STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345036	A. BUILDING _____ B. WING _____	C 10/28/2023

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ELIZABETH CITY HEALTH AND REHABILITATION	1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909

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F 000	INITIAL COMMENTS A complaint investigation was conducted from 10/27/2023 to 10/28/2023. Event ID # 2XU511. The following intakes were investigated NC00208935 and NC00209116. Two of the two complaint allegations resulted in deficiency.	F 000		
F 600 SS=G	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, staff interview, resident interview, physician interview, physician assistant interview, and family interview the facility failed to prevent intentional inappropriate touching for one of three residents reviewed for resident-to-resident abuse. Resident #1 was observed by Resident #3 touching the breasts of Resident #2 under her shirt after the conclusion of a planned activity event with a gathering of the residents. Resident #2 did not have the cognition to express an adverse outcome, inappropriate touching of their breasts	F 600	1) Resident #1 was witnessed by Resident #3 with his hand placed under the shirt of Resident #2. Resident #3 reported to activity assistant #1 what she witnessed and activity assistant #1 immediately removed resident #1 who was inappropriately touching resident #2 from the table in the dining room and sat resident #1 next to activity member #1 at their activity table. Activity Staff member #1 notified nurse#1 who informed Nurse #4, Nursing Supervisor of the incident.	11/6/23

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

Electronically Signed | 11/05/2023

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F 600	Continued From page 1 would have traumatized a reasonable female person. A family member of Resident #2 confirmed Resident #2 would have been devastated, furious, and mad at being touched inappropriately by a man if she was not cognitively impaired. Findings included: Documentation in the electronic medical record revealed Resident #1 had cumulative diagnoses some of which included stroke, hemiplegia, and vascular dementia. Documentation on a care plan for Resident #1 dated as last reviewed on 9/1/2023 had a problem area stating, "I will not show complications/behaviors [relative to diagnosis] of Vascular Dementia." The care plan had the following approaches under the problem area: "Reinforce and focus on reality. Use Clear, concise terms; obtain a [psychological] consult/psychosocial therapy as ordered; medications as ordered; maintain a calm environment and approach with me; do not confront, argue against, or deny resident's thoughts; and begin short, concise interactions with resident, increase as suspicions decreases." Documentation on a quarterly Minimum Data Set (MDS) assessment dated 9/30/2023 revealed Resident #1 had a BIMS (Brief Interview for Mental Status) score of 13 indicating he was cognitively intact. Documentation in the electronic medical record revealed Resident #2 had cumulative diagnoses some of which included Alzheimer's disease, anxiety, and depression. Documentation on a care plan for Resident #2	F 600	Nurse #4, Nursing Supervisor assessed residents and ensured they were safe and observed no noted changes in behavior or emotional distress. One-on-one supervision of resident#1 was initiated for all hours resident #1 was out of bed, beginning on 10/24/2023. A schedule was created so staff understood the one-on-one assignment. Based on mental health provider assessment of resident #1 beginning on 10/30/2023 resident was not required to have 1:1 supervision but will be monitored in all group activities and will be seated only with males. The mental health provider also did a medication review and updated his medication list based on his new behavior. 2) All residents have the potential to be impacted by this practice. An audit of 100% of all residents that were interviewable was completed on 10/24/2023 by the facility social workers with no concerns. A 100% skin check was completed by facility nurse managers for those residents who couldn’t not be interviewed on 10/24/2023 with no new findings. 3) Staff were educated by either the Nurse management team or Administrator and Facility Department managers on the definition of abuse which is defined as the willful infliction of injury; unreasonable confinement; intimidation; or punishment; with resulting physical harm, pain, or mental anguish. This education also	

