STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	414340	A. BUILDING _____ B. WING _____	4/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELS OF KENT (THE)	350 N CENTER ST LOWELL, MI 49331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS The Laurels of Kent was surveyed for an Abbreviated survey on 4/15/25-4/16/25. Intake: MI00152092 Census= 93	F0000		
F0600 SS= E	Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: This citation pertains to intake MI00152092. Based on interview and record review, the facility failed to monitor and prevent resident to resident sexual abuse for 4 of 6 residents (Resident #101, #102, #104, and #105) 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	F0600	F600 Free from Abuse and Neglect Resident #101 still resides in the facility. Resident does not express or exhibit any decline in physical, mental and psychosocial well-being. Care plan reviewed and updated as needed. Resident #102 Resident does not express or exhibit any decline in physical, mental and psychosocial well-being. Care plan reviewed and updated as needed. Resident #104 Resident does not express or exhibit any decline in physical, mental and psychosocial well-being. Care plan reviewed and updated as needed. Resident #105 Resident does not express or exhibit any decline in physical, mental and psychosocial well-being. Care plan review and updated as needed. Residents who appear to be in a relationship have the potential to be affected. Residents who appear to be gravitating towards a relationship will be met with to discuss what level of relationship to have. If resident has a guardian or DOPA, the will be met with to discuss what level of relationship they permission for the residents to have. Any concerns identified will be addressed immediately. Staff have been re-educated on the Abuse	5/6/2025

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

Electronically Signed | 05/02/2025

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.

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	Resident #101 was originally admitted to the facility on 11/23/24 with pertinent diagnoses which included personal history of traumatic brain injury and cognitive communication deficit. Review of a "Minimum Data Set" (MDS) assessment for Resident #101, with a reference date of 3/17/25 revealed a "Brief Interview for Mental Status" (BIMS) score of 3/15 which indicated Resident #101 was severely cognitively impaired. Review of Resident #101's "Letter of Guardianship" dated 12/18/24 indicated that Resident #101 was totally without the capacity to care for herself, and the court had granted Resident #101 a full guardian. Resident #102 Review of an "Admission Record" revealed Resident #102 was originally admitted to the facility on 4/26/24 with pertinent diagnoses which included cognitive communication deficit and major depressive disorder. Review of a "Minimum Data Set" (MDS) assessment for Resident #102, with a reference date of 3/24/25 revealed a "Brief Interview for Mental Status" (BIMS) score of 7/15 which indicated Resident #102 was severely cognitively impaired. Review of the "Facility Reported Incident (FRI) "dated 4/8/25 revealed, " On 4/8/25 at 10:00 pm, Registered Nurse (RN) "N" observed (Resident #101) resident laying on (Resident #102's) bed with (Resident #102) in between (Resident #101) legs. (Resident #101) pants were off one leg and around her other ankle and (Resident #102) had his pajama and underpants down to his knees, his penis was not fully exposed. (Registered Nurse		Prohibition Policy. Those currently on leave of absence or PRN will be re-educated on their next scheduled workday. Abuse Prohibition Policy was reviewed by the QA committee and deemed appropriate. Management team will complete quality rounds to evaluate for inappropriate sexual interactions weekly x 4, then monthly x 3. Concerns will be addressed immediately and findings will be reported to the QA committee for further recommendations. Administrator is responsible for sustained compliance.	

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	(RN)) "F" immediately intervened and assisted (Resident #101) back to her room. (RN "F") did not witness any intercourse but it appeared that (Resident #102) was fondling (Resident #101)..." In an interview on 4/15/25 at 1:32 PM, RN "F" reported that on 4/8/25 she had completed report with the oncoming shift when she was notified by Certified Nursing Assistant (CNA) "H" that Resident #101 was not in her room. RN "F" reported that she began to look for Resident #101 and the first place that she went was Resident #102's room. RN "F" reported that she went to Resident #102's room because she had seen Resident #101 and Resident #102 together in the hallway earlier that evening. RN "F" reported that she entered Resident #102's room and turned on the light to observe Resident #102 sitting at the end of his bed with his legs dangling over the side of his bed and Resident #101 was laying on Resident #102's bed with her legs over Resident #102's lap. RN "F" confirmed that Resident #101's pants were down to her ankles, and she did not have on underwear or a brief. RN "F" reported that Resident #102's pants and underwear were also down, but his penis was not fully exposed. RN "F" confirmed that she observed Resident #102 fondling Resident #101's vagina area, but she did not see Resident #102 penetrating Resident #101 with his fingers. RN "F" reported that the first time that she had observed Resident #101 and Resident #102 spending time together was earlier that night. RN "F" reported that she saw the residents holding hands in the hallway and thought "that is interesting" but she did not think much else of that at the time. RN "F" confirmed that staff had to redirect Resident #101 away from Resident #102's room earlier that evening. RN "F" reported that after she separated the residents, she contacted the charge nurse and the Nursing Home Administrator (NHA) "A".			

