STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235174	A. BUILDING _____ B. WING _____	07/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MARSHALL NURSING AND REHABILITATION COMMUNITY	575 N MADISON ST MARSHALL, MI 49068

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 -** Few	**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** This citation pertains to intake MI 182, MI 156 and MI 197 Based on observation, interview and record review, the facility failed to provide an environment free from abuse for 1 residents (R4), from nine residents reviewed for abuse, resulting in non-consensual sexual contact (face to face contact) by an employee with resulting embarrassment and likelihood of mental anguish. Findings include: According to the facility, Abuse Prevention Program Policy and Procedure, dated 11/2018, reflected, Intent: Each resident has the right to be free from abuse, neglect and corporal punishment of any type by staff or anyone. The facility will provide a safe resident environment and protect residents from abuse .Policy: (named cooperation) has prevention programs in which policies and procedures safeguard our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint .verbal, mental, and sexual .Definitions .Immediately means as soon as possible, in the absence of a shorter State time frame requirement, 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 .Staff to Resident Abuse: All staff are expected to be in control of their own behavior, are to behave professionally, and should appropriately understand how to work with the nursing home population .Types of Abuse & Indicators .Failure to oversee the implementation of resident care policies; Failure to provide supervision and/or monitoring of the delivery of care .Sexual Abuse: Is non-consensual sexual contact of any type with a resident. Sexual abuse includes, but not limited to: Unwanted intimate touching of any kind especially of breasts or perineal area . According to the facility, Abuse Prevention Program 7 Components, dated 11/2018, reflected, Prevention .Schedule management of qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents. Shift report and access to resident information to ensure staff assigned have knowledge of the individual residents' care needs and behaviors. Assignment & identification of the Charge Nurse as supervisor on each shift to monitor and identify inappropriate staff behaviors .INVESTIGATION 1. The Administrator and or Director of Nursing are to initiate and coordinate completion of a thorough investigation. Investigations must be initiated immediately and concluded as soon as possible not to exceed (5) days .The investigation must include but not limited to: Identify alleged perpetrator, remove from resident care area immediately, suspend pending investigation conclusion, obtain statement .Identify and begin investigating different types of alleged violations; Identify and interview (witness statements) all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation(s) such as roommate. Interviews with co-workers or other supervisors in regards to the alleged perpetrator's work performance .Body assessment and psychosocial status of the resident. Signs of catastrophic reaction .Providing complete/thorough documentation of the investigation findings (timeline of events), summary of conclusion. Follow-up actions to correct the prevent potential reoccurrence .In order to complete the Resident Abuse Investigation, all information must be gathered and reviewed, with a final summary analysis with an action plan to prevent reoccurrence . PROTECTION . Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed .Providing emotional support and counseling to the resident during and after the investigation, as needed .REPORTING/RESPONSE All alleged or suspected violations are to be reported immediately to the Administrator or Director of Nursing, which are responsible to notify required officials, including to the State Survey Agency, Adult Protective Services, Local Public Safety, Licensure Boards, Regional Director of Operations or Regional Clinical Directors .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 .Taking all necessary actions as a result of the investigation , which may include, but are not limited to, the following: a. Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences; b. Defining how care provisions will be changed and/or improved to protect residents receiving services .Response to Alleged Violations of Sexual Abuse: If an allegation of sexual abuse has been reported, the facility must immediately: g. Protect the alleged victim(s) involved. h. Report the alleged violations to the Administer and appropriate State and local authorities .j. Begin investigation of the allegation. k. Facility must not tamper with evidence during investigation . Review of the facility, Discipline, dated 4/2014, reflected, Some offenses are very serious and are subject to the employee's immediate suspension pending investigation for discharge. The following steps should be taken: 1. the employee should be immediately suspended .2. The events leading up to the suspension should be investigated by the Administrator or Manager .3. The investigation should include interviews with all witnesses, and review of all pertinent documents .G. The following is a list of unacceptable conduct or behavior .1.1 Resident abuse or neglect (physical, sexual, verbal or mental) . Resident #4 (R4) Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE], reflected R4 was a [AGE] year old female admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The MDS reflected R4 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact, and she required one person physical assist with bed mobility, locomotion on unit, dressing, toileting, hygiene, bathing and two person physical assist with transfers. R4's MDS assessment reflected no behaviors. Review of the Facility Reported Incident (FRI), submitted on 3/2/20 at 12:02 p.m., reflected R4 was a victim of a witnessed non consensual abuse incident by Certified Nurse Aid (CNA)U on 3/1/20 that was an allegation of sexual contact. The investigation reflected the witness contacted the Administrator (ADM) A on 3/1/20. The report reflected ADM A interviewed the victim (R4) on 3/2/20, with no documented time, and contacted Local Police shortly after at 11:58 a.m. The report reflected, Reported Incident: On Monday, March 2, 2020, while updating (named R4) about a customer service complaint, she reported to the Administrator and DON(Director of Nursing) that CNA (named perpetrator CNA U) grabbed my crotch and told me I was a beautiful woman. The reported reflected, R4 interview included, (named R4) stated that for no apparent reason, (named perpetrator CNA U) insisted she needed to be changed, coming into her room with a brief that was too small. She claimed to have no knowledge as to why the two aides were in her room. She states she rolled her towards herself and told (named R4) she had her right by my crotch saying, you are a beautiful woman. (Named R4) stated she did not appreciate these comments . The Report reflected CNA L witnessed the incident and reported, She stated that they changed (named R4) and then she noticed (named perpetrator CNA U) really close to (named R4). When (named perpetrator CNA U) was gone, (named R4) reported that (named perpetrator CNA U) had rubbed noses with her . The Report included an interview with CNA U that reflected, When asked about rubbing noses with (named R4), she stated she really didn't remember it. (Named CNA U) reported leaving work early due to very low blood sugar. When asked, (named CNA U) agreed it would not be considered respectful behavior. The FRI reflected a summary that included, As the interaction was witnessed by a staff

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** - Few	(continued... from page 1) member (named R4) trusts, it can be concluded that (named perpetrator CNA U) did not touch (named R4) in a sexual manner. While rubbing noses is certainly an odd behavior, it was not intended as anything more than playful . Review of the Nursing Progress Notes, dated 2/1/20 through 6/24/20, reflected no mention of abuse allegation on 3/1/20 reported by R4 including no social work visit or follow-up related to incident. During an interview on 6/24/20 at 12:25 p.m., Administrator (ADM) A reported the facility did not have any abuse allegations that had not been reported to the State Agency (SA) and that it was easier to report them. During an observation on 6/24/20 at 1:28 p.m., R4 room was labeled with contact/droplet isolation sign and 3 drawer clear plastic container outside door that contained personal protective equipment(PPE). R4 was in bed closest to the door with eyes closed. Staff exited room with only mask on carrying meal tray and placed in the cart located in the hall, returned to the room and closed door without use of PPE. During an observation and interview on 6/24/20 at 2:54 p.m., R4's call light was noted on outside of the door and sounding. Certified Nurse Aid was noted at nurse station about 20 feet from R4 room washing hands at the sink. R4 door was open to the hall and R4 was observed sitting on bedpan in bed with blankets pulled back exposing R4. CNA reported R4's roommate was a new admission therefore R4's room was an isolation room for 14 days related to possible Covid-19. CNA walked away from nurse station down hall away from R4 sounding call light. Same CNA returned to R4's room at 3:01 p.m. and donned PPE prior to entering room and closed door and turned off call light. During a telephone interview on 6/25/20 at 1:36 p.m., CNA L reported working at the facility for 8 months. CNA L reported she worked second shift on 3/1/20 at the time of R4 incident with CNA U. CNA L reported CNA U was a new employee and had her at facility for less than one week and was working with CNA L that day when she witness the incident. CNA L reported while putting R4 on the bedpan CNA U entered the room. CNA L reported she had not requested that CNA U assist but insisted on helping. CNA L reported after removing R4 from the bedpan she took the bedpan to the bathroom to empty. CNA L reported she could hear CNA U talking to R4 but unsure what was being said. CNA L reported when she returned to the room CNA U was touching R4's nose with her nose and CNA U had her hands on R4's chest. CNA L reported she told CNA U that was not appropriate and CNA U left the room. CNA L reported R4 told her that CNA U rubbed noses with her and R4 was really creeped out by CNA L behavior. CNA L reported she informed Licensed Practical Nurse (LPN) V who advised her to write witness statement and put under ADM A door and call ADM A, which was done on 3/1/20. CNA L reported that CNA U left early that day and had not worked there since incident on 3/1/20. CNA L verified witness statement, dated 3/1/20, related to staff to resident allegation. CNA L reported she reported the incident to nurse and administrator because she felt CNA U was touching R4 inappropriately and behavior was unprofessional and R4 reported she was, really creeped out by CNA U behavior and could be an example of sexual abuse. During a telephone interview on 6/25/20 at 2:26 p.m., Social Worker (SW) H reported working