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	345468	A. BUILDING _____ B. WING _____	C 03/12/2025

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 03/11/25 through 03/12/25. Event ID# MGMH11. The following intakes were investigated: NC00227863 and NC00227870. 2 of the 2 complaint 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 review, observation, and interviews with the Physician, Nurse Practitioner, resident, and staff, the facility failed to protect a cognitively intact female resident's (Resident #2) right to be free of sexual abuse when another female resident (Resident #1), who was cognitively impaired entered Resident #2's room and got into the bed with Resident #2 on 2/25/25 at 6:19 am. While in the bed Resident #1 kissed Resident #2 on the face, touched Resident #1's breasts and placed her hand inside the front of	F 600	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 03/26/2025

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 #2's brief and attempted to touch her vagina. Resident #2 yelled out and Resident #1 got out of the bed and left the room. Resident #2 stated she was scared at the time and was still upset that it happened but was no longer afraid. Resident #2 was initially afraid until she learned that it was Resident #1 in her bed and not a man. The deficient practice occurred for 1 of 5 residents reviewed for abuse (Resident #2).

The findings included:

Resident #1 was admitted to the facility on 7/13/21 and readmitted on 10/14/24 with diagnoses that included dementia.

Resident #1's care plan dated 10/15/24 revealed a problem of impaired cognitive function related to dementia with interventions that included cue, orient, supervise, and assess for unmet needs as needed. A second problem revealed Resident #1 had increased wandering and confusion and wandered into other resident rooms, woke them up and attempted to "help" other residents. Interventions included to anticipate needs when possible.

Resident # 1's quarterly Minimum Data Set (MDS) assessment dated 1/29/25 revealed Resident # 1 was severely cognitively impaired. She was not assessed to have behavioral problems or wandering during the assessment period. Resident #1 was coded as using a wheelchair for mobility but could ambulate with partial to moderate assistance for 150 feet.

Resident #2 was admitted to the facility on 11/24/21 and readmitted on 2/26/25

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Resident # 2's admission Minimum Data Set (MDS) assessment dated 2/26/25 revealed Resident # 2 was cognitively intact. She required substantial to maximum assistance for activities of daily living care and moderate to partial assistance with bed mobility and transfers.

An initial report dated 2/27/25 at 3:10 pm revealed that on 2/27/25 Resident #2 reported an allegation of abuse perpetrated by Resident #1. The report stated that Resident #1 went into Resident #2's room on 2/25/25, got into bed with Resident #2 and felt her breasts. Resident #1 then put her hand into Resident #2's brief. Resident #2 yelled for help and Resident #1 got out of the bed and left the room. Resident #1 was placed on one-to-one supervision after the facility became aware of the allegation. The report was signed by the Administrator on 2/27/25.

In an interview with Resident #2 on 3/11/25 at 10:33 am she stated Resident #1 came into her room about a week ago (could not recall date or time) and got into bed with her when it was still dark outside. Resident #2 stated it scared her at the time because she could not tell if it was a man or woman. She stated she was not strong enough to push Resident #1 off her bed. The interview further revealed Resident #1 lay down beside Resident #2 and touched her breasts, kissed her face, and placed her hand inside the front of her brief and tried to touch her vagina. Resident #2 stated Resident #1 said something to her, but she could not recall what was said. Resident #2 stated when she told Resident #1 that she was going to call the police and yelled for help that Resident #1 got out of her bed and went toward the door. Resident #2 stated when Resident #1 was near the doorway she could identify Resident

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#1, and she was no longer afraid but was still upset that it happened. Resident #2 stated she knew Resident #1 was a resident at the facility and had talked to her before. The interview further revealed that she felt safe and was no longer afraid.

During an interview with the Director of Nursing (DON) on 3/12/25 at 8:52 am she stated on 2/27/25 the Administrator made her aware of an alleged sexual abuse concern made by Resident #2 and immediately interviewed Resident #2 and completed a full body audit to include a vaginal observation. She indicated that the allegation was Resident #1 entered Resident #2's room on 2/25/25 in the early morning and got into bed with her, told her she loved her and touched her inappropriately on the chest area and attempted to put her hand in her brief. The DON stated Resident #2 reported she was afraid until she learned that it was Resident #1 that got into her bed and not a man. The DON stated interventions we put in place immediately, Resident #1 was placed on 1 on 1 observation with a staff member, was given a baby doll as a distraction to wandering, a mesh stop sign was placed across Resident #2's room door, and Resident #2 was later relocated to another hallway per the family approval. The interview further revealed Resident #1 and Resident #2 were known to one another and Resident #1 often visited Resident #2's room. The DON stated that on 2/27/25, Resident #1 had been placed on one-to-one supervision pending investigation into the incident. On 3/5/25 the Interdisciplinary Team (IDT) reviewed Resident #1 for the continued need for a 1 on 1 sitter with an intervention of a weighted baby doll (a life sized baby doll intended to simulate a real baby, used as a diversional activity for cognitively

