DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
261 Chapman Road Suite 200
Newark, DE 19702

STATE SURVEY REPORT

NAME OF FACILITY: Millcroft Living

DATE SURVEY COMPLETED: April 14, 2023

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Complaint Survey was conducted at this facility from April 11, 2023 through April 14, 2023. The deficiencies contained in this report are based on observation, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 74. The survey sample totaled 3 residents. Abbreviations/definitions used in this report are as follows: Certified Nurse Aide (CNA); Director of Human Resources (DOHR); Director of Nursing (DON); Licensed Practical Nurse (LPN); Registered Nurse (RN).		5/22/2023
3201 **3201.1.0** **3201.1.2**	**Regulations for Skilled and Intermediate Care Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code**	**Corrective Action:** . Corrective action has been ensured by the Executive Director. Director of Nursing has submitted paperwork that was omitted to the Delaware Board of Nursing Home Administrators. The Director of Nursing uploaded the required document to Delpros, and the Executive Director mailed the document priority express mail with a signature that document was received by the Delaware Board of Nursing Home Administrators. **Identification of other residents:** . All residents have the potential to be	

Provider's Signature _____ Title Executive Director Date 5/18/2023

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	requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.	affected. Residents will be protected by ensuring that the facility will have full-time administrator or management personnel in charge of the facility.	
3201.5.0	Cross refer F600, F607, and F609.		
3201.5.1	**Personnel/Administrative**	**System Changes:**	
3201.5.2	**The administrator(s) shall be responsible for complying with all applicable laws and regulations.**	. The Root Cause of the concern was a failure to follow through and make sure that all documentation was turned in to the Delaware Board of Nursing Home administrators so that the temporary license could be granted to the Director of Nursing. Moving forward the Executive Director or designee will follow up to make sure that all documentation has been submitted to the Delaware Board of Nursing Home Administrators in a timely manner.	
	Each nursing facility shall have a full-time administrator. When an administrator will be temporarily absent for a period of two weeks or more, a management employee shall be designated to be in charge. The Division shall be notified in writing upon such designation.		
	This requirement was not met as evidenced by:	**Success Evaluation:**	
	Based on interview and email, it was determined that the facility failed to ensure that the facility had a full-time Delaware licensed Nursing Home Administrator approved by the Delaware Board of Nursing Home Administrators since the last administer departed the facility in September 2022. Findings include:	. A random sample of employees will be completed by the Executive Director or designee to ensure that the facility has a full-time administrator or management employee that is always in charge. Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance.	
	On 4/18/23 at 9:53 AM, the Surveyor received an email from E1 (DON) which stated, "My application is still pending." The email contained an attachment which was the State of Delaware's Division of Professional Regulation's "Application Status" for the temporary nursing home Administrator license with a submission date of 9/8/22. The status		

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	for this application stated, "...Deficient...", thus, the facility failed to have a full-time Administrator since the departure of the last Administrator in September 2022. 4/19/23 3:15 PM – Findings were reviewed and confirmed by phone with E1 (DON) and E15 (ED).		
3201.6.0	**Services to Residents**		
3201.6.9	**Communicable Diseases**	**Corrective Action:** •Corrective actions have been ensured by the Director of Nursing. Employee E12 had the QuantiFeron done on 11/30/2022 with result on 12/2/2022. The result showed that E12 was Negative. Employee E11 has been offered the two-step tuberculin skin test to satisfy the pre-employment screening requirement. **Identification of other residents:** •All Residents have the potential to be affected. Residents will be protected by ensuring that all employees are offered the pre-employment tuberculosis (TB) testing and have documentation to that effect. A 100% audit of all employees to ensure pre-employment TB testing has been completed. All staff members noted without pre-employment TB screening identified because of this audit were removed from schedule and offered TB testing.	
3201.6.9.2	**Specific Requirements for Tuberculosis**		
3201.6.9.2.4	**Minimum requirements for pre-employment tuberculosis (TB) testing require all employees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as QuantiFeron. Any required subsequent testing according to risk category shall be in accordance with the recommendations of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of Public Health, the facility shall comply with the recommendations of the Center for Disease Control for the appropriate risk category.**		
3201.6.9.2.4.2	**Any person having a positive skin test, but a negative X-ray shall receive an annual evaluation for signs and symptoms of active TB if they cannot provide documentation of completion of treatment for LTBI (latent TB infection).**		