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	In an interview on 4/15/25 at 12:41 PM, CNA "H" reported that she came to the facility to start her shift around 9:45 PM, and after getting report she began making rounds to check on her assigned residents when she noted that Resident #101 was not in her room. CNA "H" reported that she immediately told RN "F" that Resident #101 was missing and RN "F" said she might be with Resident #102 and went towards his room. CNA "H" reported that she followed behind RN "F" and entered Resident #102's room shortly after RN "F". CNA "H" reported that when she entered Resident #102's room RN "F" had already turned the lights on, and she observed Resident #101 lying on Resident #102's bed with her pants off. CNA "H" confirmed that Resident #102's pants were also off, but that she did not observe his penis. CNA "H" reported that Resident #102 was sitting at the end of the bed when she entered the room. CNA "H" reported that she did not see interaction between Resident #101 and Resident #102, but that she had entered after RN "F" who had already begun separating the residents. CNA "H" reported that she had been told in report from the off going shift that Resident #101 and Resident #102 had been hanging around each other and that Resident #101 had to be redirected from Resident #102's room earlier that evening. In an interview on 4/15/25 at 7:45 AM, NHA "A" reported that she contacted Resident #101's guardian on 4/9/25 and made her aware of the incident between Resident #101 and Resident #102 on 4/8/25, and obtained consent for sexual intercourse to continue. NHA "A" reported that she contacted Resident #102's guardian on 4/8/25 at 10:15 PM, and obtained consent for sexual intercourse. NHA "A" confirmed that the facility had not reached out to the guardians before the incident to determine consent for the relationship between Resident #101 and Resident #102. Resident #103			

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	Review of an "Admission Record" revealed Resident #103 was originally admitted to the facility on 4/6/23 with pertinent diagnoses which included muscle weakness and adult failure to thrive. Review of a "Minimum Data Set" (MDS) assessment for Resident #103, with a reference date of 4/8/25 revealed a "Brief Interview for Mental Status" (BIMS) score of 7/15 which indicated Resident #103 was severely cognitively impaired. Review of Resident #103's "Letters of Guardianship" dated 6/5/24 revealed that Resident #103 had been appointed a full guardian. Resident #104 Review of an "Admission Record" revealed Resident #104 was originally admitted to the facility on 9/18/24 with pertinent diagnoses which included cognitive communication deficit and depression. Review of a "Minimum Data Set" (MDS) assessment for Resident #104, with a reference date of 3/26/25 revealed a "Brief Interview for Mental Status" (BIMS) score of 4/15 which indicated Resident #104 was severely cognitively impaired. Review of Resident #104's " Appointment of Guardian of Incapacitated Individual" dated 9/11/24 revealed that Resident #104 was totally unable to care for herself and was appointed a full guardian. In an interview on 4/15/25 at 1:32 PM, RN "F" reported that she was aware of a relationship between Resident #103 and Resident #104. RN			

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	"F" reported that on 4/3/25 or 4/4/25, she observed Resident #103 and Resident #104 in the lounge together. RN "F" reported that Resident #103 was "groping" Resident #104's breasts over her shirt. RN "F" reported that she did not document this incident or report it to the abuse coordinator. RN "F" confirmed that she did not know if Resident #103 and Resident #104's guardian's had consented to them having sexual interactions. Review of Resident #103's "Nurses Notes" dated 2/8/25 and documented by Licensed Practical Nurse (LPN) "G" revealed, "(Resident #103) was in the middle of the hall massaging (Resident #104) breast; educated that he could not be doing that out in the hall, in public. He stated she (Resident #104) was doing it to him, but his statement was not witnessed. (Resident #104) did not look upset or in any distress. Separated residents and he went into the shower." In an interview on 4/16/25 at 3:50 PM, LPN "G" reported that she did recall witnessing Resident #103 fondling Resident #104's breast in the hallway. LPN "G" reported that she did not know if Resident #103 and Resident #104 had consent from their guardians for their relationship. LPN "G" reported that she did not report witnessing Resident #103 massaging Resident #104's breast to the facility's abuse coordinator. In an interview on 4/16/25 at 8:53 AM, Social Worker (SW) "K" reported that she was aware that Resident #103 and Resident #104 were spending a lot of time together, and they had been observed by staff holding hands on several occasions. SW "K" reported that she was not aware that Resident #103 and Resident #104 had passed the boundary of holding hands. SW "K" reported that she had a conversation with Resident #104's guardian about Resident #103			

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	and Resident #104's relationship, and obtained consent for the relationship. SW "K" reported that she had documented the conversation she had with Resident #104's guardian on her "Care Conference Note" dated 1/9/25. SW "K" confirmed that when she spoke with Resident #104's guardian, she did not clarify with Resident #104's guardian if she gave consent for sexual intercourse, or anything beyond holding hands. SW "K" reported that she had not talked to Resident #103's guardian, and she could not recall who had obtained consent from Resident #103's guardian to have a relationship with Resident #104. Review of Resident #103's "Progress Notes" dated 7/8/24 revealed, " Writer was reported that Resident #103 was engaging in a relationship with (initials of name redacted). Resident #103 reported that he is in interest of this relationship and does not feel threaten by it. Resident #103 was explained he needs to wait until his guardian reports what kind of relationship he can engage with female resident." Review of Resident #103's "Progress Notes" dated 7/16/24 revealed, " Received a phone call from (Resident #103) guardian saying that she talked to the resident's family, and they were okay with (Resident #103) having a relationship as long as the resident do it appropriately. Incoming nurse informed." Noted that the progress notes dated 7/8/24 and 7/16/24 were before Resident #104 was admitted to the facility, and the consent that the facility obtained for this relationship was not for Resident #103's relationship with Resident #104. It is also noted that the facility did not document what kind of boundaries Resident #103's guardian had in place, and if a sexual relationship was allowed.			

