STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105816	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lilac at Bayview, The	161a Marine Street Saint Augustine, FL 32084

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30969 Based on observations, record review and interviews, the facility failed to implement the comprehensive care plan to ensure the resident's medical, physical and psychosocial needs were met and failed to ensure a cognitively impaired resident's right to be free from abuse, including sexual abuse, was implemented for one (Resident #2) of 4 residents reviewed for resident-to-resident abuse, from a total sample of 7 residents. The findings include: A review of a facility federal report generated on 11/18/24 by the Regional Director of Operation (RDO) revealed on 11/9/24 at 7:00 pm, Resident #2, a [AGE] year-old female who had been admitted the day before (11/8/24), was found in bed with Resident #3, a [AGE] year-old male. Resident #2 and #3 were allegedly having sexual intercourse. Resident #2 was noted to have a brief interview for mental status (BIMS) score of 3 out of 15 points, indicating severe cognitive impairment. Resident #3's BIMS was noted as 0 in the report (indicating severe cognitive impairment). In response, both residents were placed on 1:1 supervision that same day. When assessed by the Psychiatric Practitioner on 11/10/24, Resident #2 was unable to recall the event. The same practitioner assessed Resident #3 on 11/10/24 and noted he was alert and oriented to person, place and time. Resident #3 denied any sexual activity took place. A medical record review for Resident #2 confirmed she was admitted to the facility on [DATE] and was [AGE] years old. Her primary diagnosis was chronic respiratory failure with hypoxia or hypercapnia (a condition where the lungs cannot effectively exchange oxygen and carbon dioxide (CO2) in the blood, leading to either low oxygen or high CO2 levels in the body. The dashboard on Resident #2's electronic record instructed Every 15-minute monitoring. A review of Resident #2's Medicare minimum data set (MDS) assessment with a reference date of 11/14/24 noted she could understand others and make herself understood with a BIMS score of 6 (severe cognitive impairment). Additional diagnoses included debility, cardiorespiratory conditions, coronary artery disease, malnutrition, anxiety, psychotic disorder and depression. Discharge planning was occurring for her to return to the community after skilled care. A review of Resident #2's physician's order dated 11/9/24 noted 1:1 staff monitoring. The order was discontinued on 11/15/24 and a new order obtained for every 15-minute monitoring on each shift. (Photographic evidence was obtained) (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 was care planned on 11/10/24 for her risk for hypersexual behaviors with the goal of remaining free of such behaviors through the next review date. The interventions included one on one monitoring. On 11/19/24 the care plan focus was resolved and a new care plan developed for impaired cognitive function and thorough process related to long- and short-term memory problems. The interventions was not revised to include the 15-minute monitoring checks ordered by the physician on 11/15/24. (Photographic evidence was obtained) Review of a Psychiatric Encounter dated 11/10/24 was reflective of the aforementioned facility report, however it also noted Resident #2 was unable to give informed consent. (Photographic evidence was obtained) A review of the 15-minute monitoring logs for Resident #2 revealed they were maintained through 11/29/24 at 6:45 am, then dropped off. There was no further documentation showing Resident #2 was being monitored every 15 minutes as ordered. During an interview with Licensed Practical Nurse (LPN) B on 12/3/24 at 3:25 pm, she was asked how 15-minute checks were completed by nurses when they were tied up with medication pass or the provision of care. LPN B did not offer a verbal reply but shrugged her shoulders and continued typing notes in her computer. On 12/3/24 at 3:52 pm, the Director of Nursing (DON) was interviewed. When asked where the 15-minute checks were documented for Resident #2. He stated they were documented on paper and kept on the nurses' carts. Floor staff were responsible for documenting the checks. On 12/3/24 at 3:53 pm, Certified Nursing Assistant (CNA) A was interviewed . She stated she was assigned to Resident #2 and described her as confused. She checks on her residents every 2 hours and does not have anyone on an every 15-minute check schedule. CNA A reported she had never been asked to check on Resident #2 every 15 minutes. On 12/3/24 at 5:00 pm, the DON was shown the 15-minute monitoring records that ended on 11/29/24 at 6:45 am. When he was asked to locate additional records from 11/29/24 on, he stated he would look for the documentation. None were produced. On 12/4/24 at 10:05 am, Resident #2 was observed in her room in her bed, which is on the window side of the room. From the door, only her feet and the foot of her bed could be seen, as