STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375483	A. BUILDING _____ B. WING _____	09/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EDMOND HEALTH CARE CENTER	39 EAST 33RD STREET EDMOND, OK 73013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm -** Actual harm **Residents Affected -** Some	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide protection from abuse for three (#1, #2 and #3) of five sampled residents who were reviewed for allegations of abuse. The facility identified 62 residents who resided in the facility. Findings: The facility failed to report and investigate allegations of abuse including suspension of an alleged perpetrator during an investigation. The facility allowed the alleged perpetrator to continue to provide care to the residents who had allegations against him for a period of at least one to two months, which resulted in psychosocial harm. 1. Resident #1 had [DIAGNOSES REDACTED]. Review of the state reports dated 07/20 through 09/20 did not include any investigations of allegations of abuse. On 09/09/20 at 4:10 p.m., the resident was asked how the staff treated him. He stated they were really rough sometimes. He was asked which staff was rough. He named CNA #1. He stated CNA #1 had poked his fingers in his face and had mocked the noises he made when his legs jerked. He was asked when the last time CNA #1 had treated him this way. He stated it had been three days ago. Resident #1 was asked if he had reported to the staff about the incidents. He stated he had reported to the administrator about a week ago and it had been better since then. He stated he had also reported it to the ADON several times and she had told him she had talked to the staff until she was blue in the face. He was asked if CNA #1 was intentional in the way he treated him. He stated yes. He stated CNA #1 would enter his room when he knew he was asleep and get in his face and scream to wake him up. He stated, He laughs and thinks it's funny. He stated he had told CNA #1 he did not like it and to quit putting his nasty hands in his face. He stated, He just grunts at me like I do. The resident stated he had cried a few times over the way he had been treated. He was asked how it made him feel. He stated, I get intimidated. He stated he wanted to hit CNA #1. He stated he was tired of it. He stated, He degrades me. I feel embarrassed and ashamed about it. At 4:45 p.m. an anonomous employee stated CNA #1 was asked for assistance with resident #4 in the past. CNA #1 had stated he could do the transfer by himself. CNA #1 was rough with resident #4 during the transfer. The anonomous employee stated they had reported the situation to staff, but nothing was done. At 5: 25 p.m. CNA #1 was observed on-duty. He stated no one at the facility had ever spoken to him about employee to resident abuse. At 6:00 p.m., the DON was asked if any residents had complained about CNA #1. She stated resident #1 had reported he thought CNA #1 was rough with resident #2. The DON did not mention any allegations of abuse which involved resident #1. At 6:25 p.m., the administrator was asked if any residents had reported to her related to staff being rough during care. She stated, No. The administrator did not mention any allegations of abuse which involved resident #1. On 09/10/20 at 10:20 a.m., the ADON was asked if she had received any allegations of abuse from a resident or staff in the last three months. She stated, No. The ADON did not mention any allegations of abuse which involved resident #1. On 09/11/20 at 9:18 a.m., the DON and the administrator were asked if they had recieved any allegations of abuse which involved resident #1. They both stated no. They were informed of the allegation of abuse resident #1 had reported related to CNA #1. They stated they had suspended CNA #1 on 09/09/20 after the surveyors' arrival pending an investigation of allegations of abuse. 2. Resident #2 had [DIAGNOSES REDACTED]. Review of the state reports dated 07/20 through 09/20 did not include any investigations of allegations of abuse. On 09/09/20 at 4:10 p.m., during an interview related to abuse, resident #1 stated he thought CNA #1 was rough on his roommate (resident #2). He was asked what he meant by rough. He stated he could hear resident #2 make noises each time CNA #1 provided care to him and it sounded like the resident would hit his head on the wall. At 4:45 p.m. an anonomous employee stated CNA #1 was asked for assistance with resident #4 in the past. CNA #1 had stated he could do the transfer by himself. CNA #1 was rough with resident #4 during the transfer. The anonomous employee stated they had reported the situation to staff, but nothing was done. At 5: 25 p.m. CNA #1 was observed on-duty. He stated no one at the facility had ever spoken to him about employee to resident abuse. At 6:00 p.m., the DON was asked what she did if someone reported an allegation of abuse to her or her staff. She stated they had issues on another shift. She was asked what she meant by issues. She stated the staff had been bickering and accusing each other trying to get each other fired. The DON stated if she received an allegation of abuse she investigated it. She stated if it was accurate she reported it to the state. She was asked what she did if she substantiated abuse. She stated she suspended the alleged perpetrator during an investigation and she terminated them if it was substantiated. The DON was asked when she had