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F 000	INITIAL COMMENTS The survey team entered the facility on 4/23/25 to conduct an unannounced complaint investigation. Additional information was obtained offsite on 4/24/25 and 4/25/25. Therefore, the exit date was 4/25/25. Event ID# Y6PE11. The following intakes were investigated NC00229583 and NC00229677. 2 of the 2 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 observation, record review and interviews with staff and family member, the facility failed to protect a resident's right to be free from sexual abuse (Resident #2). Resident #1 sexually abused Resident #2 while he was sleeping in his bed. The resident's family member believed the resident would have	F 600	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 05/07/2025

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rejected a male's sexual advance, would have been angry, and was unable to protect himself. As Resident #2 was severely cognitively impaired, the reasonable person concept was applied. A reasonable person would have been traumatized by being sexually abused by a resident in their home environment making them feel angry, dehumanized, and powerless. This deficient practice affected 1 of 2 residents reviewed for abuse.

Findings included:

Resident #2 was admitted to the facility on 3/29/18 with the diagnosis of dementia.

The quarterly Minimum Data Set (MDS) assessment dated 4/16/25 for Resident #2 documented he was severely cognitively impaired. The resident was dependent for all his activities of daily living except for meals. There were no behaviors during the MDS assessment period. The resident's diagnoses included non-Alzheimer's dementia, anxiety, psychotic disorder, and cognitive communication deficit.

The care plan for Resident #2 dated 4/16/25 documented he had a cognitive deficit and was physically and verbally aggressive at times. The resident had an intervention to assure he was aware before touching or speaking to him.

Resident #1 was admitted to the facility on 10/24/22 with diagnoses that included depression and dementia with other behavioral disturbance.

The quarterly MDS assessment dated 3/12/25 documented he was severely cognitively impaired, he was feeling down nearly every day,

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and there were no behaviors or psychosis during the assessment period. The resident required partial to moderate assistance for upper body and maximal assistance for lower body bathing and dressing. The resident was always incontinent and dependent on staff for personal care. The resident's diagnoses included non-Alzheimer's dementia and intellectual disability. The resident received antipsychotic medication daily.

The care plan for Resident #1 dated 3/12/25 included behaviors of taking other's food. There was no behavioral issue of touching others identified in the care plan.

On 4/23/25 at 2:12 pm an interview was conducted with the Director of Nursing (DON). The DON stated she was aware of an incident with Resident #1 and Resident #2 and she provided staff statements.

A review of the staff's written statement by NA #2 dated 4/20/25 provided by the DON documented that NA #2 was assigned to Resident #2 on 4/19/25 evening shift from 3:00 pm to 7:00 pm. During rounds at 3:30 pm NA #2 observed Resident #2 in his bed and he had his brief open and no one else was in the room. NA #2 again observed Resident #2 had his brief open at 5:30 pm and no one was in the room. This was reported to NA #3 at shift change.

On 4/23/25 at 2:40 pm NA #2 was interviewed. NA #2 stated that Resident #2 was known to open his undergarment and staff provided privacy or closed the undergarment. The open undergarment was reported during shift change.

A review of the staff's written statement by NA #3

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dated 4/20/25 provided by the DON documented NA #3 was assigned to Resident #2 on night shift 4/19/25 7:00 pm to 7:00 am (ending 4/20/25). NA #3 observed Resident #1 in his wheelchair and put him to bed at 9:00 pm. Resident #2 was in his bed and appeared to be sleeping (Resident #1 and Resident #2 were roommates). Rounds were completed at approximately 11:30 pm, 2:30 am, and 4:00 am. Resident #1 was sitting on the fall mat watching TV and there was no touching observed during these rounding times. Resident #1 was asked to get back into bed during each time and he did. During rounds at 5:45 am Resident #1 was on Resident #2's fall mat and had his hand inside of Resident #2's brief moving back and forth. Resident #1 was asked to stop and did not. NA #3 ran out of the room to obtain help. Medication aide (MA) #1 was at the nurses' station and returned to the room with NA #3. Both staff informed Resident #1 to get away from Resident #2 and he did. MA #1 called Nurse #1 on the phone to assist and she arrived. Resident #2 appeared to be sleeping during this incident. Both residents were assessed and separated. Resident #2 was known to open or remove his own brief.

