Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: H5485028M
Compliance #: H5485287C

Date Concluded: July 27, 2021

Name, Address, and County of Licensee Investigated:
Johnson Memorial Hospital and Home
1282 Walnut Street
Dawson, MN 56232
Lac qui parle County

Facility Type: Nursing Home

Investigator's Name: Yolanda Dawson, RN
Special Investigator

Finding: Substantiated, individual responsibility

Nature of Visit:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Allegation(s):
It is alleged: The alleged perpetrators (AP), AP #1 and AP #2 sexually and emotionally abused the resident when they sat on her lap and kissed her on the lips, danced inappropriately in front of her, taunted her with a toy ball gun, and appeared to take photos or video of her.

Investigative Findings and Conclusion:
Emotional abuse was substantiated. The alleged perpetrators were responsible for the maltreatment. Security footage showed the AP's engaging in inappropriate behavior in front of the resident, which included sitting on her lap and kissing her on the lips, dancing inappropriately in front of her, taunting her with a toy ball gun, and appearing to take photos or video of her.

The investigation included interviews with facility staff including administrative staff, nursing staff, and unlicensed staff. Training records indicated adequate training procedures. Staff and resident records were reviewed. The investigation included a review of policies and procedures

related to abuse prevention and standards of behavior. Security footage was reviewed by facility management.

The resident resided on the memory care unit with a diagnosis of dementia without behavioral disturbances. The resident received services from the home care provider that included medication management, toileting assistance, dressing and hygiene assistance, and behavior monitoring. A Brief Interview for Mental Status (BIMS) indicated moderate impairment.

Review of resident's vulnerable adult assessment indicated the resident was often confused, would lose things, and wandered. She sometimes communicated well and sometimes was easily taken advantage of.

Review of an internal investigation document indicated security camera footage on the evening of the event, showed the resident was sitting on a couch in a small sitting area. AP #1 and AP #2 were twerking in front of the resident. AP #2 slapped AP #1 on the butt, and AP #1 lifted the back of her shirt to the resident. Both AP #1 and AP #2 had their phones out and appeared to be taking photos or video. AP #1 sat on the resident's lap and kissed her on the lips, while AP #2 took a picture or video. The video also showed both AP's shooting foam balls at the resident. One ball made contact with the resident's head, bounced off and hit the window. The resident's expressions cannot be seen because the position of the camera did not allow a view of her face.

During an interview, a family member stated she spoke to the resident a few days after the event, and she did not want to talk about what happened. The family member stated the resident said she did not want to leave her room because people were looking at her. When the resident was asked to clarify what she meant, she dropped the subject.

During an interview, AP #1 stated that on that evening, she and AP #2 were joking and messing around with the resident. AP #1 stated she did not think the resident liked AP #2 because she told her to get away from her, but then would later say "it's okay honey you can come back." AP #1 stated she and AP #2 were sticking their tongue out at the resident and she would do it back and laugh. AP #1 stated AP #2 found a bucket of toys with a toy gun and started shooting foam balls at the resident. AP #1 stated she and AP #2 were walking funny in front of the resident, but it was not twerking. AP #1 stated she asked the resident if she wanted a kiss, and as she backed away and moved her head the resident kissed her. AP #1 stated she did not remember if AP #2 slapped her butt. AP #1 stated she agreed that what she did to the resident was inappropriate. AP #1 also agreed she did not treat the resident with dignity and respect.

During an interview, AP #2 stated she and AP #1 were messing around and doing things they should not have been doing. AP #2 stated they were trying to get the resident to go to bed and AP #1 kissed the resident. AP #2 stated she had her phone out, but she did not take a picture or video of the resident. AP #2 stated it was inappropriate when they were walking funny in front of the resident, but it was not twerking. AP #2 stated she and AP #1 were shooting balls at the resident, but they did not make contact.

In conclusion, emotional abuse was substantiated. AP #1 and AP #2 treated the resident in a manner which a reasonable person would find derogatory, humiliating, or harassing.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Abuse: Minnesota Statutes section 626.5572, subdivision 2
"Abuse" means: …
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

Vulnerable Adult interviewed: No, cognitive decline.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrators interviewed: Yes.

Action taken by facility:
An internal investigation was conducted. Both alleged perpetrators are no longer employed by the facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc: The Office of Ombudsman for Long-Term Care
Dawson County Attorney
Dawson Police Department

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	245485	A. BUILDING _____ B. WING _____	C 05/10/2021

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JOHNSON MEMORIAL HOSP & HOME	1290 LOCUST STREET DAWSON, MN 56232

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F 000	INITIAL COMMENTS On 5/6/21 through 5/10/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5485027C (MN72522), with deficiencies cited at F600, F609, and F943. The survey resulted in an Immediate Jeopardy (IJ) at F600 when the facility failed to ensure an environment free of abuse for 1 of 1 resident (R2) who experienced an incident of physical and sexual abuse by staff. The IJ began on 5/4/21 and the immediacy was removed on 5/10/21. The above findings constituted substandard quality of care, and an extended survey was conducted on 5/10/21. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		6/14/21