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F 600	Continued From page 2 dated as last reviewed on 10/2/2023 had a problem area stating, "Resident has impaired daily decision making [relative to diagnosis] of dementia and dysphagia." The care plan had the following approaches under the care plan: Give praise when resident makes an appropriate decision; in new situations, provide support and reassure; set expectations and limits for resident; respect resident's rights to make decision(s); calm resident if signs of distress develops during the decision making process; and provide the resident opportunities to make decisions." Documentation on a significant change MDS assessment dated 10/9/2023 revealed Resident #2 had a BIMS score of 3 indicating she was severely cognitively impaired. Documentation on a quarterly MDS assessment dated 9/28/2023 revealed Resident #3 had a BIMS score of 15 indicating she was cognitively intact. An interview was conducted with Resident #3 on 10/27/2023 at 1:04 PM. Resident #3 revealed that she saw Resident #1 picking at the shirt of Resident #2 as they were sitting in the dining room at the conclusion of an activity, last Saturday (10/21/2023). Resident #3 stated Resident #1 then put his hand underneath the shirt of Resident #2 and was playing with her breasts. Resident #3 further stated she went immediately to tell Activity Assistant #1 what Resident #1 was doing. Resident #3 reported Activity Assistant #1 went over to Resident #1 and Resident #2 and asked Resident #1 what he was doing to which he replied, "What do you think I am doing. I am playing with them." Resident #3 stated she heard Activity Assistant #1 ask	F 600	included the facility's policy of reporting abuse to Director of Nursing or Administrator immediately. Any staff member who are not available will be educated before returning to work. New Hires will be educated on the definition of abuse and reporting requirements during their new hire orientation. Administrator and Activity Director educated Activity staff members on the new monitoring system and seating expectations for resident #1 and will be documenting daily when he is attending activities. Staff were educated by either the Nurse management team or Administrator and Facility Department managers on how to identify potential abuse and immediately separate residents, keep residents safe, and keep perpetrator on 1:1 until evaluated. Any staff that did not receive education will not be allowed to work until education is received. 4) Administrator / Designee will observe resident activities throughout the building 5 days a week for three weeks and then 3 days per week for 5 weeks to ensure compliance. Administrator/Designee will audit activity log book for the new monitoring system for 5 days a week for three weeks and then 3 days per week for 5 weeks to ensure proper documentation of attendance is compliant. Social worker will assess resident #1	

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F 600	Continued From page 3 Resident #1 why he was doing that to which he replied, "Because I can. They are available." Resident #3 confirmed Activity Assistant #1 separated Resident #1 from Resident #2 and took Resident #1 over to the desk in the room. An interview was conducted with Activity Assistant #1 on 10/27/2023 at 11:46 AM. Activity Assistant #1 related the following events as happening on 10/21/2023 at approximately 2:30 PM. Activity Assistant #1 was sitting at her desk in the dining room documenting who had attended the activity that had just concluded when Resident #3 came up to her reporting Resident #1 was playing with the breasts of Resident #2. Activity Assistant #1 went over to Resident #1 and Resident #2 and asked him what he was doing to which he replied, "What do you think I am doing. I am playing with them." Activity Assistant #1 then asked him why and he replied, "Because I can. They are available." Activity Assistant #1 confirmed that she saw Resident #1 with his hand underneath the shirt of Resident #2 playing with her breasts. Activity Assistant #1 removed Resident #1 away from Resident #2 taking him to the front table she has previously been sitting at. Very soon after Nurse #1 walked into the dining room and Activity Assistant #1 told Nurse #1, Resident #1 was observed playing with the breasts of Resident #2 underneath her shirt. Nurse #1 removed Resident #1 from the dining room. Activity Assistant #1 stated she had worked at the facility on 10/22/2023 but, she did not recall any concerns or problems in the activities with Resident #1 or Resident #2 the next day. Nurse #1 was interviewed on 10/27/2023 at 2:57 PM. Nurse #1 stated she was at her nursing cart on 10/21/2023 on the hallway when she	F 600	weekly for 8 weeks in various areas of the building to monitor for any inappropriate behavior. Social worker will interview 10 residents weekly for 8 weeks to ensure no resident has an allegation of abuse. 5) Administrator will review findings from the audits to the QAPI committee for review monthly for four months for compliance and any further recommendations. Compliance date 11/6/2023	

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overheard a couple of the nursing aides talking about Resident #1 touching the breasts of another resident in the dining room. Nurse #1 stated she then went to the dining room where she saw Activity Assistant #1 sitting at a desk with Resident #1. Nurse #1 revealed Activity Assistant #1 told her Resident #1 "tried to" feel the breasts of Resident #2 so the residents were separated. Nurse #1 stated she then brought Resident #1 back to his room and went to tell Nurse #4, the nursing supervisor, what Activity Assistant #1 told her. Nurse #1 revealed she had "heard stories" of Resident #1 trying to do this sort of thing before but she herself had never seen this behavior of Resident #1.

