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	345303	A. BUILDING _____ B. WING _____	C 12/07/2023

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THE LAURELS OF GREENTREE RIDGE	70 SWEETEN CREEK ROAD ASHEVILLE, NC 28803

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F 000	INITIAL COMMENTS An unannounced complaint investigation was conducted on 12/05/23 with additional information obtained through 12/07/23, therefore, the exit date is 12/07/23. Event ID# FJJ111. The following intakes were investigated: NC00210097 and NC00210809. Three (3) of 4 allegations resulted in deficiencies.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and Resident, Physician Assistant, Psychologist, Health Care Personnel Investigator and staff interviews, the facility failed to protect a vulnerable female resident (Resident #1) from inappropriate intimacy from an employee (Medication Aide #1) for 1 of 3 residents reviewed for abuse. On or around 09/27/23, Resident #1 alleged Medication Aide #1 kissed her on her mouth.	F 600	The facility will continue to ensure all vulnerable residents are protected from inappropriate intimacy from employees. Resident #1 has had no identified negative outcomes because of this allegation and continues to be seen routinely for psychiatric/psychological services. Current vulnerable residents have the potential to be affected. From	1/3/24

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

Electronically Signed | 01/02/2024

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F 600	Continued From page 1 The findings included: Resident #1 was admitted to the facility on 11/24/21 with diagnoses that included diabetes mellitus, anxiety, depression and post-traumatic stress disorder. Source of this information. Resident #1 was her own responsible party. The quarterly Minimum Data Set (MDS) assessment dated 08/18/23 revealed that Resident #1 was cognitively intact. The Resident was able to understand others and be understood. She had no behaviors such as rejection of care, physical or verbal aggression and no hallucinations or delusions during the MDS assessment period. A review of Resident #1's care plan initiated on 09/26/19 and revised on 05/12/23 addressed the area of: Resident #1 was having irrational thoughts regarding a therapist and physician having an affair and was upset because she had been in love with the physician since she had been in the community. The goals that Resident #1 would participate in decision making regarding care to enhance sense of control and she would be free of inappropriate behaviors through the next review would be attained by interventions which included referring to psychiatry. On 12/04/23 at 9:55 AM an interview was conducted with the Health Care Personnel Investigator (HCPI) who reported she went to the facility on 11/15/23 to review the personnel files of Medication Aide (Med Aide) #1 and interview the	F 600	12/6/23-12/9/23 the nursing administration team conducted interviews with all residents that have a BIMs of 13 or greater (cognitively intact) to determine if they felt safe in the facility. There were no issues identified. No residents reported inappropriate sexual advances by Med Aide #1 or any other staff member. Between 12/25/23-12/29/23 the treatment nurse conducted skin assessments on all of the residents that had BIMS of less than 13 to determine if there were any signs of abuse. No issues were identified. On 12/29/23 the Reginal Clinical Coordinator re-educated the facility Administrator and the Assistant Director of Nursing on the abuse policy and procedure. The education emphasized a resident□s right to be free from abuse. Definitions and types of abuse, prevention of abuse, identification of abuse, and protecting residents from abuse were reviewed as well as reporting examples from the state operations manual. 100% of facility staff were in-serviced by the Administrator, Assistant Director of Nursing on the abuse policy and procedure. The education emphasized a resident□s right to be free from abuse. Definitions and types of abuse, prevention of abuse, identification of abuse, and protecting residents from abuse were reviewed as well as reporting examples from the state operations manual. The education began on 12/29/23 with all education to be completed by 1/2/24. Newly hired employees after 1/2/24 will receive mandatory in person education by the Assistant Director of Nursing during	