NA #3 was interviewed on 4/23/25 at 12:43 pm. NA #3 was assigned to Residents #1 and #2 on night shift 4/19/25 7:00 pm to 7:00 am (ending 4/20/25). NA #3 stated she completed rounds by walking into the residents' room on her shift every 2 hours until 4:00 am and there was no touching observed at those times. NA #3 stated during rounds at approximately 6:00 am, Resident #1 was sitting on Resident #2's fall mat and Resident #1's back was to her. Resident #1 was observed touching Resident #2's penis with an open hand. Resident #1 was told to stop but he did not stop.

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NA #3 stated she ran out of the room to go get help. MA #1 was in the hall and came back to the room and assisted Resident #1 to stop touching Resident #2. Resident #2 was sleeping and his undergarment was completely off. Resident #2 had been known to take his undergarment off and be exposed. NA #3 stated Resident #1 had no prior history of touching anyone and that this was new behavior. NA #3 stated it had taken her about 10 seconds to get assistance. She left the room for assistance because she could not get Resident #1 to stop touching Resident #2's genitals.

A review of a staff's written statement by MA #1 dated 4/20/25 provided by the DON documented that MA #1 was requested by NA #3 to assist with an incident between Residents #1 and #2 (roommates). Resident #1 was lying on Resident #2's fall mat next to the bed. Resident #2 was facing the window and only his back was visible. As the MA entered the room, Resident #1 had his hand over Resident #2's genitals and was rubbing his penis and scrotum. Resident #2 had his brief open. Resident #1 was asked, "what are you doing" and he replied "nothing." Resident #1 stopped touching Resident #2 and sat back up on the mat with his back to Resident #2. Resident #2 appeared to be asleep. Resident #1 was asked several times to go back to his bed and he did. The charge nurse was called and MA #1 remained in the room until the nurse entered the room.

On 4/24/25 at 10:40 am MA #1 was interviewed. MA #1 stated she was assigned to the hall where the incident happened on 4/19/25 during the night shift but she was not assigned to the residents involved. NA #3 came to the nurses' station

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where MA #1 was standing and summoned her to Residents #2's room on 4/20/25 sometime after 6:00 am. Resident #1 was lying on the fall mat of Resident #2 watching TV. Resident #1 had his hand over Resident #2's genitals and was rubbing the genitals. Resident #2's brief was open. MA #1 reported that Resident #2 was sleeping, he had his back to the door, and her (MA #1) view of the incident was limited. Resident #1 was informed to stop, and he had stopped and scooted back to his side of the room. Resident #1 responded that he was doing "nothing." MA #1 stated she called for Nurse #1 by phone and the nurse arrived immediately. MA #1 stated she had not left the room until the residents were separated. Resident #2's genitals were assessed and no injuries were observed. Resident #1 was taken out of the room by wheelchair. Resident #2 had to wake up and was then undressed and assessed all over by Nurse #1. No injury was observed. Resident #2 appeared to be sleeping during the incident. He was not moving or talking when spoken to. Resident #1 was placed on a one to one (1:1) supervision. Resident #1's had a bariatric bed and needed to be dismantled to be moved to another room. After multiple attempts it was decided that Resident #2 would be moved to another room for safety. Nurse #1 informed Nurse #4 who was the supervisor for the shift.

A review of a staff's written statement by Nurse #1 dated 4/20/25 provided by the DON documented Nurse #1 had begun her shift at 7:00 pm on 4/19/25 and Resident #1 was observed moving around the unit in his wheelchair. Resident #1 received his medication at 9:00 pm and remained in his wheelchair. Shortly after 5:50 am (4/20/25) Nurse #1 received a call from MA #1 that she was needed in Resident #2's

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room. "I arrived within a couple of minutes." Resident #1 was sitting on Resident #2's fall mat and Resident #2 was lying in his bed with his undergarment open and his penis exposed. Nurse #1 had not observed the incident and had not observed nor been informed that Resident #1 inappropriately touched anyone before. Resident #2 appeared to be sleeping. The residents were separated.

On 4/23/25 at 11:59 am an interview was completed with Nurse #1. Nurse #1 stated she was assigned to Resident #1 on 4/19/25 night shift (7:00 pm to 7:00 am the following day). Nurse #1 stated MA #1 alerted her that Resident #1 was inappropriately touching Resident #2. Upon entering the residents' room, Resident #1 was sitting on Resident #2's fall mat close to his bed. Resident #2's brief was open. Resident #1 was assisted back to his bed. NA #3 was present. Resident #2 was assessed for injury and none was found. Resident #2 was then moved to another room. Nurse #4 was the supervisor for the shift and was informed. Resident #1 was placed on 1:1 supervision. Nurse #1 stated the only behavior she was aware of for Resident #1 was eating other residents' food. There was no observation or information that Resident #1 was touching staff or residents prior to this incident. This was a new behavior.