started in the DON position. She stated the end of July. She was asked if she had received any allegations of abuse. She stated one of the aides thought CNA #1 had been rough with resident #2. She was asked what she had done related to the allegation. She stated she stood back and observed CNA #1 from a distance and had not observed any concerns. She stated she had asked resident #2 if any staff had been rough with him and the resident stated no. She was asked if she had talked to CNA #1 related to the allegation. She stated, I told him to be sure he is being gentle. The DON was asked if she had interviewed any other residents related to the allegation of abuse. She stated no. The DON was asked how she documented her investigation. She stated she had not documented the investigation. The DON was asked if she had reported the allegation of abuse to anyone. She stated no. She stated she did not see it as abuse because the report was about CNA #1 being rough. She stated the staff who reported the allegation had been complaining about CNA #1 and not wanting to work with him. She stated, They just want to get him fired, I should have documented it. The DON was asked if any residents had complained about CNA #1. She stated resident #1 had reported he thought CNA #1 was rough with resident #2 because he could hear resident #2 when CNA #1 repositioned the resident. She stated she had assessed resident #2 and had not observed any signs of abuse. She was asked when resident #1 had reported the allegation. She stated about an hour after the aide had reported to her, the aide pushed resident #1 into the DON's office and stated, He has something to tell you. She stated she had mentioned it to the administrator. At 6:25 p.m., the administrator was asked what their procedure was if they received an allegation of abuse. She stated the DON checked it out. She stated they would talk to the residents and turn it in. She stated they would suspend the alleged perpetrator during the investigation and if it was substantiated they would terminate the employee. She was asked if she was aware of any allegations of abuse in the last three months. She stated the DON had just notified her of an allegation today which involved resident #2. She was asked if any allegations of abuse had been reported to her before today. She stated, No. She was asked if CNA #1 should have been suspended during the investigation of an allegation of abuse with resident #2. She stated, Yes. She was asked how they documented an allegation of abuse. She stated, On paper and keep it in a file. She was asked if an allegation of abuse was required to be reported to the OSDH. She stated, Yes. The administrator was informed the DON had not interviewed other residents during the investigation of the allegation of abuse for resident #2. She was asked how they knew if CNA #1 had abused other residents. She stated, We don't. She was asked if they had continued to allow CNA #1 to provide care to the residents without interviewing the residents related to being abused by CNA #1. She stated, Yes. On 09/10/20 at 9:30 a.m., the DON was asked for their policy and procedure related to abuse. She provided the policy and stated she had not followed their policy in regards to the

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 0600 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 1) allegation of abuse which involved CNA #1. 3. Resident #3 had [DIAGNOSES REDACTED]. A written statement, dated 09/10/20, documented, .clarification of above statement 9/10/2020 @ 11:00 am .(resident #3 name deleted) had stated that he had gotten his breast pinched by and (sic) employee. He said this to me in the shower rm a few months ago. I went & reported the alligation (sic) to the charge nurse .the employee is name (CNA #1 name deleted) . Review of the state reports dated 07/20 through 09/20 did not include any investigations of allegations of abuse. On 09/10/20 at 10:07 a.m., CNA #2 was asked what she would do if a staff was abusive to a resident. She stated she would report it to the nurse. She was asked if she had observed or heard of any staff being abusive to a resident. She stated resident #3 had reported to her about two months ago that CNA #1 had pinched him on his breasts. She stated she had reported it to a nurse that no longer worked at the facility. She was asked what the facility had done about it. She stated she did not know because she was off work for awhile after that, but when she returned CNA #1 had been moved from first shift to second shift. She stated she had told the staff on second shift to keep an eye on CNA #1. At 10:28 a.m., resident #3 was asked how the staff treated him. He stated CNA #1 had pinched his titties. He stated he could not recall the last time this had occurred, but it had been awhile. He was asked who he had reported the incidents to. He stated he could not recall who he had reported it to. He was asked how it made him feel when CNA #1 pinched him. He stated, I didn't like it. At 10:33 a.m., the DON was asked if she was aware of allegations of abuse with resident #3. She stated she had just received a written report from staff related to resident #3 and she had not completed reading it. She showed the report to the surveyor and stated it documented CNA #1 had pinched resident #3's breast. She stated she needed to clarify some information and start the investigation. She stated the allegation of abuse had not been reported to her.
