STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425139	A. BUILDING _____ B. WING _____	**07/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SENECA HEALTH & REHABILITATION CENTER	**140 TOKEENA RD SENECA, SC 29678**

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** - Minimal harm or potential for 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 record review, policy review and staff/resident interviews, the facility failed to ensure that a resident was provided a safe environment and protected from sexual abuse. As a result of this deficient practice, Resident#12 was a victim of sexual abuse at the hands of his/her roommate. The facility had one reported case of sexual abuse and this action affected one resident of 26 residents who resided on the quarantine unit C. Findings include: Review of a Face Sheet found in Resident#12's electronic medical record (EMR) revealed Resident#12 resided on the 300 Hall, with the [DIAGNOSES REDACTED]. Brief Interview for Mental Status (BIMS) of 9. Review of a Face Sheet found in Resident#7's EMR revealed Resident#7 was admitted to the facility to a room on the 300 Hall with the [DIAGNOSES REDACTED]. BIMS of 13. Review of the Department of Health and Environmental Control (DHEC) Accident/Incident Reporting Form Bureau of Health Facilities Licensing, dated 05/22/20 stated, .Give a brief description of the accident/incident .Certified Nursing Assistant (CNA) observed unusual behavior and went to get nurse. Nurse observed Resident (#12) inappropriately touching another Resident (#7) in a sexual manner. Residents immediately separated. Review of a Resident Care Assistant #2's (RCS #2) written witness statement, dated 05/19/20 stated, RCS #2 was picking up breakfast trays and walked into Resident #12 and Resident #7's room at about 8:40 (AM) and heard Resident #12 say your touching me and Resident #12 said your rubbing me and Resident #7 said yes I am rubbing you. At this point I looked behind the curtain and saw Resident #7 rubbing Resident #12's upper thigh. I walked out of the room and as I was walking back in Resident #7 had removed himself from Resident #12's bed. As I walked back by, Resident #7 was back sitting on Resident #12's bed rubbing on him/her again and I immediately went and got LPN#6 and told him/her what I had saw. I told him/her she/he needs to come now and when we both went back in the room, Resident #7 had undone Resident #12's brief and had his/her hand inside. LPN #6, at this point, asked him/her what Resident #7 was doing and Resident #7 responded by saying I was checking to see if Resident #12 was OK. A review of a Licensed Practical Nurse #6's (LPN#6) written witness statement, dated 05/19/20 stated, At 8:40 AM on 05/19/20 this nurse was approached by RCS #2 and told to stop everything and come immediately to Resident #7's room. Upon entrance of room, Resident #7 (alert and oriented x 3{person, place, and time}) was sitting on the right side of Resident #12's (alert and confused) bed with one hand rubbing Resident#12's bare leg and the other rubbing his penis. Resident #7 was confronted, stood up, and quickly walked back to his/her bed. When asked Resident #7 stated I was rubbing his/her aches and pains. Resident #7 was told not to leave his/her bed and to not touch other residents. Upon observation of Resident #12, his/her brief was unfastened with penis outside and over the top of brief. Resident #12 was speaking of being touched and stated, she/he was touching me. At 8:42 AM this nurse exited the room to call the DON and unit manager. At 8:42 AM this nurse returned to room to remove Resident #7. Upon entrance, Resident #7 was sitting on the left side of Resident#12's bed blocking the view of the resident. When addressed Resident #7 did not stop. Resident #7 was attempting to fasten brief with one hand while fully grasping and stroking Resident #12's penis with the other while speaking to him/her. Again, Resident #7 was addressed, this time standing up and exiting the bed. Resident #7 was encouraged to sit in a wheelchair and then removed from the room. At 8:45 AM Resident #7 was placed in commons area with direct one on one supervision of staff. Full body audit completed on Resident #12 to check for any signs of abuse or injury. A review of the Unit Manager's (UC#2) statement, dated 05/19/20 stated, At approximately 8:50 AM today, May 19th, 2020 I was approached by LPN #6 with a report of physical sexual abuse resident to resident. LPN #6 recounted the events of the incident and I immediately notified the DON at 8:53 AM. LPN #6 and RCS #2, that initially witnessed and reported the abuse, were asked to ensure the resident was not in the room with the abused and to place him/her on 1:1 supervision until further notice. I also instructed LPN#6 to perform a head to toe body audit to assess the abused resident for any physical signs of abuse or injury. LPN#6 reported to this writer that there were no physical signs of abuse or injury. LPN#6 stated that the abused resident's body was very clean as if s/he were recently groomed. The Social Services department was notified and began working on removing the abuser from the facility, a psych services referral was made to an inpatient psychiatric hospital service was initiated. Attempted to contact the Medical Director of the facility, was unable to reach him by phone, but left an extensive message without leaving personal details such as patient names or location on the unit. We are awaiting response while continuing to follow the facility policy and process regarding instances of resident to resident abuse. A review of Sheriff's Deputy#1's interview with Resident#7, dated 05/19/20 stated, Resident#7 stated that his/her roommate, Resident#12 said that Resident#12 was hurting, so Resident#7 went over and patted his/her brief. Resident#7 stated that Resident#12 told him it felt good so Resident #7 kept doing it. Resident #7 stated that she/he did not take Resident #12's brief off but that it did come unfastened. Resident #7 stated that Resident #12 is not a nice man/woman, so she/he was trying to help him/her out. A review of Social Work Assistant's (SWA #1's) interview with Resident #7, dated 05/19/20 stated, Upon being asked what happened between himself/herself and Resident #12 she/he stated, I asked him/her what was the problem down there (pointing to his/her private area) my roommate said she/he had a problem with his/her rectum. I touched the bandage on my roommate, and she/he said, It feels nice and my roommate's brief was open. Resident #7 also stated, My roommate said it feels good when I put my hand on him/her. A review of Psychotherapy Comprehensive Clinical Assessment