STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366360	A. BUILDING _____ B. WING _____	07/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VINEYARDS AT CONCORD, THE	119 WEST HIGH STREET FRANKFORT, OH 45628

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

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F 0600 **Level of harm -** Immediate jeopardy **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** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY Based on closed medical record review, review of a facility Self-Reported Incident (SRI), review of witness statements, review of a facility incident report, review of a local law enforcement report, staff interviews, review of a personnel file and review of facility policy and procedures, the facility failed to ensure a resident was free from sexual abuse by a facility staff member. This resulted in Immediate Jeopardy and the potential for serious harm for one resident (#01) when staff observed Housekeeper #75 inappropriately touching the resident's vaginal area. This affected one (#01) out of three residents reviewed for sexual abuse. The facility census was 26. On 07/07/20 at 10:32 A.M., Facility Manager #29 was notified that Immediate Jeopardy began on 06/24/20 at 2:45 P.M. when State tested Nursing Assistant (STNA) #80 opened Resident #01's closed door to check on the resident. Upon opening the door, STNA #80 observed Housekeeper #75 in Resident #01's room and Resident #01's pants were off while Housekeeper #75 was crouched down beside the resident's bed with both his hands on the resident's vaginal area. Resident #01 has a [DIAGNOSES REDACTED]. The Immediate Jeopardy was removed on 06/25/20 when staff education was provided regarding the identification of abuse, the abuse policy and procedures, and when and how to report abuse. The deficiency remained at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) until it was corrected on 07/03/20 when the facility implemented the following corrective actions: On 06/24/20 at 2:45 P.M., STNA #80 immediately intervened to ensure Resident #01 was safe. STNA #80 then reported the incident to management and Housekeeper #75 was immediately suspended/terminated and left the facility. On 06/24/20 at 3:09 P.M., Resident #01 was assessed for injuries. There were no injuries observed. On 06/24/20 at 3:15 P.M., Resident #01's family was notified of the incident and an emergency room visit/examination was offered, but the family declined. On 06/24/20 at 3:25 P.M., the Administrator contacted the police department regarding the incident. On 06/24/20, Social Services #43 held a Resident Council and Grievance Committee Meeting to educate residents regarding how and when to report mistreatment complaints or abuse without fear of reprisal. Residents were provided with advocacy group contact information including the Ombudsman. All residents were also interviewed and observed for any signs of abuse. The interviews revealed the residents felt safe at the facility and had no knowledge of any other sexual abuse incidents. On 06/64/20, Facility Manager #29 began in-servicing all staff regarding abuse including sexual abuse and how and when to report abuse. The education included initiating an open-door policy instructing staff to leave resident doors open unless personal care was being provided. The in-services were completed on 06/25/20. On 06/24/20, at 7:00 P.M., Resident #01 was transferred to the emergency room for evaluation. On 06/26/20, the facility Quality Assurance Performance Improvement (QAPI) committee met with Medical Director #99 to formalize a plan for continued monitoring. This ongoing plan includes meeting weekly, and as needed. The QAPI committee met on 07/01/20 and identified no further concerns regarding abuse. On 06/26/20, Facility Manager #29 and the Administrator implemented all resident screening for abuse and skin observations to be completed two to three times per week and as needed. The abuse and skin observations were completed with residents showering schedules and were completed through 07/03/20 without any further concerns regarding abuse. On 06/26/20, Social Services #43 implemented weekly resident wellness/safety checks. The Director of Nursing (DON) will monitor the wellness/safety checks and report the findings to the QAPI committee. The checks were completed on 07/01/20 without any further concerns regarding abuse. On 07/06/20, two (#02 and #03) additional resident's medical records were reviewed regarding sexual abuse. There were no concerns identified. On 07/06/20, interviews between 12:40 P.M. and 12:50 P.M. with Residents #02, #03 and #04 revealed the residents felt safe in facility and that no one had touched them inappropriately. On 07/06/20, interviews between 11:19 A.M. and 1:35 P.M. with STNA #82, STNA #86, STNA #43, STNA #80 and Registered Nurse (RN) #53 revealed no negative findings were identified regarding abuse and all were knowledgeable regarding abuse including sexual abuse definitions and how and when to report. On 07/06/20, review of the facility SRI's revealed there were no other similar SRI's regarding sexual abuse. Findings include: Review of the closed medical record for Resident #01 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Resident #01 was transferred to the emergency room for evaluation on 06/24/20 and was discharged home with family on 06/30/20. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] and the discharge MDS dated [DATE] revealed Resident #01 was severely cognitively impaired and was independent with bed mobility task, transfers, and walking. Resident #01 was assessed as needing supervision and set up for dressing task. Review of the physician progress notes [REDACTED].