Nurse #4, nursing supervisor, was interviewed on 10/27/2023 at 4:09 PM. Nurse #4 confirmed she was informed by Nurse #1 on 10/21/2023 Resident #1 was, "attempting to touch the other resident's breast." Nurse #4 stated she was also knowledgeable Resident #1 and Resident #2 were separated and monitored the rest of the night. Nurse #4 stated she did not view what Resident #1 did as an assault because residents have instincts and urges. Nurse #4 further stated she had no reason to believe it was aggression and no reason to believe there was any danger. Nurse #4 stated, if it were abuse, she would have reported it to the Director of Nursing.

Nurse Aide #1 (NA #1) was interviewed on 10/27/2023 at 11:07 AM. NA #1 related the following information. NA #1 routinely worked on the hallway Resident #1 resided and was assigned to be his nurse aide for the 7:00 AM to 7:00 PM shift. Resident #1 had over the past two weeks in October been saying and doing inappropriate things to NA #1. NA #1 had to

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provide total care for Resident #1 and when she had to roll him over to provide care, he would smack her bottom. On another occasion, after giving Resident #1 a shower she leaned over to help him pull up his pants and he told her she had "nice breasts." NA #1 tried to change the subject or divert his attention and he stated, "I guess you didn't hear me, I told you that you have nice breasts." NA #1 did not tell anyone about the inappropriate comments and actions of Resident #1 because she figured nothing could be done. NA #1 related that she had been working at the facility for 6 months and had noticed Resident #1 liked to hold hands with the female residents and rub their arms, so she knew she had to watch him. NA #1 confirmed she notified the unit manager each time she saw inappropriate or concerning interactions between Resident #1 and female residents. NA #1 overheard other nurse aides talking on 10/24/2023 about Resident #1. NA #1, after overhearing this discussion, went to the dining room to speak to Activity Assistant #1 to warn her that Resident #1 needed to be watched closely. Activity Assistant #1 told NA #1 she saw Resident #1 touching the breasts of Resident #2 under her shirt and how he told her he was doing it, "because they were available." Activity Assistant #1 told NA #1 she had not told anybody what had happened to Resident #2, so NA #1 went immediately to the Unit Manager, Nurse #2, to report the incident.

Nurse #2, the Unit Manager for the unit Resident #1 and Resident #2 resided, was interviewed on 10/27/2023 at 1:49 PM. Nurse #2 stated Resident #1 propels himself around the facility talking to other residents and routinely attends group activities. Nurse #2 confirmed NA #2 came to her on 10/24/2023 to report that Resident #1 had

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inappropriately touched the breasts of Resident #2 as reported by Activity Assistant #1. Nurse #2 stated she reported what NA #1 had told her regarding Resident #1 and Resident #2 to the Director of Nursing (DON) immediately on 10/24/2023.

Documentation in the electronic medical record revealed a BIMS score of 9 for Resident #1 was obtained on 10/24/2023, indicating Resident #1 had moderately impaired cognition.

Documentation in the electronic medical record revealed Resident #1 and Resident #2 were seen by a psychiatry nurse practitioner on 10/24/2023 with the plan to continue plan of care and notify if any changes.

Documentation in the electronic medical record revealed Resident #1 and Resident #2 were seen by the Medical Director on 10/24/2023.

The Medical Director was interviewed on 10/27/2023 at 12:21 PM. The Medical Director confirmed he saw both Resident #1 and Resident #2 on 10/24/2023. The Medical Director revealed on 10/24/2023 he had heard there were conflicting reports if Resident #1 had actually touched Resident #2. The Medical Director stated he was unsure if Resident #1 understood or remembered what he did to Resident #2. The Medical Director stated he was aware Resident #1 was on one-to-one monitoring, but he did not know when that was going to end. The Medical Director confirmed Resident #2 was completely unaware and was not cognitively capable of comprehending Resident #1 touching her inappropriately.

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Documentation in a psychiatry progress note dated 10/27/2023 written by Physician Assistant-Certified (PA-C #1) revealed Resident #1 was reassessed by a psychiatry professional. The documentation in the progress note stated in part Resident #1 did not recall the incident with Resident #2 on 10/21/2023, he was acting on impulse due to dementia, and the plan was to start him on the medication Zoloft to "curb some of his sexual preoccupations."

Documentation in a psychiatry progress note dated 10/27/2023 written by PA-C #1 revealed Resident #2 did not recall the incident when Resident #1 touched her breasts, had no change in her behavior, and did not seem anxious or agitated.