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	Review of Resident #104's "Care Conference Note" dated 1/9/25 revealed, " ...Care Plan Review:...She (Resident #104's guardian) is not worried about (Resident #104) holding hands with her new male friend. (Resident #104's guardian) reports her friend looks a lot like her dad and can see how she feels like wanting to be by him..." Noted that Resident #104's "Care Conference Note" dated 1/9/25 did not indicate if Resident #104's guardian had provided consent for anything further than Resident #104 holding hands with Resident #103. In an interview on 4/16/25 at 10:13 AM, Director of Nursing (DON) "B" reported that she was present for Resident #104's Care Conference on 1/9/25 and she recalled SW "K" asking Resident #104's guardian about consent for her relationship with Resident #103. DON "B" reviewed Resident #104's "Care Conference" note dated 1/9/25 and confirmed that the documentation did not indicate if Resident #104's guardian had consented to anything more than Resident #104 holding hands with Resident #103. DON "B" was unable to find documentation of consent from Resident #103's guardian for his relationship with Resident #104. In an interview on 4/16/25 at 11:27 AM, NHA "A" reported that she was not involved in obtaining consent from Resident #104's guardian and her relationship with Resident #103. NHA "A" reviewed Resident #104's "Care Conference"note dated 1/9/25 and confirmed that the documentation did not indicate if Resident #104's guardian had consented to anything more than Resident #104 holding hands with Resident #103. NHA "A" reported that she was not aware of the incident between Resident #103 and Resident #104 on 2/8/25 where Resident #103 was witnessed massaging Resident #104's breasts.			

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	Resident #105 Review of an "Admission Record" revealed Resident # 105 was originally admitted to the facility on 8/10/2019 with pertinent diagnoses which included dementia and depression. Review of a "Minimum Data Set" (MDS) assessment for Resident #105, with a reference date of 1/27/25 revealed a "Brief Interview for Mental Status" (BIMS) score of 10/15 which indicated Resident #105 was moderately cognitively impaired. Review of Resident #105's "Letters of Guardianship" dated 6/15/22 revealed that Resident #105 was designated two full co-guardians. Resident #106 Review of a "Admission Record" revealed Resident #106 was originally admitted to the facility on 5/6/16 with pertinent diagnoses which included muscle weakness and cognitive communication deficit. Review of a "Minimum Data Set" (MDS) assessment for Resident #106, with a reference date of 3/12/25 revealed a "Brief Interview for Mental Status" (BIMS) score of 7/15 which indicated Resident # 106 was severely cognitively impaired. Review of Resident #106's "Letter of Guardianship" dated 9/9/21 revealed that Resident #106 had been appointed a full guardian. Review of Resident #106's "Nurses Notes" dated 6/10/24 and documented by RN "C" revealed, (Resident #106) came into another resident's			

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	room and was caught by an aid doing sexual interaction with a male resident (Resident #105). Unit Manager informed of this incident and DON "B" notified...." Review of Resident #105's "Social Services Note" dated 7/18/24 revealed, " Writer contacted (Resident #105) guardian (Guardian "BB") to report relationship between (Resident #105) and female resident (Resident #106), often known to be of sexual interaction. This relationship is consensual from both residents. When (Resident #105) was interviewed; he stated he likes the female resident (Resident #106), does not feel obligated or in stress, and wish to continue to have this relationship with her. (Guardian "BB") stated he will (sic) like to talk to (co-guardian) before a decision is made about situation." In an interview on 4/16/25 at 8:19 AM, RN "C" reported that she did recall the incident between Resident #105 and Resident #106 on 6/10/24. RN "C" reported that she could not recall which CNA told her that they had found Resident #105 and Resident #106, but that she remembered that the CNA told her it was a sexual interaction, so she reported it to the Unit Manager. RN "C" could not recall what the sexual interaction between Resident #105 and Resident #106 entailed. In an interview on 4/16/25 at 12:36 PM, Former Unit Manager (UM) "DD" reported that she did recall being informed of Resident #106 being found in Resident #105's room. UM "DD" could not recall which CNA had witnessed Resident #105 and Resident #106, but she did recall that Resident #106 was observed performing oral sex on Resident #105. UM "DD" reported that she contacted Resident #105 and Resident #106's guardians to inform of the incident, and she also notified DON "B". UM "DD" reported that Resident #106's guardian did not have any			