at the facility since September 2018. SW H reported ADM A did investigation related to R4 abuse allegation. SW H reported she did not see R4 after the 3/1/20 allegation including no follow up social work visits to assess R4 mental well being. Reviewed facility Behavior Logs for past six months, dated 12/15/19 through 6/25/20, reflected four entries with no mention of making false accusations and no entries noted between 1/23/20 and 3/12/20. During a telephone interview on 6/26/20 at 1:35 p.m., LPN V reported had worked at the facility for [AGE] years. LPN V reported working second shift on 3/1/20 starting at 2:00 p.m. and did not recall R4 incident. LPN V stated, there would never be any of my CNA staff touch a resident inappropriately. LPN V reported maybe R4 incident happened prior to her shift on 3/1/20. LPN V stated, slight memory of close facial contact but resident did not report concern. During a telephone interview on 6/26/20 at 3:07 p.m., ADM A reported facility updated Employee Staff List frequently and did not keeping contact information for past employees. After review of 3/1/20 Nursing Schedule reflected several employees were no longer on the Employee Staff List. During a telephone interview on 6/30/20 at 10:25 a.m., ADM A reported being the facility Abuse Coordinator. ADM A reported R4 incident on 3/1/20 that involved CNA U rubbing noses with R4 was a complaint not an allegation and stated, something resident thought was weird. ADM A reported should have come in at the time of the complaint on 3/1/20 because during R4 interview on 3/2/20 R4 reported CNA U grabbed R4 in the crotch area. ADM A reported rubbing noses with resident was not professional and not acceptable behavior for staff to resident. ADM A reported local police were called and report completed but did not have copy. ADM A reported staff are expected to report allegations of abuse to ADM A or DON A immediately within two hours face to face or by phone in person. During a telephone interview on 6/30/20 at 1:29 p.m. CNA R reported working at the facility for five years including last week of February 2020 with CNA U. CNA R reported CNA U worked about one week as new employee and often started shift and left during shift and had odd behaviors. During a telephone interview on 6/30/20 at 1:40 p.m., CNA W reported working at the facility for six months 6 months. CNA W reported CNA U did not work long and had odd behavior and smelled of alcohol while working. CNA W would say to residents, hi sweety and rub noses with residents and residents would requested space. CNA W reported nose to nose rubbing was possible allegation of sexual abuse because made residents uncomfortable. During a telephone interview on 6/30/20 at 1:56 p.m., CNA Q reported worked at the facility for over 2 years including with CNA U second shift starting at 2:00 p.m. on 3/1/20. CNA Q reported when CNA U arrived for the second shift on 3/1/20 CNA Q told her what they would be doing including filling ice chest and became upset (that is what we do on second shift) and placed ice chest top on floor and upset because CNA Q reported they had to clean ice chest again and dump ice, CNA U became frustrated, took off, and staff were unable to find for some time. CNA Q reported another example of CNA U odd behavior was on same day (3/1/20) CNA Q and CNA U entered resident room to perform resident care and CNA U sat on roommates bed with eyes closed rocking back and forth while CNA Q performed resident care independently. CNA Q reported CNA U took off again, left for break and spilled drink on floor by clock. CNA Q reported could not find CNA U again and left last time and did not come back. CNA Q reported was training CNA U and should have remained with her during entire shift but frequently left. CNA Q reported CNA U had inappropriate conversations with residents and gave hugs as well as inappropriate sexual comments to male resident. CNA Q reported CNA U left and never returned to facility so she did not report odd behaviors to ADM A. During an interview on 6/30/20 at 4:42 p.m., CNA C reported she trained CNA U for first two days when CNA U started and reported smelled of alcohol while working and observed CNA U spill her drink that smelled like alcohol and become upset. CNA C reported another CNA staff had witnessed CNA U kissing two male residents (R10 and R11) on the lips. CNA C reported she did not report because she had not witnessed but heard about by co-worker. ADM A had not yet provided requested Police report for FRI on 3/1/20 requested on 6/24/20. Received email from ADM A, dated 6/30/20 at 5:58 p.m., reflected, It has been brought to our attention that a potential allegation went unreported. We were just notified by a CNA that she heard a rumor she felt was false about a past employee and inappropriate contact from the beginning of March. We will follow our policy with a state report and full investigation. During a telephone call to Local Police Department on 7/1/20 at 10:15 a.m., this surveyor requested investigation report for R4 on 3/2/20. Officer reported had recently sent to facility but would send copy as requested. Review of the Police Report, Incident/Investigation Report, dated 3/2/20 at 11:59 a.m., reflected case number 20- 6 related to sex offense for R4. The report reflected, On 3-2-10 Administrator (named ADM A) reported a claim of sexual assault .(named ADM A) said (named CNA U) did make inappropriate contact with (named R4) that they are addressing. (Named ADM A) said (named CNA U) leaned over (named R4) and rubbed noses with her. (Named ADM A) said (named CNA U) went home at approximately 3:30 p.m. because she claimed she was low on blood sugar. Tenants said (named CNA U) was acting strange .On 3-2-20 I made contact with (named R4) .(Named R4) said (named CNA U) grabbed her in the groin over her briefs and told her she was beautiful. (Named R4) said she couldn ' t` believe (named CNA U) just grabbed her. (Named R4) said she looked at (named CNA L) and (named CNA L) was looking at (named CNA U in disgust .On 3-3-20 I made contact with (named CNA L) and asked her what she witnessed. (Named CNA L) said she went into room [ROOM NUMBER] to assist (named R4) with her bedpan. (Named CNA L) said (named CNA U) walked in the room behind her at that time. I asked (named CNA L) if she needed (named CNA U) help. (named CNA L) said she didn`t. (Named CNA U) just walked in behind her. (named CNA L) said she was cleaning (named R4) when (named R4) did ask to be sat up in her bed. (named CNA L) said she needed (named CNA U) help for that. (named CNA L) said she when into the bathroom for a second. (named CNA L) walked out and found (named CNA U) almost face to face with (named R4). (Named R4) reported to (named CNA L) that (named CNA U) rubbed noses with her and told her she is beautiful. (Named R4) said she was creeped out by this action .Disposition .(Named R4) said she did not want to press charges, but she did want to have this incident on record .
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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** This citation pertains to intake MI 182, MI 156 and MI 197 Based on observation, interview, and record review, the facility

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) failed to immediately report abuse allegations for 4 Resident (R4, R9, R10 and R11) of 9 reviewed for abuse, resulting in allegations of abuse that were not reported to the Nursing Home Administrator (NHA) and the State Agency timely and the potential for further allegations of abuse to go unreported and not thoroughly investigated. Findings include: According to the facility, Abuse Prevention Program Policy and Procedure, dated 11/2018, reflected, Intent: Each resident has the right to be free from abuse, neglect and corporal punishment of any type by staff or anyone. The facility will provide a safe resident environment and protect residents from abuse .Policy: (named cooperation) has prevention programs in which policies and procedures safeguard our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint .verbal, mental, and sexual .Definitions .Immediately means as soon as possible, in the absence of a shorter State time frame requirement, 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 .Staff to Resident Abuse: All staff are expected to be in control of their own behavior, are to behave professionally, and should appropriately understand how to work with the nursing home population .Types of Abuse & Indicators .Neglect/Deprivation of Goods and Services by Staff: Abuse also includes the deprivation by staff of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Caregiver have been determined to have the knowledge and ability to provide care and services, but chose not, or acknowledge the request for assistance from a resident(s) and intentional or willfully fail to provide goods or services, that result in care deficits to a resident(s). Possible Indicators of Neglect .Failure to provide sufficient, qualified, competent staff, to meet resident needs .Failure to oversee the implementation of resident care policies; Failure to provide supervision and/or monitoring of the delivery of care; Failure of staff to implement resident interventions, when residents have been assessed and interventions are care planned .Sexual Abuse: Is non-consensual sexual contact of any type with a resident. Sexual abuse includes, but not limited to: Unwanted intimate touching of any kind especially of breasts or perineal area . According to the facility, Abuse Prevention Program 7 Components, dated 11/2018, reflected, Prevention .Schedule management of qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents. Shift report and access to resident information to ensure staff assigned have knowledge of the individual residents' care needs and behaviors. Assignment & identification of the Charge Nurse as supervisor on each shift to monitor and identify inappropriate staff behaviors .INVESTIGATION 1. The Administrator and or Director of Nursing are to initiate and coordinate completion of a thorough investigation. Investigations must be initiated immediately and concluded as soon as possible not to exceed (5) days .The investigation must include but not limited to: Identify alleged perpetrator, remove from resident care area immediately, suspend pending investigation conclusion, obtain statement .Identify and begin investigating different types of alleged violations; Identify and interview (witness statements) all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation(s) such as roommate. Interviews with co-workers or other supervisors in regards to the alleged perpetrator's work performance .Body assessment and psychosocial status of the resident. Signs of catastrophic reaction .Providing complete/thorough documentation of the investigation findings (timeline of events), summary of conclusion. Follow-up actions to correct the prevent potential reoccurrence .In order to complete the Resident Abuse Investigation, all information must be gathered and reviewed, with a final summary analysis with an action plan to prevent reoccurrence . PROTECTION . Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed .Providing emotional support and counseling to the resident during and after the investigation, as needed .REPORTING/RESPONSE All alleged or suspected violations are to be reported immediately to the Administrator or Director of Nursing, which are responsible to notify required officials, including to the State Survey Agency, Adult Protective Services, Local Public Safety, Licensure Boards, Regional Director of Operations or Regional Clinical Directors .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 .Taking all necessary actions as a result of the investigation , which may include, but are not limited to, the following: a. Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences; b. Defining how care provisions will be changed and/or improved to protect residents receiving services .Response to Alleged Violations of Sexual Abuse: If an allegation of sexual abuse has been reported, the facility must immediately: g. Protect the alleged victim(s) involved. h. Report the alleged violations to the Administer and appropriate State and local authorities .j. Begin investigation of the allegation. k. Facility must not tamper with evidence during investigation . Resident #4 (R4) Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE], reflected R4 was a [AGE] year old female admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The MDS reflected R4 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact, and she required one person physical assist with bed mobility, locomotion on unit, dressing, toileting, hygiene, bathing and two person physical assist with transfers. R4's MDS assessment reflected no behaviors. Review of the Facility Reported Incident (FRI), submitted on 3/2/20 at 12:02 p.m., reflected R4 was a victim of a witnessed non consensual abuse incident by Certified Nurse Aid (CNA)U on 3/1/20 that was an allegation of sexual contact. The investigation reflected the witness contacted the Administrator (ADM) A on 3/1/20. The report reflected ADM A interviewed the victim (R4) on 3/2/20, with no documented time, and contacted Local Police shortly after at 11:58 a.m. The report reflected, Reported Incident: On Monday, March 2, 2020, while updating (named R4) about a customer service complaint, she reported to the Administrator and DON(Director of Nursing) that CNA (named perpetrator CNA U) grabbed my crotch and told me I was a beautiful woman. The reported reflected, R4 interview included, (named R4) stated that for no apparent reason, (named perpetrator CNA U) insisted she needed to be changed, coming into her room with a brief that was too small. She claimed to have no knowledge as to why the two aides were in her room. She states she rolled her towards herself and told (named R4) she had her right by my crotch saying, you are a beautiful woman. (Named R4) stated she did not appreciate these comments . The Report reflected CNA L witnessed the incident and reported, She stated that they changed (named R4) and then she noticed (named perpetrator CNA U) really close to (named R4). When (named perpetrator CNA U) was gone, (named R4) reported that (named perpetrator CNA U) had rubbed noses with her . The Report included an interview with CNA U that reflected, When asked about rubbing noses with (named R4), she stated she really didn't remember it. (Named CNA U) reported leaving work early due to very low blood sugar. When asked, (named CNA U) agreed it would not be considered respectful behavior. The FRI reflected a summary that included, As the interaction was witnessed by a staff member (named R4) trusts, it can be concluded that (named perpetrator CNA U) did not touch (named R4) in a sexual manner. While rubbing noses is certainly an odd behavior, it was not intended as anything more than playful . Review of the Nursing Progress Notes, dated 2/1/20 through 6/24/20, reflected no mention of abuse allegation on 3/1/20 reported by R4 including no social work visit or follow-up related to incident. During an interview on 6/24/20 at 12:25 p.m., Administrator (ADM) A reported the facility did not have any abuse allegations that had not been reported to the State Agency (SA) and that it was easier to report them. During an observation on 6/24/20 at 1:28 p.m., R4 room was labeled with contact/droplet isolation sign and 3 drawer clear plastic container outside door that contained personal protective equipment(PPE). R4 was in bed closest to the door with eyes closed. Staff exited room with only mask on carrying meal tray and placed in the cart located in the hall, returned to the room and closed door without use of PPE. During an observation and interview on 6/24/20 at 2:54 p.m., R4's call light was noted on outside of the door and sounding. Certified Nurse Aid was noted at nurse station about 20 feet from R4 room washing hands at the sink. R4 door was open to the hall and R4 was observed sitting on bedpan in bed with blankets pulled back exposing R4. CNA reported R4's roommate was a new admission therefore R4's room was an isolation room for 14 days related to possible Covid-19. CNA walked away from nurse station down hall away from R4 sounding call light. Same CNA returned to R4's room at 3:01 p.m. and donned PPE prior to entering room and closed door and turned off call light. During a telephone interview on 6/25/20 at 1:36 p.m., CNA L reported working at the facility for 8 months. CNA L reported she worked second shift on 3/1/20 at the time of R4 incident with CNA U. CNA L reported CNA U was a new employee and had worked at facility for less than one week and was training with CNA L that day when she witness the incident. CNA L reported while putting R4 on the bedpan CNA U entered the room. CNA L reported she had not requested that CNA U assist but insisted on helping. CNA L reported after removing R4 from the bedpan she took the bedpan to the bathroom to empty. CNA L reported she could hear CNA U talking to R4 but unsure what was being said. CNA L reported when she returned to the room CNA U was touching R4's nose with her nose and CNA U had her hands on R4's chest. CNA L reported she told CNA U that was not appropriate and CNA U left the room. CNA L reported R4 told her that CNA U rubbed noses with her and R4 was really creeped

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) out by CNA L behavior. CNA L reported she informed Licensed Practical Nurse (LPN) V who advised her to write witness statement and put under ADM A door and call ADM A on 3/1/20. CNA L reported that CNA U left early that day and had not worked there since incident on 3/1/20. CNA L verified witness statement, dated 3/1/20, related to staff to resident allegation. CNA L reported she reported the incident to nurse and administrator because she felt CNA U was touching R4 inappropriately and behavior was unprofessional and R4 reported she was, really creeped out by CNA U behavior and could be an example of sexual abuse. During a telephone interview on 6/25/20 at 2:26 p.m., Social Worker (SW) H reported working at the facility since September 2018. SW H reported ADM A did investigation related to R4 abuse allegation. SW H reported she did not see R4 after the 3/1/20 allegation including no follow up social work visits to assess R4 mental well being. Reviewed facility Behavior Logs for past six months, dated 12/15/19 through 6/25/20, reflected four entries with no mention of making false accusations and no entries noted between 1/23/20 and 3/12/20. During a telephone interview on 6/25/20 at 3:08 p.m., CNA M reported witnessed verbal abuse at the facility. CNA M stated, staff get frustrated with residents and snotty with them, tell them they will be back and don't come back. Staff say residents refused care but when I talk to residents they say they never came back. CNA M reported on two occasions in May to the nurse, Director of Nursing, Assistant Director of Nursing and Unit Manager related to staff not provided resident care. During a telephone interview on 6/26/20 at 8:30 a.m., CNA J reported working at the facility for more than a year and most often on 200 hall(Madison). CNA J reported for the past three months the facility had hired Nursing Assistance that are not certified that don't know what they are doing and require repeat training on basic care needs. CNA J reported it was not unusual to have all non certified nurse aids working on third shift two time weekly. CNA J reported on several occasions residents found very wet at shift change that required full changes including linens that were reported to nurses who tell staff to make sure they do walking rounds. CNA J reported she has called ADM A on weekends about resident concern including residents found saturated at shift change and ADM A does not address until Monday. Review of facility staff punches for past two weeks, dated 6/10/20 through 6/25/20, reflected on 6/17/20 third shift only Non-Certified Nurse Assistance worked(No Certified Nurse Aids worked third shift) in entire building. During a telephone interview on 6/26/20 at 1:35 p.m., LPN V reported had worked at the facility for [AGE] years. LPN V reported working second shift on 3/1/20 starting at 2:00 p.m. and did not recall R4 incident. LPN V stated, there would never be any of my CNA staff touch a resident inappropriately. LPN V stated, slight memory of close facial contact but resident did not report concern. During a telephone interview on 6/26/20 at 3:07 p.m., ADM A reported facility updated Employee Staff List frequently and did not keeping contact information for past employees. After review of 3/1/20 Nursing Schedule reflected several employees were no longer on the Employee Staff List. During a telephone interview on 6/30/20 at 10:25 a.m., ADM A reported being the facility Abuse Coordinator. ADM A reported R4 incident on 3/1/20 that involved CNA U rubbing noses with R4 was a complaint not an allegation and stated, something resident thought was weird. ADM A reported should have come in at the time of the complaint on 3/1/20 because during R4 interview on 3/2/20 R4 reported CNA U grabbed R4 in the crotch area. ADM A reported rubbing noses with resident was not professional and not acceptable behavior for staff to resident. ADM A reported local police were called and report completed but did not have copy. ADM A reported staff are expected to report allegations of abuse to ADM A or DON B immediately within two hours face to face or by phone in person. During a telephone interview on 6/30/20 at 1:29 p.m. CNA R reported working at the facility for five years including last week of February 2020 with CNA U. CNA R reported CNA U worked about one week as new employee and often started shift and left during shift and had odd behaviors. During a telephone interview on 6/30/20 at 1:40 p.m., CNA W reported working at the facility for six months 6 months. CNA W reported CNA U did not work long and had odd behavior and smelled of alcohol while working. CNA W would say to residents, hi sweety and rub noses with residents and residents would requested space. CNA W reported nose to nose rubbing was possible allegation of sexual abuse because made residents uncomfortable. During a telephone interview on 6/30/20 at 1:56 p.m., CNA Q reported worked at the facility for over 2 years including with CNA U second shift starting at 2:00 p.m. on 3/1/20. CNA Q reported when CNA U arrived for the second shift on 3/1/20 CNA