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

Electronically Signed | 06/07/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 600	Continued From page 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 interview, document review, and video review, the facility failed to ensure an environment free of abuse for 1 of 1 resident (R2) who experienced an incident of physical and sexual abuse by staff. The survey resulted in an immediate jeopardy (IJ) that began on 5/3/21, when 2 nursing assistants in the facility lobby NA-A and NA-B made inappropriate sexual gestures, slapped, and kissed R2, and took photos and video of R2 during the incident. The administrator and director of nursing (DON) were notified of the IJ on 5/7/21 at 3:35 p.m. Findings include: Review of the 5/4/21 at 4:29 p.m., report filed to the State Agency (SA) identified the maintenence supervisor (MS) reviewed the 5/3/21 video footage on the facility surveillance camera. The	F 600	How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Observation of maltreatment by NA-A and NA-B toward R2 was observed on video (from the evening of 5/3/21) on 5/4/21 between 8am and 8:30am by the Maintenance Supervisor (MS). The MS notified the Human Resources Director (HRD) at 9am. The corrective action to ensure the safety of R2 was suspension pending investigation of NA-A and NA-B on the afternoon of 5/4/21. Following investigation, NA-A and NA-B were terminated on 5/5/21. How the facility will identify other residents having the potential to be affected by the same deficient practice:	

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F 600	Continued From page 2 camera was located at the Prairie Lane entrance. Video footage identified between 7:00 p.m. and 7:30 p.m., R2 was sitting on the couch in the lounge next to the entrance with two NAs. 1 NA was dancing in a sexually provocative manner involving thrusting hip movements and a low, squatting stance (twerking) in front of R2 and pulled up her shirt exposing her lower back. The other NA slapped the twerking NA on the bottom. One of the NAs sat on R2's lap and also had kissed R2 on the lips. Both NAs also took photos of R2 with their mobile devices, and were reported to have thrown foam balls at R2. One ball made contact with R2's head, bounced off and hit the window. Both NAs were suspended pending further investigation. Review of the 5/5/21, Internal Investigation Form identified on 5/4/21 at between 8:00 a.m. and 8:30 a.m., the MS was viewing the surveillance camera footage from 5/3/21, and discovered NA-A and NA-B engaging in inappropriate behavior with R2 near the Prairie Lane entrance between 7:00 p.m. and 7:20 p.m. At 9:00 a.m., the MS met with the human resources director (HRD). The MS identified he was reviewing surveillance camera footage and observed NA-A and NA-B twerking in front of R2 several times while recording their actions on their personal phones. NA-B kissed R2 on the lips while NA-A took photos and both nursing assistants were laughing. NA-A and NA-B also shot nerf balls at R2, and sat on her lap. At 10:00 a.m., the HRD notified the assistant director of nursing (ADON) of the incident and planned to meet after the video was downloaded to a flash drive. At 11:00 a.m., the administrator was notified of the incident. At 3:00 p.m., the HRD met with the administrator and ADON to view the video. At	F 600	Interviews of residents and family members of those residents who cannot speak for themselves were conducted by care center RN and Social Worker. Residents and families were asked if any maltreatment or substandard care has taken place. Residents and family members interviewed denied any maltreatment of substandard care. Interviews were conducted on 5/7/21 and 5/8/21. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: Although the JMHS Care Center Abuse Prevention Plan was not revised as it contained the appropriate elements, our internal Checklist for Vulnerable Adult Report & Investigation was updated to read [any] abuse or serious bodily injury MUST be reported IMMEDIATELY but no later than 2 hours and now provides the definition Abuse = verbal, physical, sexual, emotional. This updated form replaced the previous form in the Vulnerable Adult Binders at each of the Care Center nurse□s stations. In addition, the social worker updated the Notice of Reporting Reasonable Suspicion of a Crime postings in the JMHS Breakroom, and in each of the Care Center nurse□s stations. On 5/7/21, DON/LNHA held a management meeting and provided education on JMHS Care Center Abuse	

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F 600	Continued From page 3 3:20 p.m., Both NAs were placed on suspension pending investigation of the incident. Between 5/4/21, and 5/5/21, 3 staff and 4 residents who worked with NA-A and NA-B on the day the incident occurred were interviewed. Staff identified NA-A and NA-B had performance issues of not performing cares and following care plans. The residents interviewed had no concerns. No additional interviews from staff or residents were conducted. The investigation report did not identify whether education of all staff or any additional actions were taken by the facility to prevent further abuse. Review of the 5/3/21, facility surveillance camera footage identified between 7:00 p.m. and 7:20 p.m., R2 was seen sitting on a couch in the lounge next to the entrance of the Prairie Lane unit. R2 was wearing a white sweatshirt and staff were wearing blue scrubs. NA-A was seated in the window ledge next to the couch, while using a mobile device. NA-B was seated next to R2 on the right side of the couch. NA-A rose from the window ledge and sat on the arm of the couch next to R2. R2 batted her right hand towards NA-A. NA-A stood and turned her back side towards R2. NA-A was standing to the left side of R2 and pointed the mobile device towards NA-B and R2. NA-B continued to be seated on the couch. R2 turned towards NA-B, NA-B leaned into R2 and kissed her on the lips.Both NA-A and NA-B laughed boisterously. NA-B rocked backwards on the couch, clapped her hands and continued to rock back and forth and laugh. At the same time, NA-A threw her head back while laughing and viewing her mobile device. NA-B stood and walked towards NA-A. Both looked at NA-A's mobile device and continued to laugh.	F 600	Prevention Plan, including timeliness of reporting abuse defining the immediate reporting to the Administrator and DON, the 2-hour reporting requirements, identification of abuse, and the protection of residents related to JMHS Care Center Abuse Prevention Plan. All managers attended, signing in for the education session, and this sign-in sheet was given to the federal surveyors. The management team is made up of the following: Care Center DON, Care Center ADON, Dietary Mgr, Therapy Mgr, Clinic Mgr, CFO, Activities Mgr, Hospital DON, Quality Mgr, Lab Mgr/Infection Control Preventionist, Marketing Mgr, Materials Mgr, Revenue Cycle Mgr, Human Resources Mgr, Admin Assistant, Environmental Services/Maintenance Mgr, and the IT Mgr. The CEO/Administrator reported the Vulnerable Adult abuse to the Medical Director, who is also the Primary Care Physician of R2, and reviewed the steps taken with filing the VA on 5/4, immediately suspending and terminating NA-A and NA-B, R2□s skin check on 5/4 as clear, interviewing R2 on 5/4, notifying R2□s daughter on 5/4, and the interview with the Local Police Department on 5/6. Also discussed next steps with Medical Director Updated Vulnerable Adult Abuse Prohibition Plan, 1430 Policy for the Care Center portion. Section 6. Reporting/Response section for the Care Center now reads to report immediately to the CEO/Administrator and DON, and now refers directly to the Care Center	