for Resident #7 completed by Psychologist #1, dated 05/19/20 stated, Chief complaint: Pt. had an incident in the facility where she/he had inappropriate touching another resident as per facility staff reporting today. Presenting Problem and Symptoms: When discussion the issues with Resident #7 she/he confronted the issue and argued and said, My side of the story is that I was only trying to help them (meaning the staff) and my roommate in order to ease his/her pain and I did put my hand under his/her pants went all over to comfort him in his/her pain and suffering. Resident #7 also stated that at this center nobody is doing anything, and I am the one trying to help everyone the staff and the residents. It appears that she/he has taken it upon himself/herself under his/her delusional thought processes as if she/he is the director of the social services and it is his/her job to help the residents and staff .Resident #7 has communication skills but she/he is very aggressive in his/her tone as she/he becomes argumentative and in an anger tone. She/he has anxiety and an interruptive behavioral pattern. Overall, she/he exhibits delusional thought and thought processes in that she/he is in charge of the facility and others have to listen to him/her whether one is staff or resident .Treating Diagnosis: [REDACTED]. Treatment Recommendations: Psychosocial Rehabilitation, Psychiatric Medication Management, Follow-up Psychotherapy. Summary Statements and Recommendations: Resident #7 was seen in a face to face interview via Telehealth today. She/he expressed having desire to help his/her fell ow residents, but she/he has poor insight into his/her own behavioral issues/concerns regarding invading others personal space and inappropriate touching. Secondly, she/he believes that she/he is doing this to help others such as staff and residents. She/he appears to be having delusional thoughts and thought processes. Note: Resident #7 needs to be placed in an appropriate behavioral treatment unit where she/he is able to receive psychiatric medications and behavioral treatments to

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 -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) address his/her problems appropriately. A review of the Psychotherapy Comprehensive Clinical Assessment for Resident #12 completed by Psychologist #1, dated 05/19/20 stated, Resident #12 was unable to communicate appropriately today. An interview on 07/21/20 at 2:15 PM, in the conference room, with Social Work Associate (SWA#1) stated that she/he was familiar with Resident #12 and the investigation. SWA#1 stated that Resident #7 was immediately removed after the incident and placed on one to one observation until she/he was transferred to a Mental Health Hospital the following morning. SWA#1 stated that the facility staff monitors all residents to ensure that they are safe and out of harm's way. SWA#1 stated that there have not been any other sexual abuse incidents at the facility. An interview on 07/22/20 at 1:55 PM, in the conference room, with the Educator #1 (ED#1) stated that all new employees are educated about abuse and neglect upon hire and then re-educated when needed. ED#1 explained that she/he provides re-education after every abuse/neglect incident. ED #1 stated that she/he has provided education to staff regarding abuse and neglect prevention to include: 1. Education on trauma informed care and behavior management, 2. How to recognize what may trigger a resident to act out, 3. How to redirect a resident, 4. Mandated reporting, 5. Review of the facility's abuse and neglect policy. ED#1 stated the process that an employee must take when they witness abuse is to immediately intervene, remain with both parties until another staff member arrives to assist, notify Social Services, the DON and Administrator of occurrence, and a room change might be needed. An interview on 07/22/20 at 3:40 PM with Resident #12, on 300 Hall, revealed that Resident#12 was oriented to person, but not place and time. Resident#12 only stated no when asked a question. An interview on 07/22/20 at 3:45 PM with LPN #5, outside of Resident #12's room, stated that she/he was not aware that Resident #12 had been sexually abused at the facility and that Resident #12 had not shown any signs/symptoms of abuse. An interview on 07/22/20 at 3:50 PM with RCS #1, on 300 Hall, stated that she/he was not aware that Resident #12 had been sexually abused at the facility and that Resident #12 had not shown any signs/symptoms of abuse. An interview on 07/22/20 at 3:55 PM with RN #3, at 300 Hall nursing station, stated that she/he was not aware that Resident #12 had been sexually abused at the facility and that Resident #12 had not shown any signs symptoms of abuse. A review of the facility's policy, Abuse and Neglect Prohibition, revised 07/2018 stated, Policy Each resident has the right to be free from abuse .Any observations or allegations of abuse .must be immediately reported to the administrator. Purpose To help ensure a resident's right to a safe and healthy environment. Scope This policy applies to all residents. Definitions .Sexual abuse is non-consensual (the resident does not consent) sexual contact of any type with a resident. It may include, but us not limited to, .sexual assault .Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .Training 1.The facility will train each employee on this policy during orientation, annually, and more often as determined by the facility. 2. The facility will provide training regarding related policies and procedures. Prevention .3. Facility supervisors will immediately investigate and correct reported or identified situations in which abuse .is at risk for occurring .Protection 1. The facility will protect residents from harm during the investigation .Investigation 1. The facility will timely conduct an investigation of any alleged abuse/neglect .Reporting and Response 1. State Reporting Obligations: The facility will report all allegations and substantiated occurrences of abuse .to the administrator, State Survey Agency .in accordance with Federal and State law through established procedures .5. The facility will submit a summary of its investigation to the appropriate State agency within 5 days of its initial report . A review of the facility's education titled, Abuse and Neglect Education Focus: Resident to Resident Abuse, dated 05/19/20 showed, an outline for education on abuse and neglect and staff sign in sheets for that training on abuse and neglect. The education that was provided by ED#1 to the facility staff was in person or over the telephone. All staff were also provided abuse education on 06/15/20 and upon hire.