STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455761	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Nursing & Rehabilitation Center	1013 S Bryan Rd Mission, TX 78572

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 - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47573 Based on observations, interviews, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, or mistreatment, were reported immediately to the State Survey Agency, within two hours if the events that cause the allegation that involved abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, for 1 (R #1) of 5 residents reviewed for abuse/neglect. The facility failed to report allegations of resident abuse for R #1 for an incident on 04/24/24 to the State Survey Agency within the allotted time frame of 2 hours. This failure could place all residents at increased risk for potential abuse due to unreported allegations of abuse and neglect. The findings included: Record review of R #1 's file reflected [AGE] year-old female with original admitted [DATE] and last admitted [DATE]. Her diagnosis included: Alzheimer's disease, cognitive communication deficit, muscle weakness, Osteoporosis (weak bones), other specified depressive episodes, and other specified local infections of the skin and subcutaneous tissue. Record review of R #1's MDS assessment dated [DATE] reflected BIMS was not conducted as R #1 was rarely/never understood. R #1 was dependent (helper does all of the effort) for toileting hygiene (ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement). Record review of R #1's Care Plan dated 05/03/24 reflected R #1 had an ADL self-care performance deficit related to confusion, dementia, limited mobility, limited range of motion, and musculoskeletal impairment. Interventions included: R #1 required a total assist of 1-2 staff for incontinent care. Date initiated: 12/27/23. R #1 had a deficit in memory, judgement, decision making and thought process related to long term memory loss, short term memory loss, and Alzheimer's disease. Interventions included: explain each activity/care procedure prior to beginning it. Date initiated: 12/27/23. Record review of progress notes for R #1 reflected - (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455761	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Nursing & Rehabilitation Center	1013 S Bryan Rd Mission, TX 78572

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 - Few	On 04/24/24 at 5:16 PM, documented by LVN A. At 4:20 PM, LVN A rendered perineal care to R #1 and applied cream as ordered to the groin and to private area with diaper rash with FM 4 in the room. At around 4:35-4:45 PM, as soon as they finished, after few minutes, the FM 1 came in and went straight to R #1's room then went to LVN A and said she wanted to talk to LVN A. FM 1 directed LVN A to R #1's room and saw R #1's diaper open exposing her private area and FM 1 showed LVN A that R #1 had yeast on her vagina. FM 1 opened R #1's labia with her finger. LVN A explained to FM 1 that they barely changed R #1's diaper and no discharge was noted during that time and a cream was applied which may be the cream she sees as yeast. LVN A and LVN B wiped R #1's private area to verify if it's vaginal discharge but no discharge noted. FM 1 did a body check on R #1 every time she comes to see her. Notified RP and NP. Explained to NP the situation above with order to give Miconazole 1200 mg vaginal suppository x 1 dose and topical cream to outer area daily x 7 days and orders carried out. On 04/25/24 at 9:05 AM, documented by LVN A. Miconazole 7 Vaginal Cream 2 % Insert 1 application vaginally one time a day for yeast for 7 Days vagina outer area. Not in stock yet. On 04/25/24 at 11:11 AM, documented by DON. R #1 resting in bed, no signs of distress noted. As per charge nurse, R #1 had been eating well. R #1 was being repositioned constantly to prevent skin breakdown while she was in bed. Peri care was being provided as needed. R #1 required assist by 1-2 staff for ADLs. Call light within reach. On 04/25/25 at 2:52 PM, documented by LVN A. At 6:30 AM, R #1 was asleep, not in distress and no signs or symptoms pain noted. At 7:00 AM, peri care done and no vaginal discharge noted. Keep resident clean and dry. Keep head elevated with TV on. Breakfast given to resident with the help of the CNA. At 8:00 AM, R #1 showered by CNA and no vaginal discharge noted. Call light within reach. Head of bed to upright position. Touch call light within reach. Continue rounding. At 10:30 AM, again peri care done and no vaginal discharge noted. At 11:03 AM, notified NP of no vaginal discharge noted with order to discontinue Miconazole suppository and