Resident #1's nurse's note dated 4/20/25 written by Nurse #4 documented at about 6:10 am she was notified by Nurse #1 that Resident #1 sexually assaulted Resident #2. Nurse #4 went into the room to assess the situation and found Resident #1 sitting on Resident #2's fall mat. Resident #2 had his brief open. Nurse #4 directed Medication Aide #1 to remain with

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Resident #2 until a room was identified. Resident #1 was placed on 1:1 supervision. The Administrator was called, and he responded that he would be in the building later. Witness statements were obtained from staff.

On 4/23/25 at 12:28 pm an interview was completed with Nurse #4. Nurse #4 stated she was the supervisor on 4/19/25 on night shift 7:00 pm to 7:00 am the following day. Towards the end of the shift (early am 4/20/25) Nurse #4 was informed by Nurse #1 there was inappropriate touching by Resident #1 toward Resident #2. Nurse #4 stated she entered the residents' room and Resident #1 was back in his bed and Resident #2 was in his bed and his brief was all the way open. Nurse #1 had completed an assessment of Resident #2's genitals and there was no injury. Resident #1 was immediately removed from the room and was placed on 1:1 supervision. Resident #1 was interviewed by Nurse #4 and the resident could not remember what happened. Resident #2 was undressed, his entire body was assessed, and no injury was found. The incident was reported to the Administrator after the residents were assessed, separated, and safe. Nurse #4 stated she had rounded earlier during her shift 3 times and Resident #1 was always in his bed.

Resident #2 had a psychiatry progress note dated 4/22/25. The resident was evaluated after staff had reported he was sexually assaulted by another resident. The resident had a recent room change and a new roommate. Staff reported no new mood or behavioral concerns. The past history included dementia with behavioral disturbances and delusional disorder. The resident was in no acute distress and had

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cognitive decline. The resident was observed to be in his wheelchair in the dining room sleeping and not easily aroused. The staff was to monitor mood and behaviors.

Resident #2 had a psychiatry progress note addendum to the 4/22/25 note dated 4/25/25 that documented after the staff and administration completed a further review of the incident, it appeared that the resident was not actually a victim of a sexual assault, and that Resident #2 may have disrobed himself.

On 4/23/25 at 9:35 am an interview was conducted with the DON and Administrator. The resident-to-resident incident on 4/20/25 was still under investigation. Resident #1 was observed by NA #3 to be fondling the penis of Resident #2 (roommates). Resident #1 was known to be "kind of touchy feely" per the DON. The resident had never inappropriately touched another resident and was not aggressive. The facility had immediately initiated an investigation and staff education on 4/20/25.

On 4/23/25 at 10:40 am an observation was completed of Resident #2. The resident was sleeping in a low bed with a fall mat on one side. He was dressed and clean. The resident was not easily awakened.

Nurse #3 was interviewed on 4/23/25 at 1:56 pm. Nurse #3 stated she was assigned to Resident #2 today (4/23/25 day shift) and was familiar with the resident. The resident had no behaviors and could barely follow directions. He was sleeping more and his dementia was advanced. Nurse #3 stated she was aware of the resident-to-resident incident and believed Resident #2 had not

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remembered what occurred due to a poor memory. Nurse #3 stated Resident #1 was not known to inappropriately touch staff or residents prior to the 4/20/25 incident.

On 4/23/25 at 2:10 pm an observation was completed of Resident #2. He was up in his wheelchair slowly self-propelling in the hallway. He was alert and oriented to self, had a flat affect, and was hunched over. An attempt was made to interview the resident but it was unsuccessful. The resident was unable to state anything about the prior incident (on 4/20/25) or what happened earlier that morning (4/23/25).

On 4/23/25 at 3:30 pm Nurse #2 was interviewed. Nurse #2 stated she was frequently assigned to Resident #2 on day shift. She stated his vision had declined, his dementia was advanced, and he was sleeping more. The resident had a history of verbal and physical behavior but there had been none recently. He was accepting of care and not combative.

On 4/24/25 at 12:05 pm an interview was completed with Resident #2's family member. The family member stated the resident would not accept sexual advances from a male and would be very upset if that happened. The resident had dementia and would not be able to defend himself. He was sleeping more. The resident was not able to remember the incident when asked.