F 0607 **Level of harm** - Actual harm **Residents Affected** - Some	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the facility failed to implement the abuse policy as follows ~ the ADON and the administrator failed to report allegations of abuse to the DON for one (#1), ~ the DON failed to perform a thorough investigation of abuse, which included suspension of an employee during the investigation and reporting/documenting the allegation of abuse to the OSDH for one (#2), and ~ the charge nurse failed to notify the DON and the administrator of allegations of abuse for one (#3) of five sampled residents who were reviewed for allegations of abuse. The facility identified 62 residents who resided in the facility. Findings: The facility failed to report and investigate allegations of abuse including suspension of an alleged perpetrator during an investigation. The facility allowed the alleged perpetrator to continue to provide care to the residents who had allegations against him for a period of at least one to two months, which resulted in psychosocial harm. A policy, titled Investigation of Abuse Guidelines, documented, .must develop and implement policies and procedures that include the seven components . .Investigation: ensuring that as much knowledge as possible has been generated, allowing for a preliminary determination of the allegation . .Protection: ensuring that any resident alleging abuse, be protected until the investigation is completed and determination is made . .Reporting/Response: reporting and responding to State Entities and individuals in a specific time frame per State and Federal Regulations . A policy, titled Reporting and Responseing to Alleged Abuse, documented, .if the events that cause the allegation involved abuse or results in serious bodily injury the allegation will be reported within 2 hours 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 . .completion of the investigation will be sent to appropriate reporting agencies, within 5 working days of the incident, with the findings of the investigation .Every staff member must immediately report any observed or suspected abuse of a resident by another staff member .Supervisors will report all allegations to the Director of Nursing and the Administrator . .The Director of Nursing will immediately initiate and abuse incident report and begin investigation of the alleged abuse .To protect the residents during the abuse investigation, the Director of Nursing and/or Administrator will suspend the involved employee . .the Director of Nursing will inform the state survey, certification, and licensing agencies of .Evidence that all alleged violations are thoroughly investigated, and that further potential abuse has been prevented while the investigation is in progress .The results of all investigations within 5 working days of the incidents, and if the alleged violation is verified, appropriate corrective action was taken . 1. Resident #1 had [DIAGNOSES REDACTED]. At 4:50 p.m., the DON was asked for the state reportable documentation from 07/20 to current. She provided four state reports. No reports were documented related to allegations of abuse. On 09/09/20 at 4:10 p.m., the resident was asked how the staff treated him. He stated they were really rough sometimes. He was asked which staff was rough. He named CNA #1. He stated CNA #1 had poked his fingers in his face and had mocked the noises he made when his legs jerked. He was asked when the last time CNA #1 had treated him this way. He stated it had been three days ago. Resident #1 was asked if he had reported to the staff about the incidents. He stated he had reported to the administrator about a week ago and it had been better since then. He stated he had also reported it to the ADON several times and she had told him she had talked to the staff until she was blue in the face. He was asked if CNA #1 was intentional in the way he treated him. He stated yes. He stated CNA #1 would enter his room when he knew he was asleep and get in his face and scream to wake him up. He stated, He laughs and thinks it's funny. He stated he had told CNA #1 he did not like it and to quit putting his nasty hands in his face. He stated, He just grunts at me like I do. The resident stated he had cried a few times over the way he had been treated. He was asked how it made