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F 600	Continued From page 4 R2 remained seated on the couch. NA-B walked to R2, stood in front of her, turned and wiggled her bottom in front of R2. NA-B then bent forward with her bottom at R2's face level and began twerking. NA-A from the couch stood next to NA-B and slapped NA-A on the bottom while she twerked in front of R2. NA-A sat down on the right side of the couch next to R2 and looked at her mobile device. NA-B stood in front of R2 while looking at her mobile device. The image on NA-A's device was visible on the footage and identified an image of a lady in a white sweatshirt, in a seated position and a staff person dressed in blue bent over in front of the person, presumed to be R2 in the white sweatshirt. NA-A put her right leg over R2's lap and leaned into R2 with her mobile device. NA-B lay on the left arm of the couch near R2. NA-A's right arm reached towards the level of R2's face. R2's hand became visible as she raised her hand to swat NA-A's hand out away. R2 continued to swat at NA-A. R2 slapped NA-A's left shoulder. NA-A's torso leaned away from R2. NA-A turned to face R2 when R2 attempted to swat at NA-A again, NA-A placed her hand on R2's hand then made two quick slaps towards R2's face. It could not be determined if NA-A made contact with R2. R2 attempted to stand several times. Both aids distanced themselves from R2. R2 maintained a semi-seated position at the couch. Observation on 5/6/21 at 9:33 a.m., with R2 identified R2 was sitting in her recliner in her room, R2 was calm, alert, and had no signs of injury on her face or hands. R2's 3/25/21, Significant Change Minimum Data Set (MDS) identified her cognition was moderately impaired. R2 was assessed as having	F 600	Abuse Prevention Plan, which includes the JMHS Care Center Abuse Prevention Plan. This will help to ensure all JMHS employees that suspect abuse or serious bodily injury of a resident will refer to the Care Center reporting/response time limits. This updated Policy was reviewed with the Managers during the 5/7/2021 meeting, and the updated Policy was emailed to all Managers to educate their staff. Beginning 5/7/21, all JMHS Care Center employees (nursing, dietary, activities, human resources, maintenance, social services, therapy, ancillary) received re-education regarding Vulnerable Adult Policy. This education included, but was not limited to, definitions of various types of abuse, identification of abuse, indicators of abuse/neglect and immediate reporting of those indicators to the DON, or designee, for further investigation, JMHS employees are mandated reporters which requires them to immediately report observed or suspected abuse of any kind and contacting of law enforcement when abuse occurs. Educational information is from CMS SOM F600/F609 and JMHS Abuse Prevention Plan. Care Center staff working on 5/7/21 were required to complete education immediately by signing off that they have received and understood the education at the beginning of their shifts. The DON provided this education to and designated the Charge Nurses to provide this education to the staff at the beginning of	

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F 600	Continued From page 5 no rejection of care and had wandered during the observation period. R2 required extensive assistance of one staff for bed mobility, transfers, dressing, toileting, and personal hygiene. R2 required supervision for moving on and off the unit and walking in her room and in corridors. R2 had no impairment in her upper and lower extremities. R2's diagnoses included dementia. R2 used routine antipsychotic medication. R2's 5/6/21, care plan identified R2 had dementia with short-term memory loss. R2 was anxious in new situations and became upset when unable to remember information. R2 had periods of disorganized thinking and delusional thoughts, and required assistance to maintain her safety. R2's behaviors included delusional beliefs about returning home, family, refusal of assistance with toileting, changing clothes, bathing, packing clothes and personal items to go home, and wandering. Interventions included to use a calm unhurried approach, re-approach R2 when agitated, explain all cares, follow her routine closely, provide one-to-one support in new situations, and ensure R2 was safe and separated from any residents she was fearful of. Interview on 5/6/21 at 3:00 p.m., with the administrator verified she was notified of the incident by the human resources director (HRD) on 5/4/21 at 11:00 a.m. The morning of 5/4/21, the MS was viewing video surveillance from a request to check R2's WanderGuard function. The MS discovered video footage of NA-A and NA-B being physically and sexually inappropriate with R2. The MS notified the HRM of the situation. The administrator contacted director of nursing (DON) and assistant director of nursing (ADON) were also contacted. R2 was interviewed	F 600	their shift. All other Care Center staff, including contract staff, were required to receive education prior to their next scheduled shift. Please note that the only Contract Staff we currently have in the Care Center are nurses and aides. DON, or designee, provided education, ensured employee understanding, and required signatures/dates of understanding of education. Applicable policies and forms have been updated as stated above, along with the corresponding education on these policies and forms as stated above. Beginning 5/7/21, all JMHS Care Center employees (nursing, dietary, activities, maintenance, human resources, social services, therapy, ancillary) were required to receive education regarding the JMHS Cell Phone Use policy. This education included that JMHS prohibits the use of cameras in the workplace unless for business purposes, confining personal use of cell phones to employee breaks, prohibiting the use of cameras and camera phones in the workplace for nonbusiness purposes, and attaining the applicable signed consents from those whose photo is taken. Care Center staff working on 5/7/21 were required to complete education immediately. All other Care Center staff received education prior to their next scheduled shift. DON, or designee, provided education, ensured employee understanding, and required signatures/dates of understanding of education. Upon close review of our Cell Phone Use	