PA-C #1, who wrote the psychiatry progress notes dated 10/27/2023 for Resident #1 and Resident #2, was interviewed on 10/27/2023 at 4:16 PM. PA-C #1 relayed the following information. Resident #1 knew he had feelings and acted on them. He did not have the capacity to know it was inappropriate or to have forethought the consequences. He did not realize what he was doing and denied doing it because he has no memory of doing it. PA-C #1 stated she did not feel like Resident #1 needed to have one-on-one monitoring anymore. PA-C #1 denied there had been any change or effects to Resident #2.

Resident #1 was interviewed on 10/28/2023 at 8:15 AM. Resident #1 denied any memory of events that happened on Saturday 10/21/2023 and denied touching Resident #2. Resident #1 stated he remembered events in the past when he "wanted to." Resident #1 stated he was able to

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propel himself in the facility anywhere he wanted to when he was in his wheelchair but did get assistance getting to the dining room.

An observation and attempt to interview Resident #2 were made on 10/27/2023 at 1:04 PM. Resident #2 was observed to smile and nod her head but did not verbalize any information.

An interview was conducted with a family member of Resident #2 on 10/28/2023 at 2:23 PM. The family member provided the following information. Resident #2 was currently cognitively unaware of herself but when she was younger, she was always well put together with her hair and make up done perfectly. Resident #2 was a retired medical professional who would have been devastated, furious, and mad if she knew a man had touched her inappropriately. The family member revealed she was surprised that even with the state Resident #2 was in that she would allow a man to touch her breasts like that.

The facility Administrator was interviewed on 10/27/2023 at 3:45 PM. The Administrator confirmed she was made aware on 10/24/2023 of Resident #1 inappropriately touching Resident #2. The Administrator stated the facility still had an open investigation into the incident.

The DON was interviewed on 10/28/2023 at 10:17 AM. The DON confirmed she was notified on 10/24/2023 of the inappropriate actions of Resident #1 which occurred on 10/21/2023. The DON also confirmed a new BIMS score was obtained for Resident #1 on 10/24/2023 as well as one-on-one monitoring for Resident #1 when he was out of bed. The DON stated she had no knowledge Resident #1 was saying or doing

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F 600	Continued From page 9 anything inappropriate to NA #1 and would expect the nurse aides to notify a supervisor if a resident was acting inappropriately towards them so interventions could be put in place. The DON stated the care planned intervention that was started for Resident #1 was the one-on-one monitoring while he was out of bed. The DON explained that the interdisciplinary team would reevaluate the one-on-one monitoring after starting Resident #1 on the medication Zoloft to see if there are any changes in his behavior. The DON further explained it was her expectation that the nursing staff contact her immediately if there was the possibility of an abuse situation so that an investigation could be initiated.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §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 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	F 607		11/6/23

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F 607	Continued From page 10 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 record review and staff interview the facility failed to identify resident to resident abuse and failed to immediately report resident to resident abuse to the Administrator and Director of Nursing per facility policy for one of three abuse investigations reviewed. Findings included: Documentation in the abuse policies and procedures of the facility dated last reviewed on 10/2022 defined sexual abuse as, "Nonconsensual sexual contact of any type with a resident or contact with any person incapable of giving consent." The same abuse policy and procedure revealed under section "B. Intervention 1. Upon receiving reports of abuse, the supervisor, Administrator, and Director of Nursing are immediately notified." Documentation in the electronic medical record revealed Resident #1 had cumulative diagnoses some of which included stroke, hemiplegia, and vascular dementia. Documentation on a quarterly Minimum Data Set (MDS) assessment dated 9/30/2023 revealed Resident #1 had a BIMS (Basic Interview for Mental Status) score of 13 indicating he was cognitively intact.	F 607	1) Resident #1 was witnessed by Resident #3 with his hand placed under the shirt of Resident #2. Resident #3 reported to activity assistant #1 what she witnessed and activity assistant #1 immediately removed resident #1 who was inappropriately touching resident #2 from the table in the dining room and sat resident #1 next to activity member #1 at their activity table. Activity Staff member #1 notified nurse#1 who informed Nurse #4, Nursing Supervisor of the incident. Nurse #4, Nursing Supervisor assessed residents and ensured they were safe and observed no noted changes in behavior or emotional distress. The Nursing Supervisor did not report this immediately to the Director of Nursing or Administrator. At the time the deficiency was identified the Administrator and Director of Nursing immediately in-serviced the Nurse #4, Nursing Supervisor on how to identify suspected resident to resident abuse and the requirement to immediately report allegations to Director of Nursing or Administrator.	

