STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING _____ B. WING _____	C 06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

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F 000	INITIAL COMMENTS A complaint survey was conducted from 6/22/2022 through 6/23/2022. The following intake was investigated NC00190242. The one complaint allegation was substantiated resulting in a deficiency. Past-noncompliance was identified at CFR 483.12 at tag F600 at a scope and severity (J). Tag F600 constituted substandard quality of care. Noncompliance began on 06/19/2022. The facility came back in compliance effective 06/22/2022. A partial extended survey was conducted.	F 000		
F 600 SS=J	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 record review and staff interview, the facility failed to protect a resident who was	F 600	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 07/11/2022

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severely cognitively impaired (Resident #1) from sexual abuse from another resident who was moderately cognitively impaired (Resident #2). Resident #2 willfully entered Resident #1's room, removed his pants, unfastened Resident #1's brief and climbed on top of her with the intention of having sexual intercourse with her. Resident #1 was sent to the hospital emergency department and had a sexual assault nurse exam (SANE). There was no obvious trauma on exam. This deficient practice affected one of three residents reviewed for abuse.

Findings included:

Resident #1 was admitted to the facility on 4/1/14, Her diagnoses included cerebral palsy and functional quadriplegia.

A quarterly Minimum Data Set (MDS) dated 4/8/22 for Resident #1 assessed her cognition as severely impaired. She was non-verbal and required extensive to total dependence on staff with all activities of daily living.

Resident #2 was admitted to the facility on 6/19/19. His diagnoses included traumatic brain injury, schizophrenia and chronic respiratory failure with hypoxia.

An annual MDS dated 4/7/22 for Resident #2 identified his cognition as moderately impaired. No behaviors were identified during the look-back period. He was independent with one-person stand by assistance for transfers.

A care plan with an initiation date of 9/19/19 and currently active for Resident #2 identified he demonstrated sexual behavior by touching self

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(masturbating) and thought some female staff members were his girlfriends and wanted sexual favors from them.

A phone interview on 6/22/22 at 12:11 pm with Nurse Aide (NA) #1 revealed he had been the NA for Resident #1 on 6/19/22 on second shift. He stated about 7:30 pm to 7:45 pm he entered Resident #1's room to check on the residents. He stated Resident #1's roommate was still eating her dinner, so he went to check on Resident #1 and found that Resident #2 was on top of her in bed. NA #1 stated the privacy curtain was partially pulled and that was why he didn't see Resident #2 in the room when he first entered. He explained Resident #2 had his pants pulled down and Resident #1's brief had been unfastened and opened. NA #1 stated he yelled at Resident #2 to "get off of her" and then he called out for staff to come and help him. He indicated Resident #2 started to get off the bed and he assisted him back into his wheelchair. Several other NAs showed up. They took Resident #2 out into the hallway. He checked on Resident #1 and put her brief back on her. NA #1 stated he did not see if Resident #1 had an erection or if he had penetrated Resident #1. He added the Nurse #1 got to the room and assessed Resident #1 and she was sent to the hospital. NA #1 stated Resident #1 was non-verbal and couldn't call out for help or explain what had happened to her. He added he had not worked with Resident #2 and did not know if this behavior had occurred previously.

An interview with NA #2 on 6/22/22 at 12:20 pm revealed she was employed at the facility for 15 years on second shift. She stated on 6/19/22 she was assigned to another unit and heard a staff

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member calling for help. She explained when she arrived at Resident #1's room, she saw Resident #2 leaning on Resident #1's bed and he was naked from the waist down. NA #2 added she assisted NA #1 to get Resident #2 into his wheelchair and then she went out of the room to get some additional help. She stated the Nurse #1 arrived at the room and she went back to her assignment. NA #2 indicated she had taken care of Resident #2 and she had never seen him having sexual contact with any other residents, but he did frequently masturbate in his room.

A nursing progress note dated 6/20/22 about the incident on 6/19/22 for Resident #1 revealed the writer, (Nurse #1) was notified by Nurse Aide #4 (NA #4) that Resident #2 had been in Resident #1's room. When this nurse entered the hallway Resident #2 was in the hallway in his wheelchair with 2 NAs present. Upon visual assessment of Resident #1, bruising, bleeding or scratches were not noted. Administrator, Director of Nursing (DON) and Hospice were notified, and a new order was received from Resident #1's physician to send her to the emergency room. The Responsible Party was notified.

An interview on 6/22/22 at 11:14 am with Nurse #1 revealed she was the nurse for both Resident #1 and Resident #2 on 6/19/22 from 7:00 pm to 7:00am. She stated NA #4 came and got her and stated they found Resident #2 in Resident #1's room. She stated when she arrived at the room Resident #2 was sitting out in the hallway with 2 NAs and Resident #1 was lying in her bed with a brief on. Nurse #1 stated she assessed Resident #1 and did not observe any bruising, redness or bleeding and she appeared to be in her normal state of health. She explained she contacted

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Resident #1's physician who gave an order to send her out to the emergency room for evaluation. Nurse #1 stated she had worked with both residents previously and she had never observed Resident #2 have any sexual behaviors toward other residents. She added Resident #2 was placed on 1:1 monitoring until he was discharged to the hospital the next day.

