

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235250	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER Adira Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 State St Saginaw, MI 48602	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668</p> <p>This Citation pertains to Intake Number MI00146372.</p> <p>Based on interview and record review, the facility failed to implement and operationalize abuse prohibition policies and procedures to ensure adequate supervision to prevent non-consensual sexual behaviors and actions for two residents (Resident #705 and Resident #706) of five residents reviewed for abuse.</p> <p>This deficient practice resulted in a lack of timely reporting and comprehensive investigation of abuse allegations, a lack of supervision to prevent non-consensual sexual actions between cognitively-impaired residents in the locked Dementia Unit of the facility. Resident #705 and Resident #706 were found partially naked in bed with genitals exposed by staff. Resident #705 was displaying ongoing inappropriate sexual behaviors with the likelihood for psychosocial distress using the reasonable person concept.</p> <p>Findings include:</p> <p>Review of Facility Reported Incident (FRI) documentation dated as received 7/11/24 at 3:38 PM and Facility Investigation Report received on 7/18/24 at 5:58 PM revealed Resident #705 and Resident #706 were found in Resident #706's room in bed on 7/9/24 at approximately 11:00 PM with their pants off. Per the submitted documentation, the facility Administrator and Director of Nursing (DON) were informed of the incident on 7/11/24 by Unit Manager Licensed Practical Nurse (LPN) B who had worked the previous two night shifts. The FRI report detailed an investigation was initiated on 7/11/24 and LPN B received education related the importance of timely reporting of abuse allegations.</p> <p>Facility investigation documentation pertaining to Resident #705 and Resident #706 was requested from the DON on 9/17/24 at 9:45 AM.</p> <p>A review of the facility-provided Resident room list on 9/17/24 revealed Resident #706 no longer resided in the locked dementia unit of the facility.</p> <p>Resident #705:</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review revealed Resident #705 was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included bipolar disorder, major depressive disorder, disorganized schizophrenia, and dementia with anxiety. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired. The Brief Interview for Mental Status (BIMS) score was 8 out of 15. Resident #705 required supervision-to-partial assistance for ambulation, toileting, personal hygiene, and dressing. The MDS further indicated the Resident displayed no behaviors.</p> <p>Further review of Resident #705's Electronic Medical Record (EMR) revealed Resident #705 was deemed to be a Legally Incapacitated Individual by reason of mental illness, mental deficiency, and physical illness or disability and was impaired to the extent of lacking sufficient understanding or capacity to make or communicate informed decisions and unable to make their own medical decisions. The Resident had a court appointed legal guardian.</p> <p>On 9/17/24 at 10:33 AM, Resident #705 was observed in their room in the facility. The Resident was in bed with their eyes closed.</p> <p>An interview was completed with Resident #705 on 8:20 AM in their room. When asked questions, Resident #705 responded slowly. The Resident had a flat affect, was confused, and displayed disorganized thought processes.</p> <p>Review of Resident #705's EMR revealed the following progress note documentation:</p> <p>- 7/15/24: Psychiatric Evaluation & Consultation . This nursing home psychiatric visit was conducted in person . pertinent psychiatric history of schizophrenia and dementia . Facility staff reported . that she was found in bed with a male resident. Neither of them were wearing pants . was sent to the ED .</p> <p>- 7/26/24 at 7:42 PM: Staff reported that resident walked from bedroom to dining room with pants down under buttocks, aide attempted to help her get pants up. Resident went to restroom in hallway after telling staff that she had to use the restroom. She was left to do her business, when she opened restroom door trying to tell another resident (male) to join her in restroom .</p> <p>- 7/29/24 at 4:19 PM: Social Services . This writer followed up with resident on this date. Resident expressed that she had invited another resident to do it, but then decided that she would not. Resident was reminded of appropriate behaviors and the importance of personal space. Resident voiced that she would not invite a male resident into the bathroom with her again. Reminded resident of appropriate behaviors .