#01 was walking around and ambulating very well without assistance and seemed more confused than normal. Nursing staff reports no concerns and will follow up in one month. Review of the nurse's notes dated 06/21/20 revealed Resident #01 was noted in another resident's room and being argumentative with staff when redirected back to her room. Further review of nurse's notes dated 06/24/20 at 3:00 P.M. revealed a staff member reported another male staff member touching Resident #01's genital area in bed with no pants on and male staff member went into bathroom when staff walked in. Facility Manager #29 was made aware. Review of nurse's notes dated 06/24/20 at 3:15 P.M. revealed Resident #01's daughter was made aware of the incident, the administrator was made aware, nurse (RN #53) interviewed Resident #01 and she denied anyone touching her. Review of nurse's notes dated 06/24/20 at 4:03 P.M. revealed the physician was notified and a request to send to the emergency room was made. Review of a physician telephone order dated 06/24/20 revealed an order to send Resident #01 to the emergency room for evaluation after inappropriate contact to genitalia. Review of the facilities hospital transfer form dated 06/24/20 revealed Resident #01 was inappropriately touched on genitalia and no trauma noted. Review of nurse's notes dated 06/24/20 at 7:00 P.M. revealed Resident #01 was transferred to the emergency room . Review of nurse's notes dated 06/24/20 at 11:45 P.M. revealed Resident #01 returned from the emergency room transported by her daughter and her daughter did not come inside the facility and no paperwork was sent with the resident. There was no signs and symptoms of distress noted to Resident #01. A call was placed to her daughter and she stated she had no paperwork from the hospital and that the hospital was waiting on results. Further review of nurse's notes dated 06/25/20 revealed an aide reported that Resident #01 pulled her shirt up rubbing her breasts and Resident #01 stated I'm Horney. Review of nurse's notes dated 06/26/20 and 06/27/20 revealed no sexually inappropriate behaviors or statements. Review of nurses notes dated 06/29/20 revealed Resident #01's daughter called, and they plan to discharge her home tomorrow at 1:00 P.M. Review of nurse's notes dated 06/30/20 revealed Resident #01 was discharged home with her daughter and son-in-law. Review of the hospital medical records revealed Resident #01 was evaluated at the hospital on [DATE] related to a possible sexual assault. The emergency department note documented Resident #01 was reportedly in her room, a worker at the nursing home walked into the resident's room and noticed an environmental services staff member had his hands on the resident's thighs. The resident was wearing underwear but did not have pants on at the time. No reports of penetrative intercourse. Resident #01's daughter was present at the hospital and concerned about possible assault. The

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

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) Sexual Assault Nurse Examiner (SANE) examined Resident #01 and noted the resident has dementia/[MEDICAL CONDITION] and is unable to answer questions about the incident. The SANE examination noted no tears, redness or bruising upon direct visualization of the body and no areas of concern upon visualization of the face and mouth. The visualization noted a small area of concern (red area) upon examination of the vagina. Review of a facility SRI dated 06/24/20 revealed STNA #80 entered Resident #01's room and observed Housekeeper #75 with his hands on the resident's vagina and upper thighs while the resident's pants were off. He jumped up and continued cleaning the room. Resident #01 has dementia and no effects noted and she was at baseline smiling and walking with peers. Housekeeper #75 was immediately relieved from duty by the supervisor (Facility Manager #29) whom received the allegation and immediately notified the Administrator. The Administrator immediately notified the police, then sent notice to the State Agency reporting via an SRI. Resident #01's family was notified and at first declined sending the resident out to the emergency room . Later, Resident #01's family stated they wanted the resident sent to the emergency room and/or a rape kit performed per officer advice. Social services will interview all residents looking for signs of abuse and all staff will be reeducated about abuse. The SRI regarding sexual abuse was substantiated. Review of the witness statement by STNA #80 dated 06/24/20 at 3:15 P.M. revealed she walked into Resident #01's room, the resident's door was shut, once she entered room she saw Housekeeper #75 jump up from where he was crouched next to Resident #01's bed with his hands on her vagina and upper thighs and her pants were completely off. STNA #80 reported as she came into the room, Housekeeper #75 jumped up and Resident #01 covered herself up. Housekeeper #75 continued cleaning the room as she stayed in the room speaking to Resident #01's roommate. Review of facilities incident report dated 06/24/20 completed by RN #53 revealed an incident occurred in Resident #01's bedroom at 2:45 P.M. A staff member entered Resident #01's room and noted Resident #01 lying in bed with no pants on and a male staff member touching her inappropriately as his hands were on the resident's genitalia