Resident #1 had a psychiatry progress note dated 4/22/25. The resident was evaluated after staff had reported he had sexually assaulted another resident. The resident had a recent room change and a roommate added. The past medical history

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included major depression with psychotic symptoms and moderate intellectual deficits. The history also included resident-reported sexual abuse. The plan was to continue with current medication and the resident had failed a dose reduction. Paroxetine (antidepressant) was added for decreased libido and staff was to continue to monitor mood and behaviors.

Resident #1 had a psychiatry progress note addendum to the 4/22/25 note dated 4/25/25 that documented the resident (Resident #1) had significant cognitive decline and intellectual deficit, therefore, had no awareness of participating in a sexual assault and was not aware of inappropriate sexual behaviors.

On 4/23/25 at 10:40 am an observation and interview was conducted with Resident #1 in his room. He had no roommate and was sitting in his wheelchair. He appeared clean and was dressed. There was a sitter in the room with him supervising (NA #1). An interview was attempted with the resident which was unsuccessful due to poor memory. The resident had not remembered his previous roommate or any daily occurrence. Almost all his answers to questions were yes, no or don't know. The resident had a flat affect and low tone in his voice. The resident could not state what he was watching on television or which family member came to visit him. NA #1 was present and was aware of the incident (on 4/20/25) but had not provided care to Resident #1 previously.

On 4/23/25 at 11:59 am an interview was completed with Nurse #1. Nurse #1 stated Resident #1 had a room change about a month ago and had a new roommate (Resident #2) for

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about 2 weeks. Staff had not reported any concerns after the room change and Resident #1 had no prior history of inappropriately touching other residents. The incident on 4/19/25 night shift (that occurred on 4/20/25) of Resident #2 touching Resident #1's penis was a new behavior. Both residents had dementia and were unable to remember anything.

NA #3 was interviewed on 4/23/25 at 12:43 pm. NA #3 stated Resident #1 was alert to self and able to make his needs known. He was cooperative and had no behavior when care was provided. The resident had no instances of inappropriate touching of staff or residents prior to the 4/20/25 incident that the NA was aware of.

On 4/23/25 at 3:30 pm Nurse #2 was interviewed. Nurse #2 stated she was frequently assigned to Resident #1 on day shift from 7:00 am to 7:00 pm. The resident had dementia and a poor memory. He was calm, allowed care, and was cooperative. The resident was not known to touch residents or staff inappropriately.

The facility provided the following corrective action plan with a completion date of 4/22/25:

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

- Resident #1 is alert but not oriented to person and place with a Brief Interview for Mental Status (BIMs) of 3. Diagnoses include Intellectual Disabilities, Dementia, Major Depression, and unspecified lack of Physiological Development in Childhood. Resident # 2 is alert but not oriented to person and place with BIMs of 0. Diagnoses

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include dementia and cognitive-communication deficits.

On 4/20/25, at approximately 5:45 am, Nurse Aide (NA) #3, entered the room and observed Resident #1 on the fall mat on the right side of Resident #2's bed. Resident #1 was positioned sideways on the mat, with his back facing the door. Resident #2 had repositioned himself in the bed, in a reverse position with his head towards the foot of the bed and his feet toward the head of the bed, and his brief was noted to be open. Resident #1 was rubbing his hands back and forth on Resident #2 genitals. NA #3 left the room to obtain assistance from the Medication Aide (MA) #1. When MA #1 and NA #3 walked into the room, they ensured that Resident #1 had stopped physically contacting Resident #2. MA #1 called Nurse #1 via phone for assistance. Resident #2 was assessed by Nurse #1, and no injuries were noted. When Resident #1 was asked what he was doing, he replied, "Nothing." Resident #2 could not verbalize what happened during the incident due to impaired cognition. Resident #2 was moved to a private room and Resident #1 was placed on 1:1 observation by the weekend supervisor with a staff member remaining in close proximity to the resident at all times to prevent the resident from physical contact with another resident. The weekend supervisor ensured the initial assigned staff member was informed of the rationale behind the intervention. The weekend supervisor notified the Director of Nursing (DON) regarding the incident and the initiation of the one-on-one supervision. Subsequently, the DON informed the scheduler of the need to assign one-on-one coverage until further notified and to communicate the purpose of the intervention to staff at the time of assignment. Nurse #4 notified

