STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235294	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Cedar Springs	400 Jeffrey Cedar Springs, MI 49319

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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 - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 This citation pertains to intake MI00145713. Based on interview and record review, the facility failed to protect the resident's right to be free from resident to resident sexual abuse in 3 (Resident #101, #103, #104) of 4 residents reviewed for abuse resulting in the potential for a decline in physical, mental, and psychosocial well-being. Findings include: Resident #101 Review of an Admission Record revealed Resident #101 was originally admitted to the facility on [DATE] with pertinent diagnoses which included unspecified dementia. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 5/21/24 revealed a Brief Interview for Mental Status (BIMS) score of 00/15 which indicated Resident #101 was severely cognitively impaired. Resident #102 Review of an Admission Record revealed Resident #102 was originally admitted to the facility on [DATE] with pertinent diagnoses which included type 2 diabetes. Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 5/28/24 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #102 was cognitively intact. Review of the Facility Reported Incident (FRI) dated 6/21/24 revealed, At 10:15 am, a CNA (Certified Nursing Assistant) approached DON (Director of Nursing) and stated she saw perpetrator (Resident #102) sitting next to (Resident #101) with his hand up her shorts. CNA immediately separated the residents and told perpetrator (Resident #102) to knock that off. Reported to DON right away . (continued on next page)

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 - Few	During an interview on 8/21/24 at 12:06 PM, CNA P reported that she was the staff member that had observed Resident #102 with his hands up Resident #101's shorts in the corner of a common area in the facility. CNA P reported that Resident #102's hand was underneath Resident #101's shorts. CNA P reported that she could not see Resident #102's hand at all. CNA P reported that she immediately yelled knock that off as soon as she realized that Resident #102's hands were up Resident #101's shorts, but that she did not think that Resident #102 heard her because he appeared startled when CNA P approached him. CNA P reported that Resident #102 removed his hand from underneath Resident #102's shorts when he realized that CNA P was approaching him. CNA P reported that Resident #101 appeared confused and did not seem to have any idea what was happening to her. CNA P reported that she was the only staff member that had witnessed the interaction between Resident #101 and Resident #102. During an interview on 8/21/24 at 3:32 PM, DON B reported that she had been notified of the incident between Resident #101 and Resident #102 immediately after it was witnessed by CNA P. DON B reported that they immediately separated the residents and informed Resident #102 he needed to stay away from Resident #101. During an interview on 8/22/24 at 11:42 AM, Physician Assistant (PA) U reported that she assessed Resident #101 after the incident and confirmed that Resident #101 was unable to report or understand what had happened between her and Resident #102. Resident #103 Review of an Admission Record revealed Resident #103 was originally admitted to the facility on [DATE] with pertinent diagnoses which included alzheimers disease with late onset. Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of 5/28/24 revealed a Brief Interview for Mental Status (BIMS) score of 7/15 which indicated Resident #103 was moderately cognitively impaired. Review of Resident #103's Letters of Guardianship dated 7/20/21 revealed that Resident #103 had been appointed a full guardian. Review of Resident #103's Care Plan revealed, I have the potential to exhibit behaviors that sound or appear sexual in nature r/t (related to) ineffective coping skill. (Resident #103) will remain in the common areas of the facility when visiting female residents. Date initiated :4/18/22. Goals: I will not engage in behaviors that sound or appear sexual in nature in a public place. Date initiated: 4/18/22. I will not have behaviors that cause harm to myself or others through the review date. Date initiated: 4/18/22. Interventions: Do not react emotionally to my behavior. Date initiated: 4/18/22. I will be provided a private place to engage in behaviors that appear sexual in nature. Date initiated: 4/18/22. Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document. Behavior Management review as needed. Date initiated: 4/18/22. Assess and anticipate my needs: food, thirst, toileting needs comfort level, body positioning, pain ect Date initiated: 4/18/22. Assess my coping skills and support system. Date initiated: 4/18/22. Assess my understanding of the situation. Allow time for me to express self and feelings toward the situation. Date initiated: 4/18/22. Evaluate for side effects of medication. Date initiated: 4/18/22. Give me as many choices as possible about care and activities. Date initiated: 4/18/22. Behavior- Appear or sound sexual in nature (See Kardex for additional interventions) (Resident #103) will often search for secluded areas of the facility when visiting female residents. Date initiated: 4/18/22 . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #103's Kardex (Care area indicators/orders for nursing staff) revealed, . There is a female resident that I like to spend a lot of time with. Please encourage me to try and develop more independent leisure pursuits rather than be alone with her Review of Resident#103's Care Conference note dated 6/11/24 revealed, IDT (Interdisciplinary team) called guardian and informed her of friendship/relationship with another resident. Per my (sic) guardian, r/t my romantic interest in a female resident, it is OK for me to be involved with harmless physical contact w/ her. However, if I start to make other staff uncomfortable or things become sexual, staff should separate us and inform us it is inappropriate. Review of Resident #103's Nursing Progress Note dated 8/14/24 revealed, As this nurse was counting narcs (narcotic medication) with outgoing nurse this nurse observed a female's hand right under an afghan that res (Resident #103) had covering his legs. This nurse asked the female res three times to see both hands. On the third time the female res showed this nurse both of her hands. After several minutes the res (Resident #103) went to his room for the night. Review of Resident #103's Nursing Progress Note dated 7/31/24, revealed, At approximately 2325 (11:25 PM) this nurse checked in on another res (Resident #104) to ask when she would like to be washed up . and observed res (Resident #104) wheeling herself to the light switch near the door to the room and observed a (sic) this res (Resident #103) leg's behind her with his wheelchair backed up to her bed next to the night stand. I called out to this res (Resident #103) to come of the female's room and he said ok. The female res (Resident #104) wheeled herself out to the hallway to make room for this res (Resident #103) to come out. Resident #104 Review of an Admission Record revealed Resident #104 was originally admitted to the facility on [DATE] with pertinent diagnoses which included cognitive communication deficit and wernickes encephalopathy (neurological disorder marked by mental confusion). Review of a Minimum Data Set (MDS) assessment for Resident #104, with a reference date of 8/8/24 revealed a Brief Interview for Mental Status (BIMS) score of 8/15 which indicated Resident #104 was moderately cognitively impaired. Review of Resident #104's Letters of guardianship dated 4/20/23 revealed that Resident #104 had been appointed a full guardian. Review of Resident #104's Certification of Incapacity/Activation of Power of Attorney for Heath Care dated 3/9/23 indicated that two physicians had personally examined Resident #104 and determined that Resident #104 was unable to to receive and evaluate information effectively, and communicate decisions necessary to manage their healthcare . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #104's Care Plan revealed, I (Resident #104) have the potential to exhibit behaviors that sound or appear sexual in nature r/t dementia. Date initiated: 10/5/23. Goals: I will not engage in behaviors that sound or appear sexual in nature in a public place. Date initiated: 10/5/23. I will not less (sic) episodes of verbal sexual statements. Date initiated:10/5/23. I will not have behaviors that will cause harm to myself or others through the review date. Date initiated: 10/5/23. Interventions: Analyze of key times, places, circumstances, triggers and what de-escalates behavior and document. Behavior Management review as needed. Date initiated: 10/5/23. Assess and anticipate my needs: food, thirst, toileting needs, comfort level, body positioning, pain etc Date Initiated: 10/5/2023. Assess my coping skills and support system. Date Initiated: 10/5/2023. Assess my understanding of the situation. Allow time for the me to express self and feelings towards the situation. Date Initiated: 10/5/2023. Do not react emotionally to my behavior Date Initiated: 10/5/2023. Evaluate for side effects of Medications. Date Initiated: 10/5/2023. Give me as many choices as possible about care and activities. Date Initiated: 10/5/2023. If I am asking you to engage in sexual behaviors, please answer matter-of-factly that staff to not do those types of things here. (Please don't call it inappropriate and make me feel less than human).Date Initiated: 10/5/2023. If I am living in a different reality than yours, please join mine as I am unable to join yours. Date Initiated: 10/5/2023. If these behaviors occur during toileting / showering / dressing, I may be confused about what we are doing. Explain to me matter-of-factly that we are here so I can use the bathroom / toilet / get dressed Date Initiated: 10/5/2023. Monitor me frequently and document observed behaviors and attempted interventions on my POC (plan of care).Date Initiated: 10/5/2023. Provide me positive feedback and emphasize the positive aspects of following behavioral recommendations. Date Initiated: 10/5/2023. Redirect with Activity. Date Initiated: 10/5/2023. When I become agitated: Intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff need to walk away calmly and approach later. Date Initiated: 10/5/2023. Behavior - Appear or Sound Sexual in Nature (See Kardex for Additional Interventions)Date Initiated: 06/11/2024 . Review of Resident #104's Progress Notes dated 8/14/24 revealed, As this nurse