</p> <p>- 8/26/24: Psychiatric Evaluation & Consultation . has dementia and reported struggling with a down mood, along with difficulty controlling her worries and impulses. These challenges are impacting her emotional well-being and day-to-day functioning .</p> <p>- 7/29/24: Psychiatric Evaluation & Consultation .This nursing home psychiatric visit was conducted in person . Facility staff reported . that she came out of her room and invited a male resident into the bathroom with her. When staff redirected her, she stated, 'well we were gonna have sex, but we didn't' .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>There were no nurses notes in Resident #705's EMR related to the incident on 7/9/24.</p> <p>Review of Resident #705's care plans revealed a care plan entitled, I have exhibited behaviors of offering intercourse with other resident (Initiated and Revised: 7/30/24). The care plan included the interventions:</p> <ul style="list-style-type: none"> - Divert attention. Remove from situation and take to alternate location as needed (Initiated: 7/30/24) - Encourage to express feelings appropriately (Initiated and Revised: 7/30/24) - If observed unclothed redirect to resident's room and assist with re-dressing resident (Initiated: 7/30/24) - Monitor behavior episodes and attempt to determine underlying cause and document (Initiated: 7/30/24) - Redirect if I attempt to inappropriately invite other residents into personal areas, such as my room and bathroom (Initiated: 7/30/24) <p>Another care plan entitled, I have impaired cognitive function/dementia or impaired thought processes r/t (related to) Dementia as evidenced by poor recall, poor calculations, poor insight, and impaired decision making (Initiated: 7/12/24; Revised: 7/30/24). This care plan included the intervention, Cue, reorient and supervise as needed (Initiated: 7/12/24).</p> <p>Resident #706:</p> <p>Record review revealed Resident #706 was a [AGE] year-old male who was originally admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease and dementia. Review of the MDS assessment dated [DATE] revealed that the Resident was severely cognitively impaired (BIMS score 4 out of 15) and required set-up assistance with bathing, toileting, dressing, and personal hygiene.</p> <p>Further review of Resident #706's EMR revealed the Resident was deemed incompetent due to advanced Alzheimer's and dementia.</p> <p>An interview was completed with Resident #706 on 9/17/24 at 10:15 AM. The room door was closed. Upon knocking and entering, Resident #706 was observed sitting on their bed, alone in their room. Resident #706 was pleasant, very confused, and unable to provide meaningful responses to questions related to their stay in the facility.</p> <p>Review of Resident #706's EMR revealed the following documentation:</p> <ul style="list-style-type: none"> - 6/28/24 at 3:08 PM: Social Services . Late Entry: IDT met for review. Resident has had behaviors of exit seeking . attempting to take female residents into room . Resident has dementia and is not oriented to situation. Resident states that he does not understand where and why he is here. Resident is not easily redirectable. Family is aware . <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- 7/8/24 at 1:52 PM: Nursing/Clinical . Spoke with his (family) and explained the male female situation . She stated she is going to bring a sign for his door that says no girls allowed.</p> <p>- 7/8/24 at 1:48 PM: Nursing/Clinical . Patient had a female come into his room alone and shut the door . immediately went into the room and got her out of the room. They were across from each other and were not touching. Updated DON regarding situation . Educated the (female) pt (patient) (Resident #706) about going into males room .</p> <p>- 7/15/24: Psychiatric Evaluation & Consultation . Depression . nonexistent . found in bed with a female resident. Neither of them were wearing pants. His room was moved and he has a 1:1 sitter in place. He continues to have sexually inappropriate behavior, asking the sitter to play strip poker. Given this worsening, he would benefit from the addition of Paxil (antidepression medication with known side effects of decreasing sex drive and erectile dysfunction) to aid in blunting his sexual impulses.</p> <p>There were no nurses' notes in Resident #706's EMR related to the incident on 7/9/24.</p> <p>Review of Resident #706's Census documentation revealed the Resident was moved out of the locked dementia unit of the facility on 7/11/24.</p> <p>The EMR revealed documentation that Resident #706's family did not want females allowed in the Resident's room in May 2024.