STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395785	A. BUILDING _____ B. WING _____	07/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
STONEBRIDGE HEALTH & REHABILITATION CENTER	102 CHANDRA DRIVE DUNCANNON, PA 17020

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility document and policy review, and staff interview, it was determined that the facility failed to report an allegation of abuse to the facility administrator, the State Survey Agency, county adult protective services, and local law enforcement for one of three resident records reviewed (Resident 1). Findings include: Review of the facility's policy titled, Pennsylvania Resident Abuse; Section: Abuse, Neglect and Exploitation, last revision date of July 2019, revealed that the facility's policy stated, Facility staff must immediately report all (abuse) allegations to the (Nursing Home) Administrator/Abuse Coordinator. The (Nursing Home) Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy. Review of the aforementioned policy's Procedure section, subsection 6 - Initial Reports revealed it stated, a. Timing. All allegations of Abuse, Neglect, Involuntary Seclusion, Injuries of Unknown source, and Misappropriation of resident property must be reported immediately to the (Nursing Home) Administrator, Director of Nursing (DON) and to the applicable State Agency. If the event that cause the allegation involves an allegation of Abuse or serious bodily injury, it should be reported to the (Department of Health) immediately, but not later than 2 hours after the allegation is made. Review of Resident 1's clinical record on July 2, 2020, at approximately 10:00 AM, revealed [DIAGNOSES REDACTED]. Review of Resident 1's progress notes revealed a progress note entered by Director of Nursing (DON) on June 17, 2020 at 7:30 AM, which stated, Nurse noticed (Resident 1) crying and very upset. (DON) ask Resident 1 what is wrong (sic)? (Resident 1) stated (that Resident 1) was raped. (DON) asked (Resident 1) when this happened, (Resident 1) said it was a while ago. (DON) sat with (Resident 1) for a little and (DON) told her she is safe. (DON) also let her know I will talk to the social worker, and she will come and talk to you. (Resident 1) said that would be fine. During a phone interview on July 6, 2020, at approximately 11:10 AM, the Nursing Home Administrator (NHA) stated that she was not notified of the allegation of sexual abuse made by Resident 1 on June 17, 2020. During the interview, the Nursing Home Administrator was asked if the Department of Health, or any other state or local authorities were notified of Resident 1's accusation of rape on June 17, 2020; Nursing Home Administrator stated, No. During a staff interview on July 9, 2020, at approximately 1:00 PM, Nursing Home Administrator revealed that the Department of Health and other authorities should have been notified of the allegation at the time the allegation was made. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.14(c)(e) Responsibility of licensee. 28 Pa. Code: 201.18(a)(b)(1) Management.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility document review and staff interview, it was determined that the facility failed to implement policies and procedures to ensure allegations of abuse were investigated, prevent potential abuse, and report allegations of abuse to applicable State and Local authorities for one of 3 resident records reviewed (Resident 1). Findings include: Review of the facility's policy titled, Pennsylvania Resident Abuse; Section: Abuse, Neglect and Exploitation, last revision date of July 2019, revealed that the facility's policy stated, It is the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, exploitation of residents, misappropriation of resident property and injuries of unknown source. Facility staff must immediately report all such allegations to the (Nursing Home) Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediate begin an investigation . Review of the facility's abuse policy, subsection 4, Protect the Resident, revealed it stated, .Staff should not leave a resident unattended, unless it is necessary to summon assistance . Staff should not move the resident until he/she has been assessed by a nurse supervisor for possible injuries . A nurse should perform an initial assessment of the resident. The assessment should generally include the following: range of motion (ROM); full body assessment for signs of injury; and vital signs . If appropriate, the facility should send the resident to the hospital for an examination . (The Nursing Home) Administrator or designee will notify police when the facility receives a complaint of, or suspect's sexual abuse, serious bodily injury or suspicious death . In Allegations of Sexual Abuse every effort will be made to preserve evidence on both the resident and the perpetrator. Resident and perpetrator: Will not be bathed or cleaned; will not receive