STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	474020	A. BUILDING _____ B. WING _____	**3/23/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDILODGE OF HOWELL	**1333 W GRAND RIVER HOWELL, MI 48843**

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F0000 SS=	INITIAL COMMENTS Medilodge of Howellwas surveyed for an abbreviated survey on 3/23/23. Intake #'s MI00134909 and MI00135231. Census = 124.	F0000		
F0600 SS= J	Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI000134909 and MI00135251 Based on observation, interview and record review the facility failed to protect R701's right to be free from sexual abuse. This deficient practice resulted in Immediate Jeopardy to the health and safety of R701 (a cognitively impaired female) when R702, a male resident with a long history of inappropriate sexual behaviors was observed by a visitor in R701's room with his penis exposed and R701 performed non-consensual manual stimulation to his genitals. Using the reasonable person concept the sexual abuse resulted in the potential for serious psychosocial harm and/or injury to R701 and placed other female residents at risk.	F0600	F 600 1. Resident 702 resides within the facility and is at baseline. Resident is on a 1:1 and this will continue. No changes in mood and behaviors. Resident 701 no longer resides within the facility. Resident was discharged to an independent living location on 3/17/2023. 2. A one-time audit was completed of residents with a BIMS of 10 and above to ensure there are no issues with other residents and that the residents know who to report to by the IDT team by 3/22/2023. No issues or concerns were identified. Skin assessments were completed for residents with a BIMS of 9 and below by 3/22/2023 by a Licensed Nurse. No issues or concerns identified. 3. Director of Nursing and Administrator re-educated on the Abuse, Neglect, and Exploitation Policy and how to conduct an appropriate investigation of allegations of abuse by Regional Director of Operations by 3/22/2023. The Administrator/Designee has re-educated staff on the Abuse, Neglect, and Exploitation Policy, including identifying sexually inappropriate behaviors by 3/22/2023.	3/23/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/06/2023

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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	Immediate Jeopardy: The Immediate Jeopardy began 2/23/2023. The Immediate Jeopardy was identified on 3/22/2023. The Administrator was notified of the Immediate Jeopardy on 3/23/23 at 4:58 PM, and a plan to remove the immediacy was requested. The Immediacy was removed on 3/23/23 at 2:42 PM based on the facility's implementation of an acceptable plan of removal as verified on-site by the survey team. Although the immediacy was removed, the deficient practice was not corrected and remained patterned with potential for more than minimal harm that is not immediate jeopardy due to sustained compliance that has not been verified by the State Agency. A Complaint was filed with the SA that alleged a family member entered R701's room and observed R702 sexually assaulting R701. A Facility Reported Incident (FRI) was reported to the State Agency (SA) that alleged R702 was found in R701's room. R701 was performing oral sex on R702. The facility policy titled, "Abuse, Neglect and Exploitation" (revised 10/24/22) was reviewed and documented, in part: "It is the policy of this facility to provide protections from health, welfare, an rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse ...Abuse means the willful infliction of infliction of injury ...intimidation ...which can include ...certain resident to resident altercations ...Instances of		The QAPI committee reviewed the Abuse, Neglect, and Exploitation Policy and deemed it appropriate by 3/22/2023. 4. An audit of 10 employees and 10 residents will be conducted by the Administrator or designee weekly to ensure they do not have knowledge of unreported abuse or experienced abuse related concerns. Audit findings will be presented to the facility QAPI committee and will only be discontinued with substantial compliance and with approval of the facility QAPI committee. Any instances of noncompliance that are identified will be addressed per company policy concerning education and disciplinary action when necessary. The Administrator is responsible for achieving and sustaining compliance. 5. Date of compliance: 3/23/2023	

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abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish ...it includes ...sexual abuse ...Sexual Abuse is non-consensual sexual contact of any type with a resident ...III. Prevention of Abuse ...Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how and by who determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded ...".