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	This requirement was not met as evidenced by: Based on interview and review of the facility documentation, it was determined that for two (E10 and E11) out of 10 sampled employees, the facility failed to ensure employees met the minimum pre-employment requirements for tuberculosis screening. Findings include: 4/14/23 1:30 PM – During an interview with E16 (DOHR) the following employee personnel records were reviewed and E16 confirmed that the facility did not perform the minimum pre-employment TB screen for the following employees: 1. E12 (Agency CNA) – The first day in the facility was 2/28/23. A chest x-ray report (CXR) report for TB screening, dated 2/19/19, result was "No active disease in the chest." There was lack of evaluation for signs and symptoms of TB. 2. E11 (CNA) – The first day in the facility was 3/7/23. A CXR report for TB screening, dated 9/26/20, result was "No acute process in chest...". There was lack of evaluation for signs and symptoms of TB. 4/19/23 3:15 PM – Findings were reviewed and confirmed telephonically with E1 (DON) and E15 (ED).	**System Changes:** •The Root Cause of the concern was a failure to obtain the pre-employment TB screening for Employee E11. The facility system for TB Screening has been updated to include an Interdisciplinary Team (IDT) meeting involving the Administrator, Human Resources Director, Director of Nursing, and Infection Preventionist to monitor pre-employment screening of staff members to ensure that all requirements for TB screening of facility staff are met. Moving forward, all new hires will complete the 2 step PPD or the single interferon Gamma Release Assay such as QuantiFERON. The facility policy for "Tuberculosis, Employee screening" (rev. 02.2017) was reviewed and found to meet professional standards. The Director of Nursing or Designee will complete education for all staff requirements. The nursing management team will provide oversight to ensure ongoing compliance. **Success Evaluation:** •A random sample of 10% of employees will be completed by the Director of Nursing or designee to ensure that all employees meet the regulatory requirement for pre-employment TB screening; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then weekly until 100% compliance and then	

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		monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
16 Del. Code, Ch. 11 Sub-Chapter IV §1141	**The purpose of the criminal background check and drug screening requirements of this section and § 1146 of this title is the protection of the safety and well-being of residents of this State who use the services of home health agencies, hospice agencies, or personal assistance services agencies licensed under this title or who employ a person to provide care in a private residence. These sections must be construed broadly to accomplish this purpose.** **Criminal background checks.** ***(a) Purpose. —*** **The purpose of the criminal background check and drug screening requirements of this section and § 1142 of this title is the protection of the safety and well-being of residents of long-term care facilities licensed pursuant to this chapter. These sections shall be construed broadly to accomplish this purpose.** ***(b) Definitions. —*** ***(7) "SBI" means the State Bureau of Identification.***	**Corrective Action:** •Corrective actions have been ensured by the Administrator. Employee E13 has now had fingerprinting completed with no concerns noted on the employee background check. Employee E10 has been taken off the schedule and will not return to work until a fingerprinting is completed. **Identification of Other Residents:** •All Residents have the potential to be affected. Residents will be protected by ensuring that all employees meet the regulatory requirement for pre-employment screening and fingerprinting. A 100% audit of employee background checks has been completed to ensure proper completion of pre-employment screening and fingerprinting. This audit identified several employees that did not have fingerprinting completed; the fingerprinting has since been completed for these employees as required. **System Changes:**	

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	(c) An employer may not employ an applicant for work in a private residence before obtaining a criminal history. Upon request, the criminal history must be provided to the person for whom the services are to be provided, or to the person's authorized representative upon the applicant's commencement of work. **(d) The requirements of subsection (c) of this section may be suspended for 60 days if the employer wishes to employ the applicant on a conditional basis.** **(1) Before an employer may offer conditional employment, the employer must receive verification that the applicant has been fingerprinted by the SBI for purposes of the criminal history.** **This requirement was not met as evidenced by:** Based on review of facility personnel records and interview, it was determined that the facility failed to ensure that two (E13 and E10) out of 10 sampled employees had fingerprinting done prior to working in the facility. Findings include: 4/14/23 1:30 PM – During an interview with E16 (DOHR) the following employee personnel records were reviewed and E16 confirmed the lack of fingerprinting for each employee: 1. E13 (Agency CNA) – the first day working at the facility was 7/1/21.	•The Root Cause of the concern was a failure to complete the fingerprinting as required for Employee E13, and Employee E10. The facility system for pre-employment screenings and fingerprinting has been updated to ensure that no employee begins working until their fingerprinting is completed. The facility policy for "Background Screening Investigations" (rev. 3.2019) was reviewed and found to meet professional standards. The Administrator or Designee will complete education for all human resources staff regarding the pre-employment background screening investigations policy. The administrator will provide oversight to ensure ongoing compliance. **Success Evaluation:** •A random sample of 10% of employees will be completed by the Director of Nursing or designee to ensure that all employees meet the regulatory requirement for pre-employment screening and fingerprinting; Audits will have a goal of 100% compliance; Audits will be completed daily until 100% compliance is achieved for 3 consecutive evaluations, then 3 times a week until 100% compliance is achieved for 3 consecutive evaluations, then weekly until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as	

