #174. She further stated the facility had identified that Resident #174 wandered into other residents' rooms and should have put interventions in place following the 12/06/2021 incident with Resident #10. In addition, the Unit Manager revealed the facility should have placed Resident #174 on increased monitoring following the incident. Interview with the facility's former Social Services Director (SSD), on 02/11/2022 at 10:00 AM, revealed she had worked at the facility for about a year and left her position at the facility on 12/29/2021. She stated she had been aware of the incident involving Resident #174 and Resident #10 on 12/06/2021, and did not recall any specific interventions which had been put into place for Resident #174 following the incident. Continued interview revealed she recalled Resident #10 had been placed on one (1) to one (1) monitoring after the incident on 12/06/2021. She stated Resident #10's behavior on 12/06/2021, had been a new behavior for the resident as he/she had no history of sexual behavior prior to the incident date. The former SSD stated they had not looked at Resident #174's behaviors after the incident, as the resident was known to wander frequently on the unit, and it was difficult to keep residents from wandering into other residents' rooms. She revealed when employed at the facility, she had been involved with residents' psych consults, referrals, and recommendations related to a resident's behaviors on the unit. Interview revealed residents' behaviors had been discussed in the facility's morning clinical meetings; however, the facility had not perceived Resident #174's behaviors as instigating the incident on 12/06/2021. The former SSD stated therefore, they had not made changes to Resident #174's care plan. Further interview revealed it might have helped to have placed Resident #174 on increased monitoring; however, they had not due to Resident #10 having been placed on one (1) to one (1) monitoring following the incident. The former SSD further stated the facility had not identified potential for abuse concern related to Resident #174's increased wandering into other residents' rooms, as the resident had already been care planned for his/her wandering behaviors. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the former Administrator, on 02/11/2022 at 5:05 PM, revealed she had been the acting Administrator at the facility from June 2021 until December 20, 2021. She stated at the time of the incident on 12/06/2021 involving Resident #10 and Resident #174, she had been the facility's Abuse Coordinator. Continued interview revealed when staff was interviewed during the investigation of the 12/06/2021 incident, they stated nothing had happened as far as physical contact, except for Resident #10 having been observed with his/her hand on Resident #174's thigh. She revealed the skin assessments which had been completed of both residents, had not shown evidence of abuse. The former Administrator stated staff had not observed any other touching between the residents, and no one felt anything had happened, so she had not substantiated abuse had occurred. She stated both residents were seen by psych following the incident and Resident #10 was immediately placed on one (1) to one (1) monitoring after the incident. Further interview revealed she had received training on abuse by the company upon hire and had been trained on investigating and reporting abuse. The former Administrator further revealed the facility ensured residents were free from abuse, through screening all staff with a background check prior to hire, training the staff on abuse, and monitoring the residents for behaviors. 2. Review of the facility's Incident Report, dated 12/27/2021, revealed State Registered Nurse Aide (SRNA) #18 entered Resident #175's room for routine checks and found Resident #174 standing behind the door of the room, with his/her top disheveled and bra strap exposed. Continued review revealed SRNA #18 also observed Resident #175 lying on the bed with his/her pants and brief partially pulled down. Further review revealed the residents were immediately separated, and Resident #174 was directed back to his/her room. Review further revealed a head-to-toe assessment was completed on both residents with no injuries noted. In addition, review revealed Resident #175 had been placed on one (1) on (1) monitoring following the incident. Review of Resident #174's clinical record revealed the resident was admitted to the facility on [DATE], and was discharged home as a planned discharge with his/her spouse on 12/28/2021. Continued review revealed diagnoses which included Unspecified Dementia with Behavioral disturbance, and Wandering. Review of the Admission Minimum Data Set (MDS) Assessment, dated 11/05/2021, revealed the facility assessed Resident #174 with a Brief Interview for Mental Status (BIMS) score of one (1) which indicated he/she was severely cognitively impaired. Review of Resident #174's Comprehensive Care Plan dated 10/29/2021, revealed the facility had care planned the resident for wandering with interventions which included for staff to intervene as needed to protect the rights and safety of others, and remove Resident #174 from situations as needed, and take him/her to another location. Further review of the care plan revealed a goal for Resident #174 not to harm self or others, secondary to his/her behaviors. Additionally, review revealed no documentation of revisions made to his/her care plan following the 12/06/2021 sexually inappropriate incident, nor evidence of revisions made after the 12/27/2021 incident involving Resident #175. Review of Resident #175's medical record revealed the facility admitted the resident on 02/01/2021, with diagnoses including: Unspecified Psychosis; Parkinson's Disease; Unspecified Dementia; and Alzheimer's Disease. Review of Resident #175's Quarterly Minimum Data Set (MDS) Assessment, dated 10/29/2021, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of two (2), indicating he/she was severely cognitively impaired. (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 #175's Comprehensive Care Plan dated 11/26/2021, revealed a care plan had been developed for the resident's problem area of wandering. Continued review revealed care plan interventions which included intervening as needed to protect the rights and safety of others, and remove the resident from a situation and taking the resident to another location, as needed. Further review revealed the care plan goal was for Resident #175 not to harm self or others secondary to their behaviors. Interview with State Registered Nurse (SRNA) #7, on 02/10/2022 at 3:35 PM, revealed she had been working on 12/27/2021, when the incident occurred between Resident #174 and Resident #175. She stated she had been behind the nurse's station when SRNA #18 went into Resident #175's room during routine checks. Continued interview revealed SRNA #18 alerted her to come to assist as Resident #174 was in Resident #175's room. She stated by the time she arrived at the door to Resident #175's room, the residents had already been separated, and Resident #174 was exiting the room, with his/her shirt messed up. SRNA #7 stated Resident #175 had not had any issues of sexually inappropriate behaviors prior to the incident on 12/27/2021. Per interview with SRNA #7, Resident #174 frequently wandered into other residents' rooms and had to be redirected out of them by staff. Further interview revealed she did not recall any additional interventions which had been put in place for Resident #174; however, recalled Resident #175 had been immediately placed on one (1) on one (1) monitoring. The SRNA revealed she had been trained on abuse, and also trained on management of residents with Dementia and residents with behaviors. Interview with the Unit Manager, on 02/09/2022 at 2:44 PM, revealed she was aware of the incident with Resident #174 and Resident #175 that occurred on 12/27/2021. She stated Resident #175 had been placed on one (1) on one (1) monitoring on 12/27/2021, immediately following the incident. Continued interview revealed however, the Unit Manager could not recall any specific interventions which had been implemented for Resident #174 following the incident. She stated the facility had identified that Resident #174 wandered into other residents' rooms and should have placed the resident on increased monitoring following the incident. Further interview revealed staff had been trained on identifying and reporting abuse. Interview with the current Administrator, on 02/11/2022 at 4:23 PM, revealed she took the position of Administrator on 12/20/2021. She stated she was aware of the incident which occurred involving Resident #174 and Resident #175. Continued interview revealed she unsubstantiated the incident involving Resident #174 and Resident #175 on 12/27/2021, due to the facility having been unable to substantiate physical contact had occurred between the two (2) residents. The Administrator stated she had also been aware of the prior incident involving Resident #174; however, as the resident had already been identified as a wanderer, his/her increased behaviors had not been regarded as a concern. She revealed residents' behaviors were discussed in the facility's morning clinical meetings. Per interview, the DON, Unit Managers, SSD, Quality of Life staff person, and she all participated in the morning clinical meeting, discussed the residents ' behaviors, and reviewed and revised the residents' care plans as needed. Interview revealed facility staff was trained on managing residents with behaviors and the facility was currently working with their corporate Behavioral Health consultant on specific behavior training for staff. Further interview revealed staff was expected to provide for residents' safety, intervene as necessary, notify the Administrator, and put an immediate intervention in place after discussion with the Administrator and DON. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Review of the facility's Self-Reported Incident Form dated 01/15/2022, revealed on 01/15/2022, Kentucky Medication Aide (KMA) #3 reported to Licensed Practical Nurse (LPN) #10 that Resident #67 and Resident #175 were had been inappropriately touching one another (in a sexual manner). Further review of the facility's investigation documentation dated 01/21/2022, of the incident of inappropriate touching between Resident #67 and Resident #175 on 01/15/2022, revealed the Administrator had unsubstantiated sexual abuse had occurred based on information obtained from investigation. Review of Resident #67's medical record revealed the facility admitted the resident on 04/17/2021, with diagnoses including Chronic Diastolic (Congestive) Heart Failure, Atrial Fibrillation and Chronic Obstructive Pulmonary Disease (COPD) and Dementia. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], for Resident #67, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of two (2) indicating severely impaired cognition. Further review of the MDS revealed the facility assessed Resident #67 as having no behaviors. Review of Resident #67's Comprehensive Care Plan, dated 07/01/2021, revealed the facility care planned the resident as at risk for elopement due to attempts by him/her to elope from the facility. Review of Resident #67's Progress Notes for July 2021 revealed the resident had been noted as having a behavior of wandering around unit. Further review of the Progress Notes revealed no other behaviors documented. Review of Resident #175's medical record revealed the facility admitted the resident on 02/01/2021, with diagnoses which included Alzheimer's Disease, Unspecified Dementia, and Unspecified Psychosis. Review of Resident #175's Quarterly MDS assessment dated [DATE], revealed the facility had assessed the resident as severely cognitively impaired as indicated by the BIMS score of two (2). Review of Resident #175's Comprehensive Care Plan revealed the facility had initiated a behavioral care plan on 11/26/2021, related to sexually inappropriate behaviors. Continued review of the care plan revealed no description of the sexually inappropriate behaviors the resident had displayed. Review revealed the behavior care plan interventions included: for staff to intervene as needed to protect other residents' rights and safety; approach the resident in a calm manner; and remove him/her from situations and take to another location as needed. Further review revealed additional interventions included to provide geriatric psychiatric services as needed and monitor the resident's behavioral episodes. Review of Resident #175's Progress Notes for November and December 2021 revealed Resident #175 had displayed sexually inappropriate behaviors on 11/22/2021, which were noted as the resident had groped a staff member on the buttocks and made sexual statements. Continued review revealed a Note dated 11/26/2021, which documented Resident #175 as having threatened staff and other residents, touching staff and other residents in a sexual manner, cursing, and making vulgar statements to staff and other residents. Review of a Note dated 12/01/2021, revealed Resident #175 had made a verbal sexual comment to a staff member. Review of a Note dated 12/11/2021, revealed Resident #175 made several sexual statements to staff and pinched staff on the butt. Further review of the Progress Notes revealed on 12/20/2021, Resident #175 had exhibited sexually inappropriate behavior of hitting staff on bottoms; and on 12/27/2021, the resident was noted as having increased sexual behaviors and making comments to staff. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Centre for Health & Rehabilitation	642 North Third Street Danville, KY 40422

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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 Kentucky Medication Aide (KMA) #3, on 02/09/2022 at 8:30 PM; and 02/10/2022 at 9:55 AM revealed Resident #67 and #175 had been actively engaged in sexual intercourse on 01/15/2022 when she entered Resident #175's room. She stated she separated the residents at once and immediately reported the incident to Licensed Practical Nurse (LPN) #10. KMA #3 revealed Resident #175 had previously made inappropriate sexual comments toward staff; however, she was not aware of the resident displaying any sexual behaviors toward other residents, prior to the incident involving Resident #67 on 01/15/2022. Interview on 02/11/2022 at 11:25 AM, with Licensed Practical Nurse (LPN) #10 revealed KMA #3 reported to her on 01/15/2022, she had found Resident #67 and Resident #175 actively engaged in sexual intercourse on the bed in Resident #175's room. LPN #10 stated she notified the Administrator immediately of the residents having been found actively engaged in sexual intercourse. KMA #3 stated she filled out a witness statement detailing her observations and that Resident #67 and Resident #175 were having intercourse. Interview with Resident #175's Power of Attorney (POA), on 02/10/2022 at 11:11 AM, revealed she had been aware the resident had made sexual comments towards nursing staff at the facility. Interview with Kentucky Medication Aide (KMA) #1, on 02/09/2022 at 8:46 PM, revealed Resident #175 had been sexually inappropriate towards staff and cursed at staff. Further interview revealed; however, she had not been aware of any incidents of sexual behaviors towards other residents prior to 01/15/2022. Interview with the Unit Manager, on 02/10/2022 at 3:12 PM, revealed Resident #175 had started having sexual behaviors towards staff more recently. Further interview revealed the Unit Manager had been [NAME] [TRUNCATED]