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impaired residents) implemented on 3/5/25 and Resident #1 had decreased wandering into other residents' rooms and a large picture of Resident #1 and her husband had been placed on Resident #1's doorway to help her identify her room. There had been no concerns reported/identified during the resident body audits and resident interviews related to abuse or inappropriate touching. The IDT felt 1 on 1 supervision could be removed when this was discussed on 3/7/25 during the weekly Quality Assurance (QA) Meeting.

Resident #1 was observed on 3/11/25 at 10:25 am sitting in a wheelchair in her room beside her roommate's bed in a wheelchair holding a doll baby and talking about the sunshine outside. Attempts to interview Resident #1 were unsuccessful because Resident #1 was unable to hold a meaningful conversation and kept reverting to the baby doll and the sunshine. Resident #1's room was noted to be on the same hallway several rooms down the hallway from Resident #2's room.

During a phone interview with Nurse #3 on 3/11/25 at 3:14 pm she worked the 7:00 pm to 7:00 am shift on 2/25/25. She stated Resident #2 had been on her assignment that night. Nurse #3 stated while Resident #1 would go into other resident's rooms that she had never attempted to get into anyone's bed with them. She stated she did not hear Resident #2 call out for help that night and did not witness Resident #1 enter Resident #2's room.

In an interview with Nursing Assistant (NA) #3 on 3/11/25 at 3:53 pm she stated she worked the 7:00 pm to 7:00 am shift on 2/25/25 and had

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been assigned to Resident and #1 and #2. She further indicated she had not observed Resident #1 enter Resident# 2's room at any time and had not heard Resident #2 call out for help that night. She stated she would have been making rounds and may have been in another resident's room when Resident #2 called out. The interview further revealed Resident #1 could transfer herself from the bed to her wheelchair and could ambulate Independently. NA #3 further stated she assisted Resident #1 to bed at 11:00 pm on 2/25/25 and checked on her every 2 hours throughout the night and Resident #1 was not observed to be out of her bed at any time during her shift.

In an interview with the Physician for Resident #1 and Resident #2 on 3/11/25 at 3:25 pm he revealed he had been made aware that Resident #1 had gotten into bed with Resident #2 and that was unusual behavior for Resident #1. He stated Resident #1 was pleasantly confused and oriented to person only and continually called out for her husband. He stated he did not meet with Resident #2, but the Nurse Practitioner (NP) had and did not report any concerns to him regarding her well-being.

A phone interview with the NP on 3/12/25 at 10:08 am revealed she met with Resident #2 on 2/25/25 in the late afternoon and Resident #2 had not told her someone had gotten into her bed or touched her inappropriately. She stated Resident #2 was not distraught during her visit with her and was her normal happy self. The NP stated she was made aware of the concern of alleged sexual abuse a few days later by administration. She stated she did not order a psychiatric evaluation for Resident #2 because she was not distraught.

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She stated a vaginal exam was not ordered because there was no report or indication of penetration of any type.

An interview with the Administrator on 3/12/25 at 10:18 am revealed he received a text from Resident #2's family member that someone had gone into Resident #2's room before lunch on 2/25/25 and he checked the facility camera's and could not verify that anyone had entered her room during that time frame. He stated he communicated back to Resident #2's family member that camera footage did not reveal anyone entering her room. He stated he talked to Resident #2 on 2/25/25 and she had not indicated that she had been sexually abused, just that someone came into her room. He stated he communicated back and forth with the family member and continued to review video camera footage until he finally saw Resident #1 enter Resident #2's room on 2/25/25 at 6:19 am and leave the room at 6:57 am. He stated at this time he still thought the concern was that someone had entered Resident #2's room and was not aware of a sexual abuse allegation. He told the family member he would put up a mesh stop sign across Resident #2's door to deter wandering residents from entering her room and they agreed. He stated he had not been made aware of the alleged sexual abuse concern until 2/27/25 at 3:10 pm when he went to put the stop sign on Resident #2's doorway and a family member was present and they told him Resident #2 failed to tell the Administrator what happened when the person entered his room on 2/25/25 because the Administrator was a male and Resident #2 was not comfortable talking to him. He stated he asked the DON to go in to interview Resident #2 and she told the DON about the sexual abuse

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concern. The Administrator stated upon learning of the alleged sexual abuse he contacted the Division of Health Service Regulation, local law enforcement, and Adult Protective Services within the required timeframes. He further indicated that he was able to identify the person that entered the room on 2/25/25 at 6:19 am as Resident #1. The Administrator stated after he learned of the alleged sexual abuse he started an investigation, completed education with staff on resident-to-resident abuse prevention, reporting and protection.