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F 600	Continued From page 2 staff in relation to a current investigation at a sister facility. She explained that she interviewed the Administrator, Director of Nursing (DON), and Unit Manager (UM) #1 at the facility and from the interviews she felt there could have been an inappropriate relationship between Med Aide #1 and Resident #1. The HCPI continued to explain that the Administrator reported Med Aide #1 was transferred to the sister facility because he had gotten close to a resident by being an active listener because she was going through some family dynamics and there were rumors circulating about him with the staff and he had not gotten a fair shake. The DON explained that she was in the middle of a Performance Improvement Plan (PIP) with Med Aide #1 because of inappropriate interactions with female staff and she had to go out on sick leave on 10/03/23 and found out during her leave that Med Aide #1 was no longer with the facility which she assumed he had been terminated due to the PIP. The DON later found out he was transferred to a sister facility. The HCPI continued to report that Unit Manager #1 informed her that one day, she did not know the day, she noticed Resident #1 was sad and tearful and had a change in her behavior. When she spoke with the Resident about it, she would only say that he didn't say goodbye and that it was consensual but would not elaborate on what she meant. During an interview and observation made with Resident #1 on 12/05/23 at 10:10 AM the Resident who was lying on her bed fully dressed in street clothes and well-groomed explained she performed her own care without the assistance of the staff. The Resident indicated she had been at the facility for about 5 years and had to come to the facility because of her diabetes and had to	F 600	general orientation prior to the start of their first shift. The education will empathize a resident□s right to be free from abuse. Definitions and types of abuse, prevention of abuse, identification of abuse, and protecting residents from abuse were reviewed as well as reporting examples from the state operations manual. A QA monitoring tool will be utilized to ensure ongoing compliance beginning on 1/3/24. The ADON/designee will screen residents that may be more vulnerable/ more at risk for inappropriate staff to resident interactions through MDS interviews, observations by the Assistant Director of Nursing and unit managers, and through quarterly care conferences reviews at a frequency of 5 residents 5x/week x 12 weeks. Any concerns identified through facility screening will be reported to the Director of Nursing who will complete an evaluation of the resident and document any follow-up required. Variances will be corrected at the time of observation and additional education provided when indicated. The Administrator will continue to be made aware of any instances of abuse, inappropriate behavior, or any other identified concern related to citation F600 from audits by the Director of Nursing. The Administrator will audit at minimum monthly the completion of the audits stated above frequency. Observation results will be reported to the Administrator (from the Director of Nursing) weekly for the next 3 months beginning on 1/10/24 and concerns will be	

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F 600	Continued From page 3 have insulin injections. Resident #1 was calm and displayed no apprehension and stated she felt safe at the facility. Resident #1 inquired about the reason for the visit, in which she was asked if she had had a recent encounter with a staff member? The Resident responded, "why does everybody keep asking me about him?" When asked about who? The Resident replied, the name of Med Aide #1. The Resident reported "what we had was consensual and it did not involve sex". When asked what was consensual the Resident explained, "we kissed on the lips, I kissed him and he kissed me back, it wasn't all him". She stated, "it wasn't all him because she wanted it just as much as he did". She described the kiss as lasting about 3 seconds and there was no tongue involved, "just a kiss on the lips". When asked how it made her feel she indicated "good, because he must have known that I needed it". When asked how he knew she needed it, she explained that she had been very worried for weeks about her family situation and she confided in him. She stated that the Med Aide worked 7:00 PM to 7:00 AM and when he brought her nighttime medications to her, they would visit and talk about her family problems, that they became close, and he would hold her hand. Resident #1 reported the Med Aide #1 could see that she needed a friend in her life, and he was there for her. She stated when she was down, he brought a smile to her face. The Resident explained that the last night Med Aide #1 worked, he told her that he had another job that needed him to work more hours for them and she would not be seeing him for a few days. She stated the kiss happened when he tucked her in bed that night first by tucking the covers up over her legs and moving up the sides of her body then as he raised up to her face they just kissed on the lips.	F 600	reported to the Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months during January through March regularly scheduled meetings or until resolved and additional education/training will be provided for any issues identified. Date of compliance 1/3/24.	

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She stated it only happened one time and it was not planned. The Resident repeated it was "consensual". The Resident reported that happened about 2 months ago and she has not seen him since. She stated when she asked staff about him, she was told that he was not allowed back in the facility. She stated she cried over him for 3 weeks because she did not get "closure". The Resident stated if Med Aide #1 walked through the door right now she would give him a big hug and ask him where he had been. The Resident stated she had discussed her feelings with the Administrator and Nurse #1.

On 12/05/23 at 12:00 PM during a conversation with Nurse #1 she explained that she worked with Resident #1 on day shift. She continued to explain that one day (she could not remember when) Resident #1 called her into the Resident's room and relayed to her that she knew Nurse #1's husband had gone to work at the other facility where Med Aide #1 transferred to. The Resident wrote her phone number on a piece of paper and asked the Nurse if she would give the number to her husband to give to Med Aide #1 because she "needed closure" and if she did not pass the number along then she understood. The Nurse stated she did not ask the Resident what she meant by "closure" because she felt that if the Resident wanted her to know then she would have told her. Nurse #1 reported that she did not give the Resident's number to her husband but threw it away instead. The Nurse stated a few weeks later Resident #1 asked her if she passed her number to Med Aide #1 and she told her that she didn't because her husband worked a different shift and did not see the Med Aide. The Nurse reported she never informed the facility administration about Resident #1's

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request.

During an interview with Nurse Aide (NA) #1 on 12/06/23 at 7:50 AM the NA explained that one day (he could not remember when) he went to visit Resident #1 at the facility because he used to work at the facility. The NA reported that Resident #1 told him that she knew that he worked with Med Aide #1 and made the statement "nothing happened between us, we just kissed". The NA stated her comment took him aback and he did not ask her to elaborate on the comment, but he reported it to Nurse #1 who was on duty at the time. The NA continued to explain that sometime later Resident #1 asked Nurse #1 to give her phone number to NA #1 to pass along to Med Aide #1, but they threw the Resident's phone number away and did not pass it along to Med Aide #1.

A follow up interview with Nurse #1 on 12/06/23 at 11:10 AM revealed that she did not remember NA #1 telling her that Resident #1 had reported that the Resident and Med Aide #1 kissed, and nothing happened between them. The Nurse stated had she been notified of that; she would have reported it to the Administrator.

On 12/05/23 at 1:55 PM during a conversation with Unit Manager (UM) #1, she reported that one day, she did not recall the exact date, she noticed Resident #1 had walked by her office and did not stop to talk as she normally did but instead went to the other side of the facility to speak with Unit Manager #2. UM #1 stated she did not know what the conversation between Resident #1 and UM #2 was about, but knew it was upsetting to Resident #1. UM #1 continued to explain that shortly after that Resident #1 had a change in her

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behavior and was tearful which the UM thought was related to her family dynamics. The UM went to talk with Resident #1 and the Resident reported that she was upset because someone needed to "apologize" to her but when the UM asked the Resident what she was referring to the Resident stated, "he just left and didn't give her an explanation". The Resident made the comment "it was consensual" but would not say what was consensual. The UM stated she was blindsided by the comment and when she asked what was consensual and who she was referring to, again the Resident would not continue the conversation. The UM explained that although she did not state it was Med Aide #1, she put two and two together and felt it was the Med Aide she was referring to because it was right around the time Med Aide #1 left the facility. UM #1 stated she made the Administrator aware of the conversation via telephone that day or the next, she could not remember which. The UM reported Med Aide #1 no longer worked at the facility, so she thought the situation was handled.

An interview was conducted with Unit Manager #2 on 12/05/23 at 2:35 PM. The UM explained that one day about a month or so ago Resident #1 came to her side of the building and the UM could tell by the look on her face that the Resident was upset about something, so she asked her to come into her office. When they went into the UM's office Resident #1 asked her if she was Med Aide #1's girlfriend? The Resident explained that she heard the staff talking about the Med Aide seeing someone who worked at the facility and thought it was UM #2. The UM stated she ensured the Resident that she was not Med Aide's girlfriend and Resident #1 began to explain that he owed her an apology because the Med

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Aide told her that he would be gone for a while and would keep in contact with her, but she had not seen the Med Aide since he left. UM #2 explained that she asked the Resident if there was something she needed from Med Aide #1 and the Resident stated no, they had moments together that was not sexual and would not elaborate on what the "moments" were. The UM stated the Resident's statements were so concerning to her that she went straight to the Administrator and informed her of the conversation between her and the Resident. The UM stated she asked the Administrator if she needed to write a statement about the conversation and the Administrator told the UM to hold off until they could figure out what was going to happen.

During an interview with Nurse Aide #2 on 12/05/23 at 3:05 PM the NA stated she went to work at the facility in early June 2023, and discovered Med Aide #1 also worked at the facility. The NA explained that she felt like she needed to inform the Director of Nursing (DON) that there had been rumors at the other facility that Med Aide #1 was intimate with a resident on third shift, so she reported it to the DON.

An interview was made with Medication Aide #1 on 12/06/23 at 9:50 AM. The Med Aide explained that he worked the 7:00 PM to 7:00 AM shift for about 3.5 months and the last day he worked at the facility was October 22nd or 23rd. He stated it was hard to remember because he tried to put it out of his mind (would not elaborate on what was hard to put out of his mind). When asked how often he took care of Resident #1 the Med Aide stated that he would give her medications to her and obtain her blood sugar. When asked if he

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had ever kissed Resident #1 the Med Aide replied, "absolutely not, not if she is the one, I am thinking of". He stated, "I have not ever kissed her, not once, are you kidding with COVID in the building". The Med Aide continued to report "I remember her now, she gets insulin, very sweet lady and we have talked but no, I have never kissed her. We talked about nothing significant because I haven't spent a lot of time with her". When the Med Aide was asked if it was reported that he and Resident #1 had kissed in the mouth, what would he say to that and the Med Aide stated, "it would be a lie because I have never kissed her in the mouth or anywhere else, not even on the forehead". Med Aide #1 stated "I know myself pretty well and I know that I would not do that". The Med Aide explained that they had joked around a lot but that was it. When the Med Aide was asked if he ever referred to Resident #1 as being his girlfriend the Med Aide replied "No, I have a girlfriend". The Med Aide was asked if an inappropriate relationship between a resident and a staff member occurred, should it be reported and the Med Aide stated, "if it was unwanted and bothered her then yes ma'am" but I never seemed to bother Resident #1 when I was around, and she seemed to always be glad to see me'. When asked if he thought the Resident was in her right mind and could make good decisions the Med Aide replied he never interacted with her enough to make that assumption. The Med Aide denied that he ever spoke to Resident #1 about leaving the facility.

A review of Resident #1's Psychotherapy progress notes dated 11/10/23 and 11/24/23 revealed that Resident #1's speech was clear and coherent and seemed to be less stressed. They discussed personal issues that were distressing

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the Resident, and the Psychotherapist positively reinforced the use of reframing to reduce the Resident's distress.

An interview was conducted with the Psychotherapist on 12/06/23 at 12:00 PM. The Psychotherapist explained that the personal issues that were discussed between she and Resident #1 were the Resident's personal feelings that she felt for someone, and the Resident felt that the someone had those feelings for her as well, but then he left. The Resident explained that she and the staff member would spend time with her, having kind things to say to her. She liked him and was happy to have him but was struggling with her feelings because she was married. She said he had another part-time job and he left but she did not say if he left because of what they had (between them) or if he had to leave (for another reason). The Resident was sad that he left and did not come back to say goodbye. The Psychotherapist stated that she did not know anything about Resident #1 and the staff member kissing. She stated if it happened, and was consensual, it was poor judgement on the part of the staff member. She stated she did not find Resident #1 to have poor judgement and in general she seemed to have pretty good judgement. She stated she was focused and loved the time they had to talk. The Resident wasn't upset that she had spent time with the staff member and was happy about it. She enjoyed having him come and see her. The Psychotherapist stated that Resident #1 told her that she had already discussed the situation with someone, so she thought the facility was aware of it. The Psychotherapist explained that if the staff member was still there and Resident #1 was distressed about it, she would have asked her

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permission to discuss it with the facility. She was sad and had her feelings hurt but the next visit she had with her; the Resident was over it. The Psychotherapist reported that she thought Resident #1 understood her situation with the staff member and if the kiss happened the Resident could give her consent to the kiss.

During an interview with the Supervisor on 12/06/23 at 1:20 PM, the Supervisor stated that he had worked as the weekend Supervisor since June 2023. The Supervisor explained that he had worked with Medication Aide #1 at a different facility and was surprised to see that the Med Aide worked at this facility as well. He continued to explain that before he left the previous facility, he was aware of the facility investigating the Med Aide because there were reports of him having sexual misconduct or abuse toward a resident. The Supervisor stated he did not know the outcome of the investigation because he left before the investigation was complete. The Supervisor continued to explain that he had heard rumors about the Med Aide and Resident #1 having an inappropriate relationship and thought that he should report what he knew about the Med Aide from the other facility to the DON and the Assistant Director of Nursing which he did.

The Assistant Director of Nursing could not be interviewed because she was out of the country.

An interview was conducted with Nurse Aide #3 on 12/06/23 at 3:35 PM who explained that she worked as a treatment aide at the facility and one day she was talking with Resident #1 when the Resident remarked that she missed Med Aide #1, and they were really close. She stated she could not understand why he left and wasn't reaching

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out to her. The NA stated Resident #1 mentioned it being "consensual" but did not elaborate on what she meant by consensual. The NA stated she did not report the conversation to the Administrator because the Resident did not indicate the relationship was inappropriate.

On 12/07/23 at 10:30 AM during an interview with the Physician Assistant (PA), he reported he did not know Resident #1 very well because he had only been coming to the facility since early October 2023. The PA explained that he had only seen the Resident a few times but his day-to-day interaction with her was she was alert and oriented but had poor insight into her medical needs. The PA continued to explain that Resident #1 was able to understand what was going on with her on a short-term basis and was one of the more alert residents but had underlying anxiety issues. He stated her insight in judgement was questionable but was understanding in the moment. The PA stated if there was known dialog between Resident #1 and Med Aide #1, she could be misinterpreting it, but he assumed that if she did not want to kiss the Med Aide then she would say no. Resident #1 could be easily manipulated. When the PA was asked if Resident #1 could give consent to the kiss, the PA stated she was alert enough to say yes or no in the moment, but her judgement might not be appropriate.

An interview was conducted with the Director of Nursing (DON) on 12/05/23 at 4:00 PM. The DON explained that she had several disciplinary issues with Med Aide #1, but none were about inappropriate behaviors toward the residents. The DON continued to explain that she was in the middle of a disciplinary process with the Med Aide when she became ill and had to be out of work.

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While she was out, she heard from a coworker that he was transferred to a sister facility. The DON reported that she and the Administrator had a conversation, but could not remember when, about the rumors going around between Resident #1 and Med Aide #1. The Administrator told the DON that the Resident had a situation in the past where she fabricated a relationship between herself, and a previous physician and the Administrator thought it was the same thing. The Administrator told the DON that she had asked Resident #1 about the Med Aide, and the Resident told the Administrator that the Med Aide was tucking her in at night and giving her kisses and the Resident was asking when the Med Aide would be back to work. The Administrator told the DON it was the same situation that happened with a previous physician a few years earlier because apparently Resident #1 had fabricated that she was in a relationship with a physician. The DON stated the Administrator described the kiss like it was a good night kiss on the forehead. She stated she did not ask the Administrator what was done about it because the Administrator was the Abuse Coordinator, and she was under the impression that it was resolved.

On 12/05/23 at 4:40 PM and 12/07/23 at 4:15 PM during interviews with the Administrator she stated that Med Aide #1 was hired at the facility on 05/11/23 to work the 7:00 PM to 7:00 AM shift as a Medication Aide and Nurse Aide. He was transferred to a sister facility because the DON and ADON informed her that there were rumors that Med Aide #1 had been arrested because of some sort of allegation from a previous facility where he was employed. The Administrator stated she advised the ADON that they should not be spreading rumors and she spoke with the Med

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Aide later that day and told him that they had been spreading rumors. The Med Aide then asked the Administrator about transferring to a sister facility and the Administrator was in agreement and was able to provide the Med Aide with the information to the other facility. The Administrator continued to explain that it was sometime after the Med Aide had transferred to the other facility that Unit Manager #2 informed her that Resident #1 had asked her if she was dating Med Aide #1. The Administrator explained she went to talk with the Resident and the Resident was crying and stated she was sad and maybe a little mad because someone had left her. When the Administrator asked her to explain the Resident refused to talk about it, so she left the Resident alone. The Administrator stated she asked Unit Manager #1 to go talk with Resident #1, but the conversation did not go any further with Unit Manager #1. The Administrator explained that on the following Monday she went back to talk with Resident #1 and this time the Resident opened up and told her that she was upset Friday because she was dealing with family issues and Med Aide #1 would come into her room at night and would sit and listen to her so she kind of got to the point where she relied on him to be there for a shoulder to cry on. The Resident explained that the last night the Med Aide worked he told her that he would see her in a couple of days, and he never came back. The Resident stated she was sad and angry so when she heard the staff talking about Med Aide #1 having an affair the Resident thought it was with Unit Manager #2. The Administrator stated that the Resident stated she understood why the Med Aide decided to leave but was mad that he did not say goodbye. During the second conversation with the Resident, she stated she did not want to

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F 600	Continued From page 14 get the Med Aide into trouble because he would tuck her in at night, kiss her on the forehead and would tell the Resident that he loved her. The Administrator stated that it gave her pause when the Resident reported that Med Aide #1 kissed her on the forehead because the Resident fixated on any kind of male attention. She explained that a kiss on the forehead being acceptable depended on the circumstances. She stated we all kiss residents on the forehead because we take care of the residents and get close to them and if they were okay to hug or show affection then she thought a kiss on the forehead was a minimal way to do so but a kiss in the mouth was not. The Administrator stated she did not think a kiss on the forehead was appropriate between Resident #1 and Med Aide #1 because knowing what she knows now, the Med Aide seemed to groom the Resident and it was not acceptable.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75.	F 607		1/3/24

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F 607	Continued From page 15 §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on facility record review and staff interviews the facility failed to implement their abuse policy and procedure in the area of investigation when the facility became aware of a previous employee (Med Aide #1) being investigated for inappropriate sexual behavior with a resident at a sister facility for 1 of 3 residents reviewed for abuse (Resident #1). The findings include: The facility policy titled "Abuse Prohibition Policy" with a revised date of 09/09/22, read in part: Each resident shall be free from abuse, neglect, mistreatment, exploitation and misappropriation of property. Abuse shall include freedom from verbal, mental, sexual, physical abuse, corporal punishment, and involuntary seclusion. To assure residents are free from abuse, the facility shall monitor residents care and treatments on an on-going basis. It is the responsibility of all staff to provide a safe environment for the residents. Allegations of resident abuse shall be thoroughly investigated and documented by the	F 607	F607: The facility will continue to ensure that the abuse policy in the area of investigation is implemented. Resident #1 has had no identified negative outcomes because of this allegation and continues to be seen routinely for psychiatric/psychological services. Medication Aide #1 no longer works at the facility. Current vulnerable residents have the potential to be affected. From 12/6/23-12/9/23 the nursing administration team conducted interviews with all residents that have a BIMs of 13 or greater (cognitively intact) to determine if they felt safe in the facility. There were no issues identified. No residents reported inappropriate sexual advances by Med Aide #1 or any other staff member. Between 12/25/23-12/29/23 the treatment nurse conducted skin assessments on all of the residents that had BIMS of less	

