STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115618	A. Building B. Wing	04/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagle Health & Rehabilitation	405 S College St Statesboro, GA 30458

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 45555 Based on observation, staff interview, record review, review of the facility's policy titled, Abuse Prohibition, the facility failed to protect the residents' right to be free from sexual abuse by another resident for two of three residents (R) (R1 and R4) reviewed for abuse prohibition. Specifically, the facility failed to develop or implement interventions to address R2's sexual behavior to protect R1 and R4 from sexual abuse. Findings included: Review of the facility's policy titled, Abuse Prohibition, dated 12/27/2024, revealed the Intent section included, It is the intent of this center to actively preserve each patient's right to be free from mistreatment, neglect, abuse, or misappropriation of patient property. We believe that each patient has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The Guideline section included, . Identification of patients whose behavior is abusive to other patients. If a patient is identified in one of the following categories, a thorough assessment will be completed to include any identified situations or factors that trigger abusive behavior. Patients who have displayed or attempted to display abusive behavior toward other patients. ii. From the assessment, intervention strategies will be developed on the care plan or behavior management plan to prevent occurrences including monitoring for factors that trigger abusive behavior for this patient. iii. The care plan, including interventions, will be evaluated on a regular basis and revised as necessary. The Prevention section included, The center will identify, correct, and intervene in situations in which abuse, neglect, and/or misappropriation of patient property is more likely to occur. This will include an analysis of . The deployment of staff on each shift in sufficient numbers to meet the needs of the patients, and assure that the staff assigned has knowledge of the individual patients' care needs. 1. Review of R2's Face Sheet indicated the facility admitted the resident on 8/4/2023, and diagnoses included acute kidney failure, essential primary hypertension, moderate protein-calorie malnutrition, adult failure to thrive, muscle weakness, difficulty walking, lack of coordination, and unsteadiness. Review of R2's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/5/2024, revealed R2 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS indicated the resident did not have any behaviors during the seven-day look-back assessment period. (continued on next page)

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.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R2's Care Plan included care area/problem, with an onset date of 4/30/2024, that indicated the resident had inappropriate sexual behaviors of touching themself in public areas. Interventions instructed staff to administer medications for a clearly defined goal aimed at a specific target for which the drug was effective, assess patterns of behavior with a behavior monitoring tool, communicate face to face with simple descriptive statements, identify self with each contact, involve the person in activities based on their preferences and cognitive functioning, maintain a tolerant, calm manner, make sure the resident had adequate personal space and safe space to move about, provide privacy appropriate to maintain self-esteem, reward and reinforce positive behaviors, and to talk with the person, not at the person. There was no documented evidence that the facility developed/implemented a care plan for R2's potential for sexual abuse and/or sexually inappropriate behaviors toward other residents, with interventions to protect other residents from further potential sexual abuse. Review of R2's Nurses Note, dated 2/28/2024, indicated a day shift certified nursing assistant (CNA) stated she was attempting to assist R2 with getting changed into a clean incontinence brief, when the resident started rubbing the CNA's leg and became aroused, making the CNA uncomfortable. Review of a facility's 24-Hour Report log dated 4/1/2024 indicated that, during the night shift, R2 displayed inappropriate sexual behavior toward staff. Review of R2's 2's April 2024 electronic medication administration record (eMAR) revealed that medroxyprogesterone acetate (a medication used to decrease testosterone production, which may decrease sexual urges) 5 milligrams (mg) one tablet by mouth one time a day was ordered on 4/1/2024 for sexual dysfunction not due to a substance or known psychological condition. The eMAR revealed that staff documented the medication was administered to R2 beginning 4/2/2024 and was administered daily in the month of April 2024. Review of R2's Behavior Monitoring from 4/1/2024 through 