the room-dividing curtain was pulled almost all the way across the room. This writer sat at the nurses' station at the end of the hall in order to directly observe the room and determine if every 15-minute checks were being conducted by the nurse or any staff. LPN C, Resident #2's assigned nurse, was passing meds on the hall around the corner and out of view of Resident #2's room. Multiple staff members were observed walking up and down the hall and passing the room, but none looked in, or entered, Resident #2's room. At 10:37 am, a CNA emerged from a room on the same hall. She was carrying a tied trash bag and as she passed Resident #2's room, she turned her head as if to look in but kept walking. On 12/4/24 at 10:25 am, LPN A was interviewed, while this writer continued to watch Resident #2's room from the seat at the nurses' station. She stated she normally has about 15 residents on her assignment and checks on her residents every 15 minutes by peeking her head in. Everyone does the 15-minute checks and they are documented on the treatment administration record each shift. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24 at 10:38 am, LPN C was interviewed from the same location at the desk. She stated she was assigned to Resident #2. Rounding was done every 10 to 15 minutes to check on the resident(s) and she enters resident rooms completely during medication pass. Typically, the med pass takes an hour and a half from start to finish. She had up to 15 residents on her assignment for medication administration and covers a part of all 3 of the halls on the unit. CNAs step into resident rooms about every 10 to 15 minutes to ask if the resident needs anything and check on them. Resident #2 is on 15-minute checks so LPN C makes time to still check on her and lay eyes on her. They document on the 15-minute list that is in a binder on the med cart and also enter a progress note. When she was asked to see the checklists on her cart. LPN C looked on her cart and around the nurses' station, then eventually found a monitoring sheet. The sheet was dated for today (12/4/24) and had already been filled out for the whole day, every 15 minutes. LPN C insisted this form was from yesterday (12/3/24), and that she had noted the wrong date. No additional forms were produced. At 10:48 am, LPN C was advised that this writer had been watching Resident #2's room for 43 minutes and only 1 CNA turned her head while walking past to briefly look in. Nobody had entered the room, including LPN C. She was further advised the room-dividing curtain was closed and only Resident #2's feet could be seen from the door. LPN C acknowledged anyone could have been behind the curtain on the far side of the room and not be seen under those circumstances. She explained she checked on Resident #2 earlier this morning and she was sound asleep but was probably awake now. LPN C acknowledged it only takes a minute for someone to enter a room. When she was asked if it was feasible that nurses were solely responsible for the 15-minute checks and documentation between required nursing tasks and medication pass. LPN C admitted ly stated it was not that all staff should be assisting with that task if the physician ordered it to be done. At 10:51 pm, she accompanied this writer to Resident #2's room. The resident was still in bed and the curtain pulled. Only the resident's ankles and feet were visible until we reached the curtain in the middle of the room and looked around it. As of 12/4/24 at 1:10 pm, Resident #2's 15-minute monitoring logs after 11/29/24 still had not been located or produced.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30969 Based on record review, facility investigation report review, interviews, and facility's Quality Assurance and Performance Improvement (QAPI) policy review, the facility failed to implement it's written policies and procedures outlined in the Quality Assurance and Performance Improvement (QAPI) plan and failed to use data contributing to the Root Cause Analysis (RCA) of an adverse event to develop relevant activities to prevent similar future events. This had the potential to affect not only 1 (Resident #2) of 4 residents reviewed for resident-to-resident abuse but all cognitively impaired resident residing in or admitted to the facility. The findings include: A review of a facility federal report authored by the Regional Director of Operation (RDO) revealed on 11/9/24 at 7:00 pm, Resident #2, a [AGE] year-old female who had been admitted the day before (11/8/24), was found in bed with Resident #3, a [AGE] year-old male. Resident #2 and #3 were allegedly having sexual intercourse. Resident #2 was noted to have a brief interview for mental status (BIMS) score of 3 out of 15 points, indicating severe cognitive impairment. Resident #3's BIMS was noted as 0 in the report (indicating severe cognitive impairment). In response, both residents were placed on 1:1 supervision that same day. When assessed by the Psychiatric Practitioner on 11/10/24, Resident #2 was unable to recall the event. The same practitioner assessed Resident #3 on 11/10/24 and