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the physician, Administrator, and Resident #1's Resident Representative of the incident. The Director of Nursing notified Resident #2's resident representative of the incident. On 4/20/25, the Nursing Home Administrator notified the police, Adult Protective Service, and faxed the Health Care Personnel Investigation and Registry regarding the incident. On 4/21/25, the Social Worker completed a wellness visit with Residents #1 and #2 with no negative findings. On 4/21/25, Resident #1 was seen by the Nurse Practitioner. On 4/22/25, the psychiatric provider conducted an onsite visit with Resident #1 and Resident #2. Per the psychiatric provider, due to Resident #1's cognitive deficits, Resident #1 did not have the mental capacity to be aware of being sexually inappropriate. Resident #2 had no known effects from the incident. Resident #1 was moved to a private room on 4/24/25 and remained on 1:1 services until clear by the primary physician on 4/29/25.

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

- On 4/20/25, skin assessments were completed on all non-alert and oriented residents, including Resident #2, for signs or symptoms of abuse by the treatment nurse/charge nurse with a Brief Interview of Mental Status (BIMS) of 12 or below with no negative findings.

- On 4/20/25, resident interviews regarding inappropriate touching were completed for alert and oriented residents, with a BIMS of 13 or above by the Nursing Supervisor and Treatment Nurse. There was no concern of abuse reported during the interviews.

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

- On 4/22/25, the Director of Nursing initiated a 100% audit of all residents' progress notes and Nurse Aide documentation of behaviors in the last 14 days to identify residents with sexually inappropriate behaviors. The purpose of the audit is to ensure the physician and family were notified of the behaviors, interventions in place including a psych consult, and behaviors are care planned to prevent resident to resident abuse. There were no identified areas of concern noted during the audit.

- On 4/22/25, education was completed with all alert and oriented residents with a BIMS of 13 and higher, by the Nursing Supervisor and Staff Development Coordinator about abuse, including the definitions, resident rights, what to do in an abusive situation, and how to report abuse.

- On 4/22/25, an in-service was conducted, in person, by the Nursing Supervisor and Staff Development Coordinator, with 100% of all staff (Administrator, Director of Nursing, and Department Managers, nurses, nursing assistants, therapy staff, housekeeping, dietary staff, social worker, accounts receivable/payable, receptionist, maintenance, admission, and agency staff) regarding Abuse. The in-service included the definition, policy, and prevention of Abuse. On 4/22/25, an in-service was initiated by the Nursing Supervisor with all staff regarding residents with behaviors. The education covered proper procedures for reporting, intervening, and documentation including updating the care plan.

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In-services were completed by 4/22/25. After 4/22/25, Nursing Supervisor and the RN Staff Development Coordinator will continue to monitor staff completion of the in-services, including agency. If a staff member has not worked and attended the initial in-service, they will be required to complete the in-service before starting their assignments on their next scheduled shift. The Staff Development Coordinator will ensure all newly hired facility staff and agency staff receive the inservice during orientation.

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

- On 4/22/25, the decision was made by the Administrator to monitor the plan for prevention of resident to resident abuse including identifying residents with sexually inappropriate behaviors and presented to the QAPI Committee on 4/22/25.

- On 4/22/25, the Administrator made the decision for the Nursing Supervisors to review progress notes and nurse aide documentation of behaviors including Resident #1, 5 times per week x 4 weeks, then monthly x 1 month to identify behaviors including sexually inappropriate behaviors. This audit is to ensure the physician and family were notified of the behaviors, interventions in place including a psych consult, behaviors are care planned, and early identification of behaviors to prevent resident to resident abuse. The Nursing Supervisor ensure all identified concerns are addressed.

- The Administrator or Director of Nursing will present the findings of the behavior audit Tools to

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the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months to review and to determine trends and/or issues that may need further interventions and the need for additional monitoring.

Compliance Date: 4/23/25

Validation of the corrective action plan was completed on 4/25/25.

Review of documentation/staff roster of education that was completed with nursing and all non-nursing staff. The education took place between 4/20/25 through 4/22/25.

The facility used a staff abuse questionnaire to determine if there was additional resident abuse observed or reported to the staff member and whether it was immediately reported to the Administrator.

The facility used a behavior and abuse quiz to evaluate staff education.

Each resident's record for progress notes and behaviors was reviewed by the DON and documented for dates 4/8/25 through 4/22/25. No negative findings were identified.

On 4/23/25 interviews were conducted individually with Nurses #1, #2, #3, and #4 and NAs #1, #2, #3, and #4. On 4/24/25 an interview was conducted with MA #1. The staff stated they participated in education for resident abuse, reporting, and to remain with the residents until they were separated and safe.