4/30/2024 revealed the facility was monitoring the resident for inappropriate sexual behaviors daily. According to the monitoring: -R2 had two episodes of inappropriate sexual behaviors during the day shift on 4/6/2024, where the resident was redirected with no change. -R2 had two episodes of inappropriate sexual behaviors during the day shift on 4/7/2024, where the resident was redirected with a positive outcome. -R2 had two episodes of inappropriate sexual behaviors during the night shift on 4/7/2024, where the resident was redirected with no change. -R2 had two episodes of inappropriate sexual behaviors during the night shift on 4/11/2024, where the resident was redirected with no change. Review of a Social Note dated 4/15/2024 indicated a referral for psychiatric services was made. Review of R2's Nurses Note, dated 4/22/2024 at 11:30 am, indicated Licensed Practical Nurse (LPN) 4 documented that another resident observed R2 masturbating while rubbing R1's leg while in a day room with several residents present. The note indicated that the resident who observed the incident got the attention of a staff member, who also witnessed the incident. The note indicated R2 was redirected and taken to their room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Nurse Practitioner (NP) Progress Note dated 4/25/2024 indicated nursing staff and other residents reported R2 was masturbating in multiple common areas. The note indicated the resident started medroxyprogesterone on 4/1/2024, with a plan for as-needed Ativan and scheduled Seroquel with a new diagnosis of dementia with behavioral disturbances. The note revealed that R2's behavior typically started occurring at 3:00 pm, and the plan was to schedule Seroquel 25 mg at 3:00 pm. Review of a Psychiatric Diagnostic Evaluation dated 5/2/2024 revealed R2 received a psychiatric evaluation with medication and monitoring recommendations and a follow-up in one to three months. Review of a Behavior Health Evaluation document dated 5/7/2024 revealed R2 received a psychological services evaluation. Observation of R2's Resident's Consolidated Order revealed a physician's order dated 10/26/2024 for medroxyprogesterone 150 mg per milliliter (mg/mL) intramuscular (IM) every month on the 26th at bedtime. Review of R2's November 2024 eMAR revealed the end date for the order for medroxyprogesterone 5 mg by mouth was 11/14/2024. Review of R2's November 2024 and December 2024 eMAR indicated the diagnosis for the use of medroxyprogesterone was sexual dysfunction not due to a substance or known physiological condition; however, there was no documented evidence that staff administered medroxyprogesterone in November 2024 or December 2024. Review of a Patient Education note, dated 1/28/2025, indicated a social services director, accompanied by a CNA, spoke with R2 regarding inappropriate sexual behaviors. The note revealed R2 was educated that there was nothing wrong with exposing their privates in the privacy of their room; however, a public place, such as the living room and dining area, was not the place to expose themself. The note revealed R2 stated, I can not say I didn't do that, but I promise I will not do it again. The note revealed that the social service director expressed to the resident that if anyone felt they were being approached or harassed inappropriately as a result of the resident's actions, it would warrant calling the police. Per the note, the social service director conversed with a nurse who noted that the resident was placed on medication for inappropriate sexual behavior. Review of R2's clinical record revealed a document dated Every 15-minute Check Sheet dated 2/13/2025 to 2/16/2025, documenting no behaviors. Observation on 4/3/2025 at 2:29 pm revealed R2 sat in a wheelchair in their room. No inappropriate behaviors were observed. Observation on 4/4/2025 at 10:55 am revealed R2 sat in a wheelchair in the hallway outside their room. The resident provided non-sensical answers to questions that were posed. No inappropriate behaviors were observed. Observation on 4/5/2025 at 11:56 am revealed R2 sat in a wheelchair by the nurses' station. During the observation, no other residents were in the area, and no inappropriate behaviors were observed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of R1's Face Sheet indicated the facility admitted the resident on 2/11/2022, and diagnoses included diagnoses of Rett's syndrome (a genetic brain disorder), idiopathic scoliosis (curve of the spine from an unknown cause), and cognitive communication deficit. Review of R1's annual MDS, with an ARD of 2/6/2024, revealed R1 had severe impairment in cognitive skills for daily decision-making per a staff assessment of mental status (SAMS). Review of R1's Care Plan included a care area/problem dated 2/10/2025 of limited mobility as evidenced by decreased range of motion and contractures. Review of a handwritten note included with the facility's investigation revealed that a social visit was completed with Resident 1 on 5/8/2024, 5/23/2024, and 6/4/2024, and the resident displayed no signs of distress. Observation of R1 on 4/3/2025 at 2:27 pm revealed the resident was in a geriatric chair in a living room with other residents. The resident's eyes were closed, and the resident did not respond when spoken to. Observation of R1 on 4/4/2025 at 10:48 am revealed the resident sat in a geriatric chair in a living area with other residents. R1 opened their eyes when their name was vocalized, but did not answer any questions. Observation of R1 on 4/5/2025 at 11:27 am revealed the resident sat in a geriatric in a living area. The resident was not able to answer any questions. 