noted he was alert and oriented to person, place and time. Resident #3 denied any sexual activity took place. Interviews conducted with witnesses revealed the following: Licensed Practical Nurse (LPN) E stated after being alerted by the Certified Nursing Assistant (CNA) and entering the resident's room, she witnessed Resident #3 in bed with Resident #2. Resident #2 was lying on her left side with her legs pulled up near her chest. Resident 3 was behind her, naked, and actively moving as to be in the act of having sex. Resident #2 had her gown on but was naked from the waist down and her adult brief was on the floor next to the bed. LPN D stated the CNA yelled for HELP, as the two residents were having sex. After Resident #3 was asked to leave, LPN D asked Resident #2 what she was doing. The resident replied, I will **** him anytime I want. CNA C stated she heard the other CNA scream, ran to the room and saw Resident #3 naked with Resident 2. Resident #2 said she 'wanted to give him some ***** and that she is 'going to **** him whenever she gets ready to. Resident #2 referred to herself as a 'nympho. (Photographic evidence was obtained) A medical record review for Resident #2 revealed she was admitted to the facility on [DATE] and was [AGE] years old. Her primary diagnosis was chronic respiratory failure with hypoxia or hypercapnia (a condition where the lungs cannot effectively exchange oxygen and carbon dioxide (CO2) in the blood, leading to either low oxygen or high CO2 levels in the body). A review of Resident #2's Medicare minimum data set (MDS) assessment with a reference date of 11/14/24 noted she could understand others and make herself understood with a BIMS score of 6 (severe cognitive impairment). Additional diagnoses included debility, cardiorespiratory conditions, coronary artery disease, malnutrition, anxiety, psychotic disorder and depression. Discharge planning was occurring for her to return to the community after skilled care. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 was care planned on 11/10/24 for her risk for hypersexual behaviors with the goal of remaining free of such behaviors through the next review date. The interventions included one on one monitoring. On 11/19/24 the care plan focus was resolved and a new care plan developed for impaired cognitive function and thought process related to long- and short-term memory problems. The interventions was not revised to include the 15-minute monitoring checks ordered by the physician on 11/15/24. (Photographic evidence was obtained) A review of Resident #2's physician's order dated 11/9/24 noted 1:1 staff monitoring. The order was discontinued on 11/15/24 and a new order obtained for every 15-minute monitoring on each shift. (Photographic evidence was obtained) On 11/9/24, following the incident, Resident #2's BIMS was assessed by the afternoon supervisor, Licensed Practical Nurse (LPN) E, resulting in a score of 1 out of 15 points (indicating severe cognitive impairment). Resident #2 was again assessed on 11/10/24 and 11/12/24 by the Social Services Director (SSD) with scores of 9 out of 15 (indicating moderately impaired) and 6 out of 15 (indicating severely impaired) respectively. Resident #2 had a Psychiatric Encounter note dated 11/10/24 which was reflective of the facility report. In addition, it reported Resident #2 was unable to give informed consent. (Photographic evidence was obtained) A medical record review for Resident #3 found he was admitted to the facility on [DATE] and was [AGE] years old. He was discharged on [DATE]. His primary diagnosis was urinary tract infection. The electronic dashboard in his electronic record noted Resident #3 had 1:1 staff monitoring in place. A review of Resident #3's Medicare 5-day Minimum Data Set (MDS) assessment with an assessment reference date of 10/24/24 noted Resident #3 had a BIMS score of 15 of 15 points, which reflected he was cognitively intact and independent with decision making. Additional diagnoses included alcohol dependence withdrawal and history of trans-ischemic attack (stroke). Discharge planning was occurring for his return to the community. Resident #3 was care planned on 11/10/24 for his risk for hypersexual behaviors with a goal to show a decrease in behaviors by the next review date. Interventions included observing for inappropriate behaviors and redirecting/distracting, psych evaluation and treatment as needed, encourage and offer activities and 1:1 staff monitoring. He also had a physician's order for 1:1 monitoring every shift starting 11/9/24, which remained in place until his discharge. (Photographic evidence was obtained) A nursing progress note dated 11/9/24 indicated Resident #3 stated he was tired of all the questions being asked of him and that police had just been in to speak with him. Resident #3 reported nothing happened; he was just talking with Resident #2. Resident #3 had a Tele psych Encounter note dated 11/10/24 per urgent request by the Director of Nursing (DON) after patient was said to be found in a female resident's bed. The practitioner noted Resident #3 was alert and oriented to person, place and time and denied any interaction took place. He was currently on 1:1 supervision. (Photographic evidence was obtained) (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per the facility's investigation records, written statements were obtained from staff who witnessed the aforementioned event, as follows: LPN E's written statement dated 11/9/24 said she directly witnessed Resident #3 behind Resident #2, who was lying on her left side in a fetal position. Resident #3 was naked and actively moving as to be in the act of having sex. The CNA in the room yelled for him to get off of her. Resident #3 was naked from the waist down and Resident #2's brief was on the floor next to the bed. (Photographic evidence was obtained) CNA D reported on 11/9/24 she witnessed Resident #2 in bed naked from the waist down and Resident #3 was standing undressed next to her. Both residents stated they were having consensual sexual activity. Multiple staff witnessed this. (Photographic evidence was obtained) Certified Nursing Assistant (CNA) B's statement dated 11/9/24 noted she saw both residents naked and being intimate. All day she was replacing Resident #2's ripped briefs with the suspicion Resident #3 was taking them off. She ended her statement with, THE END. (Photographic evidence obtained) Registered Nurse (RN) A wrote on 11/18/24 that she heard the CNA yell down the hall from approximately 40 feet away, Hey everybody come here, this man is raping this lady. (Photographic evidence was obtained) On 12/3/24 at 2:50 pm, an interview was conducted with LPN E. She recalled the day of the event and that she had just walked in the door. She was at the nurses' station when the CNA from day shift screamed for everyone to come right now! Resident #3 was in bed with Resident #2. He was behind her and she was lying in a fetal position. They were CLEARLY having intercourse. The CNA was livid, she said she was repeatedly telling the agency nurse that shift Resident #3 was in Resident #2's room all day. Resident #2 was newly admitted . On 12/3/24 at 3:28 pm, RN A was interviewed. She recalled being at the nurses' station when CNA B called for all staff to come. RN A was in the back of the responding crowd, but when she got up to the door, saw the gentleman (Resident #3) at the foot of the bed with no pants on. The lady (Resident #2) was in a gown, and her head was at the foot of the bed. RN A added that Resident #2 was confused. On 12/3/24 at 4:50 pm, LPN D was interviewed. She stated it was shift change when the event occurred. While she actually didn't see anything, LPN D did speak briefly with Resident #3 afterward. He said, I didn't rape nobody, it was consensual. When LPN D spoke with Resident #2, the resident said she would **** anyone she wanted to and admitted to the act. In response to the incident, the facility held an Ad Hoc QAPI meeting on 11/11/24. The committee's Root Cause Analysis (RCA-a structured process to identify the root cause of an event that resulted in an undesired outcome and to develop corrective actions) noted: Problem statement: Resident (#3) found in bed with Resident (#2) Why? Resident (#2) BIMS of 9 stated she wanted to be in bed with Resident (#3). (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident (#3) BIMS of 15 and stated he didn't do anything wrong and that she invited him into her room and into her bed. Why? Residents both wanted to engage with each other and neither thought that there was anything wrong with the interaction. Both stated they are grown adults and they are allowed. Why? Upon admission the topic of intimate relations between residents is not discussed as a resident right. The rules surrounding how this can occur, if desired, is not discussed. Why? The topic is not part of the pre-admission process. Why? It has not been brought up as a needed topic. Root Cause: No explanation of intimate relations in the SNF (skilled nursing facility)/LTC (Long Term Care) setting and how that would work is not discussed with residents on admission. (Photographic evidence was obtained) Review of the facility admission log since the event from 11/10/24 - 12/4/24 revealed there had been 29 new admissions during that timeframe. (Photographic evidence was obtained) On 12/3/24 at 5:02 pm, an interview was conducted with the Regional Director of Operation (RDO). She stated the former Administrator was interim, so the RDO handled the investigation. Resident #2 was a new admit and was the one who basically invited Resident #3 into the room. She stated staff probably overreacted; since a similar incident occurred one year ago, a lot of the staff jump to conclusions about what they are seeing. Staff made some assumptions, but the residents insisted they did not have intercourse. The residents were interviewed by several people including the DON at the time, the ADON, and former Administrator. Resident #3 was admitted with a BIMS score of 3, but when they reassessed her, it was up to an 11. The Regional Nurse Consultant (RNC), also in the room, corrected her and said the score was 6. The RDO explained sometimes it appeared Resident #2 was cognitively aware. She expressed she wanted this and used all the right language. The RDO was reminded the Resident 2's BIMS score was 6, severe impairment. She agreed, saying that was pretty low. She continued, saying the residents were separated, put on increased supervision, and staff education started. The QAPI's RCA was reviewed with the RDO. She was asked if discussion about intimate relations were now being conducted with residents on admission. She stated no, they didn't decide to do anything different on admission. The RDO was asked why the contributing root cause identified by the QAPI committee was not addressed, and if she thought cognitively intact residents might hesitate before initiating sexual contact with a potentially cognitively impaired resident if they knew the difference. The RDO was asked Resident #3 if, with a BIMS score of 15, would have fully understood the risks and possibly acted differently if he knew. The RDO agreed and said education on admission was a good idea. The RNC, still in the room, argued that Resident #2 still might not have understood, even with education. They both acknowledged the probability that incoming residents with a higher BIMS might second-guess acting on impulse. The RDO stated after a similar event last year, the facility determined anyone with a BIMS score less than 9 would be unable to give consent. The RDO reviewed the RCA again, and confirmed their intent had been to add resident education to the admissions process. She said that is exactly what they should be doing; communicating with the people coming in. When asked, the RDO said she had not spoken to the Admissions Director about the plan. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24 at 11:55 am, an interview was conducted with the Admissions Coordinator. He said he did not attend the QAPI meeting on 11/9/24. Nobody had approached him about educating residents about intimacy on admission, but he does explain the rules and regulations. The education, he felt, should be handled by his marketing person while the residents were still in the hospital. On 12/4/24 at 12:00 pm, the Marketing Director was interviewed. She explained she visits potential admissions at the hospital, reviews facility information and addresses any questions. The QAPI RCA was discussed with her. She stated nobody had come to her with the information or any plan to include resident education in the pre-admission process. On 12/4/24 at 12:55 pm, during a second interview with the RDO, she explained the QAPI committee meets on the 3rd Wednesday of every month. The (new) Administrator will be the Chairperson moving forward. Key performance indicators are used to track and trend care areas in need of improvement. Once concerns are identified, the committee prioritizes them based on the facility needs. If a safety issue arose, that would be priority. A committed performance improvement project (PIP) would be proposed, and a chairperson appointed to develop and put resolution to the PIP. A RCA is always identified as part of the process. Education is provided to ensure everyone is familiar with the systematic change to improve the process. The RDO confirmed the committee's failure to address the RCA and develop a relevant PIP was an oversight after the 11/11/24 meeting. The ROD was also asked for the facility policy to prevent sexual abuse. She reviewed the Abuse and Neglect policy passage above related to establishing protocols for preventing sexual abuse. The RDO nodded her head in acknowledgement, and stated they did not have a policy. She said after the incident last year, discussions occurred with corporate leadership, but an actual policy was not developed. Review of the facility's policy Quality Assurance and Performance Improvement (QAPI) implemented 11/2020, reviewed/revised 8/8/22 found it states: Policy: It is the policy of this facility to develop, implement and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life . Policy Explanation and Compliance Guidelines section 2. states the QAA (Quality Assessment and Assurance) Committee shall be interdisciplinary and (b) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects, are necessary. (c) Develop and implement appropriate plans of action to correct identified quality deficiencies. .3. The QAPI plan will address the following elements: .c. Process addressing how the committee will conduct activities necessary to identify and correct quality deficiencies . Key components of this process include, but are not limited to, the following: .iv. Systematically analyzing underlying causes of systemic quality deficiencies. v. Developing and implementing corrective action or performance improvement activities. (Photographic evidence was obtained) (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled Abuse, Neglect and Exploitation, revised 11/2022, page 3, item III notes: Prevention of Abuse, Neglect and Exploitation, The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: A. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship. (Photographic evidence was obtained)