Monitoring was in place as indicated in the

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F 600	Continued From page 17 corrective action plan. The compliance date of 4/23/25 was validated.	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 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 interviews with staff,	F 607	Past noncompliance: no plan of	

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the facility failed to follow their abuse policy in the area of protection when Nursing Assistant (NA) #3 observed a resident-to-resident sexual assault between Resident #1 and Resident #2 and left the room during the incident to find staff assistance. This deficient practice affected 1 of 2 residents reviewed for abuse (Resident #2).

Findings included:

The facility abuse policy, last revised on 3/10/2017, documented, in part, "The facility believes that our residents have the right to be free from abuse, neglect ... Training of Employees: Orientation to the facility's policies and procedures regarding abuse, neglect, exploitation, and misappropriation of resident property will be provided to newly hired employees. Retraining programs for employees will be conducted on a regular basis. Training programs may include Indicators of resident vulnerability to abuse and related interventions. Protection: The facility shall take whatever steps are necessary to prevent further acts of abuse ..."

A review of the staff's written statement by NA #3 dated 4/20/25 documented NA #3 was assigned to Resident #2 on night shift 4/19/25 7:00 pm to 7:00 am (ending 4/20/25). NA #3 observed Resident #1 in his wheelchair and put him to bed at 9:00 pm. Resident #2 was in his bed and appeared to be sleeping. Rounds were completed at approximately 11:30 pm, 2:30 am, and 4:00 am. Resident #1 was sitting on the fall mat watching TV and there was no touching observed during these rounding times. (Resident #1 and Resident #2 were roommates) Resident #1 was asked to get back into bed during each time and he did. During rounds at 5:45 am

correction required.

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Resident #1 was on Resident #2's fall mat and had his hand inside Resident #2's brief moving back and forth. Resident #1 was asked to stop and did not. NA #3 ran out of the room to obtain help. Medication Aide (MA) #1 was at the nurses' station and returned to the room with NA #3. Both staff informed Resident #1 to get away from Resident #2 and he did. MA #1 called Nurse #1 on the phone to assist and she arrived. Resident #2 appeared to be sleeping during this incident. Both residents were assessed and separated. Resident #2 was known to open or remove his own brief.

NA #3 was interviewed on 4/23/25 at 12:43 pm. NA #3 explained she was assigned to Residents #1 and #2 on night shift 4/19/25 7:00 pm to 7:00 am (ending 4/20/25). NA #3 stated she completed rounds by walking into the residents' room on her shift every 2 hours until 4:00 am and there was no touching observed during those rounds. NA #3 stated during rounds at approximately 6:00 am, Resident #1 was sitting on Resident #2's fall mat and Resident #1's back was to her. The NA indicated Resident #1 was observed touching Resident #2's penis with an open hand and Resident #1 was told to stop but did not stop. The NA explained she left the room to get assistance because she could not get Resident #1 to stop touching Resident #2's genitals. NA #3 further stated she ran out of the room to go get help and MA #1 was in the hall at the nurses' station. The NA stated she and the MA came back to the room and assisted Resident #1 to stop touching Resident #2. NA #3 communicated that Resident #2 was sleeping and his undergarment was completely off, but Resident #2 had been known to take his undergarment off and be exposed. NA #3 stated

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Resident #1 had no prior history of touching anyone and that this was new behavior. NA #3 stated it had taken her about 10 seconds to get assistance after she left the room and then returned with the MA. NA #3 commented that she was not allowed to use her personal phone and left the room to find help. She stated she did not use the call light because she wanted to get help faster than pressing the call light button and waiting for someone to respond. NA #3 stated she participated in education that included abuse, reporting, and to remain with the resident and not leave the room in the event she discovered abuse. The NA explained staff were asked to use the call light, yell out for staff, or use their personal phone for help.

On 4/24/25 at 10:40 am MA #1 was interviewed. MA #1 stated she was working on 4/19/25 on night shift (7:00 pm to 7:00 am) and she was assigned to the hall where the abuse happened. The MA stated NA #3 came to the nurses' station where MA #1 was standing and summoned her to Residents #2's room on 4/20/25 sometime after 6:00 am. The MA explained that NA #3 told her she (NA #3) was unable to redirect Resident #1 from touching Resident #2's penis and requested MA #1 to assist. MA #1 stated she called for Nurse #1 by phone while in the resident's room and the nurse arrived immediately. MA #1 stated she was able to intervene and stop the sexual abuse and waited for Nurse #1 to arrive. MA #1 stated NA #3 should not have left the room until the residents were separated and safe.