incontinence care; incontinence brief will not be changed; clothing will not (sic) be changed; no oral care will be provided; both resident and perpetrator will be evaluated in the (emergency room); linens will be bagged and provided as evidence, if applicable; police to be notified. If a staff member is accused or suspected. If a staff member is accused or suspected of abuse, neglect, mistreatment, exploitation, involuntary seclusion and/or misappropriation of property, the Facility (will) immediately remove staff member from resident care area and request a written statement from accused staff member. The accused staff member will remain under direct supervision until statement is complete and/or law enforcement arrives if applicable. The accused staff member will then be removed from the facility and the schedule pending the outcome of the investigation. Subsection 5 of the aforementioned facility abuse policy stated, Document: Documentation in the nurses' notes should include the result of the resident's ROM, body assessment, vital signs, the notification of the physician and the responsible party, and treatment provided. Appropriate quality assurance documentation should be completed as well. Review of Resident 1's clinical record on July 2, 2020, at approximately 10:00 AM, revealed [DIAGNOSES REDACTED]. Review of Resident 1's comprehensive plan of care revealed resident 1 was care planned for cognitive loss due to dementia and vision impairment requiring the use of glasses due to [MEDICAL CONDITION]. Review of Resident 1's progress notes revealed a progress note entered by Director of Nursing (DON) on June 17, 2020 at 7:30 AM, which stated, Nurse noticed (Resident 1) crying and very upset. (DON) ask Resident 1 what is wrong (sic)? (Resident 1) stated (that Resident 1) was raped. (DON) asked (Resident 1) when this happened, (Resident 1) said it was a while ago. (DON) sat with (Resident 1) for a little and (DON) told her she is safe. (DON) also let her know I will talk to the social worker, and she will come and talk to you. (Resident 1) said that would be fine. Further review of Resident 1's progress notes revealed a note documented by the Director of Nursing on June 17, 2020 at 9:10 AM which stated, (Resident 1's attending physician) notified of this (allegation of rape) with this resident, order for No male care givers, due to male care giver had her last night and feels this triggered the (rape) in her head. (Resident 1's attending physician) ordered [DIAGNOSES REDACTED]. We will continue to monitor her. However, review of facility document, dated July 2, 2020, revealed Nursing Home Administrator collected answers from NA 1 for the following questions, Did you witness a male providing care to (Resident 1)? To which the NHA documented, No, and Did you provide care to (Resident 1) on (June 16, 2020 or June 17, 2020)? The NHA documented that NA 1's response to this question was, No. Review of the document revealed that it was signed by the NHA. Review of a written statement by NA 3, dated July 2, 2020, NA 3 stated that she provided all the care for Resident 1 on the night of July 17, 2020. Further, review of Resident 1's nursing progress notes since admission, and comprehensive plan of care,

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

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 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) including resolved/completed care plans, goals and interventions revealed no prior history of rape, or allegations of rape, evaluation for post-traumatic stress disorder, or [DIAGNOSES REDACTED]. Review of a progress note documented by Social Worker 1 (SW 1) on June 17, 2020 at 9:10 AM revealed that SW 1 documented, (Social Worker 1) received report that (Resident 1) was extremely upset and crying this morning. (SW 1) went and spoke privately with (Resident 1). (Resident 1) told (SW 1) that she was raped last night in her bed . Review of the Resident's progress notes revealed a Monthly Nursing Note, was entered by an LPN on June 17, 2020. Review of facility documentation revealed that NA 2 documented providing a shower to Resident 1 on June 17, 2020. Review of Resident 1's progress notes for the day of June 17, 2020 revealed no assessment was documented by a Registered Nurse (RN) supervisor in response to the allegation of rape by Resident 1. During a staff interview on July 6, 2020, at approximately 11:10 AM, Director of Nursing stated that during the prior night, Nurse Aide 1 (NA 1) was the only male employee in the building. Review of NA 1's employee file revealed NA 1 was not suspended on June 17, 2020. During the interview, Director of Nursing stated that she took a picture of NA 1 to show Resident 1. Director of Nursing stated that Resident 1 denied that NA 1 was the perpetrator. During the staff interview the DON stated that she had performed an assessment of Resident 1 as a result of the allegation of