Q told her what they would be doing including filling ice chest and became upset (that is what we do on second shift) and placed ice chest top on floor and upset because CNA Q reported they had to clean ice chest again and dump ice, CNA U became frustrated, took off, and staff were unable to find for some time. CNA Q reported another example of CNA U odd behavior was on same day (3/1/20) CNA Q and CNA U entered resident room to perform resident care and CNA U sat on roommates bed with eyes closed rocking back and forth while CNA Q performed resident care independently. CNA Q reported CNA U took off again, left for break and spilled drink on floor by clock. CNA Q reported could not find CNA U again and left last time and did not come back. CNA Q reported was training CNA U and should have remained with her during entire shift but frequently left. CNA Q reported CNA U had inappropriate conversations with residents and gave hugs as well as inappropriate sexual comments to male resident. CNA Q reported CNA U left and never returned to facility so she did not report odd behaviors to ADM A. CNA Q reported heard later that day(3/1/20) CNA U had assisted with R4 care at the time of the incident and must have been one of the times she took off. During a telephone call on 6/30/20 at 3:08 p.m., CNA S reported working at the facility over one year. CNA S reported CNA U only worked about three days and would randomly leave during shifts. CNA S reported often had issues with residents being left wet for next shift and needed full changes including bed linens and reported DON B had been notified with little to no changes. Resident #9 (R9) Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE], reflected R9 was a [AGE] year old female admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The MDS reflected R9 had a BIM (assessment tool) score of 12 which indicated her ability to make daily decisions was cognitively intact, and she required one person physical assist with bed mobility, locomotion on unit, dressing, toileting, hygiene, bathing and two person physical assist with transfers. The MDS reflected R9 was always continent of urine and bowels. During a telephone interview on 6/30/20 at 4:01 p.m., Non-Certified Nurse Assistant (NCNA) X reported working at the facility less than 4 months and did not feel like she received good training before working on own at facility. NCNA X reported was responsible for all Nurse Aid duties that included a lot and had never taken Nurse Aid class with exception of one day class. NCNA X reported for example was unsure what 3 drawer container were outside rooms(containers with PPE for isolation) and not aware that was how staff knew resident was to be on isolation precautions including for precautionary Covid-19. NCNA X reported was working the evening of 4/26/20 when R9 fell and fractured leg. NCNA X reported R9 was up in wheelchair in hall when she arrived for third shift at 10:00 p.m., which was unusual for R9 as she was often in recliner by that time of night. NCNA X reported R9 was continent and aware when needed to use bathroom and reported need to use bathroom within first 30 minutes of start of shift. NCNA X reported R9 preferred to us shower room bathroom related to space and NCNA X requested assistance from CNA M for transfer. NCNA X reported after R9 transferred to the toilet they noticed R9 was urine soaked through brief and clothing and required a complete change. NCNA X reported R9 old brief was saturated, heavy and dark brown in color as if it had not been changed for hours. NCNA X verified witness statement(that included above details) related to R9 fall on 4/26/20 and reported did not received report from second shift that day. NCNA X reported was never questioned by management about R9 condition prior to fall. ADM A had not yet provided requested Police report for FRI on 3/1/20 requested on 6/24/20 by 7/1/20 at 10:00 a.m. During a telephone call to Local Police Department on 7/1/20 at 10:15 a.m., this surveyor requested investigation report for R4 on 3/2/20. Officer reported had recently sent to facility but would send copy as requested. Review of the Police Report, Incident/Investigation Report, dated 3/2/20 at 11:59 a.m., reflected case number 20- 6 related to sex offense for R4. The report reflected, On 3-2-10 Administrator (named ADM A) reported a claim of sexual assault .(named ADM A) said (named CNA U) did make inappropriate contact with (named R4) that they are addressing. (Named ADM A) said (named CNA U) leaned over (named R4) and rubbed noses with her. (Named ADM A) said (named CNA U) went home at approximately 3:30 p.m. because she claimed she was low on blood sugar. Tenants said (named CNA U) was acting strange .On 3-2-20 I made contact with (named R4) .(Named R4) said (named CNA U) grabbed her in the groin over her briefs and told her she was beautiful. (Named R4) said she couldn ' t` believe (named CNA U) just grabbed her. (Named R4) said she looked at (named CNA L) and (named CNA L) was looking at (named CNA U in disgust .On 3-3-20 I made contact with (named CNA L) and asked her what she witnessed. (Named CNA L) said she went into room [ROOM NUMBER] to assist (named R4) with her bedpan. (Named CNA L) said (named CNA U) walked in the room behind her at that time. I asked (named CNA L) if she needed (named CNA U) help. (named CNA L) said she didn`t. (Named CNA U) just walked in behind her. (named CNA L) said she was cleaning (named R4) when (named R4) did ask to be sat up in her bed. (named CNA L) said she needed (named CNA U) help for that. (named CNA L) said she when into the bathroom for a second. (named CNA L) walked out and found (named CNA U) almost face to face with (named R4). (Named R4) reported to (named CNA L) that (named CNA U) rubbed noses with her and told her she is beautiful. (Named R4) said she was creeped out by this action .Disposition .(Named R4) said she did not want to press charges, but she did want to have this incident on record . During a telephone interview on 7/1/20 at 11:52 a.m., CNA M reported R9 was up in wheelchair and awake upon arrive

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	235174	A. BUILDING _____ B. WING _____	07/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MARSHALL NURSING AND REHABILITATION COMMUNITY	575 N MADISON ST MARSHALL, MI 49068

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) for second shift on 4/26/20. CNA M reported Non-Certified Nurse Assistant (NCNA) X asked her to assist with R9 in the shower room bathroom between 10:30 and 10:45 p.m. CNA M reported R9 was transfer from wheel chair with gait belt and two assist to toilet with no difficulty. CNA M reported R9 was very wet though all cloths which was odd for R9 as R9 had never been wet and had been continent prior. CNA M reported R9 brief was saturated with jelly beads from brief broke in area with increased redness in R9's peri area. CNA M reported did not get report from 2nd shift on 4/26/20 before they left and staff complain because several very wet residents found at shift change. CNA M reported DON A and UM F informed and told walking rounds needed that lasted only two weeks. CNA M verified R9 fall witness statement for 4/26/20 and reported no one question her related to R9 being soak through clothes with urine prior to fall. CNA M reported when she reports residents that need complete changes related to urine soaked linens to nurse they state, did you do walking rounds? CNA M reported if residents are changed every two hours like they should be they would not require complete cloths and linen changes at shift change and would be an example of neglect. CNA M stated second shift, just grab stuff and leave and say, I'm going to take trash out and be right back," never come back. CNA M reported had reported urine soaked residents to UM F, LPN Y and LPN Z in past. CNA M reported allegations of abuse are reported to UM F and nurse and write in communication book. CNA M reported facility had never provided abuse training and asked if they signed abuse documents CNA M reported she recalled signing that they read facility Abuse Policy but had never received an actual training. CNA M reported the facility hire several Non Certified Nurse Assistance that had never worked in the field over past four months that do not know how to care for residents. CNA M reported she witnessed NCNA AA copy resident vitals from the day prior before and one night last week NCNA AA did not ask help when offered at 5:30 a.m.(end of shift) and first shift CNA staff came and got NCNA AA from parking lot at 6:00 a.m. because they had found residents who needed complete bed changes related to urine soaked linen and clothing. CNA M reported residents found urine soaked three to four days a week out of five by certain staff. CNA M stated, if you are given the same complaint about not providing care, why are they here? Resident #10 (R10) Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE], reflected R10 was a [AGE] year old male admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The MDS reflected R10 had a BIM (assessment tool) score of 5 which indicated his ability to make daily decisions was severely impaired, and he required one person physical assist with toileting. The MDS reflected R10 did not have behaviors. Resident #11 (R11) Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE], reflected R11 was a [AGE] year old male admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The MDS reflected R11 had a BIM (assessment tool) which indicated his ability to make daily decisions was severely impaired, and he required one person physical assist with bed mobility, dressing, eating, hygeine showering and two person physical assist with transfering, locomation and toileting. The MDS reflected R10 did not have behaviors During an interview on 6/30/20 at 4:42 p.m., CNA C reported she trained CNA U for first two days when CNA U started and reported smelled of alcohol while working and observed CNA U spill her drink that smelled like alcohol and become upset. CNA C reported another CNA staff had witnessed CNA U kissing two male residents (R10 and R11) on the lips. CNA C reported she did not report because she had not witnessed but heard about by co-worker. CNA C reported facility hired several Non-Certified Nurse Assistants that do not have Nurse Aid training and stated, we are stuck having to give them extra help and if they do not know we have to take time to re-educate on simple tasks they should know how to do. Received email from ADM A, dated 6/30/20 at 5:58 p.m., reflected, It has been brought to our attention that a potential allegation went unreported. We were just notified by a CNA that she heard a rumor she felt was false about a past employee and inappropriate contact from the beginning of March. We will follow our policy with a state report and full investigation. During a telephone interview on 7/1/20 at 2:56 p.m. CNA J reported continued reported concerns with second shift leaving urine soaked residents that need full bed changes when they arrive for third shift. CNA J stated, they do not like to give report, but she does walking rounds and if full bed changes needed they are required to help before punching out. During a telephone interview on 7/2/20 at 9:23 a.m., ADM A reported no allegations of neglect reported for resident left wet for long periods of time or found urine soaked at shift change. During a telephone interview on 7/2/20 at 11:50 a.m., with both ADM A and DON B. DON B reported started walking rounds when she first started at facility end of January 2020 beginning of February. DON B reported when care needs not being met brought to her attention care provided immediately, staff provided 1:1 education and follow disciplinary tree for verbal education related to standards then if continued issues investigate and additional discipline per policy. Review of the facility, Discipline, dated 4/2014, reflected, Some offenses are very serious and are subject to the employee's immediate suspension pending investigation for discharge. The following steps should be taken: 1. the employee should be immediately suspended .2. The events leading up to the suspension should be investigated by the Administrator or Manager .3. The investigation should include interviews with all witnesses, and review of all pertinent documents .G. The following is a list of unacceptable conduct or behavior .1.1 Resident abuse or neglect (physical, sexual, verbal or mental). 