On 4/23/25 at 12:28 pm an interview was completed with Nurse #4. Nurse #4 stated she was the supervisor on 4/19/25 night shift (7:00 pm to 7:00 am [shift ends on 4/20/25]) and she

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was aware of the incident between Resident #1 and Resident #2. NA #3 observed sexual abuse by Resident #1 and could not redirect the resident. The nurse explained NA #3 left the room to find help from staff. The nurse further stated the NA should not have left the room while there was an act of abuse occurring and the NA was expected to remain with Resident #2 to keep him safe.

On 4/24/25 at 10:21 am an interview was conducted with the Administrator. The Administrator stated he was aware of the sexual abuse incident in the early morning of 4/20/25 where Resident #1 sexually abused Resident #2 and this was observed by NA #3. The Administrator explained Resident #1 was rubbing the genitals of Resident #2 and it was discovered by NA #3. The Administrator further stated NA #3 left the room briefly during the assault to obtain staff assistance and the NA should not have left the resident room. The Administrator indicated the NA left the room because she could not redirect Resident #1 from touching Resident #2, but the NA should not have left the room and should have called out into the hall for staff assistance.

The facility provided the following corrective action plan with a completion date of 4/22/25:

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

Resident #1 is alert but not oriented to person and place with a Brief Interview for Mental Status (BIMs) of 3. Diagnoses include Intellectual Disabilities, Dementia, Major Depression, and

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unspecified lack of Physiological Development in Childhood. Resident # 2 is alert but not oriented to person and place with BIMs of 0. Diagnoses include dementia and cognitive-communication deficits.

On 4/20/25, at approximately 5:45 am, Nurse Aide (NA) #3, entered the room and observed Resident #1 on the floor mat on the right side of Resident #2's bed. Resident #1 was positioned sideways on the mat, with his back facing the door. Resident #2 had repositioned himself in the bed, in a reverse position with his head towards the foot of the bed and his feet toward the head of the bed, and his brief was noted to be open. Resident #1 was rubbing his hands back and forth on Resident #2 genitals. NA #3 left the room to obtain assistance from the Medication Aide (MA) #1. When MA #1 and NA #3 walked into the room, they ensured that Resident #1 had stopped physically contacting Resident #2. MA #1 called Nurse #1 via phone for assistance. Resident #2 was assessed by Nurse #1, and no injuries were noted. When Resident #1 was asked what he was doing, he replied, "Nothing." Resident #2 could not verbalize what happened during the incident due to impaired cognition. Resident #2 was moved to a private room and Resident #1 was placed on 1:1 observation. Nurse #1 made the Nursing Supervisor, Nurse #4, aware of the incident. Nurse #4 notified the physician, Administrator, and Resident #1's Resident Representative of the incident. The Director of Nursing notified Resident #2's resident representative of the incident. On 4/20/25, the Nursing Home Administrator notified the police, Adult Protective Service, and faxed the Health Care Personnel Investigation and Registry regarding the incident. On 4/21/25, the Social

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Worker completed a wellness visit with Residents #1 and #2 with no negative findings. On 4/21/25, Resident #1 was seen by the Nurse Practitioner. On 4/22/25, the psychiatric provider conducted an onsite visit with Resident #1 and Resident #2. Per the psych provider, due to Resident #1's cognitive deficits, Resident #1 did not have the mental capacity to be aware of being sexually inappropriate. Resident #2 had no known effects from the incident.

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

On 4/20/25, skin assessments were completed on all non-alert and oriented residents, including Resident #2, for signs or symptoms of abuse by the treatment nurse/charge nurse with a Brief Interview of Mental Status (BIMS) of 12 or below with no negative findings.

On 4/20/25, resident interviews regarding inappropriate touching were completed for alert and oriented residents, with a BIMS of 13 or above by the Nursing Supervisor and Treatment Nurse. There was no concern of abuse reported during the interviews.

On 4/22/25, the Nursing Supervisor initiated an abuse questionnaire with all employees. The questionnaire included: Do you know of any resident that you witnessed, or that has verbalized abuse to you that has not been reported and addressed? All identified areas of concern will be addressed through the resident concern and abuse process as necessary by the Administrator. Questionnaires were completed by 4/22/25 for all staff that worked. After 4/22/25,

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The Nursing Supervisors and the RN Staff Development Coordinator will continue to monitor staff completion of the questionnaires, including agency. If a staff member has not worked and completed the questionnaire, they will be required to complete it before starting their assignments on their next scheduled shift.