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	2. E10 (Agency RN) - the first day working at the facility was 3/9/23. 4/19/23 3:15 PM – Findings were reviewed and confirmed telephonically with E1 (DON) and E15 (ED)._	needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

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	085021	A. BUILDING _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCROFT LIVING	255 POSSUM PARK ROAD NEWARK, DE 19711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 2567 revised post IDR on 5/17/23 An unannounced Complaint Survey was conducted at this facility from April 11, 2023 through April 14, 2023. The deficiencies contained in this report are based on observation, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 74. The survey sample totaled 3 (three) residents. Abbreviations/definitions used in this report are as follows: Assistant Director of Nursing (ADON); Clinical Specialist (CS); Family Member (FM); Forensic Nurse (FN); Forensic Nurse Examiner (FNE); Director of Nursing (DON); Interim Executive Director Operation Specialist (IEDOS); Licensed Practical Nurse (LPN); Medical Doctor (MD); Registered Nurse (RN); Staff Development Coordinator (SDC).	F 000		
F 600 SS=G	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	F 600		5/26/23

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

Electronically Signed | 05/08/2023

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 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, record review and review of other documents as indicated, it was determined that for one (R1) out of three sampled residents reviewed for an allegation of sexual abuse, the facility failed to ensure that R1 was free from abuse. R1 stated that she was raped by a male the night of 4/8/23 and was transferred to the hospital for evaluation. Review of the hospital records revealed that R1 was harmed, as injuries sustained were consistent with sexual assault. Findings include: Cross refer F607 and F609. Review of the R1's clinical record revealed: 4/6/23 - R1 was admitted to the facility from the hospital. 4/6/23 1:00 AM - The Admission History and Physical completed by E7 (MD) documented, " ...General: oriented x2 (knows who they are and where they are, but not the time), questionably 3 (awake, alert and oriented times three to person, place and time), responds appropriately to commands ...". 4/9/23 7:03 PM - According to the local law enforcement's dispatch records, FM1 (R1's family member) called 911 to report an allegation of	F 600	Corrective Action: R1 is no longer a resident in this facility. There is no opportunity for correction for this resident. All facility staff were educated on abuse prevention, maintaining evidence of a crime, and all staff members are to undergo pre-employment background checks before they are employed. Identification of other Residents: All Residents have the potential to be affected. All Residents have been interviewed by Social Services to determine any other concerns related to abuse, neglect, or residents rights. No new concerns were identified during these interviews. Residents will be protected by ensuring that all employees receive education on abuse prevention, maintaining evidence of crime, and making sure that pre-employment screening is done for all new employees. An updated background check has been completed for all male employees. System Changes: The Root Cause of the concern was a failure to ensure that R1 was free from	