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F 600	Continued From page 6 on 5/4/21, but was unable to recall the event from 5/3/21. The administrator verified the ADON submitted the report on 5/4/21 at 4:28 p.m. The afternoon of 5/4/21, NA-A and NA-B were contacted and notified they were suspended pending the investigation. Neither NA worked after 5/3/21. The facility scheduled appointments with NA-A and NA-B. NA-B met with the administrator, DON, and HRD. NA-B denied any involvement in the situation, even after she was told there was video footage of the incident. At the conclusion of the meeting, NA-B was given termination notice. NA-A texted the facility her resignation, and never met with management. The HRM began interviewing staff and residents to identify whether other residents had similar interactions. The interviews concluded the incident was isolated. The adminstrator indicated she felt the event was unfortunate, and was two teenagers who had not followed the rules. On 5/6/21, the DON and administrator met with staff who had not been available to meet on 5/5/21. The administrator indicated education was not provided regarding cell phone use or abuse during the meeting. Interview on 5/6/21 at 4:00 p.m., with the HRD identified on 5/4/21 at 8:30 a.m., the MS contacted the HRD regarding what he found the video surveillance camera. The video identified NA-A and NA-B acting inappropriately towards R2 at Prairie Lane entrance. The NAs were observed twerking, sitting on R2's lap, kissing her on the lips and shooting foam balls at R2 from a whale toy from the activity department. At 11:00 a.m., the administrator was notified of the incident. The HRD interviewed staff and residents. No concerns regarding abuse were identified however, staff reported concerns NA-A and NA-B	F 600	Policy, we updated this policy to reduce even further, if not eliminate personal electronic device usage during work time. This updated Cell Phone Use Policy has stronger wording to prohibit the use of personal cell phones in any patient/resident care areas or public area where visitors or other guests may be present. Specific examples are given. The updated policy goes on to state personal cell phone use is limited to break time and meal periods only in non-public and non-patient/residents care areas, with specific examples. Lastly, the updated policy states the consequence of unauthorized personal cell phone usage is subject to disciplinary action, up to and including termination. This updated Cell Phone Use Policy was reviewed, and education was provided to the Management Group, as listed above, on 5/9 at our Management Huddle. Managers signed off as having received and understood the updated policy on 5/9. The rest of the JMHS staff were educated and trained on this updated policy at our Employee Communication Forums on 5/11 and 5/12. Employees signed off as having received and understood the updated policy. This updated policy was effective 5/14. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: Each Care Center department, including ancillary services (HR, Admin,	

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F 600	Continued From page 7 were noted to have previously not provided cares to residents. Both NA-A and NA-B were placed on suspension following the allegation, and an appointment was set up to meet with NA-A and NA-B on 5/5/21. On 5/5/21, at 3:30 p.m., NA-B came to the facility to meet with the HR, the administrator, and the DON. During the meeting, NA-B denied using her cell phone, taking photos or videos. NA-B denied twerking and shooting green balls at R2, however she identified NA-A had shot green foam balls at R2. When informed the incident was on the surveillance camera. NA-B identified she had not kept any of the photos of video from the personal phone. The HRD provided NA-B a termination notice. NA-A texted the HRD to cancel her meeting and later texted the HRD her resignation. A termination letter was mailed to NA-A on 5/6/21. The ADON and the social worker (SW) reported the incident to the SA. The HDR identified she worked for both the long-term care (LTC) facility and the hospital. The HRD received annual vulnerable adult training through computer-based training, however she had not been trained to the facility's polices and procedures for abuse and neglect. The administrator was notified of the incident at 11:00 a.m. on 5/4/21. She confirmed the incident was not reported to the administrator or law enforcement immediately. Interview on 5/6/21 at 4:59 p.m., with licensed practical nurse (LPN)-D identified she had worked with NA-A and had concerns with NA-A's work performance in the past. She indicated she had concerns with NA-A not providing care to a resident and had reported her concerns to the DON. She was unsure of any time frames for reporting allegations of abuse.	F 600	Maintenance) will review the Care Center Abuse Prevention Plan at monthly meetings for the months of June, July, and August, specifically reviewing types of abuse and timeliness of reporting abuse. This will also be reviewed at June, July, and August monthly manager meetings. DON, or designee, will conduct audits by interviewing staff and asking questions about the Care Center Abuse Prevention Plan, specifically types of abuse (what they should report) and timeliness of reporting. This audit will begin 6/7/21 and occur once weekly for four weeks, then every other week for two weeks, then monthly for two months, then quarterly until May 31, 2022. The date that each deficiency will be corrected. 6/14/21	

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F 600	Continued From page 8 Interview on 5/7/21 at 9:00 a.m., with the MS identified on 5/4/21, he received a work request to find out if R2's WanderGuard was malfunctioning. Around 8:00 a.m., he began to reviewing surveillance camera footage. As he was forwarding through footage on high speed, and had seen two twerking, sitting on R2's lap, shooting foam balls at R2, kissing R2 on the lips, and taking photos and video during the interaction. The MS contacted the HR around 8:30 a.m., to schedule a meeting with her after his morning meeting with the other maintenance staff. He had not notified the DON because she was out of the facility. The MS confirmed he had not notified the administrator. He felt the HRD would know what to do. The MS identified he worked for both the nursing home and hospital. The maintenance department had annual abuse training through computer-based training. He had not been trained specifically to abuse policies and procedures of the nursing home as it related to reporting abuse directly to the facility. Interview on 5/6/21 at 4:39 p.m., with the DON identified she was made aware of the incident on 5/5/21. The DON met with staff to see if they had observed anything out of the ordinary. The staff who worked the evening shift on 5/3/21, were also interviewed to identify whether there were any concerns. No abuse training was provided following the incident. All staff were expected to report to the DON or admiistrator any allegation of abuse within 2 hours. Review of the abuse neglect policy was reviewed with the DON and she agreed the incident on 5/3/21, fit the description of abuse and should have been reported to the reported to administrator and the SA within two hours. Charge nurses also had the ability to report allegations of abuse to SA. The	F 600		

