STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225321	A. BUILDING _____ B. WING _____	07/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DEDHAM HEALTHCARE	1007 EAST STREET DEDHAM, MA 02026

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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for two of four sampled residents (Resident #2 and Resident #4), the Facility failed to ensure that staff implement the Abuse Policy, when it was alleged that Resident #4 sexually abused Resident #2 and staff failed to immediately report the allegations to the nursing supervisor and the Executive Director/Designee as required, and failed to ensure Resident #2 was assessed for any injuries. Findings include: The Facility's Abuse Prohibition Policy, dated December 2017, indicated that residents will not be subjected to abuse by anyone, including other residents. The Facility's Abuse Investigation Policy, dated December 2017, indicated that staff will report abuse immediately to the nursing supervisor and Executive Director/Designee, the alleged victim will be examined for injuries, and the appropriate steps will be taken to protect the residents from further mistreatment. Resident #4 was admitted to the Facility in May 2018, he/she was cognitively intact and able to make his/her own health care decisions. Review of Resident #4's Quarterly Minimum Data Set (MDS), dated [DATE], indicated that he/she was cognitively intact. Resident #2 was admitted to the Facility in July 2019, and his/her Health Care Proxy invoked on 7/15/19, due to cognitive impairment. Review of Resident #2's Minimum Data Set (MDS), dated [DATE], indicated that he/she had moderate cognitive impairment. Review Resident #2's Recreation Note, dated 7/02/20, indicated that on 6/27/20 staff intervened during an incident of inappropriate sexual behavior between him/her and Resident #4. The Note indicated that Resident #2 was upset that the Activities Director had stopped them from what they were doing. The Note indicated that Resident #4 was escorted back to his/her unit. The Note indicated that the Activities Department would continue to monitor, re-direct, and report. During an interview on 7/16/20, at approximately 1:20 P.M., the Activity Director said Non-Sampled Resident A told her that Resident #2 and Resident #4 were kissing in the hallway. The Activity Director said she saw the residents in the doorway of Resident #2's bedroom. The Activity Director said she saw Resident #4's hands up inside Resident #2's shirt. The Activity Director said she saw Resident #4 pants unbuttoned and Resident #2's hands inside his/her pants. The Activity Director said she redirected Resident #4 back to his/her unit. The Activity Director said she did not report the incident to anyone until the following day, during morning meeting with management staff, which included the Director of Rehabilitation, the Director of Nurses and the previous Adminstrator. During an interview on 7/16/20, at 2:00 P.M., the Director of Rehabilitation (Director of Rehab) said about a month ago (some time in June 2020), he walked by Resident #2's bedroom and said he saw and Resident #2 and Resident #4 kissing. The Director of Rehab said that he had asked Activity Director to redirect Resident #4 back to his/her unit. The Director of Rehab said he reported the incident to the nurse who was assigned to Resident #2 that day (exact date unknown). During an interview on 7/15/20, at 11:45 A.M., the Social Worker (SW) said she had read Resident #2's Recreation Note, dated 7/2/20. The SW said she was unsure of the details but said she had heard that Resident #2 and Resident #4 were touching each other's private areas in a public space. During an interview on 7/16/20, at 3:35 P.M., Resident #2's Physician said Resident #2 had an invoked health proxy and his/her capacity to consent to a sexual relationship had not been assessed. The Physician said that he has not received any notifications about Resident #2 having sexual relations or desire to have sexual relations with another resident at the Facility. During an interview on 7/15/20, at 12:16 P.M., the Director of Nursing (DON) said that she became aware of Resident #2's Recreation Note from 7/2/20 regarding the allegation of inappropriate sexual touching on either Monday 7/13/20 or Tuesday 7/14/20. Review of Resident #2's medical record indicated there was no documentation to support that the Activities Director immediately reported the allegation of sexual abuse to the nursing supervisor and Executive Director/Designee as required, or that Resident #2 was assessed by nursing for potential injuries
F 0608 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to ensure (1) employees report any suspicion of a crime against any resident, according to timelines; (2) post the notice of employee rights; and (3) prohibit and prevent retaliation for reporting.** Based on records reviewed and interviews, the Facility failed to ensure that the Abuse Policy was implemented, when an allegation of sexual abuse was not reported to local law enforcement in accordance with the federal regulations. Findings Include: The Facility's Abuse Identification and Reporting Policy, dated December 2017, indicated that if an allegation includes any reasonable suspicion of a crime against a resident, the Executive Director/Designee will also notify law enforcement using the timeframe in the Elder Justice Act. During an interview on 7/15/16, at approximately 3:00 P.M., the Director of Nursing (DON) said the allegation of sexual abuse with inappropriate sexual touching of Resident #2, who has cognitive limitations, by Resident #4, was not reported to law enforcement.