A review of the facility "Incident Summary" revealed in part, the following: "Date Incident Discovered: 02/23/2023 7:20 PM ...Date/Time Incident Occurred 02/23/2023 -07:10 PM ...On 2/23/2023 at approximately 7:20 PM R701's daughter-in-law called the Administrator and reported that her husband's daughter and her husband walked into R701's room and saw her laying in bed with R702 and was giving oral sex. R702 exited the room and went to his room. DON (Director of Nursing) was in the building at the time, so she went with the facility social worker (hereinafter SW "A") to interview both residents. The DON met with R702 and asked him if he was in a woman's room, he stated yes. He was asked what he was doing in there and he stated that she was playing with him. DON asked if she was using her hand or mouth and R702 said that she was using her mouth. He was questioned whether he asked for it and he stated he did not, he was then asked if R701 asked for it and he stated yes. R702 was asked if he took his pants down or did R701 take his pants down, he stated that she took his pants down ...SW "A" interviewed R701 while her son and granddaughter were in the room. R701 was asked what happened, she stated she was watching TV and R702 came into her room and laid on her bed. He unzipped his pants and pilled<sic> out his (motioned to the genital

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area). R701 stated she told him she did not think it was okay and R702 stated, no it's okay. R701 stated that R702 was attempting to zip his pants up when her family walked in. At this point in the interview R701's son (name redacted) interrupted and stated "no, ...granddaughter saw what happened, he had his penis out" ...There was no facility staff that witnessed this incident the ...Police were called in regards to the accident ...Investigation Conclusion: Based on the interviews and the facts of the investigation the facility was able to substantiate that there was sexual touching that occurred, but was not able to substantiate that any abuse or non-consensual sexual activity had occurred due to the inability to form intent due to cognitive deficits and due to the fact that R701 stated that she must have wanted it to happen at first ...".

A review of the Police Department "Incident/Investigation" (authored by Police Officer "C") report documented, in part, the following:

" ...Date/Time Reported ...02/23/2023 ...7:42 PM .... Victim (R701) ...Additional Name List ...SW "A" ...R701's Granddaughter ...R701's Son ...DON ...Criminal Sexual Conduct ...Date & Time ...Reported on Thursday, February 23, 2023 at approximately 07:42 hours ...Venue: Facility ...Offender R702 ...On the date and time, I was dispatched to the listed venue for a ...report that had just occurred. Central dispatch advised that the incident was between two residents and it was unknown at the time if the contact was consensual ...Reporting Officer Narrative ...Upon my arrival I made contact with staff on scene ...I made contact with SW "A", who advised that the incident occurred in the locked memory care unit between two patients within the unit ...SW "A" noted R701 is in the locked memory unit for diminished mental capacity due to a medical condition (dementia/Alzheimer`s). SW "A" stated that R701

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	described a sexual incident that occurred between R701 and another male resident, R702. SW "A" advised that R701 had informed her that R702 had come into her room and sat down next to her on the bed. SW "A" advised R701 went on to describe the incident and that R702 asked R701 to "pleasure" him and he pulled his pants down, exposing his penis. SW "A" stated that R701 told her she advised R701 that her family was on the way to see her, and that it was not a good time for the two to have sexual relations. SW "A" advised that R701 admitted to stroking R702's penis with her hand, but the two were interrupted when R701's granddaughter and son entered the room. SW "A" advised that when she initially asked R701 if the incident was consensual ...The DON advised ... that she had already spoken to R702 and received a partial statement from him. The DON advised that R702 had admitted going into R701's room. DON advised when she asked R702 about the incident, he stated that R701 had pulled down R702's pants and insisted that she stroke his penis ...I then made contact R701's granddaughter and R701's Son outside of R701's room. R701's Son advised that R701 was deemed incompetent by a psychologist / medical doctor ...I asked R701's Son what had happened, and R701's Son advised that he was walking down the hall to see his mother and R701's Granddaughter walked into R701's room before he had. R701's Son advised that R701's Granddaughter came rushing back out of the room, startled and in a panic. R701's Son advised R701's Granddaughter stated something along the lines of not wanting to see what she had just seen, and he entered further into the room to observed R701 stroking R702's penis. R701's Son advised that he began to rush out into the hallway and wave his arms to alert the attention of staff members assigned to the locked memory unit. I then made contact with R701's Granddaughter			