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F 600	Continued From page 9 DON identified in the situation with R2, the MS was the initial reporter and had reported the incident to the HRD. On 5/7/21, attempts to contact both NA-A and NA-B via telephone for interview were done, but unsuccessful. Review of NA-A's employee records identified a hire date of 8/25/20 and was terminated on 5/5/21 for the above incident. No corrective actions prior to 5/3/21 were included in NA-A's employee file. Review of NA-B's employee records identified a hire date of January 2021 and was terminated on 5/5/21 for the above incident. No corrective actions prior to 5/3/21 were included in NA-B's employee file. Interview on 5/7/21 at 9:26 a.m., with the medical director identified he was notified of the incident on 5/6/21, while doing rounds at the facility. He had not viewed the video of the incident. He identified the facility should have notified him before 5/6/21. He was not familiar with the facility's abuse policies, but was aware all allegations of abuse were to be reported to the SA within two hours. The medical director was not provided a timeline of events, investigation information, whether staff were immediately educated. He identified the actions of NA-A and NA-B were elderly abuse and he expected the facility to identify, report, identify, and correct any allegations of abuse and any breaks in compliance in accordance with the facility abuse policies and regulations. Review of the February 2021, Cell Phone Use policy identified cameras and camera phones	F 600		

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F 600	Continued From page 10 were prohibited in the workplace unless for business purposes. Signed consent on the official consent form must be on file from any employee, patient, or visitor whose photo is taken. Employees who violated the policy were subject to disciplinary action up to and including termination. Review of the October 2020, Care Center Abuse Prevention Plan prohibited phsyical, sexual, mental abuse and included photos or video of residents. A mandated reporter was to report any suspicion or observed incident of abuse immediately to the DON. If the DON was absent, allegations were to be reported to a designee. If reporter was unable to report the allegation verbally to the DON, ADON, or the charge nurse immediately, they were to report the allegation directly to the administrator. The incident was to be reported to the SA immediately. Reports suspected of a crime were to be reported to law enforcement. Review of the facility's July 2018, Appendix C-Decision Guide for Incident Reporting policy identified staff were to immediately report allegations of abuse and to report any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of property to the administrator and designated SA immediately, but not later than two hours after the allegation is made if the allegation involved abuse. The IJ was removed on 5/10/21 at 1:10 p.m., when it could be verified by interview and document review the facility took steps to remove the immediacy by revising policies and procedures and educating staff about reporting	F 600		

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F 600	Continued From page 11 abuse neglect and to restrict use of cell phones while in patient care areas and while on duty. Non-compliance remained at a severity of D, isolated, with the potential for actual harm that was not immediate jeopardy.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		6/14/21

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F 609	Continued From page 12 Based on interview and document review, the facility failed to timely report allegations of physical and sexual abuse for 1 of 1 resident (R1) to the administrator, the State Agency (SA), and law enforcement. Findings include: Review of the 5/4/21 at 4:29 p.m., report filed to the State Agency (SA) identified the maintenance supervisor (MS) reviewed the 5/3/21 video footage on the facility surveillance camera. The camera was located at the Prairie Lane entrance. Video footage identified between 7:00 p.m. and 7:30 p.m., R2 was sitting on the couch in the lounge next to the entrance with two NAs. 1 NA was dancing in a sexually provocative manner involving thrusting hip movements and a low, squatting stance (twerking) in front of R2 and pulled up her shirt exposing her lower back. The other NA slapped the twerking NA on the bottom. One of the NAs sat on R2's lap and also had kissed R2 on the lips. Both NAs also took photos of R2 with their mobile devices, and were reported to have threw foam balls at R2. One ball made contact with R2's head, bounced off and hit the window. Both NAs were suspended pending further investigation. Review of the 5/5/21, internal investigation Form identified the incident was discovered by the maintenance supervisor (MS) on 5/4/21 at 8:30 a.m. The MS notified the adjacent hospital's human resource director (HR) at 9:00 a.m. The HRD then notified the facility assistant director of nursing (ADON) at 10:30 a.m.. The facility administrator was notified at 11:00 a.m.. The facility made a report to the SA on 5/4/21 at 4:29 p.m., 8 hours after the incident was discovered.	F 609	How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Observation of maltreatment by NA-A and NA-B toward R2 was observed on video (from the evening of 5/3/21) on 5/4/21 between 8am and 8:30am by the Maintenance Supervisor (MS). The MS notified the Human Resources Director (HRD) at 9am. The initial VA report was not filed with the State Survey Agency until 4:29pm on 5/4/21. On 5/7/21, DON/LNHA held a management meeting and provided education on JMHS Care Center Abuse Prevention Plan, including timeliness of reporting abuse defining the immediate reporting to the Administrator and DON and the 2-hour reporting requirements. The MS and HRD attended this meeting. How the facility will identify other residents having the potential to be affected by the same deficient practice: Each time abuse is reported, and a VA report is filed, DON/LNHA, or designee, will immediately determine if report has been made timely according to Abuse Prevention Plan. DON and LNHA are notified of all VA reports; therefore, determination of timely reporting can be assessed immediately. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.	