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(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
F 607	Continued From page 11 Documentation in the electronic medical record revealed Resident #2 had cumulative diagnoses some of which included Alzheimer's disease, anxiety, and depression. Documentation on a significant change MDS assessment dated 10/9/2023 revealed Resident #2 had a BIMS score of 3 indicating she was severely cognitively impaired. Documentation on a quarterly MDS assessment dated 9/28/2023 revealed Resident #3 had a BIMS score of 15 indicating she was cognitively intact. An interview was conducted with Resident #3 on 10/27/2023 at 1:04 PM. Resident #3 related that she saw Resident #1 picking at the shirt of Resident #2 as they were sitting in the dining room at the conclusion of an activity, last Saturday (10/21/2023). Resident #3 stated Resident #1 then put his hand underneath the shirt of Resident #2 and was playing with her breasts. Resident #3 further stated she went immediately to tell Activity Assistant #1 what Resident #1 was doing. Resident #3 reported the Activity Assistant #1 went over to Resident #1 and Resident #2 and asked Resident #1 what he was doing to which he replied, "What do you think I am doing. I am playing with them." Resident #3 stated she heard Activity Assistant #1 ask Resident #1 why he was doing that to which he replied, "Because I can. They are available." Resident #3 confirmed Activity Assistant #1 separated Resident #1 from Resident #2 and took Resident #1 over to the desk in the room. An interview was conducted with Activity Assistant	F 607	2) All residents have the potential to be impacted by this practice. An audit of 100% of all residents that were interviewable was completed on 10/24/2023 by the facility social workers with no concerns. A 100% skin check was completed by facility nurse managers for those residents who couldn't not be interviewed on 10/24/2023 with no new findings. 3) All staff were educated by either the Nurse management team or Administrator and Facility Department managers on prohibiting, preventing and recognizing what constitutes abuse. This education in part included: Recognizing abuse such as staff or family report of abuse, injury of unknown source and unwanted touching. Understanding behavioral symptoms of residents that may increase the risk of abuse such as aggressive wandering or elopement, resistance to care or outbursts. Immediately ensuring resident safety by removing accused individuals from residents' care Reporting allegations of abuse to the Administrator and/or the Director of Nursing in-person or verbally immediately following resident protection Zero tolerance for resident abuse in the facility the definition of abuse which is defined as the willful infliction of injury; unreasonable confinement; intimidation; or punishment; with resulting physical harm, pain, or mental anguish. Any staff	

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	345036	A. BUILDING _____ B. WING _____	C 10/28/2023

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F 607	Continued From page 12 #1 on 10/27/2023 at 11:46 AM. Activity Assistant #1 related the following events as happening on 10/21/2023 at approximately 2:30 PM. Activity Assistant #1 was sitting at her desk in the dining room documenting who had attended the activity that had just concluded when Resident #3 came up to her reporting Resident #1 was playing with the breasts of Resident #2. Activity Assistant #1 confirmed that she saw Resident #1 with his hand underneath the shirt of Resident #2 playing with her breasts. Activity Assistant #1 removed Resident #1 away from Resident #2 taking him to the front table she had previously been sitting at. Very soon after Nurse #1 walked into the dining room and Activity Assistant #1 told Nurse #1, Resident #1 was observed playing with the breasts of Resident #2 underneath her shirt. Nurse #1 removed Resident #1 from the dining room. Nurse #1 was interviewed on 10/27/2023 at 2:57 PM. Nurse #1 stated she was at her nursing cart on 10/21/2023 on the hallway when she overheard a couple of the nursing aides talking about Resident #1 touching the breasts of another resident in the dining room. Nurse #1 stated she then went to the dining room where she saw Activity Assistant #1 sitting at a desk with Resident #1. Nurse #1 revealed Activity Assistant #1 told her Resident #1 "tried to" feel the breasts of Resident #2 so the residents were separated. Nurse #1 stated she then brought Resident #1 back to his room and went to tell Nurse #4, the nursing supervisor, what she was told by Activity Assistant #1. Nurse #4, nursing supervisor, was interviewed on 10/27/2023 at 4:09 PM. Nurse #4 confirmed she was informed by Nurse #1 on 10/21/2023	F 607	that did not receive education will not be allowed to work until education is received. New Hires will be educated on prohibiting, preventing, and recognizing what constitutes abuse and staff requirements to report any allegations of abuse immediately to the Director of Nursing or Administrator in their new hire orientation. 4) Administrator / designee will interview 20 random staff members a week for 8 weeks to evaluate their understanding of the definition of and recognizing resident-to-resident abuse and their responsibility to report immediately to Director of Nursing or Administrator any allegations of abuse. 5) The administrator will review findings from the audits to the QAPI committee for review monthly for four months for compliance and any further recommendations. Compliance date 11/6/2023	