1.2 Refusal to perform assigned duties after direct order to do so. 1.3 Failure to report any incident of or information concerning resident neglect or abuse to your Supervisor, Administrator or Manager .1.15 Conduct generally regarded as immoral, improper, fraudulent or otherwise inappropriate .H. Violations of a less serious nature will be cause for progressive discipline so the employee can take corrective action to change his/her behavior .K. The following list improper conduct or behavior, which may result in progressive discipline action up to and including discharge. 2.1 Failure to perform assigned duties in an appropriate manner or at assigned times . Review of Individual In-Service, dated 2/6/20, reflected CNA BB received verbal warning for walking rounds that included, Walking rounds is required by off going & on coming staff to ensure that resident care has been provided. Review of Individual In-Service, dated 2/6/20, reflected CNA S received verbal warning for walking rounds that included, off going & on coming shift is required to do walking rounds on each assignment to ensure resident care has been provided and best care practice has been achieved. Review of Individual In-Service, dated 5/5/20, reflected CNA D received verbal warning for walking rounds that included, All staff is required to complete walking rounds to ensure resident care has been provided . All three Individual In-Service documents were signed by DON B and 2 of three were signed by ADM A. During a telephone interview on 7/2/20 at 1:31 p.m., with both ADM A and DON B. DON B was asked what prompted verbal cisalpine for CNA BB, S and D related to walking rounds? DON B reported again received complaints from staff when she first started around February 2020 of duties consistently not completed prior to shift change that included resident waters not filled, trash left in rooms, dirty equipment and residents that needed complete bedding changes. DON B reported she had completed R9 fall investigation and was determined there was no concerns with incident. This surveyor asked of anyone did investigation into why R9 was found soaked of urine shortly after shift change and prior to fall. DON B stated, no. When asked why, DON B reported because R9's fall with fracture was the focus. DON B verbalized knowledge of witness statements that included details at the time of fall.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI 182, MI 156 and MI 197 Based on observation, interview, and record review, the facility failed to have evidence that allegations of abuse were thoroughly investigated for 4 (R4, R9, R10, R11) of 9 reviewed for abuse, resulting in allegations of abuse that were not thoroughly investigated and the potential for further allegations of abuse to not be thoroughly investigated. Findings include: According to the facility, Abuse Prevention Program Policy and Procedure, dated 11/2018, reflected, Intent: Each resident has the right to be free from abuse, neglect and corporal punishment of any type by staff or anyone. The facility will provide a safe resident environment and protect residents from abuse .Policy: (named cooperation) has prevention programs in which policies and procedures safeguard our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint .verbal, mental, and sexual .Definitions .Immediately means as soon as possible, in the absence of a shorter State time frame requirement, 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 .Staff to Resident Abuse: All staff are expected to be in control of their own behavior, are to behave professionally, and should appropriately understand how to work with the nursing home population .Types of Abuse & Indicators .Neglect/Deprivation of Goods and Services by Staff: Abuse also includes the deprivation by staff of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Caregiver have been determined to have the knowledge and ability to provide care and services, but chose not, or acknowledge the request for assistance from a resident(s) and intentional or willfully fail to provide goods or services, that result in care deficits to a resident(s). Possible Indicators of Neglect .Failure to provide sufficient, qualified, competent staff, to meet resident needs .Failure to oversee the implementation of resident care policies; Failure to provide supervision and/or monitoring of the delivery of care; Failure of staff to implement resident interventions, when residents have been assessed

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	235174	A. BUILDING _____ B. WING _____	07/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) and interventions are care planned .Sexual Abuse: Is non-consensual sexual contact of any type with a resident. Sexual abuse includes, but not limited to: Unwanted intimate touching of any kind especially of breasts or perineal area . According to the facility, Abuse Prevention Program 7 Components, dated 11/2018, reflected, Prevention .Schedule management of qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents. Shift report and access to resident information to ensure staff assigned have knowledge of the individual residents' care needs and behaviors. Assignment & identification of the Charge Nurse as supervisor on each shift to monitor and identify inappropriate staff behaviors .INVESTIGATION 1. The Administrator and or Director of Nursing are to initiate and coordinate completion of a thorough investigation. Investigations must be initiated immediately and concluded as soon as possible not to exceed (5) days .The investigation must include but not limited to: Identify alleged perpetrator, remove from resident care area immediately, suspend pending investigation conclusion, obtain statement .Identify and begin investigating different types of alleged violations; Identify and interview (witness statements) all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation(s) such as roommate. Interviews with co-workers or other supervisors in regards to the alleged perpetrator's work performance .Body assessment and psychosocial status of the resident. Signs of catastrophic reaction .Providing complete/thorough documentation of the investigation findings (timeline of events), summary of conclusion. Follow-up actions to correct the prevent potential reoccurrence .In order to complete the Resident Abuse Investigation, all information must be gathered and reviewed, with a final summary analysis with an action plan to prevent reoccurrence . PROTECTION . Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed .Providing emotional support and counseling to the resident during and after the investigation, as needed .REPORTING/RESPONSE All alleged or suspected violations are to be reported immediately to the Administrator or Director of Nursing, which are responsible to notify required officials, including to the State Survey Agency, Adult Protective Services, Local Public Safety, Licensure Boards, Regional Director of Operations or Regional Clinical Directors .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 .Taking all necessary actions as a result of the investigation , which may include, but are not limited to, the following: a. Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences; b. Defining how care provisions will be changed and/or improved to protect residents receiving services .Response to Alleged Violations of Sexual Abuse: If an allegation of sexual abuse has been reported, the facility must immediately: g. Protect the alleged victim(s) involved. h. Report the alleged violations to the Administer and appropriate State and local authorities .j. Begin investigation of the allegation. k. Facility must not tamper with evidence during investigation . Resident #4 (R4) Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE], reflected R4 was a [AGE] year old female admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The MDS reflected R4 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact, and she required one person physical assist with bed mobility, locomotion on unit, dressing, toileting, hygiene, bathing and two person physical assist with transfers. R4's MDS assessment reflected no behaviors. Review of the Facility Reported Incident (FRI), submitted on 3/2/20 at 12:02 p.m., reflected R4 was a victim of a witnessed non consensual abuse incident by Certified Nurse Aid (CNA)U on 3/1/20 that was an allegation of sexual contact. The investigation reflected the witness contacted the Administrator (ADM) A on 3/1/20. The report reflected ADM A interviewed the victim (R4) on 3/2/20, with no documented time, and contacted Local Police shortly after at 11:58 a.m. The report reflected, Reported Incident: On Monday, March 2, 2020, while updating (named R4) about a customer service complaint, she reported to the Administrator and DON(Director of Nursing) that CNA (named perpetrator CNA U) grabbed my crotch and told me I was a beautiful woman. The reported reflected, R4 interview included, (named R4) stated that for no apparent reason, (named perpetrator CNA U) insisted she needed to be changed, coming into her room with a brief that was too small. She claimed to have no knowledge as to why the two aides were in her room. She states she rolled her towards herself and told (named R4) she had her right by my crotch saying, you are a beautiful woman. (Named R4) stated she did not appreciate these comments . The Report reflected CNA L witnessed the incident and reported, She stated that they changed (named R4) and then she noticed (named perpetrator CNA U) really close to (named R4). When (named perpetrator CNA U) was gone, (named R4) reported that (named perpetrator CNA U) had rubbed noses with her . The Report included an interview with CNA U that reflected, When asked about rubbing noses with (named R4), she stated she really didn't remember it. (Named CNA U) reported leaving work early due to very low blood sugar. When asked, (named CNA U) agreed it would not be considered respectful behavior. The FRI reflected a summary that included, As the interaction was witnessed by a