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	who provided the same series of events as R701's son. R701's Granddaughter advised that she could not believe what she had seen upon entering the room and tried to leave as quickly as possible without focusing on the details ....I then made contact with R701 in her room ... I asked R701 if she could concentrate on what had occurred since she had been served dinner and asked if she remembered another patient coming into her room. R701 advised that she did and that it was a male patient who she believed was named "name redacted and different name than R702"). I asked R701 to describe "name redacted" and she advised that he was a (description redacted) ...it should be noted that R701 provided the matching physical description for R702 but was simply unaware of R702's real name. ...R701 stated that the door to her room was open and R702 walked in. R701 advised that R702 sat down next to her on the bed and began asking her for sexual favors. R701 stated that she told R702 it was "a bad time" because her family was coming to visit. R701 stated that R702 was "aggressive" with his advances. I asked R701 to describe what she meant by "aggressive" and R701 advised that R702 was being quite persistent. R701 stated that R702 pulled down his pants and she began to stroke R702's penis with her hands because he had asked her to. R701 advised that she continued to do so until R701's Son and Granddaughter walked in on them. I asked R701 if R702 had made any kind of threats to harm her or coerced her in anyway. R701 advised these actions are not like her and she stated that if she could do things over, she would not have touched R702s` penis. R701 advised she felt coerced and did not want to do it but was unable to explain further as she was becoming emotional. ...I then made contact with R702; it should be noted that the facility`s DON was present during this interview. It should also be noted that R702 had been placed in the locked memory care unit due to brain damage caused by a severe TBI (Traumatic Brain Injury). R702 was			

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	unable to answer any basic questions at this time. I asked R702 if he remembered R701 or remembered walking into a female`s room and he advised he did not ...he did not remember anyone touching his penis and denied that he had a "girlfriend" in the facility ...". On 3/22/23 at approximately 10:38 AM, R702 was observed in sitting in a chair in front of the television on the locked dementia unit. There were approximately six to eight other residents also watching the TV. One Certified Nursing Assistant (CNA) "D" was in the TV room as well. CNA "D" was asked if they had been assigned to R702 and they reported that they were not but were just with all the residents. R702 was asked if they could step out of the TV area so that they could be interviewed. R702 agreed and was able to ambulate on their own to a private room for interview. During the interview R702 was alert, spoke in a very soft voice and was not able to answer most questions asked with respect to the incident involving R701 on 2/23/23. The resident did shake his head "Yes" when asked if he recalled a police officer talking to him in the building. Other than the "Yes" response regarding the police the resident did not answer any further questions. A review of R702's clinical record revealed the resident was admitted to the facility on 12/20/21 and readmitted on 1/1/23 with diagnoses that included cerebral infarction, eplileptic syndrome, dementia and anxiety disorder. A review of R702's Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status score of 10/15 (moderately cognitively impaired) and required limited assistance for ambulation. Continued review of R702's clinical record documented, in part, the following:			

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	12/27/2021: Pertinent Charting Behavior: " ...Resident came out of his room and raised his fist at the housekeeper ...The housekeeper moved out of the way. The resident then went up behind the CNA and punched her in the back of the head ...". 2/17/2022: Pertinent Charting Behavior: " ...Resident wondering in and out of rooms ...sleeping in (name redacted) bed ...hitting (name redacted) CNA in the back of head for no reason ...female CNAs are nervous with resident ...". 2/18/2022: " ...Resident was going through his roommate's belongings ...lying in bed that belonged to roommate ...Resident reminded that he is to only utilize his personal belongings ...Resident needs to be monitored ...his attention span is not long enough for the redirection to work long term ...". 2/18/2022: Progress Note: " ...denies hitting staff ...care plan reviewed and updated to reflect resident requiring two persons for care due to safety concerns ...". 2/21/2022: Progress Note: " ...Pt is seen today for behavior evaluation ...Pt has been wandering into other resident's room ...". 2/21/2022: Pertinent Charting Behavior: " ...resident wandering in the hall and going into women's rooms ...". 3/3/2022: Nurse's Notes: " ...Resident identified as an elopement risk ...sister agreed that resident is appropriate for memory care unit ...Resident to move ...". 3/30/2022: Pertinent Charting-Behavior: " ...wondering in the hall and common area. Wouldn't stay in room ...".			