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F 600	Continued From page 2 rape. 4/9/23 8:09 PM - Review of the Hospital's Forensic Nurse Examiner's Sexual Assault Examination was initiated by FN1 (RN, FNE). FN1 reported it to law enforcement on 4/9/23 at 8:09 PM. 4/9/23 8:15 PM - A Progress Note documented, "Resident's daughter visiting this evening and stated her mother made a complain (sic) to her that she was violated sexually by a male during the night. Supervisor notified MD, DON and resident sent to the ER for evaluation." 4/9/23 8:40 PM - The Hospital's Emergency Department Physician Record documented, " ...History of Present Illness ...She reported that in the middle (sic) the night, male individual entered her room at the facility, vaginally and then turned her prone and rectally penetrated her with penile penetration ...Physical Exam ...General: No acute distress, reclining in stretcher ...Neurologic: Alert and oriented X3 ...Assessment and Plan: Sexual assault and left shoulder pain ...ED Progress ...Patient examined by forensic nurse. Reviewed photographs with her, there is evidence of significant superficial injury to the pelvis, thighs, vagina, possibly of anus without obvious bleeding. Mainly seen to be bruising injuries, with mild swelling of the labia. No obvious lacerations ...". 4/9/23 10:06 PM - The facility's Incident/Accident Report documented the following: "...Description of what happened: At around 5:30 PM, R1's daughter came to nursing station and reported that her mother is having a complain	F 600	concerns of sexual abuse. The facility policy for Abuse Prevention program (Rev. 12.2016) was reviewed and found to meet professional standards. The facility system for managing the staff Development Program has been updated to include a monthly review of abuse concerns and abuse prevention policy compliance in the quarterly Quality Assurance and Performance Improvement (QAPI) committee meetings. If concerns in abuse prevention is identified, an action plan will be initiated. Moving forward all concerns regarding allegations of abuse, neglect, or mistreatment will be reviewed with the Inter departmental team in the daily clinical meeting to ensure appropriate investigation and reporting. The Executive Director or Designee will complete education of all staff regarding the policy for abuse prevention, and maintaining evidence of a crime. The Executive director or Designee will provide oversight to ensure ongoing compliance with pre-employment screening. Success Evaluation: An initial 100% audit of all staff members will be completed by the Executive Director or designee to ensure that all staff members are educated on Abuse prevention, and maintaining evidence of crime per facility policy; then a 100% audit of all new staff members will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100%	

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F 600	Continued From page 3 (sic) that she was touched inappropriately last night. I went to her room and I asked her what happened, she stated she was raped in the morning. She then changed it was midnight. I asked her if she reported to the nurse and she said no. I called the nurse who was working with her on the shift because he was the same nurse on duty. I asked the resident if he was the one and she said no. Her daughter was in the room with us when I asked the resident...". 4/10/23 4:25 AM - Hospital History and Physical documented, " ...History of Present Illness ...She presented ...due to unfortunately being sexually assaulted while she was at a skilled nursing facility (SNF) vaginally and rectally with penile penetration. Her vital signs were stable ...She was seen by forensic nursing. Autographs (sic) were done there is evidence of significant superficial injury to pelvis thighs, vagina, anus, mostly seem to be bruising injuries with mild swelling of the labia ...(Name of the Hospital) was asked to admit patient ...Physical Exam ...General: No acute distress ...Neurologic: Alert and oriented X 3 ...Assessment/Plan ...Sexual assault of adult Seen by forensic nursing for recommendations for antibiotic and PEP (Post Exposure Prophylaxis to HIV and other sexually transmitted diseases)...". 4/10/23 5:09 PM - Review of the Hospital's Discharge Summary included hypoxemia (low oxygen levels in the blood) and sexual assault of an adult as primary and secondary diagnoses respectively. The summary further stated, " ...Hospital Course: ...recent hospitalization for hypoxia (low oxygen levels in the tissues) secondary to influenza and pulmonary edema (a critical condition caused by excess fluids in the	F 600	compliance is achieved for 3 consecutive evaluations, then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance team. An initial 100% audit of all staff members will be completed by the Executive Director or designee to ensure that all staff members have pre-employment background check completed and on file. Then, a 100% audit of all new staff members will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurrance Team.	

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F 600	Continued From page 4 lungs)...discharged to rehab on 4/6, who presented back to the hospital on 4/9 after being sexually assaulted vaginally and rectally at her SNF ...She was seen by forensic nursing and given antibiotics and HIV prophylaxis [PEP] ...". 4/13/23 5:38 PM - An interview with FN1 confirmed that the results of the Sexual Assault Examination was consistent with sexual assault. 4/14/23 3:30 PM - Findings were reviewed with E1 (DON), E2 (ADON), and E3 (CS) during the Exit Conference.	F 600		
F 607 SS=E	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. §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.	F 607		5/26/23