staff member (named R4) trusts, it can be concluded that (named perpetrator CNA U) did not touch (named R4) in a sexual manner. While rubbing noses is certainly an odd behavior, it was not intended as anything more than playful . Review of the Nursing Progress Notes, dated 2/1/20 through 6/24/20, reflected no mention of abuse allegation on 3/1/20 reported by R4 including no social work visit or follow-up related to incident. During an interview on 6/24/20 at 12:25 p.m., Administrator (ADM) A reported the facility did not have any abuse allegations that had not been reported to the State Agency (SA) and that it was easier to report them. During an observation on 6/24/20 at 1:28 p.m., R4 room was labeled with contact/droplet isolation sign and 3 drawer clear plastic container outside door that contained personal protective equipment(PPE). R4 was in bed closest to the door with eyes closed. Staff exited room with only mask on carrying meal tray and placed in the cart located in the hall, returned to the room and closed door without use of PPE. During an observation and interview on 6/24/20 at 2:54 p.m., R4's call light was noted on outside of the door and sounding. Certified Nurse Aid was noted at nurse station about 20 feet from R4 room washing hands at the sink. R4 door was open to the hall and R4 was observed sitting on bedpan in bed with blankets pulled back exposing R4. CNA reported R4's roommate was a new admission therefore R4's room was an isolation room for 14 days related to possible Covid-19. CNA walked away from nurse station down hall away from R4 sounding call light. Same CNA returned to R4's room at 3:01 p.m. and donned PPE prior to entering room and closed door and turned off call light. During a telephone interview on 6/25/20 at 1:36 p.m., CNA L reported working at the facility for 8 months. CNA L reported she worked second shift on 3/1/20 at the time of R4 incident with CNA U. CNA L reported CNA U was a new employee and had her at facility for less than one week and was training with CNA L that day when she witness the incident. CNA L reported while putting R4 on the bedpan CNA U entered the room. CNA L reported she had not requested that CNA U assist but insisted on helping. CNA L reported after removing R4 from the bedpan she took the bedpan to the bathroom to empty. CNA L reported she could hear CNA U talking to R4 but unsure what was being said. CNA L reported when she returned to the room CNA U was touching R4's nose with her nose and CNA U had her hands on R4's chest. CNA L reported she told CNA U that was not appropriate and CNA U left the room. CNA L reported R4 told her that CNA U rubbed noses with her and R4 was really creeped out by CNA L behavior. CNA L reported she informed Licensed Practical Nurse (LPN) V who advised her to write witness statement and put under ADM A door and call ADM A on 3/1/20. CNA L reported that CNA U left early that day and had not worked there since incident on 3/1/20. CNA L verified witness statement, dated 3/1/20, related to staff to resident allegation. CNA L reported she reported the incident to nurse and administrator because she felt CNA U was touching R4 inappropriately and behavior was unprofessional and R4 reported she was, really creeped out by CNA U behavior and could be an example of sexual abuse. During a telephone interview on 6/25/20 at 2:26 p.m., Social Worker (SW) H reported working at the facility since September 2018. SW H reported ADM A did investigation related to R4 abuse allegation. SW H reported she did not see R4 after the 3/1/20 allegation including no follow up social work visits to assess R4 mental well being. Reviewed facility Behavior Logs for past six months, dated 12/15/19 through 6/25/20, reflected four entries with no mention of making false accusations and no entries noted between 1/23/20 and 3/12/20. During a telephone interview on 6/25/20 at 3:08 p.m., CNA M reported witnessed verbal abuse at the facility. CNA M stated, staff get frustrated with residents and snotty with them, tell them they will be back and don't come back. Staff say residents refused care but when I talk to residents they say they never came back. CNA M reported on two occasions in May to the nurse, Director of Nursing, Assistant Director of Nursing and Unit Manager related to staff not provided resident care. During a telephone interview on 6/26/20 at 8:30 a.m., CNA J reported working at the facility for more than a year and most often on 200 hall(Madison). CNA J reported for the past three months the facility had hired Nursing Assistance that are not certified that don't know what they are doing and require repeat training on basic care needs. CNA J reported it was not unusual to have all non certified nurse aids working on third shift two time weekly. CNA J reported on several occasions residents found very wet at shift change that required full changes including linens that were reported to nurses who tell staff to make sure they do walking rounds. CNA J reported she has called ADM A on weekends about resident concern including

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	235174	A. BUILDING _____ B. WING _____	07/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MARSHALL NURSING AND REHABILITATION COMMUNITY	575 N MADISON ST MARSHALL, MI 49068

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) residents found saturated at shift change and ADM A does not address until Monday. Review of facility staff punches for past two weeks, dated 6/10/20 through 6/25/20, reflected on 6/17/20 third shift only Non-Certified Nurse Assistance worked(No Certified Nurse Aids worked third shift) in entire building. During a telephone interview on 6/26/20 at 1:35 p.m., LPN V reported had worked at the facility for [AGE] years. LPN V reported working second shift on 3/1/20 starting at 2:00 p.m. and did not recall R4 incident. LPN V stated, there would never be any of my CNA staff touch a resident inappropriately. LPN V stated, slight memory of close facial contact but resident did not report concern. During a telephone interview on 6/26/20 at 3:07 p.m., ADM A reported facility updated Employee Staff List frequently and did not keeping contact information for past employees. After review of 3/1/20 Nursing Schedule reflected several employees were no longer on the Employee Staff List. During a telephone interview on 6/30/20 at 10:25 a.m., ADM A reported being the facility Abuse Coordinator. ADM A reported R4 incident on 3/1/20 that involved CNA U rubbing noses with R4 was a complaint not an allegation and stated, something resident thought was weird. ADM A reported should have come in at the time of the complaint on 3/1/20 because during R4 interview on 3/2/20 R4 reported CNA U grabbed R4 in the crotch area. ADM A reported rubbing noses with resident was not professional and not acceptable behavior for staff to resident. ADM A reported local police were called and report completed but did not have copy. ADM A reported staff are expected to report allegations of abuse to ADM A or DON B immediately within two hours face to face or by phone in person. During a telephone interview on 6/30/20 at 1:29 p.m. CNA R reported working at the facility for five years including last week of February 2020 with CNA U. CNA R reported CNA U worked about one week as new employee and often started shift and left during shift and had odd behaviors. During a telephone interview on 6/30/20 at 1:40 p.m., CNA W reported working at the facility for six months 6 months. CNA W reported CNA U did not work long and had odd behavior and smelled of alcohol while working. CNA W would say to residents, hi sweety and rub noses with residents and residents would requested space. CNA W reported nose to nose rubbing was possible allegation of sexual abuse because made residents uncomfortable. During a telephone interview on 6/30/20 at 1:56 p.m., CNA Q reported worked at the facility for over 2 years including with CNA U second shift starting at 2:00 p.m. on 3/1/20. CNA Q reported when CNA U arrived for the second shift on 3/1/20 CNA Q told her what they would be doing including filling ice chest and became upset (that is what we do on second shift) and placed ice chest top on floor and upset because CNA Q reported they had to clean ice chest again and dump ice, CNA U became frustrated, took off, and staff were unable to find for some time. CNA Q reported another example of CNA U odd behavior was on same day (3/1/20) CNA Q and CNA U entered resident room to perform resident care and CNA U sat on roommates bed with eyes closed rocking back and forth while CNA Q performed resident care independently. CNA Q reported CNA U took off again, left for break and spilled drink on floor by clock. CNA Q reported could not find CNA U again and left last time and did not come back. CNA Q reported was training CNA U and should have remained with her during entire shift but frequently left. CNA Q reported CNA U had inappropriate conversations with residents and gave hugs as well as inappropriate sexual comments to male resident. CNA Q reported CNA U left and never returned to facility so she did not report odd behaviors to ADM A. CNA Q reported heard later that day(3/1/20) CNA U had assisted with R4 care at the time of the incident and must have been one of the times she took off. During a telephone call on 6/30/20 at 3:08 p.m., CNA S reported working at the facility over one year. CNA S reported CNA U only worked about three days and would randomly leave during shifts. CNA S reported often had issues with residents being left wet for next shift and needed full changes including bed linens and reported DON B had been notified with little to no changes. Resident #9 (R9) Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE], reflected R9 was a [AGE] year old female admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The MDS reflected R9 had a BIM (assessment tool) score of 12 which indicated her ability to make daily decisions was cognitively intact, and she required one person physical assist with bed mobility, locomotion on unit, dressing, toileting, hygiene, bathing and two person physical assist with transfers. The MDS reflected R9 was always continent of urine and bowels. During a telephone interview on 6/30/20 at 4:01 p.m., Non-Certified Nurse Assistant (NCNA) X reported working at the facility less than 4 months and did not feel like she received good training before working on own at facility. NCNA X reported was responsible for all Nurse Aid duties that included a lot and had never taken Nurse Aid class with exception of one day class. NCNA X reported for example was unsure what 3 drawer container were outside rooms(containers with PPE for isolation) and not aware that was how staff knew resident was to be on isolation precautions including for precautionary Covid-19. NCNA X reported was working the evening of 4/26/20 when R9 fell and fractured leg. NCNA X reported R9 was up in wheelchair in hall when she arrived for third shift at 10:00 p.m., which was unusual for R9 as she was often in recliner by that time of night. NCNA X reported R9 was continent and aware when needed to use bathroom and reported need to use bathroom within first 30 minutes of start of shift. NCNA X reported R9 preferred to us shower room bathroom related to space and NCNA X requested assistance from CNA M for transfer. NCNA X reported after R9 transferred to the toilet they noticed R9 was urine soaked through brief and clothing and required a complete change. NCNA X reported R9 old brief was saturated, heavy and dark brown in color as if it had not been changed for hours. NCNA X verified witness statement(that included above details) related to R9 fall on 4/26/20 and reported did not received report from second shift that day. NCNA X reported was never questioned by management about R9 condition prior to fall. ADM A had not yet provided requested Police report for FRI on 3/1/20 requested on 6/24/20 by 7/1/20 at 10:00 a.m. During a telephone call to Local Police Department on 7/1/20 at 10:15 a.m., this surveyor requested investigation report for R4 on 3/2/20. Officer reported had recently sent to facility but would send copy as requested. Review of the Police Report, Incident/Investigation Report, dated 3/2/20 at 11:59 a.m., reflected case number 20- 6 related to sex offense for R4. The report reflected, On 3-2-10 Administrator (named ADM A) reported a claim of sexual assault .(named ADM A) said (named CNA U) did make inappropriate contact with (named R4) that they are addressing. (Named ADM A) said (named CNA U) leaned over (named R4) and rubbed noses with her. (Named ADM A) said (named CNA U) went home at approximately 3:30 p.m. because she claimed she was low on blood sugar. Tenants said (named CNA U) was acting strange .On 3-2-20 I made contact with (named R4) .(Named R4) said (named CNA U) grabbed her in the groin over her briefs and told her she was beautiful. (Named R4) said she couldn ' t` believe (named CNA U) just grabbed her. (Named R4) said she looked at (named CNA L) and (named CNA L) was looking at (named CNA U in disgust .On 3-3-20 I made contact with (named CNA L) and asked her what she witnessed. (Named CNA L) said she went into room [ROOM NUMBER] to assist (named R4) with her bedpan. (Named CNA L) said (named CNA U) walked in the room behind her at that time. I asked (named CNA L) if she needed (named CNA U) help. (named CNA L) said she didn`t. (Named CNA U) just walked in behind her. (named CNA L) said she was cleaning (named R4) when (named R4) did ask to be sat up in her bed. (named CNA L) said she needed (named CNA U) help for that. (named CNA L) said she when into the bathroom for a second. (named CNA L) walked out and found (named CNA U) almost face to face with (named R4). (Named R4) reported to (named CNA L) that (named CNA U) rubbed noses with her and told her she is beautiful. (Named R4) said she was creeped out by this action .Disposition .(Named R4) said she did not want to press charges, but she did want to have this incident on record . During a telephone interview on 7/1/20 at 11:52 a.m., CNA M reported R9 was up in wheelchair and awake upon arrive for second shift on 4/26/20. CNA M reported Non-Certified Nurse Assistant (NCNA) X asked her to assist with R9 in the shower room bathroom between 10:30 and 10:45 p.m. CNA M reported R9 was transfer from wheel chair with gait belt and two assist to toilet with no difficulty. CNA M reported R9 was very wet though all cloths which was odd for R9 as R9 had never been wet and had been continent prior. CNA M reported R9 brief was saturated with jelly beads from brief broke in area with increased redness in R9's peri area. CNA M reported did not get report from 2nd shift on 4/26/20 before they left and staff complain because several very wet residents found at shift change. CNA M reported DON A and UM F informed and told walking rounds needed that lasted only two weeks. CNA M verified R9 fall witness statement for 4/26/20 and reported no one question her related to R9 being soak through clothes with urine prior to fall. CNA M reported when she reports residents that need complete changes related to urine soaked linens to nurse they state, did you do walking rounds? CNA M reported if residents are changed every two hours like they should be they would not require complete cloths and linen changes at shift change and would be an example of neglect. CNA M stated second shift, just grab stuff and leave and say, I'm going to take trash out and be right back," never come back. CNA M reported had reported urine soaked residents to UM F, LPN Y and LPN Z in past. CNA M reported allegations of abuse are reported to UM F and nurse and write in communication book. CNA M reported facility had never provided abuse training and asked if they signed abuse documents CNA M reported she recalled signing that they read facility Abuse Policy but had never received an actual training. CNA M reported the facility hire several Non Certified Nurse Assistance that had never worked in the field over past four months that do not know how to care for residents. CNA M reported she witnessed NCNA AA copy resident vitals from the day prior before and one night last week NCNA AA did not ask help when offered at 5:30 a.m.(end of shift) and first shift CNA staff came and got NCNA AA from parking lot at 6:00 a.m. because they had found residents who needed complete bed changes related to urine soaked linen and clothing. CNA M reported residents found urine soaked three to four

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) days a week out of five by certain staff. CNA M stated, if you are given the same complaint about not providing care, why are they here? Resident #10 (R10) Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE], reflected R10 was a [AGE] year old male admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The MDS reflected R10 had a BIM (assessment tool) score of 5 which indicated his ability to make daily decisions was severely impaired, and he required one person physical assist with toileting. The MDS reflected R10 did not have behaviors. Resident #11 (R11) Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE], reflected R11 was a [AGE] year old male admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The MDS reflected R11 had a BIM (assessment tool) which indicated his ability to make daily decisions was severely impaired, and he required one person physical assist with bed mobility, dressing, eating, hygeine showering and two person physical assist with transfering, locomation and toileting. The MDS reflected R10 did not have behaviors During an interview on 6/30/20 at 4:42 p.m., CNA C reported she trained CNA U for first two days when CNA U started and reported smelled of alcohol while working and observed CNA U spill her drink that smelled like alcohol and become upset. CNA C reported another CNA staff had witnessed CNA U kissing two male residents (R10 and R11) on the lips. CNA C reported she did not report because she had not witnessed but heard about by co-worker. CNA C reported facility hired several Non-Certified Nurse Assistants that do not have Nurse Aid training and stated, we are stuck having to give them extra help and if they do not know we have to take time to re-educate on simple tasks they should know how to do. Received email from ADM A, dated 6/30/20 at 5:58 p.m., reflected, It has been brought to our attention that a potential allegation went unreported. We were just notified by a CNA that she heard a rumor she felt was false about a past employee and inappropriate contact from the beginning of March. We will follow our policy with a state report and full investigation. During a telephone interview on 7/1/20 at 2:56 p.m. CNA J reported continued reported concerns with second shift leaving urine soaked residents that need full bed changes when they arrive for third shift. CNA J stated, they do not like to give report, but she does walking rounds and if full bed changes needed they are required to help before punching out. During a telephone interview on 7/2/20 at 9:23 a.m., ADM A reported no allegations of neglect reported for resident left wet for long periods of time or found urine soaked at shift change. During a telephone interview on 7/2/20 at 11:50 a.m., with both ADM A and DON B. DON B reported started walking rounds when she first started at facility end of January 2020 beginning of February. DON B reported when care needs not being met brought to her attention care provided immediately, staff provided 1:1 education and follow disciplinary tree for verbal education related to standards then if continued issues investigate and additional discipline per policy. Review of the facility, Discipline, dated 4/2014, reflected, Some offenses are very serious and are subject to the employee's immediate suspension pending investigation for discharge. The following steps should be taken: 1. the employee should be immediately suspended .2. The events leading up to the suspension should be investigated by the Administrator or Manager .3. The investigation should include interviews with all witnesses, and review of all pertinent documents .G. The following is a list of unacceptable conduct or behavior .1.1 Resident abuse or neglect (physical, sexual, verbal or mental). 1.2 Refusal to perform assigned duties after direct order to do so. 1.3 Failure to report any incident of or information concerning resident neglect or abuse to your Supervisor, Administrator or Manager .1.15 Conduct generally regarded as immoral, improper, fraudulent or otherwise inappropriate .H. Violations of a less serious nature will be cause for progressive discipline so the employee can take corrective action to change his/her behavior .K. The following list improper conduct or behavior, which may result in progressive discipline action up to and including discharge. 2.1 Failure to perform assigned duties in an appropriate manner or at assigned times . Review of Individual In-Service, dated 2/6/20, reflected CNA BB received verbal warning for walking rounds that included, Walking rounds is required by off going & on coming staff to ensure that resident care has been provided. Review of Individual In-Service, dated 2/6/20, reflected CNA S received verbal warning for walking rounds that included, off going & on coming shift is required to do walking rounds on each assignment to ensure resident care has been provided and best care practice has been achieved. Review of Individual In-Service, dated 5/5/20, reflected CNA D received verbal warning for walking rounds that included, All staff is required to complete walking rounds to ensure resident care has been provided . All three Individual In-Service documents were signed by DON B and 2 of three were signed by ADM A. During a telephone interview on 7/2/20 at 1:31 p.m., with both ADM A and DON B. DON B was asked what prompted verbal cisalpine for CNA BB, S and D related to walking rounds? DON B reported again received complaints from staff when she first started around February 2020 of duties consistently not completed prior to shift change that included resident waters not filled, trash left in rooms, dirty equipment and residents that needed complete bedding changes. DON B reported she had completed R9 fall investigation and was determined there was no concerns with incident. This surveyor asked of anyone did investigation into why R9 was found soaked of urine shortly after shift change and prior to fall. DON B stated, no. When asked why, DON B reported because R9's fall with fracture was the focus. DON B verbalized knowledge of witness statements that