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4/13/2022: Social Service Progress: " ...Resident had female friend visiting in room ...female resident was redirected out of room ...".

4/22/2022: Nurse's Notes: " ...Resident was walking down towards his room and female resident was walking up the hall to common area. They met in the middle: hugged, kissed on the lips, and then hugged again ...".

4/25/2022: Nurse's Notes: " ...Resident caught hugging female resident in her doorway ...".

5/1/2022: Nurse's Notes: " ...Resident was sitting by a female resident with his arm around her shoulders. Aide slid in between the two on couch. R702 grabbed aid's butt while on the couch ...".

5/12/2022: encounter: " ...Nursing reports that resident is having behavioral episodes that are out of normal. Per nursing, resident is asking staff to join him in bed, trying to pull a resident out of their seat, stating his groin size is a problem ...".

5/30/2022: Pertinent Charting Behavior: " ...following another female resident around closely for a couple of hours ...".

6/6/2022: Pertinent Charting Behavior: " ...Aides expressed that he was inappropriate during shower. He asked aide if he had a big penis ...".

7/8/2022: Nurses' Notes: " ...Resident pretends like he is hitting other residents ...Resident did get repeatedly re-directed and did not stop ...".

2/18/2022: Pertinent Charting Behavior: " ...when aide was giving shower resident became sexually inappropriate towards staff ...grabbed staff multiple times inappropriately ...".

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	2/23/2022 (5:09 PM): Pertinent Charting Behavior: " ...Resident was in room naked. Aide went in to get him dressed and he asked if she would take a shower with him ...". 2/23/2022 (8:00 PM): Pertinent Charting Behavior: " ...Sexually inappropriate behavior with another resident ...". R702's care plan: "Focus: The resident exhibits behavior of being affectionate towards others r/t (due to) dementia (4/25/22) ...Resident has potential to participate in sexual interactions with others (Date initiated 1/2/2023 ...Revision on 2/24/2023 ...Interventions: Administer medication as ordered (1/2/2023) ...Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by ...Explain all procedures to the resident before starting and allow the resident to adjust to changes (1/2/2023) ...If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident (1/2/2023) ...Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm matter. Divert attention. Remove from situation and take to alternate location as needed (1/2/2023) ...Monitor behavior episodes and attempt to determine underlying cause (1/2/2023) ...Observe for environmental stressors such as excessive heat, noise and overcrowding ...". R701 A review of R701's clinical record revealed the resident was admitted to the facility on 2/6/2023 with diagnoses that included, in part: type II diabetes, chronic kidney disease, and rheumatoid arthritis. A review of the residents MDS noted a Brief Interview for Mental Status (BIMS) score of 6/15 (cognitively impaired).			

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	Continued review of R701's clinical record documented the following: 2/7/2023: Nursing Evaluation Summary: "Resident admitted on 2/6/23. Resident noted to have confusion and restlessness. Resident continuously standing then sitting. Poor safety awareness noted." 2/9/2023: Pertinent Charting Behavior: "Resident awake and walking around. After exiting building yesterday resident now has an aide sitting with her and walking with her to ensure no other falls or exits ...". Census: On 2/10/23, R701 was transferred to the locked memory unit where R702 resided. Decision Making Determination Form: "I have evaluated this resident (R701) and have made the following determinations regarding decision making abilities. The resident (X) Incapable of making decisions regarding medical treatment .... Signed (name redacted) physician 2/17/23 and Psychiatrist (name redacted) 2/16/23. 2/23/2023: Social Services Progress Notes: " ...notified of sexual interaction between this resident and another ...family observed this resident with a male resident in her bedroom touching the genitals of male resident ...Writer provided support to resident who was distressed r/t (related to) family having witnessed interaction. Resident verbalized fear that son was upset with her ...Family reports that sexual behavior is uncommon for this resident ...". On 3/22/23 at approximately 12:50 PM, an interview was conducted with Police Officer (PO) "C". PO "C" was queried as to the investigation pertaining to the reported sexual assault against R701. PO "C" reported that they were dispatched			