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	concerns with the sexual interaction between Resident #105 and Resident #106, but Resident #105's guardian did. UM "DD" reported that she recalled that Resident #105's guardian was "not thrilled" and wanted the facility to keep Resident #105 and Resident #106 from having any further sexual interactions. In an interview on 4/16/25 at 2:10 PM, CNA "R" reported that Resident #105 and Resident #106 had been in a relationship for a "long time," CNA "R" reported that she was not sure if Resident #105 and Resident #106's guardians had consented to a sexual relationship. CNA "R" reported that Resident #106 used to go to Resident #105's room all the time in the past, and she had observed Resident #105's hands up Resident #106's pants before. CNA "R" could not recall the date when she had made that observation, and reported that it was "a very long time ago." In an interview on 4/16/25 at 8:53 AM, SW "K" reported that she knew Resident #105 and Resident #106 had been in a relationship together for quite some time. SW "K" reported that Resident #105 and Resident #106 did go into each other's rooms, but the staff "try to" separate them. SW "K" reported that Resident #105 and Resident #106's guardians had consented to the residents having a sexual relationship. This writer reviewed the note that SW "K" documented in Resident #105's chart that indicated that Guardian "BB" needed to discuss the relationship and boundaries and had not yet given consent. SW "K" reported that Guardian "BB" did give consent for sexual interaction. SW "K" was not able to provide further documentation to verify that Guardian "BB" had consented to sexual interactions. In an interview on 4/16/25 at 8:29 AM, Resident			

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	#105's Guardian (Guardian "BB") reported that he had been made aware of Resident #105's relationship with Resident #106. Guardian "BB" reported that the facility had contacted him in June 2024 after the incident occurred between Resident #105 and Resident #106, and in July 2024 and asked for consent for the relationship, and what kind of boundaries Guardian "BB" was comfortable with. Guardian "BB" reported that he had informed the facility that he was okay with Resident #105 and Resident #106 spending time together, holding hands, and kissing, but he was not comfortable with Resident #105 having a sexual relationship. In an interview on 4/16/25 at 10:13 AM, DON "B" reported that she knew that Resident #106's guardian had given consent for Resident #106 to have a sexual relationship, but she did not know if Resident #105's guardian had given consent for a sexual relationship. DON "B" reported that she had been made aware of the incident between Resident #105 and Resident #106 on 6/10/24. DON "B" confirmed that she did not report the incident, and the facility did not do any follow up with Resident #105 and Resident #106 after the incident. In an interview on 4/16/25 at 11:27 AM, NHA "A" reported that she was unaware of the incident between Resident #105 and Resident #106 on 6/10/24. NHA "A" confirmed that if she had been made aware of the incident, she would have reported it to the state agency and completed an investigation. NHA "A" confirmed that the facility had never obtained consent for Resident #105 to participate in a sexual relationship. In a follow up interview on 4/16/25 at 4:15 PM, NHA"A" reported that she had contacted Guardian "BB"and confirmed that he did not consent to Resident #105 having a sexual			

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	414340	A. BUILDING _____ B. WING _____	4/15/2025

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	relationship. Review of the facility's "Abuse Prohibition Policy" last revised 9/19/22 revealed, " Policy: Each guest shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. Abuse shall include freedom from verbal, mental, sexual, physical abuse...To assure guests/residents are free from abuse, neglect, or mistreatment, the facility shall monitor guest/resident care and treatments on an on-going basis. It is the responsibility of all staff to provide a safe environment for the guest/residents...Definitions:... Sexual Abuse: is non-consensual sexual contact of any type with guest/resident. "Sexual abuse" is defined as non-consensual sexual contact of any type with a guest/resident. Sexual abuse includes, but is not limited to: unwanted intimate touching of any kind especially of breasts or perineal area; all types of sexual assault or battery, such as rape, sodomy, fondling and/or intercourse or coerced nudity;forced observation of masturbation and/or pornography; and taking sexually explicit photographs and/or audio/video recordings of a guest/resident and maintaining and/or distributing them (e.g. posting on social media). Guests/residents have the right to engage in sexual activity. If at anytime the facility has reason to suspect the guest/resident does not have the capacity to consent to the sexual activity the facility should evaluate whether the guest/resident has the capacity to consent...."			
F0607 SS= E	Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such	F0607	F607 Develop/Implement Abuse/Neglect Policies Resident #103 still resides in the facility. Resident does not express or exhibit any decline in physical, mental and psychosocial well-being. Care plan reviewed and updated as needed.	5/6/2025

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	allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff implemented the abuse policy by immediately reporting an allegation of abuse to the abuse coordinator for 4 of 6 residents (Resident #103, #104, #105 and #106) reviewed for abuse, resulting in a resident to resident allegation of sexual abuse not being reported immediately to the facility Abuse Coordinator and the potential for additional allegations of abuse to go unreported. Findings include: Resident #103 Review of a "Minimum Data Set" (MDS) assessment for Resident #103, with a reference date of 4/8/25 revealed a "Brief Interview for Mental Status" (BIMS) score of 7/15 which indicated Resident #103 was severely cognitively impaired. Review of Resident #103's "Letters of		Resident #104 Resident does not express or exhibit any decline in physical, mental and psychosocial well-being. Care plan reviewed and updated as needed. Resident #105 Resident does not express or exhibit any decline in physical, mental and psychosocial well-being. Care plan reviewed and updated as needed. Resident #106 Resident does not express or exhibit any decline in physical, mental and psychosocial well-being. Care plan review and updated as needed. Residents who appear to be in a relationship have the potential to be affected. Residents who appear to be gravitating towards a relationship will be meet with to discuss what level of relationship to have. If resident has a guardian or DOPA, the will be meet with to discuss what level of relationship they permission for the residents to have. Any concerns identified will be addressed immediately. Staff have been re-educated on the Abuse Prohibition Policy. Those currently on leave of absence or PRN will be re-educated on their next scheduled workday. Abuse Prohibition Policy was reviewed by the QA committee and deemed appropriate. Management team will complete quality rounds to evaluate for inappropriate sexual interactions weekly x 4, then monthly x 3. Concerns will be addressed immediately and findings will be reported to the QA committee for further recommendations. Administrator is responsible for sustained compliance.	