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F 607	Continued From page 13	F 607		

Resident #1 was, "attempting to touch the other resident's breast." Nurse #4 stated she was also knowledgeable Resident #1 and Resident #2 were separated and monitored the rest of the night. Nurse #4 stated she did not view what Resident #1 did as an assault because residents have instincts and urges. Nurse #4 further stated she had no reason to believe it was aggression and no reason to believe there was any danger. Nurse #4 stated if it was abuse, she would have reported it to the Director of Nursing.

Documentation in the facility Resident Activity Documentation revealed on 10/22/2023 Resident #1 and Resident #2 both attended a "Social" event designated by the same color code. Documentation in the facility Resident Activity Documentation revealed on 10/23/2023 both Resident #1 and Resident #2 attended a "Parachute Fun" activity at 10:30 AM and a "Social" activity designated by the same color code.

Nurse Aide #1 (NA #1) was interviewed on 10/27/2023 at 11:07 AM. NA #1 overheard other nurse aides talking on 10/24/2023 about Resident #1. NA #1, after overhearing this discussion, went to the dining room to speak to Activity Assistant #1 to warn her that Resident #1 needed to be monitored closely. Activity Assistant #1 told NA #1 she saw Resident #1 touching the breasts of Resident #2 under her shirt and how he told her he was doing it, "because they were available." Activity Assistant #1 told NA #1 she had not told anybody what had happened to Resident #2 so NA #1 went immediately to the Unit Manager, Nurse #2, to report the incident.

Nurse #2, the Unit Manager for the unit Resident

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#1 and Resident #2 resided, was interviewed on 10/27/2023 at 1:49 PM. Nurse #2 confirmed NA #2 came to her on 10/24/2023 to report that Resident #1 had inappropriately touched the breasts of Resident #2 as reported by Activity Assistant #1. Nurse #2 stated she reported what NA #1 had told her regarding Resident #1 and Resident #2 to the Director of Nursing (DON) immediately on 10/24/2023.

An interview was conducted with the facility Administrator on 10/27/2023 at 3:45 PM. The facility Administrator revealed she was notified of the inappropriate touching of Resident #1 on 10/24/2023 and the facility still had an open investigation at that point.

The DON was interviewed on 10/28/2023 at 10:17 AM. The DON confirmed she was notified on 10/24/2023 of the inappropriate actions of Resident #1 which occurred on 10/21/2023. The DON revealed on 10/24/2023 at approximately 12:45 PM, Nurse #2 came to her office and related what Activity Assistant #1 had told NA #1 had occurred on 10/23/2023. The DON stated she immediately contacted the Assistant Administrator to notify her of the need for an investigation. The DON relayed the following events occurred in the following sequence. The Assistant Administrator went to interview Activity Assistant #1. The DON explained that the date and time of the inappropriate touching occurred was initially confused with the date 10/23/2023 and had to be clarified and confirmed by staff to be on 10/21/2023. The DON then went to interview Resident #1. Because Resident #1 did not provide any information or did not recall any information, the facility Social Worker was requested to update the BIMS score for Resident

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F 607	Continued From page 15 #1. The DON notified the Medical Director and placed Resident #1 on one-on-one monitoring. The police were notified and arrived at the facility to take statements. The facility Social Worker contacted Adult Protective Services and the Assistant Administrator sent a fax to the Division of Health Service Regulation. The DON explained the facility Administrator was away at the regional office and she was also notified at that time. The DON further explained it was her expectation the nursing staff contact her immediately if there was the possibility of an abuse situation so that an investigation can be initiated and proper notifications of can be made.	F 607		