him feel. He stated, I get intimidated. He stated he wanted to hit CNA #1. He stated he was tired of it. He stated, He degrades me. I feel embarrassed and ashamed about it. At 4:45 p.m. an anonomous employee stated CNA #1 was asked for assistance with resident #4 in the past. CNA #1 had stated he could do the transfer by himself. CNA #1 was rough with resident #4 during the transfer. The anonomous employee stated they had reported the situation to staff, but nothing was done. At 5: 25 p.m. CNA #1 was observed on-duty. He stated no one at the facility had ever spoken to him about employee to resident abuse. At 6:00 p.m., the DON was asked if any residents had complained about CNA #1. She stated resident #1 had reported he thought CNA #1 was rough with resident #2. The DON did not mention any allegations of abuse which involved resident #1. At 6:25 p.m., the administrator was asked if any residents had reported to her related to staff being rough during care. She stated, No. The administrator did not mention any allegations of abuse which involved resident #1. On 09/10/20 at 10:20 a.m., the ADON was asked if she had received any allegations of abuse from a resident or staff in the last three months. She stated, No. The ADON did not mention any allegations of abuse which involved resident #1. On 09/11/20 at 9:18 a.m., the DON and the administrator were asked if they had received any allegations of abuse which involved resident #1. They both stated no. They were informed of the allegation of abuse resident #1 had reported related to CNA #1. They stated they had suspended CNA #1 on 09/09/20 after the surveyors' arrival pending an investigation of allegations of abuse. 2. Resident #2 had [DIAGNOSES REDACTED]. Review of the state reports dated 07/20 through 09/20 did not include any investigations of allegations of abuse. On 09/09/20 at 4:10 p.m., during an interview related to abuse, resident #1 stated he thought CNA #1 was rough on his roommate (resident #2). He was asked what he meant by rough. He stated he could hear resident #2 make noises each time CNA #1 provided care to him and it sounded like the resident would hit his head on the wall. At 4:45 p.m. an anonomous employee stated CNA #1 was asked for assistance with resident #4 in the past. CNA #1 had stated he could do the transfer by himself. CNA #1 was rough with resident #4 during the transfer. The anonomous employee stated they had reported the situation to staff, but nothing was done. At 5: 25 p.m. CNA #1 was observed on-duty. He stated no one at the facility had ever spoken to him about employee to resident abuse. At 6:00 p.m., the DON was asked what she did if someone reported an allegation of abuse to her or her staff. She stated they had issues on another shift. She was asked what she meant by issues. She stated the staff had been bickering and accusing each other trying to get each other fired. She stated if she received an allegation of abuse she investigated it. She stated if it was accurate she reported it to the state. She was asked what she did if she substantiated abuse. She stated she suspended the perpetrator during an investigation and she terminated them if it was substantiated. The DON was asked when she had started in the DON position. She stated the end of July. She was asked if she had received any allegations of abuse. She stated one of the aides thought CNA #1 had been rough with resident #2. She was asked what she had done related to the allegation. She stated she stood back and observed CNA #1 from a distance and had not observed any concerns. She stated she had asked resident #2 if any staff had been rough with him and the resident stated no. She was asked if she had talked to CNA #1 related to the allegation. She stated, I told him to be sure he is being gentle. The DON was asked if she had interviewed any other residents related to the allegation of abuse. She stated no. The DON was asked how she documented her investigation. She stated she had not documented the investigation. The DON was asked if she had reported the allegation of abuse to anyone. She stated no. She stated she did not see it as abuse because the report was