3. Review of R4's Face Sheet revealed the facility admitted the resident on 12/06/2024, and diagnoses included need for assistance with personal care, cognitive communication deficit, muscle weakness, and Alzheimer's disease. Review of R4's admission MDS, with an ARD of 12/12/2024, revealed the resident had a BIMS score of 3, which indicated severe cognitive impairment. Per the MDS, R4 understood others and was usually understood (difficulty communicating some words or finishing thoughts, but was able if prompted or given time). Review of R4's Care Plan revealed a care area/problem dated 1/3/2025 that indicated the resident had cognitive impairment as evidenced by short- and long-term memory problems, severely impaired decision making, and poor decision making/need for cues. Review of the facility's investigation summary report dated 5/7/2024 indicated a resident of the facility reported to a staff member that they observed R2 with their hand down their pants in the facility's living room, apparently masturbating while rubbing the leg of R1. The report revealed the staff member proceeded immediately to the living room and found R2 had their hand down their pants and was sitting next to R1, but did not see the resident rubbing R1's leg. Further review of the report revealed that interviews with other residents and staff revealed R2 had been observed touching himself in his room and in shared areas, but had not been observed touching other residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a handwritten witness statement by Scheduling Coordinator (SC) 5, with a corrected date of 4/22/2024, revealed SC5 was traveling a hallway when R5 called her into a living room area. The statement revealed that R5 stated that R2 was masturbating as the resident was rubbing up and down on R1's leg. The statement indicated that when SC5 got into the living room, R2 had their hand in their pants. Per the statement, the staff member took the resident to the nurses' station and reported the incident to a charge nurse. Review of a facility investigation summary report dated 2/20/2025 revealed that on 2/13/2025, a staff member observed R2 rubbing R4's upper, inner thigh while the residents were in a living room. The report revealed that staff separated the residents. Further review revealed that staff assessed both residents for signs of distress, including skin assessments, and there were no concerns. The Administrator notified local law enforcement. The investigation documented that resident-to-resident abuse was unsubstantiated. During an interview on 4/3/2025 at 4:14 pm, SC5 stated R5 summoned her and told her that R2 had their hand in their pants, masturbating while touching R1. She stated she went into the living room and saw R2 sitting next to R1 with their hand in their pants, but she did not see R2 touching R1. She stated she immediately removed R2 from the living area and took them to their room. During an interview on 4/4/2025 at 2:39 pm, LPN14 stated she walked into a television room to check on the residents and saw that R2 had their hand rubbing the other resident's inner upper thigh. She stated she separated the residents, assessed R4 physically and mentally, notified the physician, and received an order for Paxil for R2. She stated R2 was also placed on every 15-minute checks. She stated staff continued to monitor R2 if the resident was out of their room and tried to keep the resident by the nurses' station, noting if R2 was in the television room, she checked on them every 15 minutes and kept R2 at a distance from other residents. During a phone interview on 4/5/2025 at 9:58 am, CNA11 stated she had witnessed R2 touching a female resident's feet while the resident slept on the couch, and she reported the incident to a charge nurse. She stated she had not been told to do anything specific for R2, but when she saw the resident in a public place, she kept her eyes on the resident and kept a distance between R2 and other residents. During a phone interview on 4/5/2025 at 10:07 am, CNA12 stated she had witnessed R2 moaning while their hands were in their pants, but it was not in public. She stated the facility told her that when the resident was not in their room, they were to be monitored. During an interview on 4/5/2025 at 11:11 am, Certified Medication Aide (CMA)8 stated he had seen R2 with their hands in their pants in their room, but not in public. He stated he was told that R2 should not be alone with other residents. He stated he watched R2 whenever they were out of their room. During an interview on 4/5/2025 at 11:18 am, CNA10 stated she had seen R2 touching another resident's feet and told them to stop, but then saw the resident do it again, so she moved R2 away from any other residents in the common areas. She stated the facility had told her not to isolate R2, but to keep them several feet away from other residents, noting the resident had to be in an area in their line of sight. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/5/2025 at 11:30 am, CNA 9 stated she had never witnessed an actual incident, but the facility told her to keep an eye on R2 frequently when the resident was out of bed and in a common area. She stated that staff made sure that R2 was not close to another resident and was kept at a safe distance away. During an interview on 4/5/2025 at 1:53 pm, the Social Service Assistant (SSA) stated she did not witness any of the incidents involving R2. She stated she conducted post-incident resident interviews, referred the residents for psychiatric services, and did well checks afterwards. She stated that the facility discussed all the incidents during a morning meeting. The SSA stated staff should monitor R2 and redirect them, and those interventions should be care-planned. During an interview on 4/5/2025 at 2:48 pm, the DON stated LPN14 met her in the hallway and said R2 was touching R4 inappropriately. She stated she called the Administrator to let him know, then went to determine what interventions they could put in place. She further stated she wanted to send R2 out for stabilization, but the PCP spoke with the psychiatric nurse practitioner, and they decided to start Paxil, so she put the resident on every-15-minute checks. The DON stated that staff had been instructed to separate R2 from other residents if the resident was close to them and that staff knew they should keep an eye on R2 whenever the resident was in a common area. In a continued interview, the DON stated she was aware that R2 did not receive the medroxyprogesterone injection in November 2024 but thought that the December 2024 dose was administered. During an interview on 4/5/2025 at 3:11 pm, the Administrator stated another resident alerted a staff member and told them what they witnessed. Per the Administrator, the staff member saw R2 with their hands down their pants, but the resident was not touching R1. The Administrator stated R1 was not a reliable historian, noting the facility conducted a head-to-toe assessment of R1 and assessed for any changes in behavior. The Administrator stated the facility initiated a behavior assessment, updated R2's care plan, and R2 was seen by psychiatric services on 5/3/2024. The Administrator stated that the primary care provider (PCP) conducted a medication review and gave new orders, and the facility was monitoring behaviors. He stated that social services also spoke with R2 about appropriate places in the facility for masturbating. Further, the Administrator stated they instructed staff to observe R2 when in public places to prevent a recurrence. During the continued interview, the Administrator stated LPN14 identified R2 in the living room rubbing R4's thighs. He stated LPN14 redirected R2 out of the room, assessed R4 for physical and mental distress, notified the DON and the physician, and placed R2 on every 15-minute checks for 72 hours. He stated R2's care plan was reviewed, and they assessed environmental factors, but no new interventions were initiated that he was able to see. He stated was unaware that R2's medroxyprogesterone was not administered in November or December of 2024. Per the Administrator, R2 was able to be up and about and could go wherever they wanted, but when R2 was mobile, they tried to make frequent observations, especially in common areas. He stated they could not tell the resident that they could not go to a common area, but they monitored the resident, including where they were and what they were doing, and redirected if needed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/6/2025 at 10:45 am, the Medical Director (MD) stated R2 was started on medroxyprogesterone due to having inappropriate behaviors with the staff. He stated he was aware that the IM medroxyprogesterone was not administered in November 2024. He stated he believed that the symptoms were well controlled, and he did not want the medication given too close to the next dose. The MD stated he was not aware that the resident did not get the dose in December of 2024. He stated he spoke with the psychiatric NP, and they decided together that the IM medroxyprogesterone was not completely effective, and the resident needed something more, so they added Paxil.