cream. Orders carried out. On 04/25/24 at 4:13 PM, documented by DON. attempted to schedule care plan meeting today with family to discuss the care being provided and family's disagreements in regard to FM 1 coming to the facility almost on a daily basis to perform head to toe assessments (skin assessments) on R #1's body including her private areas. FM 1 stated that she could not come in today but will be available tomorrow at 4pm. RP notified. On 04/25/24 at 5:39 PM, documented by DON. Called FM 1 to advise her to ask for a nurse when she wants to assess R #1's body so that she can have a witness when she inspects R #1's body. The nurse will make sure R #1 was okay and not in any kind of distress while FM 1 assesses her body. As per RP, RP was not comfortable with FM 1 completing assessments on R #1. FM 1 stated that she had to do skin assessments on R #1 because she was her advocate and the facility did not have the right to tell her not to do it. DON told FM 1 that the facility needed to protect R #1's privacy and dignity and they had to ensure their residents are safe. DON also suggested to request a skin assessment and be present while the nurse does it so that FM 1 can see if there was any skin breakdown but she was not allowed to touch R #1's private areas without asking R #1 for permission. FM 1 got upset and said that she would be in the care plan meeting tomorrow to continue with this conversation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455761	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Nursing & Rehabilitation Center	1013 S Bryan Rd Mission, TX 78572

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 - Few	On 04/26/24 at 3:38 AM, documented by DON. The facility received a visit from APS today in regard to a case on R #1. The APS worker was asking about R #1's care and about any concerns that we had about FM 1. DON notified the APS worker that DON had received a call yesterday from the police department regarding a report that a family member had filed against FM 1 due family not being comfortable about FM 1 being alone in a room with R #1. RP and other siblings fear for R #1's safety when FM 1 visits and does unsupervised head to toe skin assessments. On 04/26/24 at 4:54 PM, documented by DON. Email sent to FM 1 to advise that she must complete all visits in facility with supervision. FM 1 had been given the option of visiting in day room or dining room while there was an active APS case. RP and other siblings aware of the change. Staff have been advised of change and protocol to follow. No further questions or concerns at this moment. In an interview with APS on 05/03/24 at 9:20 AM. APS said she received an intake for R #1 with an allegation of sexual abuse from FM 1. APS said the allegation was that FM 1 had stuck her fingers inside of R #1's vagina. APS said she spoke to the DON and did explain the concerns reported for R #1. APS said that there was also concern that FM 1 took photos and sent them to the DON and staff members. APS said she was not sure exactly what the photos consisted of but the family was not comfortable with this. APS said she told DON there was an allegation of abuse but did not specify sexual abuse. APS said R #1 did not have capacity to make decisions and RP would be responsible to make decisions for R #1. APS said DON informed her that the facility was going to implement supervised visits with FM 1 to keep R #1 safe and no longer allow FM 1 to assess or take such photos of R #1. In an interview with OMB on 05/03/24 at 2:30 PM. OMB said there were family issues for many years and FM 1 used to have a power of attorney for R #1, but it was revoked by the court. OMB said the family voted and made one of the children the RP. OMB said there was a concern that the facility did not report the possible abuse of from FM 1 towards R #1. Observation of R #1 on 05/03/24 at 3:30 PM. R #1 did not respond to questions. R #1 appeared with good personal hygiene. R #1 was not injured or in distress. R #1 was in bed resting. R #1 had the touch call light within reach. R #1 had bed rails on both sides. There was a camera by the overhead light facing R #1's bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455761	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Nursing & Rehabilitation Center	1013 S Bryan Rd Mission, TX 78572