</p> <p>Review of Resident #706's EMR revealed a care plan entitled, have behaviors of . exit seeking, wandering, and agitation, related to my dementia with agitation . I attempt to bring female residents into my room and close the door . (Initiated: 3/6/24; Revised: 8/6/24). The care plan included the interventions:</p> <ul style="list-style-type: none"> - Please redirect when I attempt to bring female residents into my room (Initiated: 6/28/24) - Separate me and distance me from other female residents (Initiated: 7/12/24) <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with Licensed Practical Nurse (LPN) C on 9/17/24 at 11:11 AM. When queried if they were working when Resident #705 and Resident #706 were found in Resident #706's bed with their pants off, LPN C verbalized the Residents were found on night shift and they work day shift. LPN C then revealed they heard about the incident when they came to work the following morning. When asked if either Resident was placed on a one-to-one and/or separated following the incident, LPN C revealed Resident #706 was moved out of the Dementia Unit but not until a few days later. LPN C was then queried regarding Resident #705 and Resident #706's interactions and behaviors prior to the incident and stated, They would sit outside his room a lot. LPN C pointed out the room that Resident #706 resided in when they were in the locked dementia unit. Three regular chairs were sitting in the hallway next to the wall by the doorway to the room that Resident #706 had resided in. LPN C stated, (Resident #705) was very eyes on (Resident #705). LPN C revealed Resident #705 was territorial towards Resident #706 and wanted to be around him. LPN C stated, If (Resident #706) would come out of their room, she would go to where he was. When asked if Resident #706 seemed interested in Resident #705, LPN C revealed Resident #706 was kind of a ladies' man and was good as long as he was accompanied by a lady. When asked what they meant, LPN C revealed there was a different female resident who had moved out of the Dementia Unit that Resident #706 was friends with and who would come back to the unit to eat lunch with Resident #706. When queried if Resident #706 had displayed any sexual behaviors with that female resident, Resident #705, or with any other female residents, LPN C indicated they believed it was more about companionship to Resident #706. When asked if Resident #705 had displayed any sexually-focused behaviors prior to the incident involving Resident #706, LPN C revealed the only behaviors they noted was that they were focused on Resident #706.</p> <p>Facility investigation documentation pertaining Resident #705 and 706 was received on 9/17/24 at 12:30 PM. The investigation included a Five Day Investigation Summary which detailed an abuse investigation was initiated on 7/11/24. Per the summary, Social Services Director A went to speak to Resident #705 on 7/11/24 and Resident #705 told them that another resident invited her into his room, shut the door, and attempted to force her but was not successful. Director A notified the Administrator and DON who proceeded to interview Resident #705. The Administrator and DON interviewed Resident #705. When told they wanted to ask about what they had told Director A, Resident #705 verbalized they did not want to get in trouble or get anyone else in trouble and then stated, I was raped he raped me. The summary detailed, (Resident #705) did not appear upset nor tearful and was without alteration from her baseline. Resident #705 stated it was consensual at first, then she stated it was getting rough and it hurt. She stated she had a bruise on her thigh from the event. Resident #705 stated it had happened about a week ago. LPN B completed a skin assessment and a nickel sized purple bruise was observed on Resident #705's left knee and Resident #705 stated, I fell at my mom's house today. The Police were notified on 7/11/24 at 2:30 PM, and Resident #705 was taken to the Emergency Department for evaluation. The summary indicated Resident #705 told different versions of what occurred to Emergency Department staff. A pelvic examination was completed in the Emergency Department and no signs of sexual assault were noted. The summary revealed a 1-to-1 (staff member) was assigned to Resident #706 following notification of the allegation on 7/11/24 and the Resident was moved out of the locked Dementia Unit. The summary further detailed, A review of the cameras show (Resident #705) voluntarily went to (Resident #706's) room but did not include timeframes. The summary specified, The facility acknowledges that (Resident #705 and Resident #706) were observed partially nude but cannot substantiate sexual activity took place. In conclusion, the facility does not substantiate this allegation.