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	to the facility on 2/23/23 around 7:40 PM and was told that a female resident (R701) was sexually assaulted. The resident's family was coming to visit the resident and when the granddaughter entered the room, she witnessed R702 with his pants down, penis exposed and R702 holding the R701's penis. PO "C" interviewed R701 who stated that a male resident entered into her room uninvited and took his pants down and asked for manual stimulation to his penis. R701 further stated that she did not want to comply but felt the resident was getting aggressive. PO "C" reported that R701 started to get very emotional during the interview and he did not proceed any further with questioning. PO "C" further reported that they tried to interview R702, but the resident was not able to answer many questions asked. PO "C" reported that they interviewed facility staff that noted R702 had a past history of inappropriate sexual behaviors with staff. On 3/22/23 at approximately 2:39 PM an interview was conducted with Social Worker (SW) "B" and the DON. SW "B" reported that they were familiar with the incident involving R701 and R702 but noted that they were not present on the date it occurred (2/23/23). They indicated that SW "A" was at the facility that evening. The DON was also present. It should be noted that SW "A" was on vacation and could not be interviewed during the survey. SW "B" stated that both R701 and R702 had been deemed incompetent and there was no documentation that either resident had the capacity to consent to sexual encounters. When asked if they were aware that R702 had a history of inappropriate sexual behaviors, SW "B" noted that they were and indicated that most of the behaviors stopped in the summer of 2022 following an increase in the medication Paxil. When asked if they were aware that some inappropriate sexual behaviors started again on or about February 18, 2023, SW			

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	474020	A. BUILDING _____ B. WING _____	3/23/2023

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	"B" noted that they believed it to be a one-time event and no interventions were implemented. When asked if they were made aware of the incident involving inappropriate behavior with Staff during a shower on 2/23/22, they noted that they were not made aware of the behavior on that day and if they had known they might have initiated frequent checks on R702. On 3/23/23 at approximately 11:48 AM, a phone interview was conducted with CNA "E". CNA "E" was asked about both R701 and R702 and the incident that occurred on 2/23/23. They reported that they had worked the day shift that day from 7 AM to 7 PM. CNA "E" reported that in the AM around breakfast time on 2/23/23 they observed R701 hanging all over R702 in the common area. CNA "E" stated that they redirected both of the residents. When asked if they had reported the incident, they noted that they did not. CNA "E" then reported as they were giving a daily report to the oncoming CNA, R701's Son came down the hall and stated that there was a man in his mother's (R701) room with his "dick" out and their mom was touching it. CNA 'E" reported that they told Nurse "F" and left the facility. When asked if they ever witnessed any inappropriate sexual behavior prior to that day, CNA "E" stated that R702 would state that he wanted to kiss her and would touch me inappropriately around my waste. An attempt to contact Nurse "F" was made on 3/22/23 at 2:48 PM and 3/23/23 at 11:46 AM. No return call was made prior to the end of the survey. On 3/23/23 at approximately 2:24 PM, an interview was conducted with the Administrator/Abuse Coordinator. The Administrator reported that they started their employment at the facility about two months ago.			