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42932 Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure its abuse policy was implemented for two (2) of thirty-five sampled residents, Resident #67 and #175. Interview with Kentucky Medication Aide (KMA) #3 revealed that on 01/15/2022, Housekeeper #2 came to her and reported that she needed to come to the room of Resident #175. KMA #3 stated when she entered the room, Resident #67 and Resident #175 were engaged in sexual intercourse. Housekeeper #2 failed to stay with the residents to protect the residents from abuse and therefore failed to implement the abuse policy. The facility's failure to ensure that established policies and procedures were followed when allegations of abuse occurred has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 02/12/2022 and determined to exist on 12/06/2021 at 42 CFR 483. 12 Freedom from Abuse, Neglect and Exploitation (F600, F607, and F610) at a scope and severity (s/s) of a J, 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F657) s/s of a J, and 42 CFR 483.70 Administration (F835) at a s/s of a J. The facility was notified of the Immediate Jeopardy on 02/12/2022. An acceptable Immediate Jeopardy removal plan was received on 02/22/2022, which alleged removal of the Immediate Jeopardy on 02/19/2022. The State Survey Agency determined the Immediate Jeopardy was removed as alleged on 02/19/2022, prior to exit on 02/24/2022, which lowered the scope and severity to D at 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation, (F600, F607 and F610) 483.21 Comprehensive Resident Centered Care Plans (F657) and 42 CFR 483.70 Administration (F835), while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy titled, Abuse, Neglect, and Misappropriation of Property, last reviewed and revised 05/08/2019, revealed every stakeholder, contractor, and volunteer must intervene immediately, to the extent feasible and consistent with personal safety and the person's training, to prevent or interrupt an incident of abuse. Review of the Self-Reported Incident Form dated 01/15/2022, revealed on 01/15/2022, Kentucky Medication Aide (KMA) #3 reported to Licensed Practical Nurse (LPN) #10 that Resident #67 and Resident #175 were inappropriately touching one another. Further review of the facility investigation of the incident of inappropriate touching, dated 01/21/2022, revealed the Administrator unsubstantiated sexual abuse based on information obtained from investigation. Review of the medical record for Resident #67 revealed the facility admitted him/her on 04/17/2021, with diagnoses which included Atrial Fibrillation, Chronic Obstructive Pulmonary Disease (COPD), and Chronic Diastolic (Congestive) Heart Failure. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #67's Quarterly Minimum Data Set (MDS) Assessment, dated 11/13/2021, revealed the facility assessed Resident #67 as severely cognitively impaired as indicated by the Brief Interview for Mental Status (BIMS) score of two (2). Further review of the MDS revealed Resident #67 had disorganized thoughts, was independent with transfers and ambulation and the facility assessed the resident to not wander and therefore failed to assess that the resident's wandering would place the resident in dangerous situations. Review of the medical record for Resident #175 revealed the facility admitted him/her on 02/01/2021, with diagnoses which included Unspecified Dementia, Alzheimer's Disease, Unspecified Psychosis, and Parkinson's Disease. Review of Resident #175's Quarterly MDS Assessment, dated 10/29/2021, for Resident #175 revealed the facility had assessed the resident as severely cognitively impaired as indicated by the Brief Interview of Mental Status (BIMS) score of two (2). Further review of the MDS revealed the resident had disorganized thoughts and required supervision only with transfers and ambulation. Review of the facility's investigation documentation, dated 01/21/2022, revealed the facility unsubstantiated an allegation of inappropriate touching between Resident #67 and Resident #175. Review of Housekeeper #2's written statement, regarding the incident between Resident #67 and Resident #175, revealed Resident #175 had been standing between the two (2) residents' beds. Continued review of Housekeeper #2's statement revealed Resident #67 had been lying on Resident #175's bed with his/her pants down to the top of his/her pubis (bones forming the pelvis). Further review of the statement revealed Housekeeper #2 went and got Kentucky Medication Aide (KMA) #3 and the KMA took care of the problem. Interview with Housekeeper #2, on 02/09/2022 at 1:30 PM and 02/11/2022 04:25 PM, revealed after observing the residents in Resident #175's room, she left Resident #175's room to notify KMA #3 she needed to go to the resident's room because Resident #67 was in the room lying on Resident #175's bed. Housekeeper #2 denied observing the residents to be in close contact or engaging in physical touching. Therefore, Housekeeper #2 stated she did not feel it was inappropriate to leave the residents alone together in the room while she obtained the assistance of nursing staff. Further interview revealed she was aware of the facility's abuse policy which directed staff to stay with a resident when alleged and/or suspected abuse was discovered; however, she stated she did not stay with Resident #67 or Resident #175 in the room as per the policy. Interview with the Administrator, on 02/11/2022 at 11:47 AM, revealed KMA #3 had written out a statement regarding the incident and what she witnessed between Resident #67 and Resident #175 on 01/15/2022; however, the facility could not locate the witness statement, stating it was lost. Interview with Kentucky Medication Aide (KMA) #3 on 02/09/2022 at 8:30 PM and 02/10/2022 at 9:55 AM, revealed Resident #67 and #175 had been actively engaged in sexual intercourse when she entered the room after being notified by Housekeeper #2. She revealed she immediately separated Resident #67 and Resident #175, and redirected Resident #67 out of the room. KMA #3 stated she immediately notified LPN #10 of the interaction she had witnessed between Resident #67 and Resident #175. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 02/11/2022 at 11:25 AM, with Licensed Practical Nurse (LPN) #10 revealed KMA #3 reported her observation of Resident #67 and Resident #175 on 01/15/2022. The LPN stated KMA #3 told her she had found Resident #175 and Resident #67 actively engaged in sexual intercourse in Resident #175's room. LPN #10 stated she notified the Administrator immediately of what KMA #3 told her regarding finding the residents actively engaged in sexual intercourse. Interview with the Administrator, on 02/11/2022 at 11:47 AM and 4:43 PM, revealed all staff was expected to protect residents and follow the facility's abuse policy if abuse was alleged or suspected. **The facility implemented the following actions to remove the Immediate Jeopardy on 02/19/2022. 1.Incident # 1 occurred on 12/06/2021 involving Residents #174 and #10. The following steps were taken to ensure resident safety. For Resident #174, a skin assessment was completed on 12/06/2021, with no bruising, markings or concerns noted. The Care Plan was reviewed on 12/09/2021 by the Minimum Data Set (MDS) Coordinator, and interventions were updated on the resident's mood care plan. The MD (Medical Doctor) and the resident's POA (Power of Attorney) was notified on 12/06/2021. For Resident #10, the resident was placed on 1:1 supervision on 12/06/2021 and currently remains on 1:1 supervision. Resident #10's medications were reviewed on 12/07/2021 by the Psychiatric Nurse Practitioner and medication changes were made including Paxil started and Viibryd dose decreased. A Psychiatric Services Consult was completed for Resident #10 on 12/07/2021, and follow-up visits were completed on 12/14/2021 and 12/29/2021. The resident's care plan was reviewed by the Interim Director of Nursing (DON) on 12/06/2021 with new interventions added to the resident's psychosocial care plan. The MD and POA were notified of the incident on 12/06/2021. Incident #2 occurred on 12/27/2021 involving Resident #174 and Resident #175. For Resident #174, the Regional Nurse Consultant completed a skin assessment of Resident #174 on 12/27/21 with no concerns noted. Review of documentation revealed the resident's MD and POA were notified on 12/27/21. Resident #174 was discharged per a planned discharge to home on 12/28/2021. For Resident #175, a skin assessment was completed on 12/27/2021 by the Regional Nurse Consultant with no concerns identified. Resident #175 was provided 1:1 Supervision on 12/27/2021 and the elder was transferred to the hospital on 12/27/2021, then returned to the facility on [DATE]. The resident's MD and Family were notified on 12/27/2021. The resident's care plan was updated on 02/18/2022 related to 1:1 status and the resident's discharge to a behavior unit on 12/27/2021 by the Regional Nurse consultant. Incident #3 occurred on 01/15/2022 involving Resident #67 and Resident #175. Resident #67 was found lying in the bed of elder #175. Both elders had pants off and were engaging in sexual activities. The following steps were taken to ensure resident safety. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	For Resident #67, a psychosocial follow-up was conducted for seventy-two (72) hours to provide psychosocial support and identify any concerns. The follow-ups were conducted on 01/15/2022, 01/16/2022, and 01/17/2022 by the Administrator. The Unit Manager reviewed the resident's care plan on 01/15/2022, to reflect the needs of the resident and to reflect the psychosocial follow-up. An assessment for physical trauma/injury was completed for Resident #67 via a skin assessment by the Unit Manager on 01/15/2022. The resident's MD and POA were notified of the incident on 01/15/2022. A Dementia Scale Pain Assessment and Pain Monitoring form that assesses the resident for pain by assessing the elders breathing, negative vocalization of pain, facial expressions, body language, and consolability was completed on 01/15/2022 by a Unit Manager with a score of zero (0) which indicated no pain. This assessment was noted to also indicate the resident was not in pain as did the baseline assessment completed on 12/06/2021 by Regional Nurse Consultant. For Resident #175, a skin assessment was completed on 01/15/2022 by a Unit Manager with no concerns noted. The resident was placed on 1:1 Supervision on 01/15/2022 and remained on 1:1 supervision until the resident was discharged from the facility on 02/22/2022. The resident was transferred to the hospital on 01/15/2022 and returned 01/26/2022 and remained on 1:1 supervision until transferred to the hospital on 02/01/2022 and returned on 02/10/2022. The Resident was then placed on 1:1 supervision upon return from the hospital and remained 1:1 until the resident was discharged from the facility on 02/22/2022. The resident's MD and Family were notified of the incident on 01/15/2022. The Administrator updated the resident's care plan on 01/15/2022 to reflect the resident's 1:1 status. The Housekeeper was initially educated on the abuse policy on 01/19/2022 by the facility Administrator which included protection of the resident and the Housekeeper was educated on the abuse policy on 2/16/2022 by the Staff Development Coordinator. 2. Residents residing in the facility have been assessed for any sign/ symptoms of potential abuse. Residents with a Brief Interview for Mental Status (BIMS) score of greater that eight (8) were interviewed by the Administrator and/or Unit Manager/Staff Development Coordinator for any concerns starting on 02/14/2022 and completed on 2/16/2022 with no issues identified. Residents currently residing in the facility with a BIMS of less than eight (8) were physically assessed by the Administrator, Unit Manager or Staff Development Coordinator for any signs and symptoms of potential abuse starting on 02/14/2022 with no concerns identified. Abuse/neglect audits, assessments, interviews, and questionnaires were reviewed by the Regional Nurse Consultant or Regional [NAME] President (RVP) starting on 02/14/2022 and completed on 02/16/2022 for any indications of potential abuse concerns. No issues or concerns were identified. 3. Charts have been reviewed for all residents residing in the facility by the Independent Risk Manager for any resident status changes to include event managers and change of conditions for the past thirty (30) days starting on 02/14/2022 and completed on 02/16/2022. The charts were also reviewed for any potential abuse allegations that had not been previously reported with no concerns noted. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Care plans were reviewed by Regional Nurse Consultant #1, Regional Nurse Consultant #2 and the Behavioral Specialist starting on 02/16/2022 and completed on 02/18/2022 to ensure that the care plans were updated regarding behaviors, wandering and reflected the resident's current cognitive status. 5. All residents residing in the facility will had a BIMS assessment completed to ensure that all residents had an accurate assessment score by the Social Services Director starting on 02/14/2022 and completed on 02/15/2022. 6. Employees were interviewed by the Administrator, Staff Development Coordinator, and the Activities Director regarding any knowledge of unreported abuse or knowledge of any type of sexual relations that had not been previously reported starting on 02/16/2022 and completed on 2/18/2022 with no new concerns noted related to abuse reporting. 7. The Medical Director was notified of all the allegations on 12/06/2021, 12/27/2021, and 01/15/2022 by the Administrator in accordance with abuse reporting. The facility's Medical Director is the physician for Residents #10, Resident #67, Resident #174, and Resident #175. 