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F 0607 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 2) about CNA #1 being rough. She stated the staff who reported the allegation had been complaining about CNA #1 and not wanting to work with him. She stated, They just want to get him fired, I should have documented it. The DON was asked if any residents had complained about CNA #1. She stated resident #1 had reported he thought CNA #1 was rough with resident #2 because he could hear resident #2 when CNA #1 repositioned the resident. She stated she had assessed resident #2 and had not observed any signs of abuse. She was asked when resident #1 had reported the allegation. She stated about an hour after the aide had reported to her, the aide pushed resident #1 into the DON's office and stated, He has something to tell you. She stated she had mentioned it to the administrator. At 6:25 p.m., the administrator was asked what their procedure was if they received an allegation of abuse. She stated the DON checked it out. She stated they would talk to the residents and turn it in. She stated they would suspend the alleged perpetrator during the investigation and if it was substantiated they would terminate the employee. She was asked if she was aware of any allegations of abuse in the last three months. She stated the DON had just notified her of an allegation today which involved resident #2. She was asked if any allegations of abuse had been reported to her before today. She stated, No. She was asked if CNA #1 should have been suspended during the investigation of an allegation of abuse with resident #2. She stated, Yes. She was asked how they documented an allegation of abuse. She stated, On paper and keep it in a file. She was asked if an allegation of abuse was required to be reported to OSDH. She stated, Yes. The administrator was informed the DON had not interviewed other residents during the investigation of the allegation of abuse for resident #2. She was asked how they knew if CNA #1 had abused other residents. She stated, We don't. She was asked if they had continued to allow CNA #1 to provide care to the residents without interviewing the residents related to being abused by CNA #1. She stated, Yes. On 09/10/20 at 9:30 a.m., the DON was asked for their policy and procedure related to abuse. She provided the policy and stated she had not followed their policy in regards to the allegation of abuse involving CNA #1. 3. Resident #3 had [DIAGNOSES REDACTED]. A written statement, dated 09/10/20, documented, .clarification of above statement 9/10/2020 @ 11:00 am .(resident #3 name deleted) had stated that he had gotten his breast pinched by and (sic) employee. He said this to me in the shower rm a few months ago. I went & reported the alligation (sic) to the charge nurse .the employee is name (CNA #1 name deleted) . Review of the state reports dated 07/20 through 09/20 did not include any investigations of allegations of abuse. On 09/10/20 at 10:07 a.m., CNA #2 was asked what she would do if a staff was abusive to a resident. She stated she would report it to the nurse. She was asked if she had observed or heard of any staff being abusive to a resident. She stated resident #3 had reported to her about two months ago that CNA #1 had pinched him on his breasts. She stated she had reported it to a nurse that no longer worked at the facility. She was asked what the facility had done about it. She stated she did not know because she was off work for awhile after that, but when she returned CNA #1 had been moved from first shift to second shift. She stated she had told the staff on second shift to keep an eye on CNA #1. At 10:28 a.m., resident #3 was asked how the staff treated him. He stated CNA #1 had pinched his titties. He stated he could not recall the last time this had occurred, but it had been awhile. He was asked who he had reported the incidents to. He stated he could not recall who he had reported it to. He was asked how it made him feel when CNA #1 pinched him. He stated, I didn't like it. At 10:33 a.m., the DON was asked if she was aware of allegations of abuse with resident #3. She stated she had just received a written report from staff related to resident #3 and she had not completed reading it. She showed the report to the surveyor and stated it documented CNA #1 had pinched resident #3's breast. She stated she needed to clarify some information and start the investigation. She stated the allegation of abuse had not been reported to her.