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	Guardianship" dated 6/5/24 revealed that Resident #103 had been appointed a full guardian. Resident #104 Review of a "Minimum Data Set" (MDS) assessment for Resident #104, with a reference date of 3/26/25 revealed a "Brief Interview for Mental Status" (BIMS) score of 4/15 which indicated Resident #104 was severely cognitively impaired. Review of Resident #104's " Appointment of Guardian of Incapacitated Individual" dated 9/11/24 revealed that Resident #104 was totally unable to care for herself and was appointed a full guardian. In an interview on 4/15/25 at 1:32 PM, RN "F" reported that she was aware of a relationship between Resident #103 and Resident #104. RN "F" reported that on April 3rd or April 4th, she had observed Resident #103 and Resident #104 in the lounge together. RN "F" reported that Resident #103 was "groping" Resident #104's chest over her shirt. RN "F" reported that she did not document this incident or report it to the abuse coordinator. RN "F" confirmed that she did not know if Resident #103 and Resident #104's guardian's had consented to them having sexual interactions. RN "F" reported that she did not know that she should have reported this incident to the abuse coordinator (Nursing Home Administrator (NHA) "A". In an interview on 4/16/25 at 3:50 PM, LPN "G" reported that she did recall witnessing Resident #103 fondling Resident #104's breast in the hallway. LPN "G" reported that she did not know if Resident #103 and Resident #104 had consent from their guardians for their relationship. LPN "G" reported that she did not report witnessing			

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	Resident #103 massaging Resident #104's breast to the facility's abuse coordinator. LPN "G" reported that she "did not think she needed to report this incident to the abuse coordinator because the facility reads all the nursing notes every morning." In an interview on 4/16/25 at 11:27 AM, NHA "A" reported that she was not aware of the incident between Resident #103 and Resident #104 on 2/8/25 where Resident #103 was witnessed massaging Resident #104's breasts. Resident #105 Review of a "Minimum Data Set" (MDS) assessment for Resident #105, with a reference date of 1/27/25 revealed a "Brief Interview for Mental Status" (BIMS) score of 10/15 which indicated Resident #105 was moderately cognitively impaired. Review of Resident #105's "Letters of Guardianship" dated 6/15/22 revealed that Resident #105 was designated two full co-guardians. Resident #106 Review of a "Minimum Data Set" (MDS) assessment for Resident #106, with a reference date of 3/12/25 revealed a "Brief Interview for Mental Status" (BIMS) score of 7/15 which indicated Resident # 106 was severely cognitively impaired. Review of Resident #106's "Letter of Guardianship" dated 9/9/21 revealed that Resident #106 had been appointed a full guardian. Review of Resident #106's "Nurses Notes" dated			

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	6/10/24 and documented by RN "C" revealed, (Resident #106) came into another resident's room and was caught by an aid doing sexual interaction with a male resident (Resident #105). Unit Manager informed of this incident and DON "B" notified...." In an interview on 4/16/25 at 8:19 AM, RN "C" reported that she did recall the incident between Resident #105 and Resident #106 on 6/10/24. RN "C" reported that she could not recall which CNA told her that they had found Resident #105 and Resident #106, but that she remembered that the CNA told her it was a sexual interaction, so she reported it to the Unit Manager. RN "C" could not recall what the sexual interaction between Resident #105 and Resident #106 entailed. In an interview on 4/16/25 at 12:36 PM, Former Unit Manager (UM) "DD" reported that she did recall being informed of Resident #106 being found in Resident #105's room. UM "DD" could not recall which CNA had witnessed Resident #105 and Resident #106, but she did recall that Resident #106 was observed performing oral sex on Resident #105. UM "DD" reported that she contacted Resident #105 and Resident #106's guardians to inform of the incident, and she also notified DON "B". UM "DD" reported that she did not report this incident to the abuse coordinator because she thought that DON "B" was going to. In an interview on 4/16/25 at 2:10 PM, CNA "R" reported that Resident #105 and Resident #106 had been in a relationship for a "long time," CNA "R" reported that she was not sure if Resident #105 and Resident #106's guardians had consented to a sexual relationship. CNA "R" reported that Resident #106 used to go to Resident #105's room all the time in the past, and she had observed Resident #105's hands up			

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	Resident #106's pants before. CNA "R" could not recall the date when she had made that observation, and reported that it was "a very long time ago." CNA "R" reported that she did not report this incident to the abuse coordinator. In an interview on 4/16/25 at 10:13 AM, DON "B" reported that she had been made aware of the incident between Resident #105 and Resident #106 on 6/10/24. DON "B" confirmed that she did not report the incident, and the facility did not do any follow up with Resident #105 and Resident #106 after the incident. DON "B" reported that she did not report this incident because Resident #105 and Resident #106 had been in a relationship for a very long time, and this was not a new situation. In an interview on 4/16/25 at 11:27 AM, NHA "A" reported that she was unaware of the incident between Resident #105 and Resident #106 on 6/10/24. NHA "A" confirmed that if she had been made aware of the incident, she would have reported it to the state agency and completed an investigation. NHA "A" confirmed that the facility had never obtained consent for Resident #105 to participate in a sexual relationship. Review of the facility's "Abuse Prohibition Policy" last revised 9/19/22 revealed, " Policy: Each guest shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. Abuse shall include freedom from verbal, mental, sexual, physical abuse, corporal punishment, involuntary seclusion and any physical or chemical restraint imposed for purposes of discipline or convince that are not required to treat the guest/resident's medical symptoms...To assure guests/residents are free from abuse, neglect, exploitation, or mistreatment, the facility shall monitor guest/resident care and treatments on an on-going			

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	basis. It is the responsibility of all staff to provide a safe environment for the guests/residents...Allegations of guest/resident abuse, exploitation, neglect, misappropriation of property, adverse event, or mistreatment shall be thoroughly investigated and documented by the Administrator, and reported to the appropriate state agencies, physician, families, and/or representative. The subject of abuse should be routinely and openly discussed. Guests/residents will be educated concerning the commitment of the facility to deal quickly and effectively with abuse or suspected abuse incidents on admission and at least annually thereafter. Staff members, volunteers, family members, and others shall immediately report incidents of abuse and suspected abuse, and should be assured that they will be protected against repercussions. Abuse can be guest/resident-to-guest/resident, staff-to-guest/resident, family-to-guest/resident, visitor-to-guest/resident, etc... Definitions:..Sexual Abuse is non-consensual sexual contact of any type with a guest/resident. "Sexual abuse" is defined as non-consensual sexual contact of any type with a guest/resident. Sexual abuse includes, but is not limited to: unwanted intimate touching of any kind especially of breasts or perineal area; all types of sexual assault or battery, such as rape, sodomy, fondling and/or intercourse or coerced nudity; forced observation of masturbation and/or pornography; and taking sexually explicit photographs and/or audio/video recordings of a guest/resident(s) and maintaining and/or distributing them (e.g. posting on social media). Guests/residents have the right to engage in consensual sexual activity. If at anytime the facility has reason to suspect the guest/resident does not have the capacity to consent to sexual activity the facility should evaluate whether the guest/resident has the capacity to consent... Investigation: 1. Allegations by anyone who becomes aware of verbal, physical, mental, sexual or emotional abuse and mistreatment, neglect,			

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	exploitation, involuntary seclusion or misappropriation of property must immediately report it to his/her Administrator..."			
F0656 SS= E	Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive	F0656	F656 Develop/Implement Comprehensive Care Plan Resident #102 still resides in the facility. Care plan was reviewed and updated as needed. Resident #103 still resides in the facility. Care plan was reviewed and updated as needed. Resident #104 still resides in the facility. Care plan was reviewed and updated as needed. Resident #105 still resides in the facility. Care plan was reviewed and updated as needed. Residents who appear to be in a relationship have the potential to be affected. Residents who appear to be gravitating towards a relationship will be meet with to discuss what level of relationship to have and have been care planned. If resident has a guardian or DOPA, the will be meet with to discuss what level of relationship they permission for the residents to have and have been care planned. Any concerns identified will be addressed immediately. IDT has been re-educated on the Care Plan Policy. Care Plan Policy was reviewed by the QA committee and deemed appropriate. IDT will meet weekly to review residents who appear to be in a relationship care plans for any changes needed weekly x 4, then monthly x 3. Concerns will be addressed immediately and findings will be reported to QA committee for further recommendations. Administrator is responsible for sustained compliance.	5/6/2025

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	care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement comprehensive, person centered care plans for 4 residents (Resident #102, #103, #104 and #105) of 6 residents reviewed, resulting in unmet care needs and the potential for negative physical, mental and psychosocial outcomes. Findings include: Resident #102 Review of an "Admission Record" revealed Resident #102 was originally admitted to the facility on 4/26/24 with pertinent diagnoses which included cognitive communication deficit and major depressive disorder. Review of the "Facility Reported Incident (FRI) "dated 4/8/25 revealed, " On 4/8/25 at 10:00 PM, (Registered Nurse- RN) "N" observed (Resident #101) resident laying on (Resident #102's) bed with (Resident #2) in between (Resident #101) legs. (Resident #101) pants were off one leg and around her other ankle and (Resident #102) had his pajama and underpants down to his knees, his penis was not fully exposed. (Registered Nurse (RN)) "F" immediately intervened and assisted (Resident #101) back to her room. (RN "F") did not witness any intercourse but it appeared that (Resident #102) was fondling (Resident #101).			