</p> <p>A police report/number, staff schedule, Incident and Accident (I and A) report, and/or detailed camera timeline were not present in the provided investigation documentation.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At 12:58 PM on 9/17/24, a request to review the facility camera video footage of the incident involving Resident #705 and 706 was made via email to the DON.</p> <p>An interview and review of the investigation documentation was completed with the Administrator on 9/17/24 at 1:10 PM. When queried regarding the Head to Toe Assessment form with no date/time and/or identifying resident information on it, the Administrator reviewed the document and stated, How can I prove to you that this is (Resident #705's), I can't other than it should be in (the EMR). When queried why male genitalia was checked on the form, the administrator stated, Must be (Resident #706's) then, I don't know. I just shoved everything in the file. The Administrator was queried regarding LPN B and revealed they worked as a staff nurse in the Dementia Unit and were no longer a unit manager. When queried if LPN B immediately reported to them or the DON that Resident's #705 and 706 were found partially naked in Resident #706's bed, the Administrator responded, No. With further inquiry, the Administrator verbalized the incident should have been reported immediately and that LPN B was educated regarding abuse reporting. When queried why the education was not included in the investigation file, an explanation was not provided. The video camera footage from the Dementia Unit on 7/9/24 was requested for review at this time and the Administrator verbalized they would look but were not sure if the footage was still available to view. When asked if an Incident and Accident report was completed as it was not included in the investigation documentation, the Administrator indicated they would provide the I and A. The actual schedule of who was working on 7/9/24 was also requested at this time.</p> <p>An interview was conducted with Certified Nursing Assistant (CNA) D on 9/17/24 at 1:56 PM. When queried if they were working on 7/9/24 when the incident occurred involving Resident #'s 705 and 706, CNA D replied, Yes, I was working. CNA D was asked what had occurred and stated, So we come in and started changing people (residents) because they was wet. When queried if they were saying the resident's had been incontinent and needed incontinence care, CNA D confirmed. CNA D continued, (CNA E) came to me and said (Resident #705 and Resident #706) were butt naked in the room. When asked what happened next, CNA D revealed they got (LPN B) and stated, I went in (the Resident room) with the nurse. (Resident #705) kept saying they weren't doing nothing. (Resident #705 said,) He's my friend and I love him. (Resident #706) didn't say anything. CNA D was queried where the Residents were in the room and stated, They were laying side by side in bed with their sides touching. When asked to clarify the position of the resident, CNA D stated, They were laying on their backs and her chin and head on his shoulder. CNA D revealed both Resident's briefs were down by their ankles. When queried if the Resident's genitals were exposed, CNA D indicated they were but revealed Resident #706 attempted to cover his penis with his hand. When queried if they received any education following the incident, CNA D stated, They said we need to check all the rooms first to ensure they know where residents are prior to providing incontinence care. CNA D was then asked what time their shift starts and replied, 10:00 PM. When asked what time they found Resident #705 and Resident #706, CNA D responded, Not sure honestly and revealed it was probably around 11:00 PM. CNA D revealed CNA E started at the room and the end of the hall and Resident #706's was closest to the entrance and the last room CNA E checked. When queried regarding staffing levels at the time of the incident, CNA D stated, Two aides (CNA's) and a nurse working.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>When asked what happened next, CNA D revealed they assisted the Residents and got Resident #705 out of the room. CNA D then stated, (LPN B) immediately texted (the Administrator). When queried if they noticed anything else in the room, CNA D stated, The bed wasn't wet and Resident #706 did not have an erection. CNA D stated, (Resident #706) didn't even say anything and I could tell that he was embarrassed. With further inquiry, CNA D stated, (Resident #705) never said anything about rape. She was immediately like we weren't doing nothing. When queried where Resident #705 and Resident #706's pants were in the room, CNA D was unable to recall. When queried if they had observed either resident display any sexual behaviors prior to the incident, CNA D revealed Resident #705 was very attached to Resident #706 and always wanted to be around him. When asked if Resident #706 was attached to Resident #705 in the same way, CNA D indicated he was not and revealed all the female residents that Resident #706 could converse with would just [NAME] to him. CNA D revealed Resident #706 liked to talk.