8. The Senior [NAME] President of Regulatory Compliance educated the facility's Administrator/Regional [NAME] President and the Regional Nurse Consultant on the Center for Medicare/Medicaid Services (CMS) regulations for F610 and F835 on 02/17/2022 and the CMS regulations for F600, F607 and F657 on 02/18/2022 including: F610-responding to allegations of abuse, neglect, exploitation, or mistreatment, the facility must have evidence that all alleged violations are thoroughly investigated, prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. Report the results of all investigations to the administrator or his/her designated representative and to the other officials in accordance with state law, including to the state survey agency, within five (5) working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. F 835, the facility must be administered in manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practical physical, mental, and psychosocial wellbeing of each resident. The facility administration is not limited to the administrator and may also include the facility's governing body, management company, and/ or others identified by the facility as part of the facility administration. CMS's Abuse Critical Pathway and reporting guidelines. F600, residents have the right to be free from abuse, neglect, misappropriation, and exploitation. This includes freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. F 607, The facility must develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property/ Establish policies and procedures to investigate any such allegations and include training as required and establish coordination with the QAPI program as required. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	F 657, to ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs., and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care. 9. Starting on 02/17/2022 all allegations of abuse including physical, verbal, mental, sexual, misappropriation, neglect, involuntary seclusions, corporal punishment, injuries of unknown origin, and exploitation would be reviewed by the Regional [NAME] President, Risk Manager, and/or [NAME] President of Clinical Operations to ensure that a complete, thorough, and accurate investigation has been completed for the reportable events for the next 90 days through 05/20/2022. 10. All reportable incidents were reviewed from the last six (6) months from 08/01/2021, through 02/16/2022 by the [NAME] President of Clinical Operations starting on 02/16/2021 and completed on 02/17/2022 with no concerns noted. 11. The facility Administrator, Regional [NAME] President, Regional Nurse Consultant #1 and Regional Nurse Consultant #2, Unit Manager, Business Office Manager, Assistant Business Office Manager, Activities Director, Rehab Service Manager, Scheduler, and the Staff Development Coordinator (SDC) were educated on the abuse policy to include sexual abuse on 02/14/2022 by the Director of Behavioral Health Services. The education included the following: Abuse policy and procedure to include types of abuse, recognizing abuse and reporting abuse with an emphasis on sexual abuse, the federal regulations pertaining to abuse, and the stakeholder's role in prevention, protection, recognition and reporting of abuse. Resident Rights include that resident had the right to be free from abuse The Behavior Management policy includes supervision and interventions to redirect residents when behaviors occur. Care plan policy and procedure, to include appropriately updating the resident's care plan to reflect the resident's current care needs. Change of Condition Policy and Procedure, to include Physician and Family notification Quality Assurance Performance Improvement (QUAPI) policy and procedure to include process improvement and monitoring. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	12. Once the facility Administrator, Nursing Supervisors, SDC, Business Office Manager, Social Services Director and Activities Director were educated on (a) Abuse policy and procedure to include types of abuse, recognizing abuse and reporting abuse with emphasis on sexual abuse, the federal regulations pertaining to abuse, and the stakeholder's role in prevention, protection, recognition and reporting of abuse. (b) the resident's right to free from abuse (c) Behavior Management policy to include supervision and interventions to redirect residents when behaviors occur. (d) Care plan policy and procedure, to include appropriately updating the residents' care plan to reflect residents' current care needs. (e) Change of Condition Policy and Procedure, to include Physician and Family notification and (f) the QAPI policy and procedure to include process improvement and monitoring. The Administrator, Nursing Supervisors, SDC, Business Office Manager, Social Services Director and Activities Director were then assigned to re-educate all staff working in the facility, to include agency staff, in small groups which started on 02/15/2022 and was completed by 02/18/2022. On 02/18/2022, certified letters were sent out to the remaining PRN (as needed) staff, staff on vacation, or staff on Family Medical Leave Act (FMLA). No employee will be allowed to work until education is provided, post-test administered, and a score of 100% obtained, if employee did not score 100% on the post-test, then the employee would be immediately re-educated, and the post-test will be re-administered. This education would be included in the orientation process for all newly hired staff members. No newly hired employee will be allowed to work until education is provided, post-test administered, and a score of 100% obtained, if employee did not score 100% on post-test, then employee will be immediately re-educated and post-test re-administered. This process would continue until employee obtains a 100% score on post-test. 13. A staff post-test regarding the above education to include types of abuse, protection of the resident, and notification of abuse including MD notification would be administered daily, starting on 02/19/2022. The test will be administered by the Administrator, DON, Nursing Supervisors, SDC, Business office manager, Assistant Business Office Manager or Activities Director to six (6) different staff members on different shifts daily for two (2) weeks. After two (2) weeks, then four (4) staff member's questionnaires daily to different staff members on different shifts for two (2) weeks. Results of the staff tests will be reported to the Quality Assurance (QA) committee weekly to determine the further need of continued education or revision of the plan. At that time, based on evaluation, the QA Committee would determine at what frequency the staff questionnaire would need to continue. 14. All grievances were reviewed on 02/18/2022 by the Regional Nurse Consultant for the last thirty (30) days to determine if any items documented were a reportable event or if concerns were not resolved. No issues were identified. The Administrator or Director of Nursing would review grievances daily for two (2) weeks starting 02/18/2022, to determine if there were any concerns related to resident abuse. The Administrator would report any allegations of abuse, neglect, or misappropriation to the State Regulatory Officials, Adult Protective Services and the Ombudsman. 15. All incident reports from 11/10/2021 through 02/10/2022 were reviewed on 01/17/2022 by the Independent Risk Manager to identify any concerns related to resident abuse, and no concerns were identified. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	16. Starting on 02/19/2022 the facility Administrator, DON, Social Services Director, Assistant Director of Nursing, Staff Development Coordinator and/or Unit Manager would complete five (5) random resident observations/interviews a week to ensure residents are not exhibiting any sign or symptoms of abuse to include but not limited to being tearful, withdrawn, decreased appetite, bruising, anxiety, increased wandering, or displaying fear of staff or other elders. These audits would be ongoing for the next four (4) weeks. 17. Starting on 02/19/2022, five (5) random stakeholders would be interviewed weekly for four (4) weeks to determine if they have any knowledge of any previously unreported abuse or observed any residents exhibiting increased signs and symptoms of abuse to include but not limited to being tearful, withdrawn, decreased appetite, bruising, anxiety, increased wandering, fearful of staff or other elders. 18. Starting on 02/17/2022, all residents returning from a behavioral hospital stay would be reviewed by the Interdisciplinary Team to determine their appropriate level of supervision and/or needed modifications to their plan of care to ensure their needs were met and the needs of peers were also met. This would be ongoing to ensure resident safety. 19. Administrative oversight of the facility would be completed via telephone or in-person by the Regional Nurse Consultant, Regional [NAME] President of Operations, the Director of Clinical Operations, or a member of the regional staff daily for two (2) weeks beginning on 02/12/2022, then weekly for four (4) weeks, then monthly. This would include a review of all abuse allegations and events/incidents that occurred in the previous twenty-four (24) hours, any grievances filed, and stakeholder post-tests. 20. Starting the week of 02/12/2022, a QA meeting would be held daily for seven (7) days then weekly for four (4) weeks, then monthly for recommendations and further follow-up regarding the above-stated plan. A QA meeting was held on 02/11/2022 and an action plan was formulated and implemented at that time. On 02/12/2022, a second Quality Assurance meeting was held to review the current plan for any needed revisions, compliance and/or further education. At that time, based upon evaluation, the QA Committee would determine at what frequency any ongoing audits would need to continue. The Administrator has the oversight to ensure an effective plan was in place to ensure each resident's wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility. Corporate Administrative oversight of the QA meetings would be completed by the Regional [NAME] President of Operations, or a member of regional staff daily until the removal of immediacy beginning 02/12/2022 and then daily for seven (7) days, then weekly for four (4) weeks, then monthly. **The State Survey Agency verified the facility implemented the following corrective actions to remove the Immediate Jeopardy on 02/19/2022 as alleged: 1.Observations on 02/23/2022, revealed Resident's #10 and Resident #174 were not interviewable due to cognitive impairment. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of facility documentation and interview with the Unit Manager on 02/24/2021 at 2:14 PM, revealed she completed a skin assessment, on Resident #174 on 12/06/2021, with no concerns identified. Further review revealed the resident's POA, and MD were notified on 12/06/2021 of the incident. Review of a Psychiatric Assessment revealed the resident was assessed by Psychiatric Services on 12/07/2021, and new medications were initiated on 12/09/2021. Review of Resident #174's care plan revealed on 12/09/2021, the care plan was updated to include Mood/Anxiety interventions with a goal for the Resident to experience a reduction of relief from signs and symptoms of anxiety such as, restlessness, poor impulse control, fear/apprehension. Review of Resident #10's medical record, dated 02/23/2022, revealed Resident #10 was placed on 1:1 supervision on 12/06/2021 and remained on 1:1 supervision until 01/07/2022. Observation on 02/23/2022 revealed the facility placed the resident on every fifteen (15) minute supervision since 01/07/2022. Observation of Resident #10 on 02/23/2022, at 3:28 PM revealed the resident was in his/her room sitting at the bedside with a Personal Care Attendant (PCA) present. Further review of documentation and interview with the Unit Manager on 02/24/2021 at 2:14 PM, revealed she completed a review of Resident #10's care plan 12/06/2021 with no concerns identified. Review of a Psychiatric Assessment for Resident #10, on 12/07/2021 completed by a Psychiatric Mental Health Nurse Practitioner (PMHNP) revealed the resident's Viibryd dosage was decreased from 20 milligrams daily to 10 milligrams daily for seven (7) days and then the medication was discontinued. On 12/14/2021, the resident was again seen by the PMHNP, and Paxil was initiated daily. The PMHNP notes revealed a collaboration with a Psychiatrist and Advanced Practice Registered Nurse (APRN) and an additional visit on 12/29/2021. Record review revealed the resident's care plan was updated on 12/06/2021 with new interventions added to the identified problem of psychosocial wellbeing section of the care plan. Review of facility documentation revealed Resident #174 was involved in a second incident with Resident #175, on 12/27/2021. Review of documentation revealed a skin assessment was completed for Resident #174 on 12/27/2021 by the Regional Nurse Consultant, with no concerns identified. Further record review revealed Resident #174 was discharged home as planned on 12/28/2021. Review of documentation revealed Resident #175 had a skin assessment completed on 12/27/2021 with no concerns identified. Further review revealed the resident was transferred to the hospital on 12/27/2021, then returned to the facility on [DATE]. Review of Resident #175's medical record revealed the resident's MD and family were notified of the transfer on 12/27/2021. On 01/15/2022, another incident with Resident #175 occurred and a skin assessment was completed on 01/15/2022 by the Unit Manager with no concerns identified. Review of the Behavior monitoring log revealed Resident #175 was placed on 1:1 supervision on 1/15/2022 and transferred to the Hospital. Continued review revealed the resident returned to the facility on [DATE] and was again transferred to the hospital on 02/01/2022. Resident #175 returned to the facility on [DATE] and was discharged from the facility on 02/22/2022. Review of a facility investigation revealed Resident #67, who had a BIMS score of six (6) was involved in an incident on 01/15/2022 with Resident # 175. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #67, an Observation on 02/23/2022, at 3:35 PM, revealed the resident was sitting in the common area and was obviously cognitively impaired. Record review revealed the Administrator had completed a psychosocial follow-up with Resident #67 on 01/15/2022, 01/16/2022, 01/17/2022 with no concerns noted. Interview with the Unit Manager on 02/24/2022 at 2:14 PM revealed she had completed a physical trauma/injury assessment for Resident #67 on 01/15/2022, and no concerns were noted. Review of Resident #67's Care plan revealed it was reviewed by the Unit Manager on 01/15/2022 and it reflected the needs of the resident and the psychosocial follow-ups which had been completed on 01/15/2022, 01/16/2022, and 01/17/2022. Review of the Dementia Scale Pain Assessment and Pain Monitoring form for Resident #67 revealed the assessment was completed on 01/15/2022 by a Unit Manager with a score of zero(0) which indicated no pain. Resident #175, review of his/her skin assessment dated [DATE], revealed the skin assessment was completed on 01/15/2022 with no concerns identified. Review of the facility's behavior monitoring log revealed Resident #175 was placed on 1:1 supervision on 1/15/2022 and then transferred to the hospital. Continued review of Resident #175's medical record revealed the resident returned to the facility on [DATE] and went back out to the hospital on 02/01/2022 and returned to the facility on [DATE]. Resident #175 was discharged from the facility on 02/22/2022. Review of facility training records and interview with Housekeeper #1, on 02/24/2022 at 1:35 PM, revealed she was educated on the abuse policy on 01/19/2022 by the facility Administrator. The training included protection of the resident and the Housekeeper was educated again on the abuse policy on 02/16/2022 by the Staff Development Coordinator. Housekeeper #1 stated she felt confident and was able to verbalize appropriate measures to take with allegations of abuse. Further review of documentation revealed the Housekeeper had taken the post-test and scored 100 %. 2. Review of documentation revealed skin audits were completed on residents and review of Resident #10's medical record revealed the audit was present. Interview with the Unit Manager, on 02/24/2022 at 2:14 PM, revealed all residents residing in the facility were assessed for signs/symptoms of abuse starting on 02/14/2022 through 02/16/2022. Further interview with the Unit Manager revealed weekly skin sweeps continued on all residents. Interview with Administrator, on 02/24/2022 at 3:25 PM, revealed Nursing Staff from other sister facilities were brought in to assist with skin sweeps for a Fresh Eyes assessment and no concerns were noted. 3. Review of facility documentation and interview with the Independent Risk Manager on 02/18/2022, revealed all resident records were reviewed for any resident status changes, including event manager forms and change of condition forms for the past thirty (30) days starting on 02/14/2022 and completed on 02 [TRUNCATED]

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42932 Based on interview, record review, and facility policy review, it was determined the facility failed to thoroughly investigate three (3) allegations of sexual abuse involving four (4) of thirty (35) sampled residents (Resident #10, Resident #74, Resident #174 and Resident #175) to ensure appropriate action was taken to protect residents and prevent further sexual abuse/potential sexual abuse. Review of the facility's investigation, dated 12/06/2021, revealed Resident #174 and Resident #10 were found in Resident #10's room. Resident #10's pants were down to mid-thigh, as well as, Resident #174's pants down to mid-thigh. Resident #10 had his/her hand on Resident #174's thigh. Further review of the facility investigation revealed no root cause analysis was conducted following the incident and the facility failed to identify Resident #174's increased wandering as a potential factor in the incident. Review of the facility's investigation, dated 12/27/2021, revealed Resident #174 was found by staff behind the door in Resident #175's room, with his/her clothing disheveled and Resident #175 was on his/her bed pulling at his/her pants. Further review of the facility investigation revealed no root cause analysis was conducted following the incident and the facility failed to identify Resident #174's increased wandering although the resident was involved in a prior incident on 12/06/2021. Review of the Self-Reported Incident Form dated 01/15/2022, revealed on 01/15/2022, Kentucky Medication Aide (KMA) #3 reported to Licensed Practical Nurse (LPN) #10 that Resident #67 and Resident #175 were inappropriately touching one another. Further review of the facility investigation of the incident of inappropriate touching date 01/21/2022 revealed the administrator unsubstantiated sexual abuse based on information obtained from investigation. Interview with Kentucky Medication Aide (KMA) #3 revealed that Resident #67 and #175 were engaged in sexual intercourse on 01/15/2022 when she entered the room. She further stated that she separated the residents and immediately reported the incident to LPN #10. KMA #3 further stated in interview that she provided a written statement to the facility that stated Resident #67 and Resident #175 were engaged in sexual intercourse when she entered the room on 01/15/2022. Interview with LPN #10 revealed that on 01/15/2022 KMA #3 reported to her that Resident #67 and Resident #175 were engaged in sexual intercourse. LPN #10 stated she notified the administrator immediately that the residents had been engaged in sexual intercourse. Review of the facility's investigation revealed no witness statement from KMA #3 and interview with the administrator revealed even though she had an eye witness statement from KMA #3 stating Resident #67 and Resident #175 had been engaged in sexual intercourse, she did not believe sexual abuse occurred and therefore unsubstantiated sexual abuse. The facility's failure to thoroughly investigate allegations of sexual abuse, has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 02/12/2022 and determined to exist on 12/06/2021 at 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation (F600, F607, and F610) at the highest scope and severity (s/s) of a J, 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F657) at s/s of a J, and 42 CFR 483.70 Administration (F835) at a s/s of a J. The facility was notified of the Immediate Jeopardy on 02/12/2022. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An acceptable Immediate Jeopardy removal plan was received on 02/22/2022, which alleged removal of the Immediate Jeopardy on 02/19/2022. The State Survey Agency determined the Immediate Jeopardy was removed as alleged on 02/19/2022, prior to exit on 02/24/2022, which lowered the scope and severity to D level at 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation, (F600, F607 and F610) 483.21 Comprehensive Resident Centered Care Plans (F657) and 42 CFR 483.70 Administration (F835), while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy titled, Abuse, Neglect and Misappropriation of Property, revised 05/08/2019, revealed the facility Administrator would investigate all allegations and reports which could potentially constitute allegations of abuse. The policy stated the facility Administrator was ultimately responsible to oversee and complete the investigation and draw conclusions based on the nature of the incident. Further review revealed the facility Administrator was to make responsible efforts to determine the root cause of the violation. In addition, the policy revealed the Administrator was to implement corrective action consistent with the investigation findings, and take steps to eliminate any ongoing danger to the resident(s). 1. Review of the facility's investigation dated 12/06/2021, for the incident involving Resident #174 and Resident #10 which occurred on 12/06/2021, revealed the facility had unsubstantiated the allegation of sexual abuse as having occurred between Resident #174 and Resident #10. Continued review of the facility investigation revealed no witness statements were documented related to incident on 12/06/2021. Further review revealed the facility unsubstantiated abuse occurred due to both residents having BIMS below eight (8), there were no witnesses to any harm, and no injuries to either resident. No formal root cause analysis was conducted. Review of the clinical record for Resident #174 revealed the facility had admitted the resident on 10/29/2021, with diagnoses which included Wandering, and Unspecified Dementia with Behavioral disturbance. Review of the facility's Admission Minimum Data Set (MDS) Assessment for Resident #174 dated 11/05/2021, revealed the facility had assessed the resident as severely cognitively impaired, as indicated by a score of one (1) on the Brief Interview for Mental Status (BIMS) portion of the Assessment. Review of the clinical record for Resident #10 revealed the facility admitted the resident on 04/20/2021, with diagnoses of Wandering, and Dementia with Behavioral Disturbance. Review of the facility's Quarterly MDS Assessment for Resident #10 dated 11/18/2021, revealed the facility had assessed the resident as severely cognitively impaired by the score of three (3) on the BIMS portion of the Assessment. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 02/09/2022 at 9:35 AM, with Kentucky Medication Aide (KMA) #1 revealed she had been charting at the nurse's station when Resident #10's call light began going off. KMA #3 stated she went to answer the call light, and when she opened the closed door and entered the room the privacy curtain was pulled closed. Continued interview revealed she pulled the curtain back and saw Resident #10 sitting upright on the bed with his/her pants pulled down to mid-thigh. KMA #3 revealed she also saw Resident #174 with his/her pants down to mid-thigh with Resident #10's hand on Resident #174's thigh. KMA #1 stated she immediately separated the residents and notified her charge nurse Registered Nurse (RN) #2, who notified the Administrator and Director of Nursing (DON). Further interview revealed Resident #174 had always had wandering tendencies; however, had never had any incidents of inappropriate behaviors, prior to the incident with Resident #10 on 12/06/2021. KMA #1 further stated Resident #174 had been taken to his/her room and Resident #10 had been placed on one (1) to one (1) monitoring immediately following the incident. The KMA revealed however, she was unsure of any specific interventions which had been implemented for Resident #174 following the incident. Interview with the former Administrator on 02/11/2022 at 5:05 PM, revealed she had been the acting Administrator and the facility's Abuse Coordinator at the time of the incident on 12/06/2021, involving Resident #174 and Resident #10. The Administrator revealed when staff were interviewed during the investigation of the incident, it had been determined that nothing had happened as far as physical contact and no evidence of abuse (even though Resident #10's hand had been observed on Resident #174's thigh, while both residents' pants were pulled down to mid-thigh) She stated the staff interviewed had not observed any other touching, than Resident #10's hand on Resident #174's thigh, so she had not substantiated abuse as having occurred. According to the Administrator, Resident #10 had been immediately placed on one (1) to one (1) monitoring following the incident. Further interview revealed both residents were evaluated by psychiatric (psych) services after the incident occurred. The Administrator further revealed however, no increased monitoring had been initiated for Resident #174. In addition, the Administrator stated she had received training on abuse by the company when hired and trained on investigating and reporting abuse. 2. Review of the facility's Incident Report dated 12/27/2021, revealed SRNA #18 had found Resident #174 standing behind the door of Resident #175's room, with his/her top disheveled and bra strap exposed, and Resident #175 lying on the bed with his/her pants and brief pulled partially down. Review of the facility's investigation revealed no witness statements were obtained related to the incident on 12/06/2021. the facility unsubstantiated abuse occurred and the determining factors included that both residents had BIMS below eight (8), there were no witnesses to any harm, and no injuries to either resident. A root cause analysis was not performed. Review of the clinical record for Resident #174 revealed an admitted [DATE], and diagnoses of Unspecified Dementia with Behavioral disturbance, and Wandering. Review of Resident #174's Admission MDS assessment dated of 11/05/2021, revealed a BIMS score of one (1) which indicated the resident was severely impaired cognitively. Review of the clinical record for Resident #175 revealed an admitted [DATE], diagnoses which included Unspecified Dementia, Unspecified Psychosis, Parkinson's Disease, and Alzheimer's Disease. Review of the facility Quarterly MDS assessment dated [DATE], revealed a BIMS score of two (2) which indicated he/she had severely impaired cognition. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with State Registered Nursing Assistant (SRNA) #7 on 02/10/2022 at 3:35 PM, revealed, on the day of the incident involving Resident #174 and Resident #175, she had been at the nurse's station when SRNA #18 went into Resident #175's room during routine checks. She revealed SRNA #18 entered the room then called to her for assistance. Continued interview revealed SRNA #7 when she arrived at the doorway of Resident #175's room, Resident #174 was coming out of the room. She stated she could that Resident #174's shirt was messed up as he/she exited the room. SRNA #7 revealed she did not recall hearing of any physical contact occurring between the residents at the time of the incident. Further interview revealed Resident #174 frequently wandered into other residents' rooms and had to be redirected out of them by staff. The SRNA further revealed she did not recall additional interventions having been put into place for Resident #174 after the incident which involved Resident #174. She further stated however, Resident #175 had immediately been placed on one (1) on one (1) monitoring. Review of SRNA #18's witness statement dated 12/27/2021 revealed SRNA #18 entered Resident #175's room and opened the door to find Resident #174 standing behind the door with his/her shirt twisted and bra strap exposed through the shirt. The statement stated the SRNA immediately redirected Resident #174 out of the room. Further review revealed SRNA #18 observed Resident #175 lying on the bed attempting to pull his/her pants up. Telephone interviews were attempted with SRNA #18 on 02/11/2022, and on 02/14/2022. However, SRNA #18 was no longer employed at the facility, and the phone calls went unanswered. Interview on 02/11/22 11:47 AM and at 4:23 PM, with the Administrator revealed she was aware of the incident which occurred on 12/27/2021, between Resident #174 and Resident #175. The Administrator stated she unsubstantiated abuse regarding the incident because the facility had been unable to validate any physical contact had occurred between the two (2) residents. She stated she had been aware Resident #174 had been found in Resident #175's with his/her shirt disheveled; however, no evidence sexual abuse had occurred. Continued interview revealed when an incident occurred, as part of the investigation, the facility looked at the residents involved, and reviewed their plans of care. According to the Administrator, she had been aware of a prior incident involving Resident #174; however, the facility had not identified Resident #174's increased wandering behaviors as a concern for his/her safety. Further interview revealed staff monitored residents, and had been educated on abuse. The Administrator further stated the facility was responsible for protecting the rights of its residents. However, the facility failed to address Resident #174's behaviors of wandering into other residents rooms unsupervised which lead to Resident #174 being involved in two separate incidents of alleged sexual abuse. 3. Review of the facility's investigation document dated 01/21/2022, for the incident which occurred on 01/15/2022 involving Resident #175 and Resident #67, revealed the facility had unsubstantiated the allegation of inappropriate touching between the two (2) residents. Continued review of the investigation documentation revealed Housekeeper #2's written statement which noted Resident #175 had been standing in his/her room between the resident beds. Continued review of Housekeeper #2's written statement revealed Resident #67 had been lying on Resident #175's bed with his/her pants pulled down to top of his/her pubic area. Further review of the written statement revealed Housekeeper #2 exited the room, and went and got KMA #3 and the KMA took care of the problem after that. The investigation included no further written statements from staff. Further review of the investigation revealed no evidence of a root cause of the incident or any actions taken to prevent further incidents. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's clinical record for Resident #67's revealed an admitted [DATE], with diagnoses which included Atrial Fibrillation, Chronic Obstructive Pulmonary Disease (COPD), and Chronic Diastolic (Congestive) Heart Failure. The facility assessed Resident #67 in the Quarterly Assessment with a reference date of 11/13/2021, as having a Brief Interview for Mental Status (BIMS) score of two (2) indicating severely impaired cognition. Review of Resident #175's medical record revealed the facility admitted the resident on with diagnosis including Unspecified Psychosis, Parkinson's Disease, Unspecified Dementia and Alzheimer's Disease. Review of Resident #175's Quarterly MDS assessment dated of 10/29/2021, revealed a BIMS score of two (2) which indicated the resident was severely impaired cognitively. Interview on 02/09/2022 01:30 PM and 02/11/2022 04:25 PM, with Housekeeper #2 revealed she had left Resident #175's room after observing Resident #67 lying on Resident #175's bed with his/her pants down, and Resident #175 standing between the beds. She stated she left the room to go notify KMA #3 that she needed to go to Resident #175's room because she had seen Resident #67 in Resident #175's room lying on his/her bed. Further interview revealed Housekeeper #2 stated the facility's abuse policy directed staff to stay with a resident when alleged and/or suspected abuse incident occurred; however, she had not stayed with Resident #67 and Resident #175, as per the policy. Interview on 02/09/2022 at 8:30 PM and 02/10/2022 at 9:55 AM, with KMA #3 revealed after being notified by Housekeeper #2, she had gone to Resident #175's room. KMA #3 revealed upon entering the room, she observed Resident #67 and #175 actively engaged in sexual intercourse, and she immediately separated the residents, and reported the incident to Licensed Practical Nurse (LPN) #10. Interview on 02/11/22 at 11:47 AM and 4:43 PM, with the Administrator revealed all facility staff were expected to protect residents, and follow the facility's policy. The Administrator stated she was the facility abuse coordinator and was responsible to thoroughly investigate allegations of abuse. The Administrator further stated she was trained on investigating abuse when she was an Administrator at another facility. The Administrator stated due to the residents' cognitive impairment, there would be no willful intent to abuse, but stated she did not review their capacity to be able to consent to sexual activity. She revealed she had unsubstantiated sexual abuse occurring between Resident #67 and Resident #175. The Administrator revealed even though she had an eye witness statement from KMA #3 stating Resident #67 and Resident #175 had been engaged in sexual intercourse, she did not believe sexual abuse occurred. **The facility implemented the following actions to remove the Immediate Jeopardy on 02/19/2022. 1.Incident # 1 occurred on 12/06/2021 involving Residents #174 and #10. The following steps were taken to ensure resident safety. For Resident #174, a skin assessment was completed on 12/06/2021, with no bruising, markings or concerns noted. The Care Plan was reviewed on 12/09/2021 by the Minimum Data Set (MDS) Coordinator, and interventions were updated on the resident's mood care plan. The MD (Medical Doctor) and the resident's POA (Power of Attorney) was notified on 12/06/2021. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	For Resident #10, the resident was placed on 1:1 supervision on 12/06/2021 and currently remains on 1:1 supervision. Resident #10's medications were reviewed on 12/07/2021 by the Psychiatric Nurse Practitioner and medication changes were made including Paxil started and Viibryd dose decreased. A Psychiatric Services Consult was completed for Resident #10 on 12/07/2021, and follow-up visits were completed on 12/14/2021 and 12/29/2021. The resident's care plan was reviewed by the Interim Director of Nursing (DON) on 12/06/2021 with new interventions added to the resident's psychosocial care plan. The MD and POA were notified of the incident on 12/06/2021. Incident #2 occurred on 12/27/2021 involving Resident #174 and Resident #175. For Resident #174, the Regional Nurse Consultant completed a skin assessment of Resident #174 on 12/27/21 with no concerns noted. Review of documentation revealed the resident's MD and POA were notified on 12/27/21. Resident #174 was discharged per a planned discharge to home on 12/28/2021. For Resident #175, a skin assessment was completed on 12/27/2021 by the Regional Nurse Consultant with no concerns identified. Resident #175 was provided 1:1 Supervision on 12/27/2021 and the elder was transferred to the hospital on 12/27/2021, then returned to the facility on [DATE]. The resident's MD and Family were notified on 12/27/2021. The resident's care plan was updated on 02/18/2022 related to 1:1 status and the resident's discharge to a behavior unit on 12/27/2021 by the Regional Nurse consultant. Incident #3 occurred on 01/15/2022 involving Resident #67 and Resident #175. Resident #67 was found lying in the bed of elder #175. Both elders had pants off and were engaging in sexual activities. The following steps were taken to ensure resident safety. For Resident #67, a psychosocial follow-up was conducted for seventy-two (72) hours to provide psychosocial support and identify any concerns. The follow-ups were conducted on 01/15/2022, 01/16/2022, and 01/17/2022 by the Administrator. The Unit Manager reviewed the resident's care plan on 01/15/2022, to reflect the needs of the resident and to reflect the psychosocial follow-up. An assessment for physical trauma/injury was completed for Resident #67 via a skin assessment by the Unit Manager on 01/15/2022. The resident's MD and POA were notified of the incident on 01/15/2022. A Dementia Scale Pain Assessment and Pain Monitoring form that assesses the resident for pain by assessing the elders breathing, negative vocalization of pain, facial expressions, body language, and consolability was completed on 01/15/2022 by a Unit Manager with a score of zero (0) which indicated no pain. This assessment was noted to also indicate the resident was not in pain as did the baseline assessment completed on 12/06/2021 by Regional Nurse Consultant. For Resident #175, a skin assessment was completed on 01/15/2022 by a Unit Manager with no concerns noted. The resident was placed on 1:1 Supervision on 01/15/2022 and remained on 1:1 supervision until the resident was discharged from the facility on 02/22/2022. The resident was transferred to the hospital on 01/15/2022 and returned 01/26/2022 and remained on 1:1 supervision until transferred to the hospital on 02/01/2022 and returned on 02/10/2022. The Resident was then placed on 1:1 supervision upon return from the hospital and remained 1:1 until the resident was discharged from the facility on 02/22/2022. The resident's MD and Family were notified of the incident on 01/15/2022. The Administrator updated the resident's care plan on 01/15/2022 to reflect the resident's 1:1 status. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Housekeeper was initially educated on the abuse policy on 01/19/2022 by the facility Administrator which included protection of the resident and the Housekeeper was educated on the abuse policy on 2/16/2022 by the Staff Development Coordinator. 2. Residents residing in the facility have been assessed for any sign/ symptoms of potential abuse. Residents with a Brief Interview for Mental Status (BIMS) score of greater that eight (8) were interviewed by the Administrator and/or Unit Manager/Staff Development Coordinator for any concerns starting on 02/14/2022 and completed on 2/16/2022 with no issues identified. Residents currently residing in the facility with a BIMS of less than eight (8) were physically assessed by the Administrator, Unit Manager or Staff Development Coordinator for any signs and symptoms of potential abuse starting on 02/14/2022 with no concerns identified. Abuse/neglect audits, assessments, interviews, and questionnaires were reviewed by the Regional Nurse Consultant or Regional [NAME] President (RVP) starting on 02/14/2022 and completed on 02/16/2022 for any indications of potential abuse concerns. No issues or concerns were identified. 3. Charts have been reviewed for all residents residing in the facility by the Independent Risk Manager for any resident status changes to include event managers and change of conditions for the past thirty (30) days starting on 02/14/2022 and completed on 02/16/2022. The charts were also reviewed for any potential abuse allegations that had not been previously reported with no concerns noted. 4. Care plans were reviewed by Regional Nurse Consultant #1, Regional Nurse Consultant #2 and the Behavioral Specialist starting on 02/16/2022 and completed on 02/18/2022 to ensure that the care plans were updated regarding behaviors, wandering and reflected the resident's current cognitive status. 5. All residents residing in the facility will had a BIMS assessment completed to ensure that all residents had an accurate assessment score by the Social Services Director starting on 02/14/2022 and completed on 02/15/2022. 6. Employees were interviewed by the Administrator, Staff Development Coordinator, and the Activities Director regarding any knowledge of unreported abuse or knowledge of any type of sexual relations that had not been previously reported starting on 02/16/2022 and completed on 2/18/2022 with no new concerns noted related to abuse reporting. 7. The Medical Director was notified of all the allegations on 12/06/2021, 12/27/2021, and 01/15/2022 by the Administrator in accordance with abuse reporting. The facility's Medical Director is the physician for Residents #10, Resident #67, Resident #174, and Resident #175. 8. The Senior [NAME] President of Regulatory Compliance educated the facility's Administrator/Regional [NAME] President and the Regional Nurse Consultant on the Center for Medicare/Medicaid Services (CMS) regulations for F610 and F835 on 02/17/2022 and the CMS regulations for F600, F607 and F657 on 02/18/2022 including: (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	F610-responding to allegations of abuse, neglect, exploitation, or mistreatment, the facility must have evidence that all alleged violations are thoroughly investigated, prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. Report the results of all investigations to the administrator or his/her designated representative and to the other officials in accordance with state law, including to the state survey agency, within five (5) working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. F 835, the facility must be administered in manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practical physical, mental, and psychosocial wellbeing of each resident. The facility administration is not limited to the administrator and may also include the facility's governing body, management company, and/ or others identified by the facility as part of the facility administration. CMS's Abuse Critical Pathway and reporting guidelines. F600, residents have the right to be free from abuse, neglect, misappropriation, and exploitation. This includes freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. F 607, The facility must develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property/ Establish policies and procedures to investigate any such allegations and include training as required and establish coordination with the QAPI program as required. F 657, to ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs., and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care. 9. Starting on 02/17/2022 all allegations of abuse including physical, verbal, mental, sexual, misappropriation, neglect, involuntary seclusions, corporal punishment, injuries of unknown origin, and exploitation would be reviewed by the Regional [NAME] President, Risk Manager, and/or [NAME] President of Clinical Operations to ensure that a complete, thorough, and accurate investigation has been completed for the reportable events for the next 90 days through 05/20/2022. 10. All reportable incidents were reviewed from the last six (6) months from 08/01/2021, through 02/16/2022 by the [NAME] President of Clinical Operations starting on 02/16/2021 and completed on 02/17/2022 with no concerns noted. 11. The facility Administrator, Regional [NAME] President, Regional Nurse Consultant #1 and Regional Nurse Consultant #2, Unit Manager, Business Office Manager, Assistant Business Office Manager, Activities Director, Rehab Service Manager, Scheduler, and the Staff Development Coordinator (SDC) were educated on the abuse policy to include sexual abuse on 02/14/2022 by the Director of Behavioral Health Services. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	13. A staff post-test regarding the above education to include types of abuse, protection of the resident, and notification of abuse including MD notification would be administered daily, starting on 02/19/2022. The test will be administered by the Administrator, DON, Nursing Supervisors, SDC, Business office manager, Assistant Business Office Manager or Activities Director to six (6) different staff members on different shifts daily for two (2) weeks. After two (2) weeks, then four (4) staff member's questionnaires daily to different staff members on different shifts for two (2) weeks. Results of the staff tests will be reported to the Quality Assurance (QA) committee weekly to determine the further need of continued education or revision of the plan. At that time, based on evaluation, the QA Committee would determine at what frequency the staff questionnaire would need to continue. 14. All grievances were reviewed on 02/18/2022 by the Regional Nurse Consultant for the last thirty (30) days to determine if any items documented were a reportable event or if concerns were not resolved. No issues were identified. The Administrator or Director of Nursing would review grievances daily for two (2) weeks starting 02/18/2022, to determine if there were any concerns related to resident abuse. The Administrator would repor [TRUNCATED]