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	Actions taken by the facility: ... H. Care plans have been updated..." Review of Resident #102's "Care Plan" revealed, " (Resident #102) is experiencing episodes of hypersexuality. Sexual behavior in an appropriate setting. Date Initiated: 04/15/2025. Goals: Will have no episodes of inappropriate sexual behavior through the review date. Date Initiated: 04/15/2025. Interventions: Allow resident to express feelings, concerns or questions related to sexuality. Date Initiated: 04/15/2025. Discuss possible alternatives for intimacy within setting as needed. Date Initiated: 04/15/2025. Psych consult as needed. Date Initiated: 04/15/2025. Set limits/guidelines for behaviors as needed. Date Initiated: 04/15/2025." It was noted that Resident #102's "Care Plan" had not been updated until 4/15/25, and the care plan did not address Resident #102's relationship with Resident #101, and what boundaries were in place for this relationship. In an interview on 4/15/25 at 11:16 AM, Social Worker (SW) "K" reported that she had forgotten to update Resident #102's "Care Plan" after the incident between Resident #101 and Resident #102, and that she had just created the Care Plan for Resident #102 that morning. SW "K" confirmed that Resident #102's "Care Plan" did not include what boundaries were in place for his relationship with Resident #101. Resident #103 Review of a "Admission Record" revealed Resident #103 was originally admitted to the facility on 4/6/23 with pertinent diagnoses which included muscle weakness and adult failure to thrive.			

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	Review of Resident #103's "Care Plan" revealed, " (Resident #103) enjoys spending time with female residents, holding hands, sitting and talking with them. He is appropriate and kind. He does not initiate this interaction, but is approached by specific female residents. Date Initiated: 05/19/2023. Goal: (Resident #103) will stop interacting with any resident that he is not comfortable with and be accepting of staff intervention when needed. Date Initiated: 05/19/2023. Intervention: Check in with (Resident #103) to ensure his comfort with other residents. Intervene as needed. Date Initiated: 05/19/2023. (Resident #103) is experiencing episodes of hypersexuality with a female resident from 100 hall Sexual behavior in an appropriate setting. Date Initiated: 07/24/2024. Goals: Will have no episodes of inappropriate sexual behavior through the review date. Date Initiated: 07/24/2024. Interventions: Allow resident to express feelings, concerns or questions related to sexuality. Date Initiated: 07/24/2024. Discuss possible alternatives for intimacy within setting as needed. Date Initiated: 07/24/2024. Provide time and an environment for privacy as needed/available. Date Initiated: 07/24/2024. Psych consult as needed. Date Initiated: 07/24/2024. Set limits/guidelines for behaviors as needed. Resident is not allowed into female room Date Initiated: 07/24/2024..." It was noted that Resident #103's "Care Plan" did not address his relationship with Resident #104, or what boundaries were in place for their relationship. Resident #103's "Care Plan" addressed previous relationships he had with other residents in the facility. Resident #104 Review of a "Admission Record" revealed Resident #104 was originally admitted to the			

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	414340	A. BUILDING _____ B. WING _____	4/15/2025

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	facility on 9/18/24 with pertinent diagnoses which included cognitive communication deficit and depression. Review of Resident #104's "Care Plan" revealed, " (Resident #104) likes to hold hands with a male resident. (Resident #104's guardian) reports her friend looks a lot like her dad and can see how she feels like wanting to be by him and gives consent as long as both of them are comfortable and is consensual. Date Initiated: 04/15/2025. Goals: Will have no episodes of inappropriate sexual behavior through the review date. Date Initiated: 04/15/2025. Interventions: Encourage participation in diversional activities of interest. Date Initiated: 04/15/2025. Psych consult as needed. Date Initiated: 04/15/2025. Set limits/guidelines for behaviors as needed. Date Initiated: 04/15/2025." In an interview on 4/15/25 at 1:32 PM, Registered Nurse (RN) "F" reported that she was aware of a relationship between Resident #103 and Resident #104. RN "F" reported that on April 3rd or April 4th, she had observed Resident #103 and Resident #104 in the lounge together. RN "F" reported that Resident #103 was "groping" Resident #104's chest over her shirt. RN "F" reported that she was unaware of what boundaries were in place for Resident #103 and Resident #104. Review of Resident #103's "Nurses Notes" dated 2/8/25 and documented by Licensed Practical Nurse (LPN) "G" revealed, "(Resident #103) was in the middle of the hall massaging (Resident #104) breast; educated that he could not be doing that out in the hall, in public. He stated she (Resident #104) was doing it to him, but his statement was not witnessed. (Resident #104) did not look upset or in any distress. Separated residents and he went into the shower."			

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	In an interview on 4/16/25 at 3:50 PM, Licensed Practical Nurse (LPN) "G" reported that she did recall witnessing Resident #103 fondling Resident #104's breast in the hallway. LPN "G" reported that she did not know if Resident #103 and Resident #104 had any boundaries in place for their relationship. In an interview on 4/16/25 at 8:53 AM, SW "K" reported that she was aware that Resident #103 and Resident #104 were spending a lot of time together, and they had been observed by staff holding hands on several occasions. SW "K" reported that she was not aware that Resident #103 and Resident #104 had passed the boundary of holding hands. SW "K" confirmed that she did not create Care Plans for Resident #103, and had just initiated a Care Plan for Resident #104 the day prior to address the relationship between Resident #103 and Resident #104. SW "K" confirmed that Resident #104's "Care Plan" did not address what boundaries were in place for Resident #103 and Resident #104's relationship. SW "K" reported that she had just forgotten to update Resident #104's "Care Plan." Resident #105 Review of an "Admission Record" revealed Resident # 105 was originally admitted to the facility on 8/10/2019 with pertinent diagnoses which included dementia and depression. Review of Resident #105's "Care Plan" revealed, " (Resident #105) likes to spend time with a female resident that often rubs his back and call girlfriend. Date Initiated: 04/15/2025..." It was noted that Resident #105's "Care Plan" related to his relationship with Resident #106 was not initiated until 4/15/25, and did not include interventions to discuss what boundaries were in			