</p> <p>On 9/17/24 at 2:41 PM, an interview was completed with CNA E. When queried if they recalled the incident involving Resident #'s 705 and 706 on 7/9/24 and, CNA E confirmed they did. When asked what transpired, CNA E revealed they arrived to work at 10:00 PM and started checking on Residents. CNA E indicated they started at the end of the hallway, furthest from the entrance door of the locked unit. CNA E stated, When I opened (Resident #705's) bedroom, they were not in their room. I told the nurse that she wasn't in their room. CNA E continued, When I opened (Resident #706's) door, they were both naked in bed. I turned on the light and then shut it off, closed the door and told the nurse. CNA E was asked if Resident #706's room door was closed when they started their shift and verbalized it was. CNA E was queried how long they were in the room and reiterated they just opened the door and turned on the light then saw Resident #705 and Resident #706 laying naked in the bed, so they shut off the light and closed the door. When queried what they meant when they said the Residents were naked, CNA E replied, No body had underwear on. With further inquiry regarding what they observed including if the Residents were touching, CNA E stated, Laid down straight but was unable to provide further details when asked. CNA E stated, I was shocked and closed the door. I was shocked and didn't know what to do. When queried if they informed the nurse or the other CNA working, CNA E indicated they informed the nurse.</p> <p>When asked how long it took them to locate the nurse, CNA E was unable to provide a specific timeframe. CNA E revealed they went back into the room with other staff and stated, (Resident #705) said he just kissed me, we didn't have sex. CNA E was asked what time they found the Residents and replied, A little after 11:00 PM. When queried if they had seen either Resident during their shift prior to finding them partially naked in bed, CNA E revealed they had not. When asked why they did not look for Resident #705 when they noted they weren't in their room, CNA E verbalized they were doing their checks and providing incontinence care but did not provide further explanation. When queried regarding staffing levels on 7/9/24, CNA E stated there were two CNA's and a nurse working in the dementia unit. When asked if that number of staff is sufficient to monitor and assist the residents who reside in the locked Dementia Unit, CNA E responded, No.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/17/24 at 4:18 PM, an interview was completed with the DON. When queried if LPN B contacted them on 7/9/24 and informed them about finding Resident #705 and Resident #706 partially naked in Resident #706's room, the DON stated, When (LPN B) called the night they found them, (LPN B) never said they were in bed together. (LPN B) made it sound like they were standing on opposite sides of the bed with no pants on. With further inquiry, the DON stated, On 7/11 (2024), (LPN B) was in the office with (Administrator) and I and casually dropped the bombshell that they were in bed together. When queried how long they were alone in room with the door closed, the DON stated, I really don't know. The DON was asked if they were able to determine the length of time Resident #705 was in Resident #706's room from the video footage and revealed they did not review the camera footage because the Administrator had. When queried why they would not initiate an investigation and implement interventions if the Resident's were found alone and partially undressed in a room with the door closed for an undetermined amount of time, the DON reiterated it was a bombshell when they were notified that the Residents were in bed together with their clothes off.