On 4/22/25, the Nursing Home Administrator posted an abuse action checklist at each nurses' station on bright-colored paper for nurses to use as a reference during allegations of abuse. The checklist includes ensuring the resident is safe and out of harm's way and immediately reporting the incident.

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

On 4/22/25, an in-service was initiated, in person, by the Nursing Supervisor and Staff Development Coordinator, with 100% of all staff , to include NA #3, (Administrator, Director of Nursing, Department Managers, nurses, nursing assistants, therapy staff, housekeeping, dietary staff, social worker, accounts receivable/payable, receptionist, maintenance, admission, and agency staff) regarding abuse. The in-service included the definition and prevention of abuse. Additionally, the in-service emphasized to always ensure the resident is out of harm's way first when abuse is suspected and to remain with the resident until the resident is safe, and calling for assistance if needed by yelling, utilizing the call bell, or utilizing a phone. In-services were completed by 4/22/25. After 4/22/25, The Nursing Supervisor and the RN Staff Development Coordinator will continue to monitor staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENHAVEN HEALTH AND REHABILITATION CENTER	801 GREENHAVEN DRIVE GREENSBORO, NC 27406

(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 25	F 607		

completion of the in-services, including agency. If a staff member has not worked and attended the initial in-service, they must complete it before starting their assignments on their next scheduled shift. The Staff Development Coordinator will ensure all newly hired facility and agency staff receive the in-service during orientation.

On 4/22/25, quizzes were initiated, in person, with all staff, including NA #3 and agency, by the Nursing Supervisor and Staff Development Coordinator to ensure a successful understanding of the abuse education, including the first thing to do when abuse is suspected is to ensure the resident is out of harm's way. Any staff that does not pass the quiz after 3 attempts will not be allowed to work until they are re-educated and successfully pass. The quizzes will be completed on 4/22/25 for all staff that worked. After 4/22/25, The Nursing Supervisor and the RN Staff Development Coordinator will continue to monitor staff completion of the quiz including agency. If a staff member had not worked and received the initial quiz, they will be required to complete it before starting their assignments on their next scheduled shift.

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

On 4/20/25, the decision was made to monitor the plan for abuse and presented to the QAPI Committee by the Administrator on 4/21/25.

On 4/20/25, the decision was made by the Administrator, for the Nursing Supervisors to review progress notes, grievances, and reportable allegations including Residents #1 and

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F 607	Continued From page 26	F 607		

#2, 5 times per week x 4 weeks, then monthly x 1 month to identify any allegations of abuse. This audit is to ensure all allegations of abuse have been appropriately addressed to include ensuring the safety of the residents by staff remaining with the resident until out of harm's way, calling for assistance if needed by yelling, utilizing the call bell, or utilizing a phone, and policy and procedures were followed. The Nursing Supervisor will immediately report all identified concerns to the Administrator and Director of Nursing. The Administrator or Director of Nursing will ensure all concerns are addressed including reeducation of staff as needed.

The Nursing Supervisors and RN Staff Development Coordinator will complete 10 quizzes with staff including NA #3 and agency, weekly x 8 weeks. The purpose of the quizzes are to ensure staff remain knowledgeable of what to do when abuse is suspected, including ensuring the resident is out of harm's way first and remain with the resident until the resident is safe. The Nursing Supervisor will immediately reeducate staff as needed for all identified areas of concern.

The Administrator or Director of Nursing will present the findings of the quizzes and audit of the progress notes, grievances, and reportable allegations to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months to review and to determine trends and/or issues that may need further interventions and the need for additional monitoring.

Date corrective actions completed: 4/22/25

Compliance Date: 4/23/25

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F 607	Continued From page 27 Validation of the corrective action plan was completed on 4/24/25. Review of documentation/staff roster of education that was completed with nursing and all non-nursing staff. The education took place between 4/20/25 through 4/22/25. On 4/23/25 interviews were conducted individually with Nurses #1, #2, #3, and #4 and NAs #1, #2, #3, and #4. On 4/24/25 an interview was conducted with MA #1. The staff stated they participated in education for resident abuse, reporting, and to remain with the residents until they were separated and safe. Monitoring was in place as indicated in the corrective action plan. The compliance date of 4/23/25 was validated.	F 607		