and staff member immediately left bedside. Witness was STNA #80. Resident #01 denied being touched by anyone and denied any pain or discomfort. Male staff member was immediately sent home and the family and physician were notified. Review of the local Sheriff's Report dated 06/26/20 revealed a report was made on 06/24/20 at 3:25 P.M. by the Administrator to law enforcement for a possible rape at the nursing home. The suspect was identified as Housekeeper #75, the victim was identified as Resident #01, and the witness was identified as STNA #80. When Officer #22 arrived, Resident #01's family was at the facility and advised they were taking her to the local hospital for a Sexual Assault Nurse Examiner (SANE) kit to be completed. Officer #22 spoke with Facility Manager #29 who stated STNA #80 came to her and stated Housekeeper #75 was in Resident #01's room and the door was closed, and when STNA #80 opened the door she saw Housekeeper #75 crouched next to Resident #01's bed and he had his hands on her upper thigh and vagina area. Resident #01 was not wearing any clothing from the waist down and was not covered by a blanket. STNA #80 then reported Housekeeper #75 jumped up hurriedly to the cleaning cart and then into the bathroom in the room. She stated Resident #01 hurried up and covered herself with a blanket and STNA #80 stayed in the room until Housekeeper #75 left the room and she reported the incident. Facility Manager #29 stated she advised Housekeeper #75 to leave the premises and go home and not to return about 15 minutes after the incident, and he did not ask why and she did not state anything further. Facility Manager #29 stated Housekeeper #75 did have some communication barriers and had been employed by the facility for well over a year, was a good worker, and never had any complaints from staff or residents. Review of the local Sheriff's Report dated 06/29/20 revealed a report was written from Officer #23 that revealed on 06/24/20 he met Officer #22 at the facility and he interviewed STNA #80 who stated while performing her duties, she entered Resident #01's room without giving notice and once in the room she clearly observed Resident #01 laying on her bed naked from the waist down and Housekeeper #75 was crouched down beside Resident #01 with both of his hands touching Resident #01's vagina. She stated Housekeeper #75 jumped and immediately grabbed some cleaning supplies and once he left the room, she checked on Resident #01 and her roommate. STNA #80 reported the incident to Facility Manager #29. Officer #23 spoke with Facility Manager #29 who stated she told Housekeeper #75 to turn in his key and go home and he was not to return. Further interview with STNA #80 revealed she had been in Resident #01's room about five minutes prior to the incident trying to calm her roommate down and that Resident #01 was fully clothed and the door was open. When questioned again if STNA #80 was one hundred percent sure she could clearly see Housekeeper #75 touching Resident #01's exposed vagina with his hands, she stated she was positive he was touching her vagina but could not tell if his fingers were inside her vagina only that he was touching her. On 06/25/20, an arrest was made on Housekeeper #75 and he was charged with Gross Sexual Imposition. An interview was not done with Housekeeper #75 due to needing an interpreter. A call was made to Housekeeper #75's daughter and she stated he told her he was ordered to go home from work and not to return. She stated her father (Housekeeper #75) told her that he walked into a room where a female resident was lying in bed naked and that he immediately left the room and did not touch her. On 07/06/20 at 9:44 A.M., an interview with Facility Manager #29 revealed Housekeeper #75 had worked at the facility for about two years and the facility had no prior concerns with his work performance or having any inappropriate behaviors. Facility Manager #29 stated they immediately sent Housekeeper #75 home after STNA #80 reported she observed him in Resident #01's room touching her vagina. Facility Manager #29 further stated the facility screened all residents for any injuries with no concerns. On 07/06/20 at 11:19 A.M., an interview with STNA #82 revealed he stated he was working the day of the incident on 06/24/20 and that STNA #80 had reported to him about Housekeeper #75 touching Resident #01 and they told Facility Manager #29 and he was removed from the facility. STNA #82 stated he was in shock about Housekeeper #75 and that he had never seen any concerns from him prior to this incident. STNA #82 stated he had not received any complaints from residents being touched inappropriately. He stated he received abuse training before and after the incident on 06/24/20 and that he would report immediately to the supervisor any signs of abuse after he ensured the resident was safe. STNA #82 stated Resident #01 was very confused and normally would walk around the facility and had no sexual behaviors. On 07/06/20 at 12:25 P.M., an interview with Social Services #43 revealed Housekeeper #75 was friendly, always smiling, and she had never seen anything inappropriate from him. She stated she was working on 06/24/20 and never had any residents complain about Housekeeper #75 or being afraid or that anyone had touched them inappropriately. She stated after the incident on 06/24/20 she stayed over that day to talk to each resident and made sure they also knew what to do if anyone touched them inappropriately. On 07/06/20 at 1:00 P.M., an interview with RN #53 revealed she