was counting the narcs with outgoing nurse this nurse observed res' (Resident #104) right hand under an afghan that (Resident #103) had covering his legs. This nurse asked (Resident #104) three times to see both hands. On the third time res (Resident #104) showed the nurse both of her hands. After several minutes (Resident #103) went to his room for the night. Review of Resident #104's Progress Notes dated 7/31/24 revealed, At approximately 23:25 (11:25 PM) this nurse checked in on res to ask when she would like to be washed up .and observed Resident #104 wheeling herself to the light switch near thr door to the room and observed (Resident #103's) legs behind (Resident #104) with his wheelchair backed up to her bed next to her night stand. I called out to (Resident #103) to come out of Resident #104's room and he said ok Review of Resident #104's Physician Progress Note dated 8/16/24 and documented by Physician Assistant (PA) U revealed, .Details: Evaluation after resident to resident sexual interaction (Resident #104) was seen today for evaluation after resident to resident sexual encounter. This resident (Resident #104) is in a relationship with another resident. DPOA/Guardians of both parties are aware of and have boundaries set for interactions that allow hand holding and small kissing. Per nursing note (Resident #103) found in (Resident #104's room) at 4:30 AM with his pants half down, fondling each other. (Resident #103) was asked to please leave the room. I am able to educate on her on the situation and rules that are in place. (Resident #104) had a room change as an intervention to prevent further incidents . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/21/24 at 12:06 PM, CNA P reported that she had been told by facility management that Resident #103 and Resident #104 were supposed to be kept separated because Resident #103 has been sneaking into Resident #104's room at night. CNA P was not able to report what boundaries were in place for Resident #103 and Resident #104 or what type of interactions their guardians had approved or disapproved of. During an interview on 8/21/24 at 1:50 PM, Licensed Practical Nurse (LPN) S reported that she had observed Resident #103 fondling Resident #104's breasts recently, but she could not recall the date. LPN S reported that when she observed Resident #103 fondling Resident #104's breast, she told them to keep their hands to themselves. LPN S reported that at the time that she had observed this interaction she was under the impression that the residents were allowed to have sexual interactions. LPN S reported that she had never dealt with residents in a relationship before and that she was unclear on what she was supposed to document, report, or allow/not allow between residents. LPN S reported that she had found Resident #103 in Resident #104's room within the last week and had recently observed Resident #104's hands under a blanket which was on Resident #103's lap. LPN S reported that she was not able to determine if the residents were having sexual contact, but that it did take her asking Resident #104 three times to show her hands before she removed them from under the blanket on Resident #104's lap. During an interview on 8/21/24 at 12:24 PM, CNA T reported that she had observed Resident #103 and Resident #104 have sexual contact within the past month. CNA T reported she was providing care for a resident when the resident stated that someone needs to do something about those two and pointed outside to the courtyard outside of her room window. CNA T reported that she observed Resident #103 with his fingers in Resident #104's pants and it appeared that Resident #103 was penetrating Resident #104 with his fingers. CNA T reported that she immediately went to her RN Unit Manager (RN-UM) C who advised her to go break them up and have them go somewhere private. CNA T reported that she went out to the courtyard with CNA L and separated the residents. CNA T reported that she did not report this to anyone else because she was under the impression that Resident #103 and Resident #104 were allowed to have sexual interactions. CNA T reported that the facility had allowed them to go into a private room together on multiple occasions and would place a do not disturb sign on that door. During an interview on 8/21/24 at 4:30 PM, CNA L reported that she had observed Resident #103 and Resident #104's sexual interaction with each other within the last month, but she also did not recall the date. CNA L reported that she had observed Resident #103 kissing Resident #104 and putting his fingers his Resident #104's pants, where it appeared that he was penetrating Resident #104 with his fingers. CNA L confirmed that the encounter was immediately reported to RN-UM C who advised them to go break the residents up. CNA L reported that Resident #103 and Resident #104 stopped the interaction when they (CNA T and CNA L) entered the courtyard. CNA L reported that she did not report the interaction to anyone else, and believed that the residents were allowed to have sexual interactions, but that staff were supposed to intervene when the interactions occurred in public settings. During an interview on 8/21/24 at 12:50 PM, CNA O reported that she had heard from other staff members that Resident #103 and Resident #104 were suppose to remain arm's length away from each other because Resident #103 was caught sneaking into Resident #104's room. CNA O reported that Resident #103 and Resident #104 were previously allowed to be as close as they wanted together, and that staff were supposed to intervene if they were having sexual interactions in public areas and have them go to a private area. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/22/24 at 9:58 AM, CNA I reported that she had observed Resident #103 and Resident #104 fondling each other multiple occasions, and that she had also witnessed Resident #103 in Resident #104's room with his hands in Resident #104's pants in July 2024. CNA I reported that until the end of July the facility had allowed Resident #103 and Resident #104 to go into the conference room together with a sign on the door to not disturb the residents. During an interview on 8/22/24 at 4:38 PM, RN-UM C reported that she had thought that Resident #103 and Resident #104's guardians had initially allowed them to have whatever kind of contact they wanted, but then they changed the boundaries in July 2024. RN-UM C reported that several staff members had observed Resident #103 and #104 in the courtyard with their hands in each other's pants. RM-UM C confirmed that the facility was offering for the residents to go into a private room with a sign to not disturb them until the end of July 2024. During a follow up interview on 8/22/24 at 2:39 PM RN-UM C reported that she had instructed staff to redirect Resident #103 and Resident #104 to the private room any time that they were found in public and engaging each other. RN-UM C reported that she did have one resident complain about witnessing Resident #103 and Resident #104 engaging in sexual interactions in the courtyard. RN-UM C reported that sometime in late July or early August she had observed Resident #103 standing over Resident #104 with his pants down to his thighs and in a position that looked as if they were about to engage in some kind of intercourse. During an interview on 8/22/24 at 9:28 AM, LPN Unit Manager (LPN-UM) K reported that the facility had allowed Resident #103 and Resident #104 to go into a private room together until recently when one the resident's guardians changed their minds on what interactions were allowed. LPN-UM K reviewed Resident #103 and #104's care plans and orders with the surveyor and reported that there was not documentation for Resident #103 or Resident #104 that instructed staff on what kind of interactions their guardians had given consent to. LPN-UM K reported that the care plan and orders is where facility staff would go to find this information, and social work must have missed this. During an interview on 8/22/24 at 11:42 AM, Physician Assistant (PA) U reported that she had assessed Resident #104 after discovering an alert in the electronic health record (EHR) about Resident #103 being found in Resident #104's room. PA U' reported that she had not been notified about the interaction from facility staff. PA U showed the surveyor the alert in EHR which stated (Resident #103) found in (Resident #104's room) at 4:30 AM with his pants half down, fondling each other. (Resident #103) was asked to please leave the room. PA U reported that she assessed Resident #104 for distress and reiterated to Resident #104 that Resident #104's guardian did not consent to Resident #104 having a sexual relationship with Resident #103. During an interview on 8/22/24 at 3:31 PM, Nursing Home Administrator A reported that he had been made aware of the EHR alert on 8/16/24 regarding Resident #103 being found in Resident #104's room fondling each other with Resident #103's pants down. NHA A reported that he interviewed the CNA that witnessed the resident's and the nurse that placed the alert in EHR. NHA A reported that CNA F reported that she had found Resident #103 in Resident #104's room overnight and she had observed Resident #104's hand on Resident #103's leg, and that his pants were down, but it did not seem sexual. NHA A reported that LPN E had reported that she was made aware of CNA F' observation and placed the alert in the chart. NHA A reported that LPN E' used the word fondling but that she had not witnessed fondling. NHA A reported that he did not report this interaction because he could not substantiate that it had occurred. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This surveyor attempted to contact CNA F and LPN E to discuss the details of the interaction between Resident #103 and Resident #104 that was witnessed by CNA F and documented by LPN E on 8/16/24, but they could not be reached by survey exit. During an interview on 8/22/24 at 8:25 AM, Guardian Q reported that she had been made aware of the relationship between Resident #103 and Resident #104 by the facility in May 2024. Guardian Q reported that she had met with Guardian R and they had decided together to consent to Resident #103 and Resident #104 holding hands and kissing. Guardian Q reported that she did not consent to any other type of contact. Guardian Q reported that she had never given the facility consent to allow Resident #103 and Resident #104 to spend time together privately, and she had never consented to a sexual relationship between Resident #103 and Resident #104. Guardian Q reported that on July 5th, 2024 she had called to check on Resident #103 and was informed by the staff member that she spoke with that Resident #103 was currently in a private locked room with Resident #104. Guardian Q reported that she requested that staff immediately remove Resident #103 and Resident #104 from the room because she had not given her consent for that kind of an interaction. Guardian Q reported that she had not heard from the facility since she called that day, and she never received any follow up. During an interview on 8/22/24 at 9:00 AM, Guardian R reported that she had been made aware of the relationship between Resident #103 and Resident #104 in May 2024. Guardian R reported that she had consented to Resident #103 and Resident #104 holding hands and kissing. Guardian R reported that she had informed the facility that she did not consent to excessive public displays of affection, or any kind of interaction that would make others uncomfortable. Guardian R reported that the facility had never discussed consent for a sexual relationship between Resident #103 and Resident #104 and that she had no idea at the time that it would get to that point. Guardian R reported that she had been informed by Guardian Q that Resident #103 and Resident #104 had been allowed to go into a locked private room, so she followed up with the facility to let staff know that she was not okay with any kind of sexual relationship between Resident #103 and Resident #104. During an interview on 8/22/24 at 12:01 PM, Social Services Manager (SSM) J reported that she reached out to Resident #103 and Resident #104's guardians when she had discovered they were interested in pursuing a relationship together in June 2024. SSM J reported she and former NHA H met with Resident #103 and Resident #104's guardians to establish what kind of interactions the guardians would consent to. SSM J reported that Guardian Q was agreeable to consenting to what Guardian R was comfortable with. SSM J reported that Guardian R had consented to harmless physical contact but that she did not want Resident #103 and Resident #104 making other people uncomfortable. SSM J confirmed that she did not clarify with Guardian R if she gave consent for Resident #104 to have sexual interactions with Resident #103. SSM J reported that she should have discussed consent for sexual interactions between Resident #103 and Resident #104, but she did not. SSM J reported SSM J reported that she did not update Resident #103 or Resident #104 care plan or orders to reflect what kind of interactions Resident #103 and Resident #104's guardian had consented to. During an interview on 8/22/24 at 2:26 PM, Former Nursing Home Administrator (NHA) H reported that he was part of the conversation between Guardians Q and Guardians R with SSM J. NHA H confirmed that Guardian Q had given consent to whatever Guardian R consented to. NHA H confirmed that they did not ask for consent for sexual encounters between Resident #103 and Resident #104. NHA H reported that he did not think it was necessary to ask about sexual encounters because he did not think that Resident #103 and Resident #104 were showing interest in a sexual relationship. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Abuse policy last revised 6/23, revealed, Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property Definitions: .Sexual Abuse is non-consensual sexual contact of any type with a resident .III. Prevention A. The facility will establish a safe environment that supports, to the extent possible, a resident ' s consensual sexual relationship and by establishing policies for preventing sexual abuse .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 This citation pertains to intake MI00145713. Based on interview and record review, the facility failed to: 1.) thoroughly investigate an allegation of resident to resident sexual abuse, and 2.) prevent the potential for further resident to resident sexual abuse 1 (Resident #101) of 4 residents reviewed for abuse, resulting in the potential for additional abuse and abuse allegations. Findings include: Resident #101 Review of an Admission Record revealed Resident #101 was originally admitted to the facility on [DATE] with pertinent diagnoses which included unspecified dementia. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 5/21/24 revealed a Brief Interview for Mental Status (BIMS) score of 00/15 which indicated Resident #101 was severely cognitively impaired. Resident #102 Review of an Admission Record revealed Resident #102 was originally admitted to the facility on [DATE] with pertinent diagnoses which included type 2 diabetes. Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 5/28/24 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #102 was cognitively intact. Review of the Facility Reported Incident (FRI) dated 6/21/24 revealed, At 10:15 am, a CNA (Certified Nursing Assistant) approached DON (Director of Nursing) and stated she saw perpetrator (Resident #102) sitting next to (Resident #101) with his hand up her shorts. CNA immediately separated the residents and told perpetrator (Resident #102) to knock that off. Reported to DON right away . During an interview on 8/21/24 at 12:06 PM, CNA P reported that she was the staff member that had observed Resident #102 with his hands up Resident #101's shorts in the corner of a common area in the facility. CNA P reported that Resident #102's hand was underneath Resident #101's shorts. CNA P reported that she could not see Resident #102's hand at all. CNA P reported that she immediately yelled knock that off as soon as she realized that Resident #102's hands were up Resident #101's shorts, but that she did not think that Resident #102 heard her because he appeared startled when CNA P approached him. CNA P reported that Resident #102 removed his hand from underneath Resident #102's shorts when he realized that CNA P was approaching him. CNA P reported that Resident #101 appeared confused and did not seem to have any idea what was happening to her. CNA P reported that she was the only staff member that had witnessed the interaction between Resident #101 and Resident #102. CNA P reported that the only intervention that she was aware of that was in place after the interaction was to keep Resident #102 away from Resident #101. (continued on next page)

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	235294	A. Building B. Wing	08/22/2024

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/21/24 at 3:32 PM, DON B reported that she had been notified of the incident between Resident #101 and Resident #102 immediately after it was witnessed by CNA P. DON B reported that she had completed the initial interventions for the incident, and that and that Nursing Home Administrator (NHA) H completed the remainder of the investigation. DON B reported that they immediately separated the residents and informed Resident #102 he needed to stay away from Resident #101. DON B reported that the facility placed both residents on 15 minute checks and moved Resident #101 to another room away from Resident #102. DON B reported that she took the witness statement, had nursing and the facility provider assess Resident #101 and contacted the police. DON B confirmed that in July 2024 two additional residents in the facility reported allegations of sexual abuse by Resident #102 two days after the facility discontinued the 15 minute checks on Resident #102. During an interview on 8/21/24 at 12:24 PM, CNA T reported that after the incident between Resident #101 and Resident #102 that Resident #102 was placed on 15 minute checks. CNA T reported that she felt like the 15 minute checks were helpful for Resident #101 but it seemed like Resident #102 began turn his attention to other female residents in the facility and she noticed that Resident #102 began to spend a lot more time at the puzzle table where female residents congregated. CNA T reported that she was not aware of any other interventions in place for Resident #102 other than the 15 minute checks. CNA T reported that the 15 minute checks were not easy to complete when the facility was short staffed. During an interview on 8/22/24 at 1:50 PM, Licensed Practical Nurse (LPN) S reported that she had been made aware of the incident between Resident #101 and Resident #102 in June 2024. LPN S reported that the only intervention in place that she was aware of was 15 minute checks for Resident #102. LPN S reported that the 15 minute checks for Resident #102 were sometimes an issue because when the facility was short staffed it was hard to monitor Resident #102. During an interview on 8/22/24 at 8:29 AM, LPN M reported that the only intervention that she was aware of the that the facility had in place after the incident between Resident #101 and Resident #102 was 15 minute checks on Resident #102. During an interview on 8/21/24 at 9:28 AM, LPN Unit Manger K reported that the only intervention that she was aware of after the incident between Resident #101 and Resident #102 was 15 minute checks for Resident #102 and to move Resident #101 away from Resident #102. During an interview on 8/22/24 at 9:58 AM, CNA I reported that the only intervention that she was aware of that were in place after the incident between Resident #101 and Resident #102 was 15 minute checks for Resident #102. CNA I reported that she did not feel like the 15 minute checks for Resident #102 were helpful because the facility could not adequately monitor him when they were short staffed. During an interview on 8/22/24 at 11:42 AM, Physician Assistant (PA) U reported that she did not assess Resident #102 after the incident between Resident #101 and Resident #102. PA U reported that the only interventions that she was aware of after the incident was to place Resident #102 on 15 minute checks. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/22/24 at 12:01 PM, Social Services Manager (SSM) J reported that the only interventions that the facility had in place after the incident between Resident #101 and Resident #102 was to move Resident #101 to a room away from Resident #102 and place Resident #102 on 15 minute checks. SSM J reported that she felt that the incident between Resident #101 and Resident #102 was an isolated incident so she did not think there was a need to put more interventions in place. SSM J reported that the facility had not considered interventions to keep Resident #102 from assaulting other residents. SSM J confirmed that she had not assessed Resident #101 after the incident to determine if there were any underlying behaviors or triggers that needed to be addressed. SSM J reviewed Resident #102's care plan and orders with this surveyor and confirmed that the only order in place was to keep Resident #102 away from Resident #101.SSM J confirmed that she did not review or update Resident #102's care plan or orders after the incident to alert staff to this incident or Resident #102's potential to assault another resident. SSM J confirmed that the facility missed assessing and implementing interventions for Resident #102 after the incident to prevent further incidents of abuse by Resident #102 towards other residents. During an interview on 8/22/24 at 2:54 PM, DON B reported that Resident #102 had been tasked to monitor for sexual behaviors since admission as part of the standard admission orders. DON B reviewed Resident #102's EHR with surveyor and confirmed that staff had not documented sexual behaviors under this charting. DON B confirmed that the only interventions in place for Resident #102 after the incident were 15 minute checks on Resident #102. DON B confirmed that the facility did not complete any assessments on Resident #102. DON B reported that the facility did not feel that they needed to put interventions in place to decrease the likelihood that Resident #102 assaulted any other residents because the facility did not substantiate abuse in their investigation,and therefore did not think it was necessary. DON B confirmed that the investigation was completed by Former NHA H. During an interview on 8/22/24 at 2:26 PM, Former NHA H reported that DON B completed the reporting and the investigation of the incident between Resident #101 and Resident #102. Former NHA H reported that the only intervention he was aware of in place for Resident #102 after the incident was to keep Resident #101 and Resident #102 away from each other and 15 minute checks for Resident #102. NHA H reported that he did not know if Resident #102 was assessed by social work or the facility provider. NHA H could not report any interventions that were in place to prevent Resident #102 from potentially assaulting other residents.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview and record review, the facility failed to maintain complete and accurate medical records for 2 (Resident #103 and Resident #104) of 5 residents reviewed for medical records, resulting in inaccurate and incomplete medical records and the potential for facility staff and providers not having all of the pertinent information to care for residents. Findings include: Resident #103 Review of an Admission Record revealed Resident #103 was originally admitted to the facility on [DATE] with pertinent diagnoses which included alzheimers disease with late onset. Review of a Minimum Data Set (MDS) assessment for Resident #, with a reference date of 5/28/24 revealed a Brief Interview for Mental Status (BIMS) score of 7/15 which indicated Resident #103 was moderately cognitively impaired. Review of Resident #103's Care Plan revealed, I have the potential to exhibit behaviors that sound or appear sexual in nature r/t (related to) ineffective coping skill. (Resident #103) will remain in the common areas of the facility when visiting female residents. Date initiated :4/18/22. Goals: I will not engage in behaviors that sound or appear sexual in nature in a public place. Date initiated: 4/18/22. I will not have behaviors that cause harm to myself or others through the review date. Date initiated: 4/18/22. Interventions: Do not react emotionally to my behavior. Date initiated: 4/18/22. I will be provided a private place to engage in behaviors that appear sexual in nature. Date initiated: 4/18/22. Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document. Behavior Management review as needed. Date initiated: 4/18/22. Assess and anticipate my needs: food, thirst, toileting needs comfort level, body positioning, pain ect Date initiated: 4/18/22. Assess my coping skills and support system. Date initiated: 4/18/22. Assess my understanding of the situation. Allow time for me to express self and feelings toward the situation. Date initiated: 4/18/22. Evaluate for side effects of medication. Date initiated: 4/18/22. Give me as many choices as possible about care and activities. Date initiated: 4/18/22. Behavior- Appear or sound sexual in nature (See Kardex for additional interventions) (Resident #103) will often search for secluded areas of the facility when visiting female residents. Date initiated: 4/18/22 . Resident #104 Review of an Admission Record revealed Resident #104 was originally admitted to the facility on [DATE] with pertinent diagnoses which included cognitive communication deficit and wernickes encephalopathy (neurological disorder marked by mental confusion). Review of a Minimum Data Set (MDS) assessment for Resident #104, with a reference date of 8/8/24 revealed a Brief Interview for Mental Status (BIMS) score of 8/15 which indicated Resident #104 was moderately cognitively impaired. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #104's Care Plan revealed, I (Resident #104) have the potential to exhibit behaviors that sound or appear sexual in nature r/t dementia. Date initiated: 10/5/23. Goals: I will not engage in behaviors that sound or appear sexual in nature in a public place. Date initiated: 10/5/23. I will not less (sic) episodes of verbal sexual statements. Date initiated:10/5/23. I will not have behaviors that will cause harm to myself or others through the review date. Date initiated: 10/5/23. Interventions: Analyze of key times, places, circumstances, triggers and what de-escalates behavior and document. Behavior Management review as needed. Date initiated: 10/5/23. Assess and anticipate my needs: food, thirst, toileting needs, comfort level, body positioning, pain etc Date Initiated: 10/5/2023. Assess my coping skills and support system. Date Initiated: 10/5/2023. Assess my understanding of the situation. Allow time for the me to express self and feelings towards the situation. Date Initiated: 10/5/2023. Do not react emotionally to my behavior Date Initiated: 10/5/2023. Evaluate for side effects of Medications. Date Initiated: 10/5/2023. Give me as many choices as possible about care and activities. Date Initiated: 10/5/2023. If I am asking you to engage in sexual behaviors, please answer matter-of-factly that staff to not do those types of things here. (Please don't call it inappropriate and make me feel less than human).Date Initiated: 10/5/2023. If I am living in a different reality than yours, please join mine as I am unable to join yours. Date Initiated: 10/5/2023. If these behaviors occur during toileting / showering / dressing, I may be confused about what we are doing. Explain to me matter-of-factly that we are here so I can use the bathroom / toilet / get dressed Date Initiated: 10/5/2023. Monitor me frequently and document observed behaviors and attempted interventions on my POC (plan of care).Date Initiated: 10/5/2023. Provide me positive feedback and emphasize the positive aspects of following behavioral recommendations. Date Initiated: 10/5/2023. Redirect with Activity. Date Initiated: 10/5/2023. When I become agitated: Intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff need to walk away calmly and approach later. Date Initiated: 10/5/2023. Behavior - Appear or Sound Sexual in Nature (See Kardex for Additional Interventions)Date Initiated: 06/11/2024 . During an interview on 8/21/24 at 12:24 PM, Certified Nursing Assistant (CNA) T reported that she had observed Resident #103 and Resident #104 engaging in a sexual interaction in the courtyard of the facility, and she went into the courtyard with CNA L to break the residents up. CNA T could not recall the date that this incident occurred, but stated it had happened with the last month. CNA T reported that she immediately reported the interaction she had observed to her unit manager, but she did not document the incident in Resident #103 or Resident #104's electronic health record (EHR). During an interview on 8/21/24 at 4:30 PM, CNA L' reported that had observed Resident #103 and Resident #104 engaging in a sexual interaction in the courtyard of the facility, and she had went into the courtyard with CNA T to break the residents up. CNA L could not recall the date that this incident occurred. CNA L confirmed that she did not document the incident in Resident #103 and Resident #104's EHR. During an interview on 8/21/24 at 4:38 PM, Registered Nurse Unit Manager (RN-UM) C reported that she had been made aware by staff members on multiple occasions that Resident #103 and Resident #104 had been observed in the courtyard engaging in sexual acts, making out, and fondling each other. RN-UM C reported that she had not documented the incidents in Resident #103 and Resident #104 EHR. RN-UM C confirmed that she had gone out to the courtyard to break up Resident #103 and Resident #104 in late July or early August but she could not recall the date. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 8/22/24 at 2:39 PM, RN-UM C reported that she did not think that staff needed to document the incidents between Resident #103 and Resident #104 because the residents care plans indicated that they needed to be redirected, so she did not see the need for staff to document these observations. During an interview on 8/22/24 at 9:58 AM, CNA I reported that she had observed Resident #103 with his hands in Resident #104's pants in July 2024. CNA I reported that she had reported it to the administrator, but she did not document the incident in Resident #103 or Resident #104's EHR. During an interview on 8/22/24 at 12:01 PM, Social Services Manager (SSM) J reported that she had spoke with Resident #104's guardian on June 27, 2024 and discussed that Resident #104's regarding consent that was given for what kind of interactions were allowed between Resident #103 and Resident #104. SSM J reported that she did not document the conversation she had with Resident #104's guardian in Resident #103 and Resident #104's EHR. SSM J confirmed that she did not update Resident #103 and Resident #104's care plans or orders to make staff aware of boundaries set forth by Resident #104's guardian. During an interview on 8/22/24 at 3:31 PM, Nursing Home Administrator (NHA) A reported that on 8/16/24 he had read an alert placed in the facility EHR dashboard by Licensed Practical Nurse (LPN) E about Resident #103 being found in Resident #104's room fondling Resident #104. NHA A reported that he followed up with LPN E about the alert in the chart and was told that she had entered that alert did not witness Resident #103 fondling Resident #104, but she had heard that from CNA F. NHA A reported that CNA F reported that she did not witness Resident #103 fondling Resident #104, but he was in her room. NHA A reported that the documentation from LPN E was inaccurate. This surveyor attempted to contact CNA F and LPN E to discuss the details of the interaction between Resident #103 and Resident #104 that was witnessed by CNA F and documented by LPN E on 8/16/24, but they could not be reached by survey exit.