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	When asked about the incident involving R701 and R702 that noted that they were not at the facility at the time of the incident but were familiar with what occurred. When asked if they were familiar with R702 past history of inappropriate sexual behavior and whether they had any IA (incidents/accidents)pertaining to prior incidents, the Administrator noted that they could not locate any prior IAs. When asked if they were aware that R702 exhibited signs of inappropriate sexual behavior starting the morning of 2/23/23, they reported that they did not and if they would have know they might have initiated additional interventions. When asked if the residents were competent to consent to sexual activity, they indicated both residents had been deemed incompetent. Removal plan for IJ of Abuse (3/23/23) As a result of the finding of immediate jeopardy by the survey team on 3/22/2023 related to resident 702 the facility has reviewed the below to determine causation. Findings include: Resident 702 was admitted to facility on 12/20/2021 from Home with diagnosis of Cerebral Infarction, Localized-Related Symptomatic Epilepsy and Epileptic Syndromes, Unspecified Dementia, Hyperlipidemia, Anxiety Disorder, Gastro-Esophageal Reflux Disease, Essential Hypertension, Muscle Weakness, Dysphagia, Major Depressive Disorder, Vitamin B12 Deficiency, Hip-Osmolality and Hyponatremia, Deviated Nasal Septum, Diaphragmatic Hernia, Hypothyroidism, Adjustment Disorder, Difficulty in Walking, and Cognitive Communication Deficit. Due to the states findings from the incident that occurred on 2/23/2023 that the facility should have acted upon the first encounter of resident 702 becoming sexually inappropriate with staff and noted earlier			

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	in the day on 2/23/2023 that resident was in his room naked. The facility is re-educating staff on the potential for abuse involving sexual behaviors. Resident 702 was immediately relocated away from unit. Resident 702 remains in the facility and remains on 1:1 supervision as of 2/24/2023. No inappropriate sexual behavior noted. Resident 701 discharged home per resident and family request with home health services. Total of 124 residents, 59 out of the 59 residents that are capable of making their own decisions have been interviewed by the IDT (interdisciplinary team) regarding sexual behaviors from other residents on 3/22/2023. " Do you feel adequately supported by staff? " Do you have any concerns with other residents that have not already been addressed? " Do you feel safe in the facility? Of the 59 residents' questioned, there were no sexual inappropriate events voiced by these residents. If a resident voices any events of sexual inappropriateness, the Administrator will immediately interview the resident, ensure their safety, notify the police and the State of Michigan. The Administrator will notify Psych services for assistance with psychological harm and provide emotional support. The Administrator will notify the resident's responsible party of the event immediately.			

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	Remaining 65 Residents that are cognitively impaired have been assessed by Unit managers/DON for s/s (signs and symptoms) of sexual inappropriateness using a skin assessment on 3/22/2023. " Any signs of physical abuse? " Any signs of psychosocial distress? " Any bruising, skin tears? 65 out of 65 residents had no findings of physical sexual abuse noted on their skin assessments. The administrator has reviewed the last 6 months of behavior documentation to ensure no other inappropriate sexual abuse has occurred. Residents with a history have been reviewed to ensure proper interventions in place. No other issues identified. Systemic changes include: When behaviors of a sexual nature occurs between residents the facility staff will: " Immediately separate the residents " Ensure residents safety by providing 1:1 supervision for residents as needed " Notify Administrator " Nurse will complete a physical assessment to ensure no harm " Social services will complete an assessment to ensure psychological stability. Psych-services will be notified for additional support if needed. " Administrator will ensure other residents safety			

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	by interviewing other like residents for identification of previous events. " Administrator will interview staff witnessing the event for prior history of non-consensual sexual behavior. " The Administrator will screen grievances as well as Incident Reports daily Monday-Friday for possible events that involve resident to resident contact that are sexual in nature. The QAPI (quality improvement process improvement) committee has reviewed the Abuse policy and has deemed it appropriate. The facility had an Adhoc QAPI meeting including the Medical Director on 3/22/2023 and deemed this abatement plan appropriate. Current staff will be re-educated on the Abuse policy regarding sexual behavior, reporting guidelines and investigation by the DON/designee on 3/22/2023, any staff not currently working will be re-educated prior to their next scheduled day to work. During this education, staff will be questioned about other potential residents whose behaviors indicate sexual behaviors. The administrator will audit incident reports for possible sexual abuse daily M-F (Monday-Friday) and via phone on the weekends. Social services will complete random interviews of residents for verbalization of feeling safe in their environment. The Administrator is responsible for continued compliance.			