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	place for the relationship. Resident #106 Review of an "Admission Record" revealed Resident #106 was originally admitted to the facility on 5/6/16 with pertinent diagnoses which included muscle weakness and cognitive communication deficit. Review of Resident #106's "Care Plan" revealed, "(Resident #106) enjoys to engage (sic) in kissing and physical behaviors with other male residents at the facility. Guardian is aware. Date Initiated: 10/22/2022. Goals: Appropriate boundaries will be identified and implemented during these times, as needed. Date Initiated: 01/20/2022. Interventions: Allow resident to express feelings, concerns or questions related to sexuality. Date Initiated: 01/20/2022. Encourage participation in diversional activities of interest. Date Initiated: 01/20/2022. Set limits/guidelines for behaviors as needed. Date Initiated: 01/20/2022. (Resident #106) has a history of experiencing a budding relationship with a resident...Discusses relationship boundaries. this guest has agreed and verbalized understanding to only holding hands and kissing with resident and speaking in common areas. This resident expired. However, (Resident #106) currently holds a romantic relationship with a new resident. Date Initiated: 04/09/2020. Goal: Will have no episodes of inappropriate sexual behavior through the review date. Date Initiated: 05/20/2024. Interventions: Psych consult as needed. Date Initiated: 05/20/2024. set limits and guidelines as needed Date Initiated: 05/20/2024..." Review of Resident #106's "Nurses Notes" dated 6/10/24 and documented by RN "C" revealed, (Resident #106) came into another resident's			

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	room and was caught by an aid doing sexual interaction with a male resident (Resident #105). Unit Manager informed of this incident and DON "B" notified...." Review of Resident #105's "Social Services Note" dated 7/18/24 revealed, " Writer contacted (Resident #105) guardian (Guardian "BB") to report relationship between (Resident #105) and female resident (Resident #106), often known to be of sexual interaction. This relationship is consensual from both residents. When (Resident #105) was interviewed; he stated he likes the female resident (Resident #106), does not feel obligated or in stress, and wish to continue to have this relationship with her. (Guardian "BB") stated he will like to talk to (co-guardian) before a decision is made about situation." In an interview on 4/16/25 at 8:19 AM, RN "C" reported that she did recall the incident between Resident #105 and Resident #106 on 6/10/24. RN "C" reported that she could not recall which CNA told her that they had found Resident #105 and Resident #106, but that she remembered that the CNA told her it was a sexual interaction, so she reported it to the Unit Manager. RN "C" could not recall what the sexual interaction between Resident #105 and Resident #106 entailed. RN "C" was not aware what boundaries were in place for the relationship between Resident #105 and Resident #106. In an interview on 4/16/25 at 2:10 PM, Certified Nursing Assistant (CNA) "R" reported that Resident #105 and Resident #106 had been in a relationship for a "long time," CNA "R" reported that she was not sure if Resident #105 and Resident #106's guardians had consented to a sexual relationship. CNA "R" was not aware what boundaries were in place for the relationship between Resident #105 and Resident #106.			

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	In an interview on 4/16/25 at 8:53 AM, SW "K" reported that she had Resident #105 and Resident #106 had been in a relationship together for quite some time. SW "K" reported that Resident #105 and Resident #106 did go into each other's rooms, but the staff "try to" separate them. SW "K" confirmed that she had not updated Resident #105 until 4/15/25 and had not updated Resident #106's Care Plan related to the relationship between the residents. SW "K" confirmed that Resident #105 and Resident #106's "Care Plans" did not address what boundaries were in place for Resident 3105 and Resident #106's relationship. SW "K" reported that she had just "missed this." In an interview on 4/16/25 at 1:58 PM, CNA "T" reported that she was not aware what boundaries were in place for Resident #103 and Resident #104's relationship, or Resident #105 and Resident #106's relationship. CNA "T" reported that CNA's should have that information available in the resident care plan, but that the facility was "not good" at keeping up on that and communicating "those type of things" in the care plans. In an interview on 4/16/25 at 10:13 AM, DON "B" reported that staff utilized the resident's Care Plan to know what boundaries were in place for residents that had romantic relationships in the facility. DON "B" confirmed that the facility had not ensured that care plans were initiated following the discovery of the relationships between Resident #103 and Resident #104 and between Resident #105 and Resident #106. Review of the facility's "Care Planning" policy dated 3/3/25 revealed, " Purpose: Every resident in the facility will have a person-centered Plan of Care developed and implemented that is consistent with the resident rights.. Additional resources will also be utilized to ensure that any			

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	additional needs or risk areas are identified... Procedure: ...7. The care plan must be specific, resident centered, individualized and unique to each resident and may include: It should be oriented toward preventing avoidable declines, How to manage risk factors... involve and communicate the needs of the resident with direct care staff..."			