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 - Few	In an interview with FM 1 on 05/06/24 at 11:25 AM. FM 1 said on 4/24/24, she visited R #1 and removed the brief to check for a rash or redness. FM 1 said FM 4 was present. FM 1 said she was only checking for a rash but she saw an abnormal discharge so she rushed to call the nurse. FM 1 said LVN A claimed that she had just changed R #1 5 minutes prior to when FM 1 arrived. FM 1 said LVN A called LVN B to the room and LVN B told her they could discuss things because she was not RP. FM 1 said she insisted on the nurses getting orders for testing and LVN B said they would notify NP/RP. FM 1 said there was an APS case opened against her. FM 1 said that on 4/24/24 she did not do anything wrong. FM 1 said she did not touch R #1's vagina or touch her inappropriately in any way. FM 1 said the nurses explained that they had just changed R #1 and that the discharge was ointment or rash cream, not a yeast infection, but she did not believe so. FM 1 said she was wearing gloves but she did not open R #1's private area or vagina. FM 1 said DON had asked her why she opened R #1's vulva but she did not do that. FM 1 said she did not put her fingers inside of R #1's vagina. FM 1 said that DON informed her she had to ask a nurse to assess R #1 and she also had to be supervised during visits. FM 1 said that before this she would do assessments, but it was only to check R #1's skin, and she never removed R #1's brief until this time on 4/24/24 because she did not believe them that the rash was clear or getting better. FM 1 said she never sent photos of R #1's private areas. FM 1 said she did take photos of R #'1 private areas but it was to show DON or her family that she had a rash, not because she had any malice or sexual intent. FM 1 said hid the private areas and did not expose the genitals in the photos. FM 1 said maybe she should not have done that but she was upset at the time and did not process if it was right or wrong. Observation of R #1 on 05/07/24 at 9:30 AM. R #1 did not respond to questions. R #1 appeared with good personal hygiene. R #1 was sitting in her wheelchair by the nurse's station and wearing the brace boots on both feet. In an interview with FM 4 on 05/07/24 at 12:15 PM. FM 4 said she was present on 4/24/24 when FM 1 visited R #1. FM 4 said the staff had changed R #1 about 5-10 minutes before FM 1 arrived. FM 4 said she informed FM 1 of the brief change. FM 4 said FM 1 still took off R #1's pants and opened her brief. FM 4 said she did not look because she did not want to see R #1 in that way, exposed. FM 4 said FM 1 got upset and went to call the nurse. FM 4 said she did not remember if FM 1 left the brief open, but she probably did. FM 4 said FM 1 told the nurse that R #1 had something, but the nurse told FM 1 that it was the medicine they had put on her. FM 4 said that was all she remembered. FM 4 said she did not see if FM 1 did anything to R #1's private area, but she was not very close because she did not want to see R #1 naked. FM 4 said she did see when the staff changed R #1 before FM 1 arrived and the staff had put 2 different creams on her private areas. FM 4 said she did not see FM 1 open R #1's vagina or do anything inappropriate but she stayed away from the bed and did not see or look at everything that was going because she knew how FM 1 was and she tried to avoid problems with her. FM 4 said she visited R #1 about 3 times a week and assisted in feeding her. FM 4 said she had no concerns with the care provided to R #1 as R #1 was always clean and ate well. In an interview with FM 2 on 05/07/24 at 1:15 PM. FM 2 said RP was notified of an incident that happened on 4/24/24 regarding FM 1 putting her fingers inside of R #1's vagina. FM 2 said she was not present during that time and did not witness this. FM 2 said the family was not comfortable with FM 1 doing this or doing assessments on R #1. FM 2 said the facility did initiate supervised visits and no longer allowed FM 1 to conduct assessments. FM 2 said the situation was better. FM 2 said she had no concerns regarding the care provided to R #1 by the facility staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455761	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Nursing & Rehabilitation Center	1013 S Bryan Rd Mission, TX 78572

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 - Few	In an interview with RP on 05/07/24 at 4:45 PM. RP said he was informed by the facility of an incident on 4/24/24 where FM 1 put her fingers in R #1's vagina because she was assessing her. RP said he did not think FM 1 needed to be doing that and he did not want her checking R #1. RP said R #1 did not comprehend what was going on and he did not think what FM 1 did was justified. RP said he tried to get a restraining order with the police against FM 1, but the police told him that it would be a process, depending on the outcome of the investigations opened with APS and the state. RP said he had no concerns with the care provided to R #1 by the facility staff. In