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F 607	Continued From page 16 Administrator. On 12/04/23 at 9:55 AM an interview was conducted with the Health Care Personnel Investigator (HCPI) who reported she went to the facility on 11/15/23 to review the personnel files of Medication Aide (Med Aide) #1 and interview the staff in relation to a current investigation at a sister facility. She explained that she interviewed the Administrator, Director of Nursing (DON), and Unit Manager (UM) #1 at the facility and from the interviews she felt there could have been an inappropriate relationship between Med Aide #1 and Resident #1. The HCPI continued to explain that the Administrator reported Med Aide #1 was transferred to the sister facility because he had gotten close to a resident by being an active listener because she was going through some family dynamics and there were rumors circulating about him with the staff and he had not gotten a fair shake. The HCPI continued to report that Unit Manager #1 informed her that one day, she did not know the day, she noticed Resident #1 was sad and tearful and had a change in her behavior. When she spoke with the Resident about it, she would only say that he didn't say goodbye and that it was consensual but would not elaborate on what she meant. Resident #1 was admitted to the facility on 11/24/21. The quarterly Minimum Data Set (MDS) assessment dated 08/18/23 revealed that Resident #1 was cognitively intact. An interview was conducted with Resident #1 on 12/05/23 at 10:10 AM. The Resident reported that she and Med Aide #1 had a "consensual	F 607	than 13 to determine if there were any signs of abuse. No issues were identified. On 12/29/23 the Reginal Clinical Coordinator re-educated the facility Administrator and the Assistant Director of Nursing on the abuse policy and procedure. The education emphasized a resident□s right to be free from abuse. Definitions and types of abuse, prevention of abuse, identification of abuse, and protecting residents from abuse were reviewed as well as reporting examples from the state operations manual. On 12/29/23 the Reginal Clinical Coordinator re-educated the facility Administrator and the Assistant Director of Nursing on the process for transferring an active employee from one facility to another. The education emphasized the process for communicating allegations of abuse from one facility to another and expanding investigations as appropriate. 100% of facility staff were in-serviced by the Administrator, Assistant Director of Nursing on the abuse policy and procedure. The education emphasized a resident□s right to be free from abuse. Definitions and types of abuse, prevention of abuse, identification of abuse, and protecting residents from abuse were reviewed as well as reporting examples from the state operations manual. The education began on 12/29/23 with all education to be completed by 1/2/24. Newly hired employees after 1/2/24 will receive mandatory in person education by the Assistant Director of Nursing during general orientation prior to the start of their first shift. The education will	

