STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

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F 000	INITIAL COMMENTS An unannounced onsite complaint survey was conducted 10/11/2023. Intake NC00208151 was investigated. Event ID# 3WP111. 1 of 1 allegations resulted in deficiency.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §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: Based on record reviews, observations, resident, and staff interviews, the facility failed to protect a resident's right to be free from sexual abuse for 2 of 2 residents investigated for resident-to-resident sexual abuse (Resident #1, resident #2). The findings included: Resident #1 was admitted to the facility on 12/16/2022 with diagnoses that included cerebral infarct, traumatic brain injury, and dementia. The resident's quarterly Minimum Data Set	F 600	F-600 Abuse 1. Resident #1 and Resident #2 were immediately separated on 10/05/2023 and placed on 1:1 supervision immediately. Administrator and Director of Nursing educated all staff 10/5/23 on sexual abuse to ensure that each resident is free of abuse and neglect. Administrator and Director of Nursing educated all staff 10/5/23 on how to	10/27/23

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

Electronically Signed | 10/27/2023

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F 600	Continued From page 1 (MDS) dated 8/18/2023 indicated Resident #1 was severely visually impaired and severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 3 out of 15. The resident required extensive assistance of one person to complete bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS reflected the resident did not have behavioral symptoms directed toward others, to include public sexual acts, during the assessment period. Resident #1's care plan last revised on 9/12/2023 contained a focus for impaired cognition related to history of cerebral vascular accident (stroke) and traumatic brain injury. Interventions included verbal cueing and reorientation as needed. The care plan also had a focus for inappropriate sexual behaviors as evidence by masturbating in public/common areas. Interventions included redirecting the resident and removing the resident from public areas to a more private area. Resident #1 was followed by the Psychiatric Mental Health Nurse Practitioner (PMHNP). An after-visit summary dated 9/28/2023 indicated the resident was seen for neurocognitive disorder due to dementia without behaviors. Staff reported no concerns or behaviors. No apparent changes in behavior were noted by the PMHNP. Resident #1 was receiving Aricept for cognitive support and Depakote for mood stabilization. He also received fluoxetine for mood and anxiety symptoms. Recommendations were to continue current medications and redirection as needed. Resident #2 was admitted to the facility on 5/3/2023 with diagnoses that included dementia without behaviors, psychotic disturbance, mood	F 600	determine if sexual activity is consensual, the meaning of consent, and residents that currently have the capacity to consent. 2. All residents have the potential to be affected by the deficient practice. Social Worker conducted a facility wide audit on all residents with BIMS 10 or great to determine desire for consensual sexual contact on 10/5. 3. Beginning 11/10, the facility will implement a new process in admission care plan meeting to discuss consent to sexual activity upon new admission. Designee will interview all existing residents with BIMS over 10 or greater their ability to consent to sexual activity. Social Worker will monitor routinely for new relationship cues, sexual preferences, and desires to accommodate for consensual activity. 4.The Administrator and Director of Nursing or designee will bring these audits and results of interviews to Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurances Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. 5. Compliance Date: October 5, 2023	

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F 600	Continued From page 2	F 600		

disturbance, and anxiety.

The resident's MDS dated 8/7/2023 documented Resident #2 was cognitively intact with a BIMS of 14 out of 15. Resident #2 required minimum assistance with dressing, toileting, and personal hygiene during the assessment period. He required supervision only for ambulation. He received no medications and had no behaviors during the assessment period.

Resident #2's care plan was last updated on 8/10/2023. The care plan contained a focus for risk of impaired thought process related to dementia. Interventions included administering medications as ordered and monitoring for changes in behaviors and side effects. On 10/5/2023 the care plan was revised to include a focus for inappropriate sexual behavior. The interventions included the use of redirection and monitoring for behaviors.

Resident #2 was followed by the PMHNP. An after visit summary dated 10/2/2023 indicated the resident was seen for neurocognitive disorder related to Alzheimer's type dementia. He was receiving Namenda and Aricept for cognitive support and was tolerating medication. Staff reported no concerns or issues. The PMHNP recommended no medications changes at that time.

Record review revealed Resident #1 and Resident #2 were roommates from 5/3/2023 until 10/5/2023.

The resident's medical record included a nursing note dated 10/5/2023. A Nurse Assistant (NA) observed Resident #2 standing next to Resident

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#1's bed. Resident #1 was lying in his bed. Resident #2 has his penis in Resident #1's mouth. The Medical Director (MD) was notified of the incident. Both residents' Responsible Party (RP) were notified by the Social Worker (SW) and the residents were separated and placed on every 15-minute (Q15) safety checks.