rape. During the staff interview, DON stated that she interviewed NA 1 at the time of the allegation and DON revealed that NA 1 stated he had been in Resident 1 room the prior night, a couple times, but that Resident 1 did not seem upset. DON also revealed that NA 1 stated to her, at the time, that NA 1 was in Resident 1's room with other staff. During the staff interview, Director of Nursing revealed she did not document the aforementioned interview. During a staff interview on July 1, 2020, at approximately 12:30 PM, Nursing Home Administrator was asked if the facility received any allegations of abuse during the Months of May and June, 2020. During the interview, Nursing Home Administrator stated that there were no allegations or investigations of abuse during May and June, 2020. During a staff interview on July 6, 2020, Nursing Home Administrator stated that she was not informed of an allegation of sexual abuse by Resident 1. During the interview it was revealed that Nursing Home Administrator did not have knowledge of the allegation of rape allegation prior to July 6, 2020. During a staff interview on July 9, 2020, at approximately 1:00 PM, Director of Nursing stated that she had reported the allegation to the former facility Director of Nursing who was the Director of Nursing at the time of the rape allegation. Review of facility documentation submitted to the Pennsylvania Department of Health by the Nursing Home Administrator at the time of the change in Director of Nursing for the facility, revealed that DON 1 was the Director of Nursing as of June 6, 2020; indicating that DON 1 was the acting Director of Nursing at the time of the rape allegation on June 17, 2020. During the staff interview on July 9, 2020, at approximately 1:00 PM, the Nursing Home Administrator revealed that the allegation of rape should have been investigated per the facility's abuse policy. During the staff interview, Nursing Home Administrator revealed that the Nursing Home Administrator was the facility's designated Abuse Coordinator and that the Nursing Home Administrator should have been notified of the allegation of rape when it occurred. As of the staff interview, the facility was unable to provide any documentation or evaluation that supported the Director of Nursing's conclusion; that care provided to Resident 1 by a male caregiver triggered a post-traumatic stress disorder event for Resident 1 which resulted in an allegation of rape. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services
F 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** Based on clinical record review, facility document review and staff interview it was determined that the facility failed to be administered in a manner to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident by failing to ensure allegations of abuse were reported, investigated, in a manner that protected the residents of the facility, and documented in a manner consistent with the facility's policy and procedures, and in accordance with applicable Federal and State requirements. Findings include: Review of the facility's job description for the Director of Nursing position revealed that the position summary stated, As the Director of Nursing it is your responsibility to organize, develop and direct the overall operations of the Nursing Service Department in accordance with current federal, state and local standards, guidelines and regulations that govern the facility. The Director of Nursing is to work directly with the (Nursing Home) Administrator and the Medical Director to ensure the highest degree of quality of care is maintained for each resident at all times. Further review of the facility's job description for the position of Director of Nursing revealed that the Director of Nursing was responsible for reporting to the Nursing Home Administrator. Further review of the Director of Nursing job description reveale d Essential Function, Duties and Responsibilities, included, Responsible for the reporting of any known or suspected allegations of abuse and/or misappropriation of resident property in accordance to the state guidelines . Review of the Director of Nursing job description's section titled, Core Competencies/Skill Sets, revealed it stated that the Director of Nursing position, Complies with applicable legal requirements, standards, policies and procedures including but not limited to those within the Compliance Process, Code of Conduct and HIPAA, and that the Director of Nursing, Must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulation and guidelines that pertain to nursing care facilities. Review of the facility's policy titled, Pennsylvania Resident Abuse; Section: Abuse, Neglect and Exploitation, last revision date of July 2019, revealed that the facility's policy stated, Facility staff must immediately report all (abuse) allegations to the (Nursing Home) Administrator/Abuse Coordinator. The (Nursing