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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. 45555 Based on staff interviews, record review, and facility document review, and review of the facility's policy titled, Abuse Prohibition-Reporting and Investigating, the facility failed to ensure allegations of sexual abuse for three of three residents (R) (R1, R3, and R4) reviewed for abuse prohibition were reported to the state survey agency (SSA) no later than two hours after the allegations were made. Findings included: Review of the facility's policy titled, Abuse Prohibition-Reporting and Investigating, dated 12/27/2024, revealed the Guidelines section included, Any person hearing a complaint of abuse, corporal punishment, involuntary seclusion, neglect, mistreatment, misappropriation of patient property, or exploitation must immediately tell the Administrator, the Director of Nursing, the Social Services Director, any specific department leader, or the nurse in charge. Any person identifying any signs and symptoms of abuse as listed in the Abuse Prohibition policy related to a specific patient is responsible to immediately inform the Administrator, the Director of Nursing, the Social Services Director, any specific department leader, or the nurse in charge. All allegations of abuse or allegations involving serious bodily injury must be reported immediately, but no later than 2 hours. The Administrator or designee will notify the Complaint Investigation Intake and Referral Unit and the legal representative and/or responsible party of the incident and the pending investigation. 1. Review of a handwritten witness statement by Scheduling Coordinator (SC) 5, with a corrected date of 4/22/2024, revealed SC5 was traveling a hallway when R5 called her into a living room area. The statement revealed that R5 stated that R2 was masturbating as the resident was rubbing up and down on R1's leg. The statement indicated that when SC5 got into the living room, R2 had their hand in their pants. Per the statement, the staff member took the resident to the nurses' station and reported the incident to a charge nurse. Review of R2's Nurses Note, dated 4/22/2024 at 11:30 am, indicated Licensed Practical Nurse (LPN) 4 documented that another resident observed R2 masturbating while rubbing R1's leg while in a day room with several residents present. The note indicated that the resident who observed the incident got the attention of a staff member, who also witnessed the incident. The note indicated R2 was redirected and taken to their room. During an interview on 4/03/2025 at 4:07 pm, LPN4 stated that she was notified of the incident with R2 and documented the incident in nursing notes. Per LPN4, she also notified the Administrator of the incident. Review of a Facility Incident Report Form, dated 4/30/2024, indicated R2 was observed touching another resident on the leg in a potentially unwanted manner. Further review of the report revealed the number was Not available at this time and no other agencies [were] involved. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/4/2025 at 12:43 pm, the Administrator stated he found out about the incident on 4/30/2024 while reviewing R2's chart for something unrelated. He stated he saw the note that LPN 4 had written. According to the Administrator, staff did not tell him about the incident. Per the Administrator, after speaking with LPN4 and SC5, each staff member thought the other was going to report the incident. During an interview on 4/5/2025 at 3:11 pm, the Administrator stated he reported the incident to the SSA on 4/30/2025. 2. Review of the Concern Manager Grievance Intake Form, dated 1/16/2025 and written by the Healthcare Navigator for Skilled Nursing Services (HNSNS), indicated that at approximately 12:00 pm, she observed R3 and R2 alone in a community room. The form indicated R3 was in distress and calling out for assistance. The form revealed that when the HNSNS went in to speak to R3, the resident was pointing to their genital area. Review of the Facility Incident Report Form, dated 1/16/2025, indicated R3 expressed to staff that R2 touched them without permission. According to the report form, the time of the incident was 2:50 pm, not approximately 12:00 pm as documented on the Concern Manager Grievance Intake Form. Review of an email from the SSA to the facility Administrator, dated 1/16/2025 at 4:50 pm, revealed the SSA had received the facility's incident report. During an interview on 4/4/2025 at 11:37 am, the HNSNS stated she reported the incident to a nurse on duty. She stated the Administrator was not in the building, so she called him to inform him about the incident. The HNSNS stated the Administrator asked LPN13 to interview R3 and write a statement. During an interview on 4/05/2025 at 11:00 am, the HNSNS stated she did not see anything happen with R3, but knew that something was not right because of how upset the resident was, which was not their normal behavior. She stated she took the resident to Certified Nursing Assistant (CNA) 9, and CNA 9 told her she needed to report it to the Administrator right away, so she called him. She stated the Administrator thanked her for letting him know, but did not give her any instructions. During an interview on 4/4/2025 at 11:39 am, LPN 13 stated that the HNSNS witnessed the incident and removed R2, then told the Administrator. She stated the Administrator and Director of Nursing (DON) were not in the building at that time, and the Administrator called her and told her to start conducting interviews. A follow-up interview on 4/5/2025 at 11:25 am, LPN 13 revealed that the Administrator had notified her of the incident via phone, but she did not remember what time she had spoken with the Administrator. During an interview on 4/5/2025 at 11:49 am, the SC revealed she was present when LPN 13 was interviewing R3, noting the resident stated that they were being touched while in the living room. She stated the incident occurred between 12:00 pm and 12:15 pm. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/5/2025 at 2:48 pm, the DON stated she and the Administrator were at training, and she was not involved with the associated investigation. She stated staff should report any suspected abuse to the supervisor immediately, and they had two hours from the time it was observed or reported to report the incident to the SSA. During an interview on 4/5/2025 at 3:25 pm, the Administrator stated he received a call from the HNSNS at lunchtime. Per the Administrator, the HNSNS reported that she saw R3 and R2 in the living room, and R3 was upset. He stated R3 was in distress for some reason, and the HNSNS removed R2 from the area. He stated nothing immediately struck him as suspicious because the resident got upset at times for reasons like the television being too loud. The Administrator stated he had asked a nurse to talk to R3. He stated that when LPN13 spoke with the resident, they called him back, and he reported the allegation to the SSA. He stated he considered the event to have occurred when R3 communicated to LPN13 that something had happened. The Administrator also stated that he documented in the report the time that the incident was reported to him. 3. Review of a handwritten witness statement by LPN14, dated 2/13/2025, indicated that at 11:35 am, she observed R2 rubbing between R4's thighs. The statement indicated that the Director of Nursing (DON) and the physician were notified. Review of a Facility Incident Report Form, dated 2/13/2025, indicated staff observed R2 touching R4 in a potentially unwanted manner. Further review of the report indicated the incident occurred on 2/13/2025 at 1:00 pm. The report did not have the date and time the SSA was notified of the allegation. However, an email from the SSA to the facility administrator dated 2/14/2025 at 2:40 pm indicated the SSA received the facility's incident report. During an interview on 4/4/2025 at 2:39 pm, LPN14 stated she walked into a television room to check on the residents and saw that R2 had their hand rubbing another resident's inner, upper thigh. LPN14 stated she reported to the DON right after it happened. During an interview on 4/5/2025 at 2:48 pm, the DON stated LPN14 met her in the hallway and reported that R2 was touching R4 inappropriately. She stated she had notified the Administrator by telephone call immediately. The DON stated staff should report any suspected abuse to the supervisor immediately, noting they had two hours from the time it was observed or reported to report the incident to the SSA. During an interview on 4/5/2025 at 3:52 pm, the Administrator stated LPN14 identified R2 in the living room rubbing R4's thighs. He stated the nurse notified the DON and the physician. He stated he thought it was the DON that called him at 12:37 pm to notify him. He further stated that once he was notified, he contacted his clinical consultant to see if it should be reported. He stated he had asked the DON to get more information, and she had LPN14 document a detailed statement. He stated he found out later that the incident needed to be investigated and reported. He stated he documented that the incident occurred at 1:00 pm on the incident form because he was trying to do the report while he was mobile. He agreed that the witness statement indicated the event happened at 11:35 am. The Administrator confirmed that once he was notified of an allegation, he had two hours to report to the SSA.