an interview with LVN B on 05/07/24 at 2:55 PM. LVN B said on 04/24/24, FM 1 was upset so she went in to assess R #1 with LVN A. LVN B said FM 1 had R #1's legs open and her brief was open. LVN B said FM 1 opened R #1's labia with her fingers and tried to scoop out what FM 1 thought was yeast from R #1's vagina, but really it was cream that LVN A had just applied during a brief change. LVN B said she explained to FM 1 that she should not be doing that because she could cause trauma or introduce bacteria into R #1's vagina, but FM 1 said it was her right. LVN B said FM 1 insisted that was yeast and that they needed to get orders right away. LVN B said R #1 had not shown signs of a yeast infection, however, LVN A notified the NP of the situation. LVN B said she believed this incident would be sexual abuse because she was putting her fingers inside of R #1's vagina and she did not think it was okay. LVN B said she did not believe it was with sexual intent but R #1 was not able to voice if she gave permission and FM 1 did not explain to R #1 what she was doing. LVN B said she did notify the DON about this incident that same day. LVN B said FM 4 was in the room during the situation but was not sure what she saw. In an interview with LVN A on 05/07/24 at 4:40 PM. LVN A said on 4/24/24, FM 1 visited R #1 and FM 4 was in the room. LVN A said FM 1 called LVN A to the room and when she walked in the room, R #1 had her brief open and her legs were spread apart. LVN A said FM 1 opened R #1's labia with her fingers and said that R #1 had a yeast infection. LVN A said explained to FM 1 that she had just changed R #1's brief and applied the cream/ointment for R #1's rash in that area. LVN A said FM 1 insisted so she called LVN B to assist her. LVN A said she and LVN B returned to the room, and FM 1 again showed them what FM 1 thought was yeast. LVN A said FM 1 opened R #1's labia and showed LVN B. LVN A said LVN B explained to FM 1 that it was not yeast and that R #1 did not have signs or symptoms of a yeast infection. LVN A said she was not able to tell FM 1 to stop but LVN A did not think it was right for FM 1 to do that, to check R #1 in that manner. LVN A said she did not remember FM 1 putting her fingers inside of R #1's vagina or if she did more than open her labia. LVN A said FM 1 did get the substance that she thought was yeast with her fingers, like with a swooping motion, and was trying to show them that it was yeast, but it was the cream and ointment LVN A had applied. LVN A said she and LVN B cleaned R #1 and ensured she was okay before they left the room. LVN A said she notified NP about the situation and obtained orders. LVN A said the NP did discontinue the orders the following day when she followed up regarding R #1 not having signs or symptoms of a yeast infection. LVN A said she continued to monitor R #1 for a yeast infection but she did not show signs or symptoms. LVN A said what she saw what FM 1 was doing to R #1 on 4/24/24, checking her vagina in that manner, LVN A would consider it abuse because it was R #1's private area and R #1 did not know what was going on. LVN A said FM 1 did not explain to R #1 what she was doing and even if R #1 did not understand, FM 1 should have told R #1 that she was going to undress her, open her brief, or check her vagina, but she did not. LVN A said she and LVN B explained to R #1 the care that was being rendered that day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455761	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Nursing & Rehabilitation Center	1013 S Bryan Rd Mission, TX 78572

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 - Few	In an interview with the DON on 05/14/24 at 10:55 AM. DON said the facility implemented supervised visits with FM 1 for R #1 when APS informed them about an open investigation. DON said APS informed her that there were concerns regarding FM 1 taking photos of R #1 and that the family was not comfortable with FM 1 assessing R #1 in the manner like it happened on 4/24/24. DON said the staff knew that FM 1 would assess R #1 almost every time she visited, but they were not aware of the extent of the assessments until 4/24/24 when FM 1 showed the nurses what she thought was a yeast infection. DON said they thought FM 1 would only check R #1's skin for bruises or rashes. DON said LVN B notified her on 4/24/24 that FM 1 had removed R #1's pants, opened her brief, and had put her fingers in R #1's vagina because she thought she had a yeast infection. DON said FM 1 should not have been assessing R #1 in that manner by exposing her private areas and putting her hands/fingers on R #1's vagina for any reason. DON said FM 1 was not a nurse or trained