was the nurse working with Resident #01 on 06/24/20. RN #53 stated she was sitting at the nurses station when STNA #80 and STNA #82 told her that Housekeeper #75 had touched Resident #01 on her vagina and it was immediately reported also to Facility Manager #29. She stated Facility Manager #29 had asked Housekeeper #75 to leave the facility. She stated Resident #01 had no injuries and no recollection of the incident. RN #53 stated Resident #01 did have dementia and was confused. RN #53 stated she had worked with Housekeeper #75 and had never seen anything that would suggest he would do anything inappropriate. On 07/06/20 at 1:35 P.M., an interview with STNA #80 revealed she was working on 06/24/20 and she had walked into Resident #01's room to attend to her roommate (Resident #02) and when she left the room Resident #01 was fully dressed and she left the door open when she exited the room. STNA #80 stated no longer than five to ten minutes later she came down the hallway and saw Resident #01's door closed so she opened the door without knocking and saw Resident #01 laying on her bed with no clothes on from the waist down and Housekeeper #75 was crouched beside her and he had both his hands on her vaginal area. She then stated he jumped up, grabbed cleaning supplies and went into the bathroom and then left the room while she was talking with Resident #01 and Resident #02. STNA #80 stated she made sure Resident #01 and Resident #02 were safe. STNA #80 stated Resident #01 immediately covered herself with a blanket. STNA #80 stated there were no injuries or signs of distress from Resident #01 and Resident #02 did not see anything. STNA #80 stated Resident #01 and Resident #02 were confused. STNA #80 stated she then saw Housekeeper #75 in the hallway cleaning, and she reported the incident immediately to STNA #82, RN #53, and to Facility Manager #29. She stated Facility Manager #29 asked Housekeeper #75 to leave immediately. She stated she had worked with Housekeeper #75 before and never had any concerns. Review of Housekeeper #75's personnel file revealed his first day of work was on 09/08/17. He had a Bureau of Criminal Investigation (BCI) check completed on 08/28/17 and had no negative findings. Housekeeper #75 had an evaluation completed on 06/01/20 that revealed his attendance was excellent and he was kind and considerate to coworkers and residents and he always was dressed professionally. Housekeeper #75's duties did not involve any personal care with residents only cleaning duties. Housekeeper #75 was last in-serviced on abuse including sexual abuse on 01/31/20 and it included definitions of abuse and when to report. His signature was on the in-service staff sign-in sheet dated 01/31/20. Review of facilities Resident Abuse and Neglect Policy dated June 2019 revealed the facility shall act immediately when any resident, employee, relative, or person reports an incident of either abuse/neglect or suspected abuse/neglect. If any person observes or becomes aware of an incident or resident abuse that person must report to nursing supervisor immediately. The nursing supervisor will initiate the procedure for incident reporting, which shall serve as initial investigation. Should the alleged abuser be present, the supervisor in charge has the authority to

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) immediately remove the person from any area of the facility and grounds, and/or release the person from duty, should the situation call for such. Resident should be assured of safety, security and no reprisal as needed. Nursing supervisor or staff shall notify the Administrator. The Administrator or delegate shall assure all appropriate agencies are notified. In the event a crime is suspected, the Ross County Sheriff's Department shall be notified by the Administrator within two hours and a report number shall be obtained for facilities records. The policy further documented abuse includes, but is not limited to: interference, coercion, discrimination, or reprisal in exercising one's rights. Each resident has a right to a dignified existence, and to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusions among other rights listed in Am. Sub. HB 600. Sexual abuse includes but is not limited to, harassment, coercion or assault. Sexual abuse may include unexplained difficulty in walking or sitting; torn, stained, or bloody underclothing; pain/itching in genitalia; bruising or bleeding of genitalia, vaginal or anal area; unwillingness to participate in certain physical activities, unexplained and unusually infantile behavior; bizarre sexual behavior or knowledge; report of sexual assault, coercion, or harassment. Review of facilities Abuse Reporting Policy dated June 2019 revealed the facility will not tolerate any abuse by anyone. This includes staff members, other residents, consultants, volunteers, physicians, family members, legal guardians, sponsors, friends, staff, or other agencies serving our residents, or other individuals. Any suspicion that abuse, neglect, or misappropriation is occurring, or has occurred, must be reported immediately to the supervisor on duty and administration. The Administrator shall report abuse as soon as possible to the Ohio Department of Health within less than 24 hours. Alleged suspicious party shall not be permitted on site until and if cleared by investigation. When a crime is suspected, the Administrator shall also notify the local police authority within two hours. This deficiency substantiates Master Complaint Number OH 819 and Complaint Number OH 814.