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F 609	Continued From page 13 Interview on 5/6/21 at 3:00 p.m., with the administrator confirmed she was notified of the incident by the HR on 5/4/21 at 11:00 a.m. The MS received a maintenance slip from the previous evening shift (5/3/21) to check why a WanderGuard had malfunctioned. The MS reviewed video surveillance footage of the evening prior and discovered 2 staff members NA-A and NA-B engaging in inappropriate physical and sexual conduct with R2. On 5/4/21 at 8:30 a.m., the MS contacted the HRD to meet at 9:00 a.m. The administrator was notified of the incident at 11:00 a.m.. She agreed she did not immediately report to the SA and local law enforcement the allegations of abuse or suspicion of a crime. Interview on 5/6/21 at 4:00 p.m., with the HRD identified on 5/4/21 at 8:30 a.m., the MS contacted the HRD regarding what he found the video surveillance camera. The video identified NA-A and NA-B acting inappropriately towards R2 at Prairie Lane entrance. The NAs were observed twerking, sitting on R2's lap, kissing her on the lips and shooting foam balls at R2 from a whale toy from the activity department. At 11:00 a.m., the administrator was notified of the incident. The HRD identified she worked for both the long-term care (LTC) facility and the hospital. The HRD received annual vulnerable adult training through computer-based training, however she had not been trained to the LTC's polices and procedures for reporting abuse and neglect. Interview on 5/7/21 at 9:00 a.m., with the MS identified on 5/4/21, he received a work request to find out if R2's WanderGuard was malfunctioning. Around 8:00 a.m., he began to	F 609	Although the JMHS Care Center Abuse Prevention Plan was not revised as it contained the appropriate elements, our internal Checklist for Vulnerable Adult Report & Investigation was updated to read [any] abuse or serious bodily injury MUST be reported IMMEDIATELY but no later than 2 hours and now provides the definition Abuse = verbal, physical, sexual, emotional. This updated form replaced the previous form in the Vulnerable Adult Binders at each of the Care Center nurse□s stations. In addition, the social worker updated the Notice of Reporting Reasonable Suspicion of a Crime postings in the JMHS Breakroom, and in each of the Care Center nurse□s stations. On 5/7/21, DON/LNHA held a management meeting and provided education on JMHS Care Center Abuse Prevention Plan, including timeliness of reporting abuse defining the immediate reporting to the Administrator and DON, the 2-hour reporting requirements, identification of abuse, and the protection of residents related to JMHS Care Center Abuse Prevention Plan. All managers attended, signing in for the education session, and this sign-in sheet was given to the federal surveyors. The management team is made up of the following: Care Center DON, Care Center ADON, Dietary Mgr, Therapy Mgr, Clinic Mgr, CFO, Activities Mgr, Hospital DON, Quality Mgr, Lab Mgr/Infection Control Preventionist, Marketing Mgr, Materials	

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F 609	Continued From page 14 reviewing surveillance camera footage. As he was forwarding through footage on high speed, and had seen two twerking, sitting on R2's lap, shooting foam balls at R2, kissing R2 on the lips, and taking photos and video during the interaction. The MS contacted the HR around 8:30 a.m., to schedule a meeting with her after his morning meeting with the other maintenance staff. He had not notified the DON because she was out of the facility. The MS confirmed he had not notified the facility administrator. He felt the HRD "would know what to do". The MS identified he worked for both the nursing home and hospital. He had broad annual abuse training through computer-based training, but identified he had not been trained specifically to abuse policies and procedures of the nursing home as it related to reporting abuse directly to the facility. Review of the October 2020, Care Center Abuse Prevention Plan identified a mandated reporter was to report any suspicion or observed incident of abuse immediately to the DON. If the DON was absent, allegations were to be reported to a designee. If reporter was unable to report the allegation verbally to the DON, ADON, or the charge nurse immediately, they were to report the allegation directly to the administrator. The incident was to be reported to the SA immediately. Reports suspected of a crime were to be reported to law enforcement. Review of the facility's July 2018, Appendix C-Decision Guide for Incident Reporting policy identified staff were to immediately report allegations of abuse and to report any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of property to the	F 609	Mgr, Revenue Cycle Mgr, Human Resources Mgr, Admin Assistant, Environmental Services/Maintenance Mgr, and the IT Mgr. The CEO/Administrator reported the Vulnerable Adult abuse to the Medical Director, who is also the Primary Care Physician of R2, and reviewed the steps taken with filing the VA on 5/4, immediately suspending and terminating NA-A and NA-B, R2□s skin check on 5/4 as clear, interviewing R2 on 5/4, notifying R2□s daughter on 5/4, and the interview with the Local Police Department on 5/6. Also discussed next steps with Medical DirectorUpdated Vulnerable Adult Abuse Prohibition Plan, 1430 Policy for the Care Center portion. Section 6. Reporting/Response section for the Care Center now reads to report immediately to the CEO/Administrator and DON, and also now refers directly to the Care Center Abuse Prevention Plan, which includes the JMHS Care Center Abuse Prevention Plan. This will help to ensure all JMHS employees that suspect abuse or serious bodily injury of a resident will refer to the Care Center reporting/response time limits. This updated Policy was reviewed with the Manager□s during the 5/7/2021 meeting, and the updated Policy was emailed to all Managers to educate their staff. Beginning 5/7/21, all JMHS Care Center employees (nursing, dietary, activities, human resources, maintenance, social services, therapy, ancillary) received	