The medical record contained a nursing note by the Unit Manager dated 10/5/2023 noted Resident #1 made a statement about letting Resident #2 come back to "finish". Resident #1 was assessed. There was no oral trauma or evidence of semen when oral care was completed.

A nursing progress note by the Unit Manager dated 10/5/2023 revealed Resident #2 was assessed to have no injury. He was immediately relocated to another room. The resident was angry, agitated, and yelling out in response to being moved into another room.

Resident #1 was assessed by PMHNP on 10/11/2023. Per the visit summary, when the PMHNP asked Resident #1 about the incident with his roommate, he indicated it was consensual but would not disclose any additional information or answer any other questions regarding the incident.

Resident #2 was assessed by the PMHNP on 10/11/2023. Per the visit summary, the resident could not recall the incident when asked about staff reports of Resident #2 participating in oral sex with his roommate.

An interview was conducted with Resident #2 on 10/11/2023 at 8:15AM. He was in a private room.

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There was no staff in the room or outside the door of Resident #2's room. Resident #2 stated he did not recall an incident on 10/5/2023. He stated he did have a roommate up until 10/5/2023. He did not know why the facility staff moved him to another room.

An interview was conducted with Resident #1 on 10/11/2023 at 11:00AM. He stated he did not recall the incident between him and his roommate on 10/5/2023. He further stated he had not been asked to participate in sexual activities against his will. He felt he was in a safe place.

A second interview with Resident #1 at 2:06PM. He stated he could not recall the incident that occurred on 10/5/2023. He denied being asked to participate in sexual activity against his will. He stated he felt he was in a safe place.

Nurse Assistant (NA) #1 was interviewed on 10/11/2023 at 11:15AM. She stated she entered the room of Resident #1 and Resident #2 to obtain a weight on Resident #2. She stated when she entered the room, the curtain between the beds was pulled. As she looked around the curtain, she saw Resident #2 standing at the top of Resident #1's bed. Resident #2 had his penis in Resident #1's mouth. NA#1 stated she was startled, apologized, and backed out of the room. NA#1 stated as she exited the room she saw Nurse #1 was across the hall and she reported her observation to Nurse #1. While NA#1 was speaking with Nurse#1 in the hall, Resident #2 exited the room and walked down the hall to the nurse's station. She and Nurse #1 then walked down the hall and reported the incident to the Unit Manger. NA#1 stated she did not ask either resident about the incident. She stated Resident

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#1 kept the covers over his head or kept looking down while staff moved Resident #2 and his personal belongings into another room. Resident #2 became angry and agitated over being moved into another room. He was yelling and making derogatory statements about the facility and the staff to the point it was disrupting to other residents. NA#1 stated she had never observed any sexual behaviors between Resident #1 and Resident #2 in the past.

An interview was conducted with Unit Manger #1 on 10/11/2023 at 11:30AM. She stated Nurse #1 informed her of the incident. She immediately went to the room and Resident #1 was alone. She made sure Resident #1 was safe. During her assessment, Resident #1 stated he was fine and asked if Resident #2 was going to come back so they could "finish". Unit Manager #1 stated Resident #1 had previous behaviors that included masturbating in public areas. She had never observed any sexual behaviors between Resident #1 and Resident #2 in the past.

A telephone interview was conducted with Nurse #1 on 10/11/2023 at 12:22PM. She stated she was across the hall from Resident #1 and Resident #2's room when NA#1 alerted her to the situation. By that time Resident #2 was in the hall making his way to the nurse station. She immediately notified the Unit Manger. The residents were separated and placed on Q15 minute safety checks. She further stated Resident #2 was immediately moved into a private room. He became very agitated over the move. Nurse #1 stated she was very familiar with both residents and had never observed any sexual behaviors between them in the past.

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F 600	Continued From page 6 The Director of Nursing was not available for interview. On 10/11/2023 at 12:31PM an interview was conducted with the Administrator. She stated when she was made aware of the incident, the residents were immediately separated and assessed for injury. When the residents were interviewed independently, neither would indicate who initiated the interaction but neither appeared to be in any distress. Resident #2 was placed in a private room. She stated the Medical Director (MD), each resident's Responsible Party (RP) were made aware of the incident. The police department was contacted and declined to complete a report on the incident and the staff were provided in-service education on prevention of abuse. The Administrator stated mandatory reports to Adult Protection Services (APS) and DHHS were completed on 10/5/2023.	F 600		