A documented interview of Resident #2 by the facility Senior Administrator on 6/20/22 revealed, in part, Resident #2 was asked if he knew why a staff member was following him around today and he responded, "because I was on top of that girl." When asked why he was on top of that girl, Resident #2 responded, "I tried to have sex with her, but I couldn't." Resident #2 was asked if he placed his penis in Resident #1 and he replied, "No." He added he laid on top of her for about 10 minutes. Resident #2 was asked why he did this, and he replied, "Something in my head told me to do this." When asked if he understood what he did last night was wrong he responded, "Yes, I know it was wrong."

A documented interview of Resident #1's roommate, Resident #10, by the facility Senior Administrator on 6/20/22 revealed she saw a man enter her room, take his pants off and climb on the woman in the bed next to hers. She stated her roommate did not make any noise when the man was on top of her.

Hospital records dated 6/19/22 indicated a SANE evaluation was performed and the Resident #1 was medically cleared.

The facility provided the following corrective action plan with a correction date of 6/21/22.

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1.) Corrective action for Resident #1 was accomplished on 6/19/22 by ensuring Resident #1's safety. Resident #2 was immediately assisted into his wheelchair, taken out of the room, and placed on 1:1 monitoring by Certified Nursing Assistant #1, Certified Nursing Assistant #2, and Certified Nursing Assistant #3. Nurse #1 completing a visual assessment of Resident #1. Nurse #1 observed no visual scratches or markings. Nurse #1 notified Resident #1's physician. The physician gave an order to send Resident #1 to the hospital for evaluation. Nurse #1 notified Resident #1's representative that the resident was being transported to the hospital.
2.) Corrective action for all residents having the potential to be affected, on 6/19/22, 100% skin checks were initiated on all residents who could not report signs/symptoms of abuse by the nursing supervisors. The skin checks were completed on 6/20/22 with no identified areas of concern. On 6/19/22, the Nursing Supervisors completed a 100 % assessment of all non-alert residents that are unable to report signs and symptoms of abuse, to include sexual abuse. The Nursing Supervisors utilized a resident census to complete the audit. No other resident had signs or symptoms of abuse, to include sexual abuse. On 6/20/22, the Social Worker completed 100 % Resident Questionnaires with all alert and oriented residents with a BIMS of 13 or higher. The Questionnaire asked: 1.) Do you know what it means to be abused to include sexual abuse? 2.) Are there any instances that you felt you were abused in any way to include touched inappropriately or sexual abuse? 3.) Are there any residents, staff, or visitors, coming into your room unwelcomed? On 6/20/22, the Western Regional Clinical Director audited 100% of

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resident progress notes for the last 30 days. The audit ensured that no other resident had any documentation of sexually inappropriate behaviors or entering other residents' rooms uninvited. There was no other resident identified during the audit.

3.) Education was conducted for all residents on what to do if they suspect or observe resident abuse by the Social Worker on 6/21/22. Also, the Regional Vice President educated the Resident Council on sexual abuse identification and reporting on 6/21/2022. There were no concerns voiced after the education. On 6/19/22 and 6/20/22 an in-service was initiated by the Social Worker and Nursing Supervisors with 100% of all staff to include nurses, certified nursing assistants, medication aides, dietary staff, laundry and housekeeping staff, therapy staff, administrator, admissions coordinator, accounts receivable, account payable, activities director, activities assistant, medical records, central supply clerk, maintenance director, maintenance assistant, ward clerk, including agency and contract staff, and all part-time staff regarding resident to resident abuse and residents that wander into other residents room unwanted or uninvited. On 6/21/22, the Social Worker and Nursing Supervisors completed in-servicing with all staff, including agency and contract staff who had worked on 6/19/22, 6/20/22 and/or 6/21/22. After 6/21/22, the receptionist mailed the in-services via certified mail to any remaining staff who has not worked and not received the in-service with instructions to review, sign the in-service, and return to the Director of Nursing or Assistant Director of Nursing prior to next scheduled work shift.

4.) Continued compliance will be maintained, beginning on 6/21/22 Behavioral Monitoring in

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Cardinal Interdisciplinary Team Meeting (Administrator, Director of Nursing, Social Worker, Unit Managers, Dietary Manager, and Therapy Managers) by monitoring progress notes to identify residents wandering into rooms unwelcomed or uninvited. 5 days a week x 4 weeks. Beginning 6/21/22, Skin assessments utilizing the Skin Checks User Defined Assessment in Point Click Care Computer by the Director of Nursing, Assistant Director of Nursing, Treatment Nurse, Unit Managers and/or House Supervisor for residents with BIMS less than 13, for 5 residents per week x 4 weeks. Beginning 6/21/22 100% Safe Surveys for all resident with a BIMS of 13 or higher per week x 4 weeks completed by the Social Worker, RN supervisor and/or the Admissions Director. These audits are to ensure interventions are in place to prevent potential abuse. All findings will be given to the Quality Assurance Performance Improvement Committee for review and recommendations. The Quality Assurance Performance Improvement Committee will meet monthly x 2 months to review the Behavioral Monitoring Audit Tool, the Skin Checks Assessment, and the Safe Survey's to determine trends and/or issues that may need further interventions put in place and to determine the need for further and/or frequency of monitoring.
5.) Date of alleged Immediate Jeopardy removal on 6/21/22.

The facility's corrective action plan was validated on 6/23/22. Neither resident was in the facility. Skin checks were completed on 6/20/22. Residents were educated on what to do if they suspected abuse. Resident questionnaires had been completed. Education was provided to members of the Resident Council. Staff

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F 600	Continued From page 8 in-service was completed on 6/21/22. This information was validated through signed in-service documentation and staff interview. The deficient practice was corrected on 6/22/2022.	F 600		