professional and did not know how to properly conduct an assessment regarding the vagina or that area. DON said FM 1 was wearing gloves during the incident on 4/24/24 from what the nurse reported, however, FM 1 the gloves are not sterile and she could introduce bacteria into the vaginal canal. DON said she was aware that FM 1 would take photos of R #1 as FM 1 sent the photos to her to show that R #1 had a rash, but at that point the nurse was already aware and the rash or concern had already been addressed with the NP or MD. DON said she did not believe the photos were taken with sexual intent, but it did become a bit much to deal with. DON said on 4/24/24, the staff had performed incontinent care and had applied the cream/ointment for R #1's rash in the groin and vagina area. DON said there were no signs or symptoms of a yeast infection. DON said the staff tried to tell FM 1 that she could not assess R #1 in that manner, but FM 1 said that it was her right. DON said after that, the facility implemented the supervised visits and informed FM 1 that she was not allowed to assess R #1. DON said R #1 was not injured from this incident on 4/24/24. Observation of R #1 on 05/14/24 at 11:55 AM. R #1 did not respond to questions. R #1 appeared with good personal hygiene. R #1 was sitting in her wheelchair by the nurse's station and wearing the brace boots on both feet. Record review of grievances, R #1's electronic medical chart, and the state reporting system completed on 5/14/24 at 12:20 PM reflected the incident on 4/24/24 was not reported to the State Survey Agency. In an interview with the DON on 5/14/24 at 1:10 PM. DON said APS did not tell her that they were investigating abuse but the APS worker did say it was regarding concerns about what had happened on 4/24/24. DON said R #1 was not injured and did not have a negative outcome because of the facility not reporting this incident to the state. DON said she saw the importance of reporting to the state within required timeframes. DON said they should have reported this incident to the state although APS never mentioned abuse or neglect. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455761	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Nursing & Rehabilitation Center	1013 S Bryan Rd Mission, TX 78572

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 - Few	In an interview with the Administrator on 05/14/24 at 2:00 PM. The Administrator verified this incident regarding FM 1 checking R #1's vagina with her fingers was not reported to the state by the facility. The Administrator said if it had been a staff or another resident that did this to R #1, that would have been reported, but since it was a family member and it was not abuse, in his eyes, he did not report it. The Administrator said his train of thought was that since it was not done with sexual intent, like FM 1 was checking R #1 because she thought she had a yeast infection and she was trying to do an assessment although FM 1 was not a nurse. The Administrator said since there was no sexual intent, it was not sexual abuse or abuse. The Administrator said FM 1 had brought up a lot of issues throughout the time since R #1 had been admitted so he was more focused on keeping R #1 safe and doing what was best on her behalf. The Administrator said FM 1 had sent him photos of R #1's private areas, showing a rash or a concern she had. The Administrator said although it made him uncomfortable, he saw it as FM 1 bringing up concerns, not as sexual abuse or abuse of any kind. The Administrator said APS brought up concerns but did not specify abuse as far as he knew. The Administrator said perhaps maybe there was a miscommunication from what the nurses saw, to what was reported to the family, and what was reported to APS. The Administrator said from what the nurses (witnesses) reported to the facility, they never saw the incident as malice, and what was reported was not considered abuse as FM 1 was not doing it with sexual intent, it was like just like FM 1 was playing nurse. The Administrator said the supervised visits implemented have been sufficient in keeping FM 1 from continuing to do these assessments and to keep R #1 safe. The Administrator said although he did not see it as abuse, and R #1 was not injured or negatively impacted from the incident or by the facility not reporting to the state, he could see both sides of reporting or not. Record review of Abuse Prevention Program Policy (revised December 2016) Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation: As part of the resident abuse prevention, the administration will: 1. Protect our residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements.