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	824350	A. BUILDING _____ B. WING _____	**8/3/2023**

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F0000 SS=	INITIAL COMMENTS Four Seasons Nursing Center of Westland was surveyed for an Abbreviated survey on 8/3/23. Intake: MI00137967. Census = 146	F0000		
F0600 SS= D	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 Number: MI00137967. Based on observation, interview, and record review, the facility failed to ensure two (R801 and R802) of two residents reviewed for abuse who were known to be attracted to one another but were not cognitively able to consent to sexual activity, did not engage in sexual activity. Findings include: Review of a facility policy titled, "Abuse", updated on 5/24/23, revealed, in part, the following: "Residents have the right to be free	F0600	Element #1 Residents #801 and #802 continue to reside in facility and show no ill-effects from alleged incident. Resident #801 and #802's care plans and reviewed and updated to reflect interventions regarding sexual activity, what is permitted, what should be monitored, and what interventions staff should use to prevent it. Residents #801 and #802 have been placed on frequent visual checks. Element #2 Current residents residing in the facility have the potential to be affected by the alleged deficient practice. Current residents residing in facility have been assessed for showing any current intimacy/sexual behaviors. Those identified will have care plans reviewed and updated with interventions as needed. Element #3 The facility on Abuse has been reviewed and deemed appropriate. Facility staff has been educated on Abuse to include Non-consensual sexual contact of any type. Element #4 Social Worker and/or designee will conduct audits of residents for showing signs of sexual desires towards other residents 3 times weekly x 4 weeks, 1 x weekly for 4 weeks, then monthly until substantial compliance is achieved and maintained. Any ill-findings will be immediately addressed and corrected.	8/23/2023

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

Electronically Signed | 08/16/2023

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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	from abuse...Prevention consists of facility systems designed to detect, identify, correct, and prevent the occurrence of abuse...The facility's procedures include: Establishing a safe environment that support, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse, such as how to identify the when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship...Sexual Abuse...Non-consensual sexual contact of any type with a resident including but not limited to unwanted touch especially breasts or perineal area..." The facility was asked to provide the policy mentioned in the "Abuse" policy that read, "The facility's procedures include: Establishing a safe environment that support, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse, such as how to identify the when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship". A policy titled, "Decision Making Capacity Policy" was provided, however, that policy did not address specifics about how the facility assessed for or handled consent and capacity to make decisions related to sexual		Results of audits will be provided to QAPI committee for review and further recommendations. The Administrator is responsible for sustained compliance.	

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	activity. Review of a complaint submitted to the State Agency revealed an allegation that R801 was found outside on the patio with R802 engaging in sexual activity. The complaint further alleged that R801 was not able to consent to the sexual activity. On 8/3/23 at 9:50 AM, R801 was observed sitting on the side of her bed. R801 appeared pleasantly confused. When asked if she felt safe in the facility, R801 reported she fell one time. When asked if anyone ever made her feel uncomfortable or unsafe, R801 did not respond. R801 reported she was allowed to go outside as long as there were two people out there. R801 reported staff did not have to go outside with the residents. R801 reported she had friends in the facility, but did not give any further information. On 8/3/23 at 10:54 AM, R802 was observed self propelling in a wheelchair around the facility. R802 was holding a football. When asked how he was doing, R802 reported he was having a good day and stated, "I never have a bad day!" R801 Review of R801's clinical record revealed R801 was admitted into the facility on 5/5/21 with a diagnosis of Alzheimer's Disease. Review of a Minimum Data Set (MDS) assessment dated 5/12/23 revealed R801 had moderately impaired cognition, no behaviors, and was able to walk independently. Review of R801's progress notes revealed the following:			

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	A "Social Work" progress note dated 4/26/23 that documented, "Social worker had contacted daughter of (R801) to speak of the public display of affection that occurred between (R801) and male resident the night before (kiss). Daughter questioned on protocol and what steps are being taken especially with (R801) having some memory concerns. Social worker indicated that (R801) and other resident would be closely monitored to make sure that things do not escalate." A "Social Work" progress note dated 5/19/23 documented, "Social worker had contacted daughter... in regards to public display of affection between (R801) and male resident. Social worker admitted that male resident was being transferred to Autumn Unit (locked care unit) for separation of the two residents. Daughter was content with this however expressed that she believes that (R801) will potentially be frustrated and agitated over the weekend due to not being able to see the male resident. Social worker indicated that staff will monitor (R801) with her being adding to be seen by psych and psychologist in the next handful of days." A "Psychiatry" note dated 5/20/23 documented, "Admitting dx (diagnosis): Alzheimer's disease with early onset. Pt has reportedly been showing public displays of affection with male resident. Male resident was recently transferred to Autumn locked unit..." A "Psychiatry" note dated 5/23/23 documented, "Patient was very friendly with another male resident who was moved to Autumn unit which she is not able to visit. Nursing states she has been more down and			