Home) Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy. Review of the aforementioned policy's Procedure section, subsection 6 - Initial Reports revealed it stated, a. Timing. All allegations of Abuse, Neglect, Involuntary Seclusion, Injuries of Unknown source, and Misappropriation of resident property must be reported immediately to the (Nursing Home) Administrator, Director of Nursing (DON) and to the applicable State Agency. If the event that cause the allegation involves an allegation of Abuse or serious bodily injury, it should be reported to the (Department of Health) immediately, but not later than 2 hours after the allegation is made. Review of Resident 1's progress notes revealed a progress note entered by Director of Nursing (DON) on June 17, 2020 at 7:30 AM, which stated, (Resident 1 observed) crying and very upset. (DON) ask Resident 1 what is wrong (sic)? (Resident 1) stated (that Resident 1) was raped. (DON) asked (Resident 1) when this happened, (Resident 1) said it was a while ago. (DON) sat with (Resident 1) for a little and (DON) told her she is safe. (DON) also let her know I will talk to the social worker, and she will come and talk to you. (Resident 1) said that would be fine. Review of a progress note documented by Social Worker 1 (SW 1) on June 17, 2020 at 9:10 AM revealed that SW 1 documented, (Social Worker 1) received report that (Resident 1) was extremely upset and crying this morning. (SW 1) went and spoke privately with (Resident 1). (Resident 1) told (SW 1) that she was raped last night in her bed . During a staff interview on July 6, 2020, at approximately 11:10 AM, the Director of Nursing revealed that it was believed that Resident was had suffered an episode of post-traumatic stress disorder in which Resident 1 had experienced historical trauma and reliving the trauma on June 17, 2020. However, during the staff interview the Director of Nursing stated that at the time of the allegation she interviewed Nurse Aide 1 (NA 1) as NA 1 was the only male caregiver on the evening of June 16, 2020. Director of Nursing also stated that she showed Resident 1 a picture of NA 1 to Resident 1 in order to identify a perpetrator. Director of Nursing was asked during the staff interview if there was documentation of an interview with NA 1, or documentation of providing Resident 1 a photograph of NA 1 to identify/rule out a suspected perpetrator. Director of Nursing stated that it was not documented. Review of NA 1's employee file revealed that NA 1 was not suspended pending any investigation at the time of the allegation of rape by Resident 1 on June 17, 2020. During the staff interview on July 6, 2020, at approximately 11:10 AM, the Nursing Home Administrator (NHA) stated that she was not notified of the allegation of sexual abuse made by Resident 1 on June 17, 2020. Nursing Home Administrator stated that she was notified that Resident 1 had, a (Post-Traumatic Stress Disorder) incident, but the allegation of rape was not reported to the Nursing Home Administrator by the Director of Nursing. During the interview, the Nursing Home Administrator was asked if the Department of Health, or any other state or local authorities were notified of Resident 1's accusation of rape on June 17, 2020; Nursing Home Administrator stated, No. Review of available facility records revealed that there was no submission, or report to any State or Local authorities that Resident 1 made an allegation of rape on June 17, 2020. Review of facility documentation revealed that the Director of Nursing did not implement the facilities abuse policy's and procedures consistent with applicable Federal and State regulation in regards to notification of the Nursing Home Administrator, reporting the allegation of abuse to applicable State and Local authorities, investigation of the allegation of abuse; protection of residents during an investigation of alleged abuse; and investigation and documentation of the

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F 0835 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) allegation of abuse made by Resident 1, directly to Director of Nursing, on June 17, 2020. During the staff interview on July 6, 2020, at approximately 11:10 AM, Nursing Home Administrator stated that the facility did not have a designated Abuse Coordinator, further the Nursing Home Administrator stated that she was not familiar with the Abuse Coordinator term. During the staff interview, the Director of Nursing did not identify a facility staff member that functioned as the Abuse Coordinator. During a staff interview on July 9, 2020, at approximately 1:00 PM, Nursing Home Administrator revealed that per confirmation with facility corporate leadership, the Nursing Home Administrator was designated as the facility Abuse Coordinator. Refer to F609 and F610 28 Pa. Code: 201.18(b)(1) Management 28 Pa. Code: 201.18(b)(3) Management 28 Pa. Code:211.12(c)(d)(5) Nursing Services