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F 607	Continued From page 5 §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 interview and other documentation as indicated, it was determined that the facility failed to develop and implement written policies and procedures for report of suspicion of a crime; an allegation of rape. Findings include: Cross refer F600 and F609. Review of the facility's policy titled Reporting Suspicion of a Crime, with a revision date of July 2017, stated, " Resident Abuse Protection Program, with a revision date of 7/10/2019, stated, " ...12. All staff will receive training on the following points related to this policy: a. Who is considered a 'covered individual'; b. Examples of 'crime' as defined by the political subdivision in which the facility is located; c. The obligation to report a reasonable suspicion of a crime; d. Time frames required for reporting; e. Definitions of and how to recognize 'serious bodily injury'; f. Possible (but not required) formats for reporting; g. Employee rights to be free of retaliation for reporting; and h. Employee rights to file a complaint against the facility for retaliation ...". 1. The facility failed to implement requirements for all staff training: 4/12/23 11:10 AM - During an interview with E4 (SDC), the Surveyor reviewed the educational	F 607	Corrective Action: Resident R1 is no longer a resident in the facility. There is no opportunity for correction for this resident. All facility staff were educated on Abuse Prohibition, timely reporting of suspicion of a Crime, and maintaining the integrity of evidence. Identification of other Residents: All Residents have the potential to be affected. All residents were interviewed by Social Services or designee to determine any concerns related to abuse, neglect, or resident's rights. No new concerns were identified. Residents will be protected by ensuring that all employees continue to be educated on Abuse prevention/prohibition, timely reporting of suspicious crime, and maintaining the integrity of evidence. System Changes: The Root Cause of the concerns were failure to ensure that staffs were properly educated on Abuse prevention/Prohibition, timely reporting of suspicious crime, and maintaining the integrity of evidence. The facility Policy for Abuse Prevention Program (REV. 12.2016) was reviewed	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 6 content of the Abuse Prohibition training for all employees with E4. E4 confirmed that the training did not include the required training components, as stated in the above policy titled Reporting Suspicion of a Crime. 2. The facility failed to implement reporting requirements for a suspicious crime: 4/9/23 9:26 PM - The facility filed an incident with the State Agency concerning R1's allegation of sexual abuse. There was lack of evidence that the facility identified the above allegation was a suspected crime and they failed to report this immediately to local law enforcement. 4/11/23 2:02 PM - An interview with E1 (DON) and E2 (ADON) confirmed that the reporting to law enforcement took place on 4/10/23 between 10:00 AM and 12:00 PM; greater than 16 hours after the facility became aware of the allegation of rape. The facility failed to report this immediately as required to local law enforcement. 3. The facility failed to develop and implement a process for maintaining the integrity of evidence: Review of the above policy and procedure failed to include a written process that the facility must ensure to maintain integrity of evidence related to a suspicious crime. 4/14 23 12:30 PM - During an interview with E1 and E2, they confirmed that the facility did not have a written process for maintaining the integrity of evidence related to a suspicious crime scene.	F 607	and found to meet professional standards. The facility policy for reporting suspicion of crime (Rev. 7.2017) was reviewed and found to meet professional standards. The facility policy on maintaining the integrity of evidence was reviewed and found to meet professional standards. The Executive Director or designee will educate all staff on Abuse prohibition, reporting suspicious crime, and maintaining the integrity of evidence. The facility system for managing the staff development program has been updated to include a monthly review of abuse concerns and abuse prevention policy compliance at the quarterly Quality Assurance and Performance Improvement (QAPI) committee meeting. If concerns are identified an action plan will be initiated. Success Evaluation: A random sample of 10% of staff members will be interviewed by the Executive Director or designee to ensure that staff members have the required training for Abuse prohibition, reporting suspicion of a crime, and maintaining the integrity of evidence per policy. Then, 10% of staffs will be interviewed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will	

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	085021	A. BUILDING _____ B. WING _____	C 04/14/2023

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F 607	Continued From page 7 4/14/23 3:30 PM - Findings were reviewed with E1, E2, and E3 (CS) during the Exit Conference.	F 607	be reviewed by the Quality Assurance team.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(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: Based on interview, record review and review of other facility documentation, it was determined	F 609	Corrective Action: R1 is no longer a resident in the facility.	5/26/23