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F 609	Continued From page 15 administrator and designated SA immediately, but not later than two hours after the allegation is made if the allegation involved abuse.	F 609	education regarding Vulnerable Adult Policy. This education included, but was not limited to, definitions of various types of abuse, identification of abuse, indicators of abuse/neglect and immediate reporting of those indicators to the DON, or designee, for further investigation, JMHS employees are mandated reporters which requires them to immediately report observed or suspected abuse of any kind and contacting of law enforcement when abuse occurs. Educational information is from CMS SOM F600/F609 and JMHS Abuse Prevention Plan. Care Center staff working on 5/7/21 were required to complete education immediately by signing off that they received and understood the education at the beginning of their shifts. The DON provided this education to and designated the Charge Nurses to provide this education to the staff at the beginning of their shift. All other Care Center staff, including contract staff, were required to receive education prior to their next scheduled shift. Please note that the only Contract Staff we currently have in the Care Center are nurses and aides. DON, or designee, will provide education, ensure employee understanding, and require signatures/dates of understanding of education. Applicable policies and forms have been updated as stated above, along with the corresponding education on these policies and forms as stated above. How the facility will monitor its corrective	

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F 609	Continued From page 16	F 609	actions to ensure that the deficient practice is being corrected and will not recur: Each Care Center department will review the Care Center Abuse Prevention Plan at monthly meetings for the months of June, July, and September, specifically reviewing types of abuse and timeliness of reporting abuse. DON, or designee, will conduct audits by interviewing staff and asking questions about the Care Center Abuse Prevention Plan, specifically types of abuse (what they should report) and timeliness of reporting. DON, or designee, will also review each VA submitted to determine if report was made within the appropriate time according to policy. This audit will begin 6/7/21 and occur once weekly for four weeks, then every other week for two weeks, then monthly for two months, then quarterly until May 31, 2022. The date that each deficiency will be corrected. 6/14/21	
F 943 SS=D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse,	F 943		6/14/21

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F 943	Continued From page 17 neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to appropriately train 2 of 2 staff (the maintenence supervisor (MS) and the human resources director (HRD) who were employed by the adjacent hospital, but performed occasional duties at the facility) to the facility's abuse policies for timely reporting allegations of abuse regarding 1 of 1 resident (R2). Findings include: Review of the 5/4/21 at 4:29 p.m., report filed to the State Agency (SA) identified the maintenance supervisor (MS) reviewed the 5/3/21 video footage on the facility surveillance camera. The camera was located at the Prairie Lane entrance. Video footage identified between 7:00 p.m. and 7:30 p.m., R2 was sitting on the couch in the lounge next to the entrance with two NAs. 1 NA was dancing in a sexually provocative manner involving thrusting hip movements and a low, squatting stance (twerking) in front of R2 and pulled up her shirt exposing her lower back. The other NA slapped the twerking NA on the bottom. One of the NAs sat on R2's lap and also had kissed R2 on the lips. Both NAs also took photos of R2 with their mobile devices, and were reported to have threw foam balls at R2. One ball	F 943	How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Observation of maltreatment by NA-A and NA-B toward R2 was observed on video (from the evening of 5/3/21) on 5/4/21 between 8am and 8:30am by the Maintenance Supervisor (MS). The MS notified the Human Resources Director (HRD) at 9am. The initial VA report was not filed with the State Survey Agency until 4:29pm on 5/4/21. On 5/7/21, DON/LNHA held a management meeting and provided education on JMHS Care Center Abuse Prevention Plan, including timeliness of reporting abuse defining the immediate reporting to the Administrator and DON and the 2-hour reporting requirements. The MS and HRD attended this meeting. How the facility will identify other residents having the potential to be affected by the same deficient practice.	

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F 943	Continued From page 18 made contact with R2's head, bounced off and hit the window. Both NAs were suspended pending further investigation. Review of the 5/5/21, internal investigation Form identified the incident was discovered by the maintenance supervisor (MS) on 5/4/21 at 8:30 a.m. The MS notified the adjacent hospital's human resource director (HR) at 9:00 a.m. The HRD then notified the facility assistant director of nursing (ADON) at 10:30 a.m.. The facility administrator was notified at 11:00 a.m.. The facility made a report to the SA on 5/4/21 at 4:29 p.m., 8 hours after the incident was discovered. Interview on 5/6/21 at 3:00 p.m., with the administrator confirmed she was notified of the incident by the HR on 5/4/21 at 11:00 a.m. The MS received a maintenance slip from the previous evening shift (5/3/21) to check why a WanderGuard had malfunctioned. The MS reviewed video surveillance footage of the evening prior and discovered 2 staff members NA-A and NA-B engaging in inappropriate physical and sexual conduct with R2. On 5/4/21 at 8:30 a.m., the MS contacted the HRD to meet at 9:00 a.m. The administrator was notified of the incident at 11:00 a.m.. She agreed she did not immediately report to the SA and local law enforcement the allegations of abuse or suspicion of a crime. Interview on 5/6/21 at 4:00 p.m., with the HRD identified on 5/4/21 at 8:30 a.m., the MS contacted the HRD regarding what he found the video surveillance camera. The video identified NA-A and NA-B acting inappropriately towards R2 at Prairie Lane entrance. The NAs were observed twerking, sitting on R2's lap, kissing her on the	F 943	All newly hired employees or contracted staff of JMHS will received education on the Care Center Abuse Prevention Plan. The education will include, but is not limited to, timeliness of reporting abuse, definitions of various types of abuse, identification of abuse, indicators of abuse, and mandated reporter. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: Although the JMHS Care Center Abuse Prevention Plan was not revised as it contained the appropriate elements, our internal Checklist for Vulnerable Adult Report & Investigation was updated to read [any] abuse or serious bodily injury MUST be reported IMMEDIATELY but no later than 2 hours and now provides the definition Abuse = verbal, physical, sexual, emotional. This updated form replaced the previous form in the Vulnerable Adult Binders at each of the Care Center nurse□s stations. In addition, the social worker updated the Notice of Reporting Reasonable Suspicion of a Crime postings in the JMHS Breakroom, and in each of the Care Center nurse□s stations. On 5/7/21, DON/LNHA held a management meeting and provided education on JMHS Care Center Abuse Prevention Plan, including timeliness of reporting abuse defining the immediate reporting to the Administrator and DON, the 2-hour reporting requirements,	