</p> <p>When queried where the Resident's pants were in the room, the DON stated, (Resident #706's) were around their ankles and (Resident #705's) were on the floor. I think by the side of the bed on the floor. When asked if an I and A report was completed, the DON replied, I think so, but I won't swear to it. When queried, the DON revealed they were not present at the facility when the incident transpired. When queried where the location of Resident #705 and Resident #706's pants were documented, the DON was unable to recall. The DON was then asked if either Resident had a history of sexual behaviors prior to the incident on 7/9/24 and replied, No. The DON then stated, Some history of females going into (Resident #706's) room. When asked to explain, the DON revealed female residents had gone into Resident #706's room but there had never been any issues related to sexual behaviors prior to this incident. When queried how Resident #705 and Resident #706's families responded when they were informed of what had occurred, the DON stated, (Resident #706's) family was very upset. The DON revealed Resident #706's family verbalized the Resident's personality was very friendly and liked to make jokes, but they would not act in a sexually inappropriate manner and believed Resident #705 had instigated what transpired.</p> <p>An interview was conducted with LPN B on 9/17/24 at 5:02 PM. When queried what occurred on 7/9/24 involving Resident #705 and Resident #706, LPN B stated, I think the aide came and got me. We went in the room, and they were in bed. When asked to clarify, LPN B responded that Resident #705 and Resident #706 were in Resident #706's room in their bed. LPN B continued, They were on their backs but touching, it didn't seem like they had had sex. When asked if the Residents were covered, LPN B replied, They were naked. LPN B was asked to explain what naked mean and stated, I think he had a white t shirt on. Not sure about her, think a night shirt but not sure. Briefs were down by feet. When asked if Resident #705 and Resident #706's genitals were exposed, LPN B confirmed they were. LPN B was then asked where the Resident's pants were and replied, I don't know. When asked what happened next, LPN B replied, Got them up and dressed and specified Resident #705 was taken back to her room. When asked to explain what they meant when they said it did not seem like the Resident's had sex, LPN B revealed they did not see any fluids on the bed to indicate intercourse had occurred. LPN B was then asked if they informed the DON and/or Administrator and stated, I told the DON. LPN B revealed they contacted the DON immediately after the Residents were separated.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235250	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER Adira Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 State St Saginaw, MI 48602	
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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>When asked why the investigation did not begin until 7/11/24, LPN B replied, I don't know. When asked if Resident #706's room door was closed, LPN B verified it was and indicated the Resident typically kept their room door closed when they were in their room. LPN B was then queried how long Resident #705 had been in Resident #706's room prior to staff finding them undressed in bed and revealed they were not sure. LPN B was then asked when they last saw Resident #705 and replied, It was during med pass, so 8:00 (PM) or 9:00 (PM). When queried when they last saw Resident #706, LPN B responded that it would have been during the same time frame during medication pass. When queried if they notified Resident #705 and Resident #706's responsible parties/guardians of the incident, LPN B revealed they did not. When queried if either Resident #705 and/or Resident #706 had exhibited sexually inappropriate behaviors prior to this incident, LPN B revealed they were not aware of anything like that happening in the past. LPN B verbalized Resident #706 was very sociable, that Resident #705 was always interested in Resident #706, wanted to be where they were, and had developed an emotional attachment to Resident #706. LPN B revealed they would go into Resident #706's room to watch TV. With further inquiry regarding Resident #705 going into Resident #706's room to watch TV, LPN B verbalized other residents also went in Resident #705's room and staff tried to make sure the door was open when other residents were in the room.</p> <p>An interview was completed with CNA F on 9/18/24 at 8:40 AM. When queried if they had ever observed Resident #705 or Resident #706 display sexually inappropriate behaviors, CNA F revealed Resident #705 attempted to go in another male resident's room after they were found in bed with Resident #706.