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42932 Based on interview, record review, and review of facility policy it was determined the facility failed to review and revise the person-centered comprehensive care plan for four (4) of thirty-five (35) sampled residents (Resident #10, Resident #37, Resident #67, Resident #174 and Resident #175). Record review and interview revealed Resident #37, Resident #67, Resident #174, and Resident #175 had displayed behaviors that put them at risk for abuse and had care plans in place for behavioral problems. Review of the facility's investigation revealed, on 12/06/2021, Resident #174 and Resident #10 were found in Resident #10's room with Resident #10's pants down to mid-thigh. Resident #174's pants were down to mid-thigh and Resident #10 had his/her hand on Resident #174's thigh. Further review of the care plans for Resident #10 and Resident #174 revealed no evidence the care plan was revised after the incident to prevent further incidents. Review of the facility's Incident Report dated 12/21/2021, revealed Kentucky Medication Aide (KMA) #1 had entered Resident #37's room after hearing a noise in the room. Further review revealed upon entering the resident's room, KMA #1 observed Resident #37 holding an empty cup, and Resident #174 with water on his/her face and both residents were pulling each other's hair. Further review revealed the residents were immediately separated. Review of the care plan for Resident #37 and Resident #174 revealed the care plan was not revised after the incident to prevent further incidents. Review of a facility investigation revealed on 12/27/2021, Resident #174 was found in Resident #175's room. Resident #174 was found by staff behind the door in Resident #175's room with his/her clothing disheveled and Resident #175 was on the bed pulling at his/her pants. Review of the care plans for Resident #174 and Resident #175 revealed the care plans were not revised after the incident to prevent further incidents. Review of a facility investigation and interview with facility staff revealed on 01/15/2022, Resident #67 was found in Resident #175's room engaged in sexual intercourse. Review of the care plans for the residents revealed the care plans were not revised for Resident #67 and Resident #175 with individualized interventions to prevent further incidents. In addition, on 12/21/2021, Resident #174 wandered into Resident #37's room and upon entering the room staff found Resident #174 had water on his/her face with Resident #37 holding an empty cup and both residents were pulling each other's hair. The residents were immediately separated, and Resident #37 was placed on one (1) on one (1) monitoring following the incident and referred to psych for evaluation. There was no evidence that the care plans were reviewed and revised to prevent further incidents. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's failure to ensure resident person-centered care plans were reviewed and revised has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 02/12/2022 and determined to exist on 12/06/2021 at 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation (F600, F607, and F610) at the highest scope and severity (s/s) of a J, 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F657) at s/s of a J, and 42 CFR 483.70 Administration (F835), at s/s of a J. The facility was notified of the Immediate Jeopardy on 02/12/2022. An acceptable Immediate Jeopardy removal plan was received on 02/22/2022, which alleged removal of the Immediate Jeopardy on 02/19/2022. The State Survey Agency determined the Immediate Jeopardy was removed as alleged on 02/19/2022, prior to exit on 02/24/2022, which lowered the scope and severity to D level at 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation, (F600, F607 and F610) 483.21 Comprehensive Resident Centered Care Plans (F657) and 42 CFR 483.70 Administration (F835), while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy titled, Comprehensive Care Plans, dated 07/19/2018 revealed the facility developed person-centered comprehensive care plans that included measurable objectives and timetables for each resident's medical, nursing, mental and psychosocial needs. Continued review revealed care plans were ongoing and revised as information about the resident and the resident's condition changed. Review revealed care plan interventions were implemented after consideration of the resident's problem areas and causes. Further review revealed the interventions were to address the underlying source(s) of the resident's problem area(s), rather than addressing only symptoms or triggers. Review further revealed the interventions were to reflect action, treatment, or procedure to meet the objectives toward achieving the resident's goals. 1. Review of Resident #174's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses of Unspecified Dementia with Behavioral Disturbance, and Wandering. Review of the facility's Admission Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed Resident #174 to have a Brief Interview for Mental Status (BIMS) score of one (1), indicating the resident had severe cognitive impairment. Continued review of the Admission MDS Assessment revealed the facility had assessed Resident #174 as having behaviors placed him/her at risk of physical illness or injury, which significantly interfered with the resident's care, and wandering behaviors that significantly intruded on the privacy or activities of others during the assessment period. Review of the facility's Comprehensive Care Plan for Resident #174 dated 10/29/2021, revealed a problem area noted regarding the resident's wandering behavior. Continued review revealed the care plan interventions included for staff to remove the resident from a situation and take him/her to another location as needed, and to intervene as needed to protect the rights and safety of others. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's Incident Report dated 12/06/2021 revealed Kentucky Medication Aide (KMA) #1 responded to Resident #10's call light. Review revealed upon entering the resident's room KMA #1 observed Resident #174 lying on the bed with his/her pants pulled down to the thigh area, and Resident #10 seated at the head of the bed, feet on floor with his/her pants pulled down to knees. Continued review revealed Resident #10 had his/her hand on Resident #174's thigh area. Further review revealed the residents were immediately separated and a head to toe skin assessment was conducted of both. In addition, review further revealed no injuries were found on either resident, both residents were unable to recall the incident, and Resident #10 was placed on one (1) to one (1) monitoring. Continued review of Resident #174's care plan dated 10/29/2021, revealed no documented evidence of revisions made to the resident's care plan following the incident on 12/06/2021, involving Resident #10. Interview on 02/09/2022 at 9:35 AM, with KMA #1 revealed she had been charting at the nurse's station when Resident #10's call light started going off. Per KMA #1, she went to answer the call light, and the room door was closed. She stated she entered the room and the privacy curtain was pulled closed. Continued interview revealed she pulled the curtain open and observed Resident #10 sitting upright on the bed with his/her feet on the floor, and his/her pants down to mid-thigh. KMA #1 stated she also observed Resident #174 and his/her pants were also down to mid-thigh, and Resident #10's hand was lying on Resident #174's thigh. Further interview revealed Resident #10 had been placed on one (1) to one (1) monitoring immediately following the incident; however, she was not aware of any specific interventions having been put in place for Resident #174 after the incident. In addition, she stated Resident #174 was known to wander, but had not had any incidents of inappropriate behavior prior to the incident with Resident #10. Interview with the Unit Manager on 02/09/2022 at 2:44 PM revealed neither of the two (2) residents involved in the 12/06/2021 incident, Resident #10 and Resident #174, had a history of any incidents prior to that date. The Unit Manager revealed after the incident on 12/06/2021, Resident #10 had been placed on one (1) on one (1) monitoring and remained on one (1) on one (1) at the time of interview. Continued interview revealed the Unit Manager could not recall any specific interventions which had been implemented for Resident #174 following the incident. Additionally, the UM stated the facility had identified Resident #174's behavior of wandering into other residents' rooms and the resident's care plan should have been reviewed and revised with interventions implemented following the 12/06/2021 incident involving Resident #10. Interview with the former Social Services Director (SSD), on 02/11/2022 at 10:00 AM, revealed she was unable to recall any specific interventions which were put into place for Resident #174 following the incident with Resident #10 on 12/06/2021. Continued interview revealed; however, she did recall Resident #10 had been placed on one (1) to one (1) monitoring. She stated the facility had not looked at Resident #174's behaviors as the resident was known to wander frequently on the unit and it was difficult to keep the residents on that unit from wandering into other residents' rooms. She stated residents' behaviors had been discussed in the morning clinical meetings, which included Resident #174's behaviors; however, the facility had not perceived Resident #174's behaviors as instigating the incident with Resident #10. Further interview revealed it might have helped to place Resident #174 on increased monitoring; however, had not done that due to Resident #10 having been placed on one (1) to one (1) monitoring following the incident. The former SSD further stated the facility had not identified a potential for abuse concern regarding Resident #174's increased wandering into other residents' rooms, as the resident had already been care planned for his/her wandering behaviors. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the former Administrator on 02/11/2022 at 5:05 PM, revealed she been the acting Administrator and facility's Abuse Coordinator when the incident involving Resident #174 and Resident #10 occurred on 12/06/2021. The former Administrator stated following the incident both the residents were evaluated by psych services, and Resident #10 had been placed on one (1) on one (1) monitoring immediately following the incident. Further interview revealed the former Administrator had been unable to recall any specific care plan revisions or interventions implemented for Resident #174. The former Administrator further stated however, Resident #174's and Resident #10's care plans should have been reviewed and revised following the incident which occurred on 12/06/2021. 2. Review of the clinical record for Resident #37 revealed the resident had been admitted to the facility on [DATE], with diagnoses which included Delirium due to psychological condition, and Dementia with Behavioral Disturbance. Review of the facility's Quarterly MDS assessment dated [DATE] for Resident #37 revealed the facility assessed the resident with a BIMS score of three (3), which indicated severe cognitive impairment. Continued review of the MDS Assessment revealed the facility had assessed Resident #37 as having verbal behaviors of screaming, cursing or threatening others during the observation period. Further review of the MDS Assessment revealed the facility had assessed Resident #37 as having no occurrences of physical behaviors during the observation period. Review of Resident #37's care plan dated 04/12/2021 revealed a problem area of behaviors with interventions to Administer and observe effectiveness and side effects of medications as ordered, intervene as needed to protect rights and safety of others, approach in calm manner, divert attention, remove from situation and take to another location as needed, with goal that resident will not harm themselves or others secondary to behaviors. Review of the clinical record for Resident #174's revealed an admitted [DATE], and diagnoses which included Wandering and Unspecified Dementia with Behavioral Disturbance. Review of Resident #174's Admission MDS assessment dated [DATE], revealed the facility assessed the resident as severely cognitively impaired as indicated by a BIMS score of one (1). Continued review of the Admission MDS Assessment revealed Resident #174 had been assessed to have wandering behaviors which markedly intruded on other people's privacy or activities. Further review of the Assessment revealed Resident #174 had also been assessed with behaviors which placed the resident at risk of injury. Review of Resident #174's Comprehensive Care Plan dated 10/29/2021, revealed the facility had care planned the resident for his/her wandering behaviors. Review revealed the care plan interventions included for staff to intervene as needed to protect the rights and safety of others, and remove Resident #174 from a situation and move the resident to another location as needed. Further review revealed the goal was for Resident #174 not to harm self or others resultant to his/her behaviors. Review of the facility's Incident Report dated 12/21/2021, revealed KMA #1 had entered Resident #37's room after hearing a noise there. Review revealed upon entering the resident's room KMA #1 observed Resident #37 holding an empty cup, and Resident #174 with water on his/her face, both residents pulling each other's hair. Further review revealed the residents were immediately separated, and Resident #37 was placed on one (1) on one (1) monitoring and referred for a psychiatric evaluation due to his/her increased behaviors. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	However, further review of Resident #37's Comprehensive Care Plan dated 04/12/2021, revealed no documented evidence of revisions made to the resident's care plan following the incident with Resident #174 on 12/21/2021. (Even though the Incident Report noted the resident had been placed on the one [1] to one [1] monitoring and had been referred for a psych evaluation due to his/her increase behaviors) Further review of Resident #174's Comprehensive Care Plan dated 10/29/2021, revealed no documented evidence of revisions made to the resident's care plan following the incident with Resident #37 on 12/21/2021. Interview on 02/10/2021 at 10:38 AM with KMA #1 revealed she had been working on documentation behind the nursing station on 12/21/2021, when she heard a ruckus going on in Resident #37's room. KMA #1 stated upon entering the resident's room she observed Resident #37 to have an empty cup in his/her hand, and Resident #174 with water on his/her face, and the two (2) residents pulling each other's hair. Continued interview revealed she immediately separated the residents and notified the Unit Manager and the Administrator. Further interview revealed Resident #37 had been placed on one (1) to one (1) monitoring immediately after the incident; however, she could not recall Resident #174 having been placed on any specific interventions after the incident. Interview on 02/10/2022 at 11:00 AM with SRNA #6 revealed she had not been working when the 12/21/2021 incident between Resident #37 and Resident #174 occurred. She stated however, she was aware Resident #37 had been placed on one (1) to one (1) monitoring after the incident. Further interview revealed she could not recall any specific behavior interventions put into place for Resident #174 after the incident though. Interview with Unit Manager on 02/09/22 at 2:44 PM revealed Resident #37 was immediately placed on one (1) on one (1) monitoring after the incident on 12/21/2021. She stated she recalled discussion of Resident #174's behaviors after the incident; however, did not recall any specific behavior interventions implemented for the resident after the incident though. Continued interview revealed Resident #174's wandering into other residents' rooms behavior should have had interventions put in place following the first incident on 12/06/2021 which involved Resident #10. Further interview revealed an intervention to increase Resident #174's monitoring should have also been implemented after the first incident. In addition, she revealed Resident #37's and Resident #174's care plans should have been reviewed and revised following the incident on 12/21/2021. Interview with former Social Services Director (SSD) on 02/11/2022 at 10:00 AM, revealed additional interventions for Resident #174 and Resident #37 had not really been discussed after the incident on 12/21/2021, because both residents had already been care planned for their Dementia diagnoses and wandering behaviors. Further interview revealed the facility had determined the incident occurred due to Resident #37 becoming upset that Resident #174 had wandered into his/her room, therefore, the residents care plans were not reviewed and revised following the incident. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Administrator on 02/11/22 at 4:23 PM, revealed Resident #174 had wandered into Resident #37's room and Resident #37 had thrown water in Resident #174's face. The Administrator stated when staff entered Resident #37's room, the two (2) residents were also observed pulling each other's hair. Continued interview revealed Resident #37 was known to be territorial of his/her space and did not like others in his/her space. She stated the facility felt Resident #37 had been the aggressor in the incident due to being territorial and had thrown water on Resident #174. Per interview, Resident #37 was immediately placed on one (1) to one (1) monitoring following the incident. She stated Resident #174's care plan was reviewed following the incident with Resident #37; however, the resident's care plan was not revised with new interventions due to Resident #37 having been placed on one (1) to one (1) monitoring. Further interview revealed the facility should have put new interventions in place for Resident #174's wandering behaviors though, and his/her behaviors should have been thoroughly addressed on the resident's care plan. The Administrator further stated both residents' care plans should have been reviewed and revised following the incident on 12/21/2021. 3. Review of the facility's Self-Reported Incident Form dated 01/15/2022, revealed KMA #3 reported to a nurse (Licensed Practical Nurse #10) on 01/15/2022, that Resident #67 and Resident #175 had been inappropriately touching one another. Review of the facility's investigation documentation of the incident of inappropriate touching date 01/21/2022, revealed the Administrator unsubstantiated sexual abuse based on information obtained from investigation. Review of Resident #175's clinical record revealed the facility admitted him/her on 02/01/2021, with diagnoses including Unspecified Psychosis, Parkinson's Disease, Unspecified Dementia and Alzheimer's Disease. Review of Resident #175's Quarterly MDS assessment dated [DATE], revealed the resident had been assessed to have a BIMS score of two (2), indicating severely impaired cognition. Review of the Comprehensive Care Plan for Resident #175 revealed on 11/26/2021 a behavioral care plan for sexually inappropriate behaviors had been initiated. Continued review of the care plan revealed no description of the sexually inappropriate behavior Resident #175 had displayed. Review of the care plan revealed the interventions included: intervene as needed to protect the rights and safety of others, approach in a calm manner, divert attention, and remove from the situation and take to another location as needed. Further review of the care plan revealed additional interventions which included geriatric psychiatric services as needed and to monitor behavioral episodes. Review of the Progress Notes for Resident #175 for the months of November and December 2021 revealed the resident had displayed sexually inappropriate behaviors on 11/22/2021, where he/she groped a staff member's buttocks and made sexual statements. Continued review revealed a Note dated 11/26/2021 which noted Resident #175 was threatening other staff and residents, cursing and making vulgar comments, and was touching staff and other residents. Further review revealed a Note dated 12/01/2021 which documented Resident #175 had made a verbal sexual comment to a staff member, and a Note dated 12/11/2021, which noted the resident made several sexual statements towards staff and pinched staff on the butt. Additional review of the Progress Notes revealed a Note dated 12/20/2021, documenting Resident #175 had exhibited sexually inappropriate behavior by hitting staff on bottoms; and a Note dated 12/27/2021, which recorded the resident as having increased sexual behaviors of making comments to staff. Further review of Resident #175's Comprehensive Care Plan revealed the care plan had not been updated to reflect the sexual behaviors toward resident(s) and staff documented in the Progress Notes. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with KMA #3 on 02/09/2022 at 8:30 PM and 02/10/2022 at 9:55 AM, revealed Resident #67 and #175 had been actively engaged in sexual intercourse on 01/15/2022, when she entered the room. She further stated she separated the residents and immediately reported the incident to LPN #10. 4. Review of Resident #67's clinical record revealed the facility admitted the resident on 04/17/2021, with diagnosis including Chronic Diastolic (Congestive) Heart Failure, Atrial Fibrillation and Chronic Obstructive Pulmonary Disease (COPD). Review of the Quarterly MDS assessment dated [DATE], revealed a BIMS score of two (2) which indicated severely impaired cognition. Further review of the MDS revealed the resident had been assessed to have no behaviors. Review of the Comprehensive Care Plan for Resident #175 dated 07/01/2021, revealed the resident had been care planned as at risk for elopement due to attempts to elope from the facility. Review of Progress Notes for July 2021 for Resident #67 revealed the resident had been care planned for wandering around [the] unit, with no other behaviors documented. Further review of Resident #67's care plan revealed no documented evidence of any revisions/updates to address sexual behaviors toward other resident(s). Interview with the facility's Minimum Data Set (MDS) Coordinator on 02/12/22 at 5:32 PM, revealed the facility's Interdisciplinary Team (IDT) had the responsibility to ensure residents' care plans were updated/revised. She stated Resident #67's and Resident #175's care plan should have been updated and revised to reflect any new and/or worsening behaviors. Further interview revealed she was unaware why the resident's care plans were not accurately revised/updated. Interview with the Director of Nursing (DON) on 02/11/2022 at 4:22 PM revealed she expected the MDS staff to update and revise each resident's plan of care and make necessary changes as needed. The DON stated she routinely reviewed resident care plans to ensure their appropriateness. Interview with the Administrator on 02/11/2022 at 04:15 PM revealed she expected revisions be made to each resident's care plan timely and appropriately. The Administrator stated she had not identified any concerns with care plans not being revised when a change occurred. **The facility implemented the following actions to remove the Immediate Jeopardy on 02/19/2022. 1.Incident # 1 occurred on 12/06/2021 involving Residents #174 and #10. The following steps were taken to ensure resident safety. For Resident #174, a skin assessment was completed on 12/06/2021, with no bruising, markings or concerns noted. The Care Plan was reviewed on 12/09/2021 by the Minimum Data Set (MDS) Coordinator, and interventions were updated on the resident's mood care plan. The MD (Medical Doctor) and the resident's POA (Power of Attorney) was notified on 12/06/2021. For Resident #10, the resident was placed on 1:1 supervision on 12/06/2021 and currently remains on 1:1 supervision. Resident #10's medications were reviewed on 12/07/2021 by the Psychiatric Nurse Practitioner and medication changes were made including Paxil started and Viibryd dose decreased. A Psychiatric Services Consult was completed for Resident #10 on 12/07/2021, and follow-up visits were completed on 12/14/2021 and 12/29/2021. The resident's care plan was reviewed by the Interim Director of Nursing (DON) on 12/06/2021 with new interventions added to the resident's psychosocial care plan. The MD and POA were notified of the incident on 12/06/2021. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Incident #2 occurred on 12/27/2021 involving Resident #174 and Resident #175. For Resident #174, the Regional Nurse Consultant completed a skin assessment of Resident #174 on 12/27/21 with no concerns noted. Review of documentation revealed the resident's MD and POA were notified on 12/27/21. Resident #174 was discharged per a planned discharge to home on 12/28/2021. For Resident #175, a skin assessment was completed on 12/27/2021 by the Regional Nurse Consultant with no concerns identified. Resident #175 was provided 1:1 Supervision on 12/27/2021 and the elder was transferred to the hospital on 12/27/2021, then returned to the facility on [DATE]. The resident's MD and Family were notified on 12/27/2021. The resident's care plan was updated on 02/18/2022 related to 1:1 status and the resident's discharge to a behavior unit on 12/27/2021 by the Regional Nurse consultant. Incident #3 occurred on 01/15/2022 involving Resident #67 and Resident #175. Resident #67 was found lying in the bed of elder #175. Both elders had pants off and were engaging in sexual activities. The following steps were taken to ensure resident safety. For Resident #67, a psychosocial follow-up was conducted for seventy-two (72) hours to provide psychosocial support and identify any concerns. The follow-ups were conducted on 01/15/2022, 01/16/2022, and 01/17/2022 by the Administrator. The Unit Manager reviewed the resident's care plan on 01/15/2022, to reflect the needs of the resident and to reflect the psychosocial follow-up. An assessment for physical trauma/injury was completed for Resident #67 via a skin assessment by the Unit Manager on 01/15/2022. The resident's MD and POA were notified of the incident on 01/15/2022. A Dementia Scale Pain Assessment and Pain Monitoring form that assesses the resident for pain by assessing the elders breathing, negative vocalization of pain, facial expressions, body language, and consolability was completed on 01/15/2022 by a Unit Manager with a score of zero (0) which indicated no pain. This assessment was noted to also indicate the resident was not in pain as did the baseline assessment completed on 12/06/2021 by Regional Nurse Consultant. For Resident #175, a skin assessment was completed on 01/15/2022 by a Unit Manager with no concerns noted. The resident was placed on 1:1 Supervision on 01/15/2022 and remained on 1:1 supervision until the resident was discharged from the facility on 02/22/2022. The resident was transferred to the hospital on 01/15/2022 and returned 01/26/2022 and remained on 1:1 supervision until transferred to the hospital on 02/01/2022 and returned on 02/10/2022. The Resident was then placed on 1:1 supervision upon return from the hospital and remained 1:1 until the resident was discharged from the facility on 02/22/2022. The resident's MD and Family were notified of the incident on 01/15/2022. The Administrator updated the resident's care plan on 01/15/2022 to reflect the resident's 1:1 status. The Housekeeper was initially educated on the abuse policy on 01/19/2022 by the facility Administrator which included protection of the resident and the Housekeeper was educated on the abuse policy on 2/16/2022 by the Staff Development Coordinator. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	F 835, the facility must be administered in manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practical physical, mental, and psychosocial wellbeing of each resident. The facility administration is not limited to the administrator and may also include the facility's governing body, management company, and/ or others identified by the facility as part of the facility administration. CMS's Abuse Critical Pathway and reporting guidelines. F600, residents have the right to be free from abuse, neglect, misappropriation, and exploitation. This includes freedom from corporal punishment, involuntary seclusion and any physical or chemical re [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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42932 Based on interview, record review, review of the Administrator's Job Description, and review of the facility's policies and procedures, it was determined the facility failed to ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being and protect its residents from abuse/potential abuse. The facility's Administration failed to ensure residents were free from abuse; failed to ensure its abuse policies were implemented; failed to ensure thorough investigations of abuse allegation incidents were conducted; and, failed to implement residents' Comprehensive Care Plans (CPs) for four (4) of four (4) allegations of resident abuse. (Refer to F600, F607, F610, and F656) The facility's failure to ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to protect its residents from abuse/potential abuse, has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 02/12/2022 and determined to exist on 12/06/2021 at 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation (F600, F607, and F610), 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F657), and 42 CFR 483.70 Administration (F835). The facility was notified of the Immediate Jeopardy on 02/12/2022. An acceptable Immediate Jeopardy removal plan was received on 02/22/2022, which alleged removal of the Immediate Jeopardy on 02/19/2022. The State Survey Agency determined the Immediate Jeopardy was removed as alleged on 02/19/2022, prior to exit on 02/24/2022, which lowered the scope and severity to D level at 42 CFR 483.12 Freedom from Abuse, Neglect and Explotation, (F600, F607 and F610) 483.21 Comprehensive Resident Centered Care Plans (F657) and 42 CFR 483.70 Administration (F835), while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's Job Description for the Administrator with a revision date of December 2018, revealed the Administrator was to lead and direct the overall operations of the facility in accordance with government regulations. Review of the facility's policy titled, Abuse, Neglect and Misappropriation of Property with a revision date of 05/08/2019, revealed the Administrator was to investigate all allegations, reports, grievances and incidents that potentially could constitute allegations of abuse, injuries of unknown source, exploitation, or suspicions of crime. Review further revealed the facility's Administrator retained the ultimate responsibility for overseeing and completing the investigations, and to draw conclusions regarding the nature of the incident. 1. Review of the Self-Reported Incident Form dated 01/15/2022, revealed on 01/15/2022, a Kentucky Medication Aide (KMA) reported to the nurse her observation of Resident #67 and Resident #175 inappropriately touching one another. (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 investigation of the incident dated 01/15/2022, revealed no documented evidence of written statements from KMA #3 or LPN #10 regarding the incident. Interview with KMA #3, on 02/09/2022 at 8:30 PM and 02/10/2022 at 9:55 AM, revealed she had observed Resident #67 and #175 actively engaged in sexual intercourse on 01/15/2022. Review of Resident #67's and Resident #175's clinical record revealed both residents had been assessed as severely cognitively impaired making them unable to consent to sexual activity with another person. Interview with the Administrator, on 02/11/2022 at 11:47 AM, revealed she unsubstantiated sexual abuse for the 01/15/2022 investigation. Interview revealed the Administrator stated the investigation for the 01/15/2022 incident had been unsubstantiated due to Resident #67 and #175 had no willful intent for sexual abuse. Further interview revealed the witnesses had given conflicting statements. 2. Review of the Self-Reported Incident Form dated 12/27/2021, revealed a State Registered Nurse Aide (SRNA) reported to a charge nurse her observation of Resident #175 lying on the bed pulling at the waist of his/her pants, and Resident #174 with his/her blouse disheveled. Review of the Witness Statement completed by the SRNA revealed Resident #174 had been standing behind the door of Resident #175's room with his/her shirt twisted and his/her bra showing through the crisscross of his/her shirt. Continued review revealed the SRNA noted observing Resident #175 on his/her bed with his/her pants down. Review of Resident #174's and Resident #175's clinical records revealed the residents had been assessed as severely cognitively impaired making them unable to consent to sexual activity with another person. Interview with the Administrator, on 02/11/2022 at 11:47 AM, revealed she unsubstantiated sexual abuse for the investigation of the incident on 12/27/2021. Per the Administrator, the investigation for 12/27/2021 incident had been unsubstantiated due to lack of evidence that sexual abuse had occurred. 3. Review of the Self-Reported Incident Form dated 12/06/2021, revealed KMA #1 entered Resident #10's room, and observed Resident #174 lying on the bed with Resident #10 sitting on the bed with his/her hand on Resident #10's thigh. Review of the Summary of Incident documentation revealed KMA #1 observed Resident #174 lying on Resident #10's bed with his/her pants down to the mid-thigh area, with Resident #10 seated at the head of the bed with his/her pants down to the knees and his/her hand on Resident #174's thigh. Review of Resident #10's and Resident #174's clinical records revealed the facility had assessed both residents as severely cognitively impaired, and unable to consent to sexual activity with another person. (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 former Administrator, on 02/11/2022 at 5:05 PM, revealed she unsubstantiated sexual abuse for the investigation of the 12/06/2021 incident involving Resident #174 and Resident #10. Per the Administrator, she unsubstantiated sexual abuse as when she interviewed staff regarding the incident they stated nothing had happened as far as physical contact aside from Resident #10's hand on Resident #174's thigh. Further interview revealed skin assessments had been completed for both residents and there was no evidence of sexual abuse. 4. Review of the facility's Incident Report dated 12/21/2021, revealed KMA #1 found Resident #174 in Resident #37's room with water on his/her face, and Resident #37 holding an empty cup. Continued review revealed the KMA also observed both residents pulling each other's hair. Further review revealed Resident #37 had been placed on one (1) on one (1) monitoring and referred for a psychiatric (psych) evaluation due to increased behaviors. However, review further revealed no documented evidence that the facility had identified Resident #174's increased wandering into other resident rooms, or identified that Resident #174 was involved in one (1) prior incident of alleged abuse on 12/06/2021 after wandering into another resident room. Interview with the Unit Manager, on 02/09/22 at 2:44 PM, revealed she was aware of the altercation between Resident #174 and Resident #37 on 12/21/2021. However, the Unit Manager stated no interventions were initiated related to Resident #174's wandering behavior, but Resident #37 was placed on 1:1 monitoring and referred for a psychiatric evaluation. Interview with the Administrator on 02/11/2022 at 4:23 PM, revealed she stated Resident #174 wandered into Resident #37's room on 12/21/2021, and Resident #37 threw water on Resident #174's face, and then the two (2) began pulling each other's hair. Further interview with the Administrator revealed revealed the facility concluded that Resident #37 had been the aggressor because the resident threw water on Resident #174's face, and immediately placed Resident #37 on one (1) to one (1) monitoring. Continued interview with the Administrator revealed Resident #37 was territorial of his/her space and did not like others in his/her space. However, the Administrator stated she did nor consider that Resident #174's wandering into Resident #37's room was the precipitating event that led to the altercation, and therefore failed to implement any action to prevent Resident #174 from being assaulted again if the resident continued to wander into dangerous situations. **The facility implemented the following actions to remove the Immediate Jeopardy on 02/19/2022. 1.Incident # 1 occurred on 12/06/2021 involving Residents #174 and #10. The following steps were taken to ensure resident safety. For Resident #174, a skin assessment was completed on 12/06/2021, with no bruising, markings or concerns noted. The Care Plan was reviewed on 12/09/2021 by the Minimum Data Set (MDS) Coordinator, and interventions were updated on the resident's mood care plan. The MD (Medical Doctor) and the resident's POA (Power of Attorney) was notified on 12/06/2021. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	For Resident #10, the resident was placed on 1:1 supervision on 12/06/2021 and currently remains on 1:1 supervision. Resident #10's medications were reviewed on 12/07/2021 by the Psychiatric Nurse Practitioner and medication changes were made including Paxil started and Viibryd dose decreased. A Psychiatric Services Consult was completed for Resident #10 on 12/07/2021, and follow-up visits were completed on 12/14/2021 and 12/29/2021. The resident's care plan was reviewed by the Interim Director of Nursing (DON) on 12/06/2021 with new interventions added to the resident's psychosocial care plan. The MD and POA were notified of the incident on 12/06/2021. Incident #2 occurred on 12/27/2021 involving Resident #174 and Resident #175. For Resident #174, the Regional Nurse Consultant completed a skin assessment of Resident #174 on 12/27/21 with no concerns noted. Review of documentation revealed the resident's MD and POA were notified on 12/27/21. Resident #174 was discharged per a planned discharge to home on 12/28/2021. For Resident #175, a skin assessment was completed on 12/27/2021 by the Regional Nurse Consultant with no concerns identified. Resident #175 was provided 1:1 Supervision on 12/27/2021 and the elder was transferred to the hospital on 12/27/2021, then returned to the facility on [DATE]. The resident's MD and Family were notified on 12/27/2021. The resident's care plan was updated on 02/18/2022 related to 1:1 status and the resident's discharge to a behavior unit on 12/27/2021 by the Regional Nurse consultant. Incident #3 occurred on 01/15/2022 involving Resident #67 and Resident #175. Resident #67 was found lying in the bed of elder #175. Both elders had pants off and were engaging in sexual activities. The following steps were taken to ensure resident safety. For Resident #67, a psychosocial follow-up was conducted for seventy-two (72) hours to provide psychosocial support and identify any concerns. The follow-ups were conducted on 01/15/2022, 01/16/2022, and 01/17/2022 by the Administrator. The Unit Manager reviewed the resident's care plan on 01/15/2022, to reflect the needs of the resident and to reflect the psychosocial follow-up. An assessment for physical trauma/injury was completed for Resident #67 via a skin assessment by the Unit Manager on 01/15/2022. The resident's MD and POA were notified of the incident on 01/15/2022. A Dementia Scale Pain Assessment and Pain Monitoring form that assesses the resident for pain by assessing the elders breathing, negative vocalization of pain, facial expressions, body language, and consolability was completed on 01/15/2022 by a Unit Manager with a score of zero (0) which indicated no pain. This assessment was noted to also indicate the resident was not in pain as did the baseline assessment completed on 12/06/2021 by Regional Nurse Consultant. For Resident #175, a skin assessment was completed on 01/15/2022 by a Unit Manager with no concerns noted. The resident was placed on 1:1 Supervision on 01/15/2022 and remained on 1:1 supervision until the resident was discharged from the facility on 02/22/2022. The resident was transferred to the hospital on 01/15/2022 and returned 01/26/2022 and remained on 1:1 supervision until transferred to the hospital on 02/01/2022 and returned on 02/10/2022. The Resident was then placed on 1:1 supervision upon return from the hospital and remained 1:1 until the resident was discharged from the facility on 02/22/2022. The resident's MD and Family were notified of the incident on 01/15/2022. The Administrator updated the resident's care plan on 01/15/2022 to reflect the resident's 1:1 status. (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 documentation revealed a skin assessment was completed for Resident #174 on 12/27/2021 by the Regional Nurse Consultant, with no concerns identified. Further record review revealed Resident #174 was discharged home as planned on 12/28/2021. Review of documentation revealed Resident #175 had a skin assessment completed on 12/27/2021 with no concerns identified. Further review revealed the resident was transferred to the hospital on 12/27/2021, then returned to the facility on [DATE]. Review of Resident #175's medical record revealed the resident's MD and family were notified of the transfer on 12/27/2021. On 01/15/2022, another incident with Resident #175 occurred and a skin assessment was completed on 01/15/2022 by the Unit Manager with no concerns identified. Review of the Behavior monitoring log revealed Resident #175 was placed on 1:1 supervision on 1/15/2022 and transferred to the Hospital. Continued review revealed the resident returned to the facility on [DATE] and was again transferred to the hospital on 02/01/2022. Resident #175 returned to the facility on [DATE] and was discharged from the facility on 02/22/2022. Review of a facility investigation revealed Resident #67, who had a BIMS score of six (6) was involved in an incident on 01/15/2022 with Resident # 175. Resident #67, an Observation on 02/23/2022, at 3:35 PM, revealed the resident was sitting in the common area and was obviously cognitively impaired. Record review revealed the Administrator had completed a psychosocial follow-up with Resident #67 on 01/15/2022, 01/16/2022, 01/17/2022 with no concerns noted. Interview with the Unit Manager on 02/24/2022 at 2:14 PM revealed she had completed a physical trauma/injury assessment for Resident #67 on 01/15/2022, and no concerns were noted. Review of Resident #67's Care plan revealed it was reviewed by the Unit Manager on 01/15/2022 and it reflected the needs of the resident and the psychosocial follow-ups which had been completed on 01/15/2022, 01/16/2022, and 01/17/2022. Review of the Dementia Scale Pain Assessment and Pain Monitoring form for Resident #67 revealed the assessment was completed on 01/15/2022 by a Unit Manager with a score of zero(0) which indicated no pain. Resident #175, review of his/her skin assessment dated [DATE], revealed the skin assessment was completed on 01/15/2022 with no concerns identified. Review of the facility's behavior monitoring log revealed Resident #175 was placed on 1:1 supervision on 1/15/2022 and then transferred to the hospital. Continued review of Resident #175's medical record revealed the resident returned to the facility on [DATE] and went back out to the hospital on 02/01/2022 and returned to the facility on [DATE]. Resident #175 was discharged from the facility on 02/22/2022. Review of facility training records and interview with Housekeeper #1, on 02 [TRUNCATED]