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	245485	A. BUILDING _____ B. WING _____	C 05/10/2021

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F 943	Continued From page 19 lips and shooting foam balls at R2 from a whale toy from the activity department. At 11:00 a.m., the administrator was notified of the incident. The HRD identified she worked for both the long-term care (LTC) facility and the hospital. The HRD received annual vulnerable adult training through computer-based training, however she had not been trained to the LTC's polices and procedures for reporting abuse and neglect. Interview on 5/7/21 at 9:00 a.m., with the MS identified on 5/4/21, he received a work request to find out if R2's WanderGuard was malfunctioning. Around 8:00 a.m., he began to reviewing surveillance camera footage. As he was forwarding through footage on high speed, and had seen two twerking, sitting on R2's lap, shooting foam balls at R2, kissing R2 on the lips, and taking photos and video during the interaction. The MS contacted the HR around 8:30 a.m., to schedule a meeting with her after his morning meeting with the other maintenance staff. He had not notified the DON because she was out of the facility. The MS confirmed he had not notified the facility administrator. He felt the HRD "would know what to do". The MS identified he worked for both the nursing home and hospital. He had broad annual abuse training through computer-based training, but identified he had not been trained specifically to abuse policies and procedures of the nursing home as it related to reporting abuse directly to the facility. Review of the October 2020, Care Center Abuse Prevention Plan identified a mandated reporter was to report any suspicion or observed incident of abuse immediately to the DON. If the DON was absent, allegations were to be reported to a designee. If reporter was unable to report the	F 943	identification of abuse, and the protection of residents related to JMHS Care Center Abuse Prevention Plan. All managers attended, signing in for the education session, and this sign-in sheet was given to the federal surveyors. The management team is made up of the following: Care Center DON, Care Center ADON, Dietary Mgr, Therapy Mgr, Clinic Mgr, CFO, Activities Mgr, Hospital DON, Quality Mgr, Lab Mgr/Infection Control Preventionist, Marketing Mgr, Materials Mgr, Revenue Cycle Mgr, Human Resources Mgr, Admin Assistant, Environmental Services/Maintenance Mgr, and the IT Mgr. Updated Vulnerable Adult Abuse Prohibition Plan, 1430 Policy for the Care Center portion. Section 6. Reporting/Response section for the Care Center now reads to report immediately to the CEO/Administrator and DON, and now refers directly to the Care Center Abuse Prevention Plan, which includes the JMHS Care Center Abuse Prevention Plan. This will help to ensure all JMHS employees that suspect abuse or serious bodily injury of a resident will refer to the Care Center reporting/response time limits. This updated Policy was reviewed with the Manager□s during the 5/7/2021 meeting, and the updated Policy was emailed to all Managers to educate their staff. Beginning 5/7/21, all JMHS Care Center employees (nursing, dietary, activities, human resources, maintenance, social services, therapy, ancillary) were required	

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F 943	Continued From page 20 allegation verbally to the DON, ADON, or the charge nurse immediately, they were to report the allegation directly to the administrator. The incident was to be reported to the SA immediately. Reports suspected of a crime were to be reported to law enforcement. Review of the facility's July 2018, Appendix C-Decision Guide for Incident Reporting policy identified staff were to immediately report allegations of abuse and to report any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of property to the administrator and designated SA immediately, but not later than two hours after the allegation is made if the allegation involved abuse.	F 943	to receive education regarding Vulnerable Adult Policy. This education included, but was not limited to, definitions of various types of abuse, identification of abuse, indicators of abuse/neglect and immediate reporting of those indicators to the DON, or designee, for further investigation, JMHS employees are mandated reporters which requires them to immediately report observed or suspected abuse of any kind and contacting of law enforcement when abuse occurs. Educational information was from CMS SOM F600/F609 and JMHS Abuse Prevention Plan. Care Center staff working on 5/7/21 were required to complete education immediately by signing off that they received and understood the education at the beginning of their shifts. The DON provided this education to and designated the Charge Nurses to provide this education to the staff at the beginning of their shift. All other Care Center staff, including contract staff, were required to receive education prior to their next scheduled shift. Please note that the only Contract Staff we currently have in the Care Center are nurses and aides. DON, or designee, will provide education, ensure employee understanding, and require signatures/dates of understanding of education. Applicable policies and forms have been updated as stated above, along with the corresponding education on these policies and forms as stated above. How the facility will monitor its corrective	

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F 943	Continued From page 21	F 943	actions to ensure that the deficient practice is being corrected and will not recur: Each Care Center department will review the Care Center Abuse Prevention Plan at monthly meetings for the months of June, July and September, specifically reviewing types of abuse and timeliness of reporting abuse. DON, or designee, will conduct audits by interviewing staff and asking questions about the Care Center Abuse Prevention Plan, specifically types of abuse (what they should report) and timeliness of reporting. This will also be reviewed at June, July, and August monthly manager meetings. DON, or designee, will also review each VA submitted to determine if report was made within the appropriate time according to policy. This audit will begin 6/7/21 and occur once weekly for four weeks, then every other week for two weeks, then monthly for two months, then quarterly until May 31, 2022. The date that each deficiency will be corrected. 6/14/21	