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.** Based on records reviewed and interviews, for two of four sampled residents (Resident #2 and Resident #4), the Facility failed to ensure their Abuse Policy was implemented and followed when the facility failed to report allegations of sexual abuse to the Department of Public Health within 2 hours of receipt of the allegation, as required. Findings Include: The Facility's Abuse Identification and Reporting Policy, dated December 2017, indicated that the Executive Director or his/her designee will evaluate the allegation. If it cannot be immediately determined that the alleged incident did not occur, a preliminary report will be sent to the Department of Public Health (DPH) via electronic communication (Virtual Gateway). The Policy indicated the report to DPH must be made immediately but not later than 2 hours after forming the suspicion. Review of the Health Care Facility Reporting System (HCFRS), indicated that the Facility submitted the report of the abuse allegation to DPH on 7/16/20, which was approximately 20 days after the alleged incident occurred. During an interview on 7/15/20, at approximately 3:00 P.M., the Director of Nursing (DON) said the allegations of sexual abuse of Resident #2, who has cognitive limitations, by Resident #4, was not reported to the Department of Public Health.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** Based on records reviewed and interviews, after becoming aware of an an allegation of potential sexual abuse involving Resident #2 and Resident #4, the Facility failed to ensure that an investigation was initiated. Findings Include: The Facility's Abuse Investigation Policy, dated December 2017, indicated that staff shall gather pertinent information regarding an alleged, witnessed or observed incident that will facilitate proper reporting and follow up as indicated and

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) documentation of the incident will be entered into the medical record, and the Designee will assemble the investigation file. Review of Resident #2's Recreation Note, dated 7/2/20, indicated that on 6/27/20 staff intervened when they observed Resident #2 and Resident #4 engaging in inappropriate sexual behavior in the hallway. Resident #2 was admitted to the Facility in July 2019, and his/her Health Care Proxy invoked on 7/15/19, due to cognitive impairment. During an interview on 7/15/20, at 2:15 PM, the Director of Nursing (DON) and the Director of Clinical Operations said they had read Resident #2's Recreation Note, dated 7/02/20, and spoke with staff to determine what inappropriate sexual behaviors meant. The DON and Director of Clinical Operations said that based on conversations they had with staff, it was determined that the alleged behaviors were not sexual in nature. The DON and Director of Clinical Operations said Resident #2's Health Care Proxy had been invoked and he/she had not been assessed for capacity to consent to a sexual relationship. The DON said that Resident #2 is always in Resident #4's bedroom. The DON said she spoke to the staff regarding the allegation but all staff denied seeing anything inappropriate; therefore, an internal investigation was not completed. This information conflicts with the interviews with Activity Director and Director of Rehabilitation, who both reported witnessing incidents of potential sexual abuse with inappropriate behaviors between Resident #2 and Resident #4, which required staff intervention. During an interview on 7/16/20, at approximately 1:20 P.M., the Activity Director said on 6/27/20, she saw the both residents in the doorway of Resident #2's bedroom, she saw Resident #4's hands up inside Resident #2's shirt, Resident #4 pants were unbuttoned and Resident #2's hands inside his/her pants. The Activity Director said she redirected Resident #4 back to his/her unit. The Activity Director said she did not report the incident to anyone until the following day, during morning meeting with management staff, which included the Director of Rehabilitation, the Director of Nurses and the previous Adminstrator. During an interview on 7/16/20, at 2:00 P.M., the Director of Rehabilitation (Director of Rehab) said about a month ago (some time in June 2020), he walked by Resident #2's bedroom and said he saw and Resident #2 and Resident #4 kissing. The Director of Rehab said that he had asked Activity Director to redirect Resident #4 back to his/her unit. The Director of Rehab said he reported the incident to the nurse who was assigned to Resident #2 that day (exact date unknown). The Director of Clinical Operations said that she and the Director of Nurses (DON) had interviewed staff and residents informally, but said they did not conduct an investigation into the alleged abuse because it was all second-hand information. The Director of Clinical Operations said Resident #2 had not been assessed for his/her capacity to consent to a sexual relationship. Review of Resident #2's clinical record indicated there was no documentation to support that the Facility conducted a thorough investigation.