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	crying more. She hasn't been taking her medication regularly, it is very difficult to get her to take her medication. She is seen in private. She says that she feels bad because he was her boyfriend. She thinks the girl that took him in was trying to marry him for his money. She says she is sleeping ok. She says she thinks lost some weight, she isn't feeling as hungry. She says she is upset that they took her boyfriend away. She says he was a very funny guy, she says she doesn't know how to explain it, but he was always kissing her on the head. She says she doesn't know if he died, she says he was so unhappy after he left. She says they were together all the time. She would rub his head because he didn't have hair. She says she doesn't want to move on, there are no men up here. She says she just walks around because she doesn't have anything else to do, she has no one to talk to." A "Social Work" progress note dated 6/27/23 documented, "Care conference took place today with IDT (interdisciplinary) team and family (daughters-by phone). Part of the conversation included the topic of the relationship with male resident and the public display of affection that has taken place. Both of the daughters realize that both parties are equally seeking each other out and the mental sadness that comes into play when separated. Daughters both verbalized that they are content with the hand holding and potential risk of kissing however they hope things will not go further between (R801) and male resident. It was reported by administrator that they will be on visual checks the next several days to make sure of the appropriateness between them. Present for above conversation include unit managers, DON (Director of Nursing),			

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	administrator and this social worker." R802 Review of R802's clinical record revealed R802 was admitted into the facility on 7/29/22 with a diagnosis of dementia. Review of a MDS assessment dated 5/5/23 revealed R802 had moderately impaired cognition and was independent for locomotion on the unit using a wheelchair. Review of R802's progress notes revealed the following: A "Social Work" note dated 4/26/23 documented, "Social worker had contacted spouse of (R802) to speak of the public display of affection that occurred between (R802) and female resident the night before (kiss). Spouse did not seem concerned at this time of the situation due to the dementia of (R802). Social worker indicated that (R802) and other resident would be closely monitored to make sure that things do not escalate." A "Physician Team - Progress Note" dated 5/15/23 documented, "Pt (patient) seen to follow-up on multiple medical issues. Pt's dementia is causing issues on the unit. Social work is discussing room move with family. Pt appears calm and verbally contracted with provider not to elope. He states he is frustrated at times no <sic> not be at home." A "Physician Team - Progress Note" dated 5/19/23 documented, "Pt seen for increased wandering, social worker will speak with family and move patient to locked unit. This is expected with the progression of dementia			

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	disease progress. Pt is medically stable." A "Social Work" progress note dated 5/19/23 documented, "Social worker spoke with (R802) in regards to (R802) threatening to leave facility. Due to cognition and threats of leaving the facility, discussion was had of going to the Autumn unit for the time being for safety issues. Social worker had contacted the spouse who was initially a little hesitant however understood the reasoning of safety concerns." A "Psychiatry" progress note dated 5/23/23 documented, "Staff reports he is seeking other females for kisses. He was just moved to Autumn, dementia unit. He has a little higher libido and is kissing female residents. Patient is alert with confusion. He is a poor historian due to dementia...He says he is upset because he wants to go up front and play football...He says he will just stay and lay in bed." A "Physician Team - Progress Note" dated 6/2/23 documented, "...Pt verbalized feeling depressed about being on locked unit, and states his wife is cheating on him. Pt has dementia..." A "Psychiatry" progress note dated 6/7/23 documented, "Behaviors triggered, wandering x1 within the past 14 days. Spoke with patients wife...she hasn't noticed much change. He still has a high sex drive. She is worried about him because she doesn't want him to stay in the lock down unit long because he likes to socialize. He is seen sitting in his wheelchair holding a football. He says he wants to go outside, but he can't without help...he says he just wants to be able to go outside and get some sunlight."			