F 0610 **Level of harm -** Actual harm **Residents Affected -** Some	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to complete a thorough investigation related to an allegation of abuse for one (#2) of five sampled residents who were reviewed for allegations of abuse. The facility identified 62 residents who resided in the facility. Findings: The facility failed to report and investigate allegations of abuse including suspension of a perpetrator during an investigation. The facility allowed the perpetrator to continue to provide care to the residents who had allegations against him for a period of at least one to two months, which resulted in psychosocial harm. A policy, titled Investigation of Abuse Guidelines, documented, .Investigation: ensuring that as much knowledge as possible has been generated, allowing for a preliminary determination of the allegation . .Protection: ensuring that any resident alleging abuse, be protected until the investigation is completed and determination is made . A policy, titled Reporting and Responseing to Alleged Abuse, documented, .The Director of Nursing will immediately initiate and abuse incident report and begin investigation of the alleged abuse .To protect the residents during the abuse investigation, the Director of Nursing and/or Administrator will suspend the involved employee . .the Director of Nursing will inform the state survey, certification, and licensing agencies of .Evidence that all alleged violations are thoroughly investigated, and that further potential abuse has been prevented while the investigation is in progress .The results of all investigations within 5 working days of the incidents, and if the alleged violation is verified, appropriate corrective action was taken . Resident #2 had [DIAGNOSES REDACTED]. On 09/09/20 at 4:10 p.m., during an interview related to abuse, resident #1 stated he thought CNA #1 was rough on his roommate (resident #2). He was asked what he meant by rough. He stated he could hear resident #2 make noises each time CNA #1 provided care to him and it sounded like the resident would hit his head on the wall. At 4:45 p.m. an anonomous employee stated CNA #1 was asked for assistance with resident #4 in the past. CNA #1 had stated he could do the transfer by himself. CNA #1 was rough with resident #4 during the transfer. The anonomous employee stated they had reported the situation to staff, but nothing was done. At 4:50 p.m., the DON was asked for the state reportable documentation from 07/20 to current. She provided four state reports. No reports were documented related to allegations of abuse. At 5: 25 p.m. CNA #1 was observed on-duty. He stated no one at the facility had ever spoken to him about employee to resident abuse. At 6:00 p.m., the DON was asked what she did if someone reported an allegation of abuse to her or her staff. She stated they had issues on another shift. She was asked what she meant by issues. She stated the staff had been bickering and accusing each other trying to get each other fired. The DON stated if she received an allegation of abuse she investigated it. She stated if it was accurate she reported it to the state. She was asked what she did if she substantiated abuse. She stated she suspended the alleged perpetrator during an investigation and she terminated them if it was substantiated. The DON was asked when she had started in the DON position. She stated the end of July. She was asked if she had received any allegations of abuse. She stated one of the aides thought CNA #1 had been rough with resident #2. She was asked what she had done related to the allegation. She stated she stood back and observed CNA #1 from a distance and had not observed any concerns. She stated she had asked resident #2 if any staff had been rough with him and the resident stated no. She was asked if she had talked to CNA #1 related to the allegation. She stated, I told him to be sure he is being gentle. The DON was asked if she had interviewed any other residents related to the allegation of abuse. She stated no. The DON was asked how she documented her investigation. She stated she had not documented the investigation. The DON was asked if she had reported the allegation of abuse to anyone. She stated no. She stated she did not see it as abuse because the report was about CNA #1 being rough. She stated the staff who reported the allegation had been complaining about CNA #1 and not wanting to work with him. She stated, They just want to get him fired, I should have documented it. The DON was asked if any residents had complained about CNA #1. She stated resident #1 had reported he thought CNA #1 was rough with resident #2 because he could hear resident #2 when CNA #1 repositioned the resident. She stated she had assessed resident #2 and had not observed any signs of abuse. She was asked when resident #1 had reported the allegation. She stated about an hour after the aide had reported to her, the aide pushed resident #1 into the DON's office and stated, He has something to tell you. She stated she had mentioned it to the administrator. At 6:25 p.m., the administrator was asked what their procedure was if they received an allegation of abuse. She stated the DON checked it out. She stated they would talk to the residents and turn it in. She stated they would suspend the alleged perpetrator during the investigation and if it was substantiated they would terminate the employee. She was asked if she was aware of any allegations of abuse in the last three months. She stated the DON had just notified her of an allegation today which involved resident #2. She was asked if any allegations of abuse had been reported to her before today. She stated, No. She was asked if CNA #1 should have been suspended during the investigation of an allegation of abuse with resident #2. She stated, Yes. She was asked how they documented an allegation of abuse. She stated, On paper and keep it in a file. She was asked if an allegation of abuse was required to be reported to OSDH. She stated, Yes. The administrator was informed the DON had not interviewed other residents during the investigation of the allegation of abuse for resident #2. She was asked how they knew if CNA #1 had abused other residents. She stated, We don't. She was asked if they had continued to allow CNA #1 to provide care to the residents without interviewing the residents related to being abused by CNA #1. She stated, Yes. On 09/10/20 at 9:30 a.m., the DON was asked for their policy and procedure related to abuse. She provided the

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F 0610 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 3) policy and stated she had not followed their policy in regards to the allegation of abuse which involved CNA #1.