Review of Surveillance video footage of the hallway outside of Resident #2's doorway was reviewed with the Administrator on 3/12/25 at 10:30 am and confirmed Resident #1 entered Resident #2's room on 2/25/25 at 6:19 am and exited the room at 6:57 am.

The facility provided the following corrective action plan with a compliance date of 3/6/2025.

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

On 2/27/2025, the Director of Nursing (DON) assessed Resident #2 for any noted change in condition or injuries with none noted.

On 2/28 The IDT which consists of the DON, Unit Managers, Staff Development Coordinator, Administrator, Social Worker and MDS Coordinator completed a root cause analysis of Resident # 1's incident and determined she thought she was getting in bed with her husband based on Resident #2's statement that she

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(Resident #1) told her she has always loved her, and that Resident #1 frequently asked for her husband.

On 2/27/25, Resident #1 was placed on one-to-one supervision pending investigation, a stop sign was placed on Resident #2's doorway to deter any wandering into her room. Resident #2 was moved to the rehab hall on 3/5/25 per family and resident's request. Resident #1 was to remain on one-to-one supervision until the IDT evaluated the effectiveness of the implemented interventions.

On 2/27/25, the Administrator notified the local police department and Adult Protective Services (APS).

On 2/27/25 the Administrator submitted the initial report to the State Agency.

On 2/27/25, the DON/designee notified the Physician and responsible parties of Resident #1 & Resident #2.

On 2/27/25 Resident #1's roommate had a skin assessment completed and was assessed for signs and symptoms of emotional distress with no noted decline. Resident #1 was on one-to-one during the abuse investigation.

On 3/5/25 Resident #1's implemented interventions included a weighted babydoll, which has decreased residents wandering into other residents' rooms, and a large picture of Resident #1 and her husband was placed on her doorway to help her identify her room.

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2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

On 2/28/25 the Social Worker (SW) interviewed alert and oriented residents concerning abuse with no noted concerns identified.

On 2/28 /25 the Director of Nursing (DON) and Unit Managers (UMs) performed skin checks on cognitively impaired residents with no areas of concern identified.

On 2/28/25 the Administrator reviewed grievances and Resident Council minutes for the previous 30 days with no concerns of inappropriate touching or abuse.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

On 2/28/25, the Staff Development Coordinator (SDC) and Director of Nursing (DON) began re-education for all staff regarding Abuse, which included reporting process and types of abuse along with Handling Challenging Behaviors. This education was completed by all staff including agency on 3/5/25.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

The Facility initiated monitoring and one-to-one on 2/27/25. The Reportable Incident was reviewed on 2/28/25 in the weekly Quality Assurance Meeting. The Administrator or Social Worker are conducting random interviews on 6

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cognitively intact residents. The interviews will include questions related to abuse and any inappropriate touching. Residents were, and are encouraged to report any issues related to abuse or inappropriate touching by Administrator or Social Worker during initial interviews and follow-up interviews conducted per the plan of correction. Nursing will conduct 3 body audits on non-cognitively intact residents to make sure there are no signs of suspicious skin injuries or signs of abuse. These interviews /audits will be conducted weekly for two weeks, and monthly for three months. The IDT will monitor the 24-hour report (a report shared between shift to communicate resident conditions) which is reviewed daily Monday through Friday and on the weekends the Shift Supervisors will report to the DON any concerns from 24-hour report or grievances for any safety concerns, or inappropriate touching. Staff will immediately place resident on one-to-one if identified. All data will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager.

Alleged Date of compliance: 3/6/2025

Validation of the corrective action was completed on 3/12/25. This included staff interviews regarding resident-to-resident abuse. An observation of Resident #1 verified the weighted baby doll intervention was implemented.

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F 600	Continued From page 11 Education was verified for staff on abuse, resident protection, reporting, and handling challenging behaviors. The audits completed by the SW, DON, UMs, and Administrator were verified and there were no concerns identified. Skin assessment for Resident #2, documentation of one on one observation of Resident #1, and documents that indicated notification was made to the State Agency, local police, APS, Physician and responsible parties for Resident #1 and Resident #2 were all verified. As indicated in the corrective action plan, Resident #1 remained on one on one supervision until the IDT evaluated the effectiveness of interventions. On 3/7/25 the IDT determined the implemented interventions were affective and one on one supervision was removed. The facility's alleged compliance date of 3/6/25 was validated.	F 600		