</p> <p>On 9/18/24 at 9:00 AM, an interview was completed with CNA I. When queried regarding Resident #705 and Resident #706, CNA I verbalized they were not working but were aware of the incident. With further inquiry regarding the Residents, CNA I stated, (Resident #705) got upset with me. She kept trying to go in (Resident #706's) room and take her clothes. CNA I was asked if this was before of after the incident, CNA I replied, The week of. She kept trying to go in there (Resident #706's) room and take her clothes off when the room was empty. When queried regarding Resident #705's cognitive status and level of confusion, CNA I replied, It's day to day with her. CNA I continued, That week she (Resident #705) kept trying to say I was after him (Resident #706) and I was trying to take her boyfriend. When queried if either Resident had displayed any other inappropriate prior to the incident on 7/9/24, CNA I replied, We always watched and make sure the door was open when they were in there (Resident #706's room) watching TV. CNA I was asked if Resident #705 frequently went in Resident #706's room and indicated they did. CNA I verbalized residents would also sit in the chairs in the hallway outside of Resident #706's room.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>When queried where they sat when they were watching TV in the room, CNA I replied, There were chairs in their room. Sometimes they (Resident #705 and Resident #706) would get on the bed together and I would try to get them to move to sit to the chairs. When asked, CNA I stated, There were two or three chairs in there (Resident #706's) room. CNA I then stated, (Resident #705) thought they were boyfriend/girlfriend or married. When queried regarding Resident #706's cognition and if they acted the same way towards Resident #705, CNA I Resident #706 was pleasant but very confused consistently and did not seem to understand Resident #705's behavior. CNA I stated, Sometimes (Resident #706) would call (Resident #705) by his baby sister's name. CNA I stated, I tried to keep the (room) door open and then she (Resident #705) got upset with me. CNA I was asked when Resident #705 got upset with them for trying to keep the room door open and revealed it was before that happened. When queried if they informed the nurse, CNA I replied, Yeah, but we got different nurses. CNA I continued, I kept telling them (nurses) that she (Resident #705) was going in there (Resident #706's room). CNA I then stated, We had her (Resident #705) on 15 minutes checks before that. When asked the reason Resident #705 was on 15-minute checks, CNA I indicated it was related to her going into Resident #706's room alone and stated, Neither family wanted them in there alone. CNA I continued, She likes attention. When queried regarding interventions implemented following the occurrence, CNA I revealed additional interventions were not implemented for a few days. CNA I was unable to recall specific dates.</p> <p>Review of facility provided schedule revealed the following staff worked on 7/9/24 in the Dementia Unit:</p> <ul style="list-style-type: none"> - Day shift: LPN C, CNA I, and CNA J - Afternoon shift: LPN B, CNA G, and Trainee H - Midnight shift: LPN B, CNA D, and CNA E <p>The facility schedule further revealed LPN C, CNA I, and CNA K worked days on 7/10/24 in the Dementia Unit.</p> <p>CNA J was contacted on 9/18/24 at 10:05 AM. A voicemail was left with return phone number.</p> <p>On 9/18/24 at 11:23 AM, Former Trainee CNA Staff H was contacted via phone. The number provided was not in service.</p> <p>On 9/18/24 at 11:30 AM, Former CNA G was contacted via phone. The number provided was not in service.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A follow-up interview was completed with CNA I on 9/18/24 at 11:57 AM. When queried when Resident #705 started going into Resident #706's room, CNA I replied, Started as soon as she came to the unit. CNA I verbalized other residents also went into Resident #706's room to watch TV because not all residents had TVs in their rooms. CNA I reiterated that Resident #705 would get mad at them when they would open Resident #706's room door or attempt to redirect them out of Resident #706's room and had verbalized they thought CNA I was trying to take Resident #706 from them. When queried if either Resident #705 or Resident #706 had increased/more frequent monitoring in place prior to the incident on 7/9/24, CNA I replied, (Resident #706's) door open when up and dressed. CNA I revealed Resident #706 liked their room door closed when they were in bed. CNA I was asked where 15-minute checks are documented in the EMR as indicated in previous interview and indicated it should be on the care plan. When queried why 15-minute checks were not present on Resident #705's care plan, CNA I replied, I was sure she was on 15-minute checks. When asked if they had concerns related to behavior related to Resident #705</p>		