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F 607	Continued From page 17 relationship that did not involve sex, it was a kiss on the lips". The Resident described the Med Aide as caring and would hold her hand and would be there for her when she needed a friend to discuss her family problems with. Resident #1 explained that she was sad when the Med Aide left but then the sadness turned to anger when he did not come back after a few weeks before she was told that Med Aide #1 could not come back to the facility. During an interview with Nurse Aide #2 on 12/05/23 at 3:05 PM the NA stated she went to work at the facility in early June 2023, and discovered Med Aide #1 also worked at the facility. The NA explained that she felt like she needed to inform the Director of Nursing (DON) that there had been rumors at the other facility that Med Aide #1 was intimate with a resident on third shift, so she reported it to the DON. During an interview with the Supervisor on 12/06/23 at 1:20 PM, the Supervisor stated he went to work at the facility in June 2023 and explained that he had worked with Med Aide #1 at a different facility and was surprised to see that the Med Aide worked at this facility as well. The Supervisor continued to explain that he was aware of Med Aide #1 being investigated at another facility for sexual misconduct or abuse of a resident. The Supervisor stated that he had heard rumors about the Med Aide and Resident #1 having an inappropriate relationship and thought he should report what he knew about the Med Aide from the other facility to the DON and the Assistant Director of Nursing which he did. An interview was conducted with the Director of Nursing (DON) on 12/05/23 at 4:00 PM. The DON	F 607	empathize a resident□s right to be free from abuse. Definitions and types of abuse, prevention of abuse, identification of abuse, and protecting residents from abuse were reviewed as well as reporting examples from the state operations manual. A QA monitoring tool will be utilized to ensure ongoing compliance by the Regional Clinical Coordinator beginning on 1/3/24. The Regional Clinical Coordinator will review all transfer packets weekly x 12 weeks to ensure that the employee transfer process is being followed and that any/all allegations of abuse involving transferred employees are communicated from one facility to another with expanded investigations conducted as appropriate. Variances will be corrected at the time of review and additional education provided when indicated. All findings will be documented on QA monitoring tool by the Regional Clinical Coordinator. The Administrator will audit this tool at a minimum of monthly. Observation results will be reported to the Administrator (from the Regional Clinical Coordinator) weekly for the next 3 months beginning on 1/10/24 and concerns will be reported to the QA committee during monthly meetings. Continued compliance will be monitored through the facility□s Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months during the January through March regularly scheduled meetings or until resolved and additional education/training will be	

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F 607	Continued From page 18 explained that she was in the middle of a disciplinary process with Med Aide #1 when she became ill and had to be out of work therefore, she could not personally complete the process. While she was out, she heard from a coworker that the Med Aide was transferred to a sister facility. The DON reported that she and the Administrator had a conversation about the rumors going around between Resident #1 and Med Aide #1. The Administrator told the DON that she had asked Resident #1 about the Med Aide, and the Resident told the Administrator that the Med Aide was tucking her in at night and giving her kisses and the Resident was asking when the Med Aide would be back to work. The DON stated the Administrator described the kiss like it was a good night kiss on the forehead. On 12/05/23 at 4:40 PM and 12/07/23 at 4:15 PM interviews were conducted with the Administrator. The Administrator explained that Med Aide #1 was transferred to a sister facility because she was informed that there were rumors that the Med Aide had been arrested because of some sort of allegation from a different facility where he was employed, and the rumors were going around this facility. She stated it was after Med Aide #1 was transferred that she received reports from staff about concerning comments that Resident #1 had made. The Administrator went to interview Resident #1 twice and the Resident reported she was sad because Med Aide #1 had left her, but the Resident would not explain what she meant until she visited the Resident again on a different day. The Administrator explained that on the second visit, Resident #1 reported that when she would be upset about her family issues, Med Aide #1 would go into her room at night and spend time with her and listen to her, so she got	F 607	provided for any issues identified. Date of compliance 1/3/24.	

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to the point where she relied on the Med Aide to be there for a shoulder to cry on. The Resident reported that the Med Aide told her he would see her in a few days, and he had not been back and that made her sad and angry since he did not say goodbye to her. The Administrator stated that Resident #1 continued to inform her that she did not want to get the Med Aide into trouble because when he would tuck her into bed at night, he would kiss her on the forehead and tell her that he loved her. The Administrator explained that a kiss on the forehead was a minimal way to show affection toward the residents if they allowed it. The Administrator explained that when she found out that Med Aide #1 was being investigated at their sister facility for inappropriate behaviors with a resident it should have sparked her to interview Resident #1 again, but she felt that the Resident's interview would stay the same. She stated if she had opened up an investigation then she would have followed the facility's abuse policy that would include interviewing more residents other than Resident #1. She stated they had a conference call with the corporate staff after it was known their sister facility received a jeopardy citation related to Med Aide #1's inappropriate behavior with a resident and she was not given any direction to reinvestigate the situation Resident #1 and the Medication Aide. She stated since she was made aware of Resident #1 reporting that Med Aide #1 had kissed her in the mouth, she reopened the investigation.