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F 609	Continued From page 8 that for one (R1) out of three sampled residents reviewed for an allegation of sexual abuse, the facility failed to ensure that an alleged violation involving sexual abuse was reported immediately. For R1, the facility was made aware of an allegation of rape on 4/9/23 at approximately 5:30 PM and the facility failed to report it timely to local law enforcement and to the State Survey Agency. Findings include: Cross refer to F600 and F607. Review of the facility's policy titled Reporting Suspicion of a Crime, with a revision date of July 2017, stated, "...4. The timing of reporting will be based on the events that cause suspicion and will be as follows: a. If the event results in serious bodily injury, the suspicion will be reported immediately for not more than two hours after the individual first suspects that a crime has occurred ...c. 'Serious bodily injury' is defined as an injury involving: ...(4) sexual abuse or aggravated sexual abuse...". Review of the facility's policy titled Abuse Investigation and Reporting, with a revision date of July 2017, stated, "...Reporting...2. An alleged violation of abuse ...will be reported immediately, but no later than: a. two (2) hours if the alleged violation involve abuse OR has resulted in serious bodily injury...". Review of the R1's clinical record revealed: 4/6/23 - R1 was admitted to the facility from the hospital. 4/9/23 8:15 PM - A Progress Note documented "Resident's daughter visiting this evening and	F 609	There is no opportunity for correction for this resident. All facility staff were educated on reporting requirements for a suspicious crime. Identification of other Residents: All Residents have the potential to be affected. All residents have been interviewed by Social Services to determine any other concerns related to reporting a suspicious crime. No new concerns were identified during these interviews. Residents will be protected by ensuring that staff members are educated on reporting alleged violation involving suspicion of crime immediately per facility policy. System Changes: The Root Cause of the concern was a failure to educate staff properly on facility policy for reporting a suspicious crime to local law enforcement and the state survey agency. The facility policy for Reporting suspicion of a crime (Rev. 7.2017) was reviewed and found to meet professional standards. All facility staff are to be educated on requirements for timely reporting of suspicion of crime. The facility system for managing the staff development program has been updated to include a monthly review of abuse concerns and compliance with reporting requirements in the quarterly Quality Assurance and Performance Improvement (QAPI) committee meeting. If concerns are identified an action plan	

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F 609	Continued From page 9 stated her mother made a complain (sic) to her that she was violated sexually by a male during the night. Supervisor notified MD, DON and resident sent to the ER for evaluation." 4/9/23 9:26 PM - The facility reported to the State Agency an allegation of sexual abuse, approximately 4 hours after the facility was made aware of R1's allegation on 4/9/23 at approximately 5:30 PM on 4/9/23. There was lack of evidence that the facility identified that the above sexual abuse allegation of rape was a suspicious crime and the facility failed to report it immediately to local law enforcement. 4/9/23 10:06 PM - The facility's Incident/Accident Report stated the following: "...Description of what happened: At around 5:30 p.m. R1's daughter came to nursing station and reported that her mother is having a complain (sic) that she was touched inappropriately last night. I went to her room and I asked her what happened, she stated she was raped in the morning. She then changed it was midnight. I asked her if she reported to the nurse and she said no. I called the nurse who was working with her on the shift because he was the same nurse on duty. I asked the resident if he was the one and she said no. Her daughter was in the room with us when I asked the resident...". 4/11/23 2:02 PM - An interview was conducted with E1 (DON), E8 (IEDOS) and E2 (ADON). The Surveyor inquired when and who the reporting was completed by to the local law enforcement of this allegation of sexual abuse; rape. E1 and E2 stated that law enforcement was	F 609	will be initiated The Executive Director or designee will complete education for all staff regarding reporting of suspicion of a crime. Success Evaluation: An initial 100% audit of staffs by the Executive Director or designee will be completed to ensure that staffs are educated on timely reporting of suspicion of crime to state agency and law enforcement per facility policy. Then, a 100% audit of newly hired staff will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance team. A 100% audit of all report of alleged abuse will be completed by the Executive Director or designee at the time of the report of the alleged abuse to ensure that all allegation of abuse is reported timely per facility policy. The results of the audits will be reviewed by the Quality Assurance team.	

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F 609	Continued From page 10 notified on 4/10/23 between 10:00 AM and 12:00 PM, although the facility was made aware of the suspicious crime on 4/9/23 at approximately 5:30 PM. 4/14/23 3:30 PM - Findings were reviewed with E1, E2, and E3 (CS) during the Exit Conference.	F 609		