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide sufficient trained nursing staff to provide nursing services to assure resident safety and maintain the highest practicable physical, mental, and psychosocial well-being for one resident (R9) of a total sample of nine residents, resulting in non certified aids providing direct resident care that may have contributed to R9 fall with fracture on [DATE] and death on [DATE]. Finding include: According to the facility, NON-CERTIFIED NURSING ASSISTANTS POLICY (FOR MICHIGAN OHIO WISCONSON), dated [DATE], reflected, Purpose (named cooperation) wants to ensure the safety of our residents and employees .GUIDELINES Effective immediately and until further notice, facilities in Michigan, Ohio, and Wisconsin may employee individuals as non-certified nursing assistants under the following guidelines: a. These individuals must complete the AHCA temporary nurse aide online course or sate designated course .c. The Director of Nursing (or their designee) needs to complete the competency checklist .e. These individuals may work for 120 days, unless specified by individual state, after completing their sate required training and their competencies. f. The position will be paid $1 less than the certified nursing assistant rate at each facility .i. Depending on the individual state requirements, upon completing of the 120 days, the individual may work with (named corporation) to determine if continued employment is available and how to become eligible for such employment . Resident #9 (R9) Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE], reflected R9 was a [AGE] year old female admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The MDS reflected R9 had a BIM (assessment tool) score of 12 which indicated her ability to make daily decisions was cognitively intact, and she required one person physical assist with bed mobility, locomotion on unit, dressing, toileting, hygiene, bathing and two person physical assist with transfers. The MDS reflected R9 was always continent of urine and bowels. During a telephone interview on [DATE] at 8:30 a.m., CNA J reported working at the facility for more than a year and most often on 200 hall(Madison). CNA J reported for the past three months the facility had hired Nursing Assistance that are not certified that don't know what they are doing and require repeat training on basic care needs. CNA J reported it was not unusual to have all non certified nurse aids working on third shift two time weekly. CNA J reported on several occasions residents found very wet at shift change that required full changes including linens that were reported to nurses who tell staff to make sure they do walking rounds. CNA J reported she has called ADM A on weekends about resident concern including residents found saturated at shift change and ADM A does not address until Monday. Review of facility staff punches for past two weeks, dated [DATE] through [DATE], reflected on [DATE] third shift only Non-Certified Nurse Assistance worked (No Certified Nurse Aids worked third shift) in entire building. According to the facility, Fall RCA and investigation, dated [DATE], reflected R9 fell in the shower room while being transferred from the toilet to the wheelchair with two person staff assist at approximately 11:25 p.m. that resulted in pain and left lower leg fracture and was transferred to local hospital. Nurse aides hiring criteria: temporary nurse aide position that has been opened by state, have to complete 8h course that the State of MI has. After that, come in and work side by side with CNA's. Once they are completed with orientation packet and ready to come off, do competency with myself and UM. That is a checklist. We do some things verbally, some things we have to make sure they do per our standard and policies. Brand new CNA's get 6d, split 3d on each side, base of where supplies are and what routine needs to be. Nurse aides follow the exact routine of what a CNA During a telephone interview on [DATE] at 2:59 p.m. Director of Nursing (DON) B reported the facility had hired several Non Certified Nurse Aides(NCNA) that have completed the temporary eight hour training. DON B reported NCNA staff don't do competency review with one of the nurse managers because they don't get the hands on learning with the eight hour course and after done with the preceptor, they can do the competency review. DON B

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F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 8) reported the competency review look included ,[DATE] page document that facility goes through including: IC stuff .blood borne pathogens and body mechanics, choking, making beds, transfers, positioning, assisting with ostomies, meals and elimination, behavior symptoms and had have not had any end of life care that they have been exposed to or care of a body after death however had gone over what that looks like. DON B reported day one is general orientation; tax forms, core competencies, HIPAA, abuse, all corporate compliance stuff and second day NCNA are on the floor for the shift they are hired for. DON B reported the facility started using NCNA [DATE] and reported the facility currently had six NCNA employed and stated, We have had quite a few of them, and most of them don't last. DON B reported Temporary Aides (NCNA) and CNA's use the same job description and reported this was a way for the state to fill the gap and help with staffing shortage. Review of an email sent by Administrator (ADM) A, dated [DATE], reflected the facility had ten Non-Certified Nurse Assistance (Temporary Nurse Aid) currently working at the facility. During a telephone interview on [DATE] at 4:01 p.m., Non-Certified Nurse Assistant (NCNA) X reported working at the facility less than 4 months and did not feel like she received good training before working on own at facility. NCNA X reported was responsible for all Nurse Aid duties that included a lot and had never taken Nurse Aid class with exception of one day eight hour class. NCNA X reported for example was unsure what 3 drawer container were outside rooms(containers with PPE for isolation) and not aware that was how staff knew resident were to be on isolation precautions including for precautionary Covid-19. NCNA X reported was working the evening of [DATE] when R9 fell and fractured leg. NCNA X reported R9 was up in wheelchair in hall when she arrived for third shift at 10:00 p.m., which was unusual for R9 as she was often in recliner by that time of night. NCNA X reported R9 was continent and aware when needed to use bathroom and reported need to use bathroom within first 30 minutes of start of shift. NCNA X reported R9 preferred to us shower room bathroom related to space and NCNA X requested assistance from CNA M for transfer. NCNA X reported after R9 transferred to the toilet they noticed R9 was urine soaked through brief and clothing and required a complete change. NCNA X reported R9 old brief was saturated, heavy and dark brown in color as if it had not been changed for hours. NCNA X verified witness statement(that included above details) related to R9 fall on [DATE] and reported did not received report from second shift that day. NCNA X reported was never questioned by management about R9 condition prior to fall. NCNA X reported after R9 used the toilet both CNA M and herself attempted to transfer R9 to a standing position when R9's knees felt like they buckled and they lowered R9 back to toilet. NCNA X reported they attempted again to stand R9 from the toilet and again NCNA X reported R9's legs gave out and both CNA M and NCNA X lowered R9 to the floor. NCNA X reported after nurse was informed all three staff attempted to transfer R9 from floor to wheelchair but were unable. NCNA X reported a second nurse arrived and reported R9 lower leg appeared fractured and displaced and emergency services were called and R9 remained on bathroom floor until they arrived. During a telephone interview on [DATE] at 11:52 a.m., CNA M reported R9 was up in wheelchair and awake upon arrive for second shift on [DATE]. CNA M reported Non-Certified Nurse Assistant (NCNA) X asked her to assist with R9 in the shower room bathroom between 10:30 and 10:45 p.m. CNA M reported R9 was transferred from the wheelchair with gait belt and two assist to toilet with no difficulty. CNA M reported R9 was very wet through all cloths which was odd for R9 as R9 had never been wet and had been continent prior. CNA M reported R9 brief was saturated with jelly beads from brief broke in area with increased redness in R9's peri area. CNA M reported R9 was weak when both herself and NCNA X attempted to transfer off the toilet when it felt like R9's knees buckled and R9 was lowered back to toilet and attempted again to stand R9 when R9's knees seemed to, buckled hard, and R9 was then lower to the floor with R9's head resting on CNA M feet. CNA M reported NCNA X went to get nurse and both return to shower room. CNA M reported the three of them were unable to transfer R9 up off floor and addition assist was needed and another nurse arrived to assist who stated, wait something is wrong with leg. CNA M stated R9's leg was twisted and looked broke. CNA M reported had not got report from 2nd shift on [DATE] before they left and staff complain because several very wet residents found at shift change. CNA M reported DON A and UM F informed and told walking rounds needed that lasted only two weeks. CNA M verified R9 fall witness statement for [DATE] and reported no one question her related to R9 being soak through clothes with urine prior to fall. CNA M reported when she reports residents that need complete changes related to urine soaked linens to nurse they state, did you do walking rounds? CNA M reported if residents are changed every two hours like they should be they would not require complete cloths and linen changes at shift change and would be an example of neglect. CNA M stated second shift, just grab stuff and leave and say, I'm going to take trash out and be right back," never come back. CNA M reported had reported urine soaked residents to UM F, LPN Y and LPN Z in past. CNA M reported allegations of abuse are reported to UM F and nurse and write in communication book. CNA M reported facility had never provided abuse training and asked if they signed abuse documents CNA M reported she recalled signing that they read facility Abuse Policy but had never received an actual training. CNA M reported the facility hire several Non Certified Nurse Assistance that had never worked in the field over past four months that do not know how to care for residents. CNA M reported she witnessed NCNA AA copy resident vitals from the day prior before and one night last week NCNA AA did not ask help when offered at 5:30 a.m.(end of shift) and first shift CNA staff came and got NCNA AA from parking lot at 6:00 a.m. because they had found residents who needed complete bed changes related to urine soaked linen and clothing. CNA M reported residents found urine soaked three to four days a week out of five by certain staff. CNA M stated, if you are given the same complaint about not providing care, why are they here?