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A "Physician Team - Progress Note" dated 6/23/23 documented, "Pt seen to follow-up on inappropriate behaviors. Pt is no longer in locked unit and followed by psych. Spouse is aware, not concerned...Psych is following for hypersexual behaviors..."

A "Social Work" progress note dated 6/27/23 documented, "Care conference took place today with IDT team and spouse of (R802), by phone. Part of the conversation included the topic of the relationship with female resident and the public display of affection that has taken place. Spouse admitted that she is ultimately content with hand holding and kissing that may occur between (R802) and the female resident. Spouse is not content with anything beyond the hand holding and kissing at this time. Education was provided that both (R802) and the female resident equally seek each other out and the mental sadness that comes into play when separated. It was reported by administrator that they will be on visual checks the next several days to make sure of the appropriateness between them...Present for above conversation include unit managers, DON, administrator and this social worker."

Review of R802's Physicians Orders revealed an order for "Frequent visual checks every hour for 7 days Monitor behavior and whereabouts" with a start date of 6/21/23 and an end date of 6/28/23.

On 8/3/23 at 11:10 AM, all incident reports and any investigations conducted by the facility for R802 between April 2023 and the current day were requested from the Administrator.

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	On 8/3/23 at 11:28 AM, an interview was conducted with Social Worker (SW) 'E'. When queried about R802's cognition and whether he was able to make his own decisions, SW 'E' reported R802 was deemed incompetent to make decisions and his wife was his legal decision maker. When queried about R801's cognition and whether she was able to make her own decisions, SW 'E' reported R801 was deemed incompetent and her daughter was her legal decision maker. When queried about the documentation in R802's clinical record on 4/29/23 that noted there was a "public display of affection with a female resident", SW 'E' identified the female resident as R801. When queried about what the display of affection was, SW 'E' reported she thought it was hand holding and kissing. When queried about why R802 was moved to a locked unit on 5/19/23, SW 'E' reported R802 had a dementia diagnosis and was making threats of exit seeking. When queried about the documentation in R801's clinical record that noted R801's daughter was called and informed the "male resident was moving to the locked unit in order to separate residents", SW 'E' did not offer a clear response. SW 'E' reported it was due to "hand holding". When queried about why there was a care conference held with R801 and R802's legal representatives on 6/27/23, SW 'E' reported it was to get consent for hand holding and "no more than kissing". SW 'E' was asked if she as aware of any other sexual activity, alleged or witnessed, between R801 and R802 and reported only hand holding and kissing as mentioned above. On 8/3/23 at approximately 11:40 AM, SW 'E'			

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	followed up and reported there was one more incident that was previously discussed during the facility's morning meeting when activities staff "thought they saw something" (sexual between R801 and R802) and explained the facility did an investigation into it. On 8/3/23 at 11:42 AM, the Administrator followed up and reported there were no incident reports for R802, but there were two investigations conducted by the facility for 5/19/23 and 6/22/23. The investigations were requested at that time. Review of the investigation files provided revealed the following: On 5/19/23 at 11:30 AM, "(R802) and (R801) were observed by Dietary Aide...at table in dining room giving a quick kiss and holding hands...Both residents denied the kiss. (R802) became very agitated and stated 'my wife is ok with me having a friend'. When (R802) was further explained the GA (guardian) of (R801) was not ok with the kidding he then started saying to social worker (SW 'E') that he was just going to leave and go home and began exit seeking. (R802) (guardian/wife) approved resident to be moved back to secure unit on autumn as a safety measure to ensure resident did not leave facility..." A second investigation documented the following: "On 6/22/23 at apprx (approximately) 4:15pm Activity Director (AD 'A') called and reported to Admin (Administrator) that on 6/22/23 at approx. 4:10pm, Activity staff (AS 'B' and AS 'C') were looking out window into patio area			

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	and they observed (R802) and (R801) sitting outside the window kissing and touching each other (on top of clothing). They immediately went outside with residents while (AD 'A') got (Nurse 'D') to go to patio as well. Resident both denied touching and became upset when they were asked to come inside by (Nurse 'D'), however both residents did return back inside without incident. Both residents denied doing anything wrong with kissing each other and holding hands when interviewed by administrator on 6/22/23 at approx. 4:45pm and said they were just talking and enjoying each other's company when observed by staff being on patio kissing...Thorough investigation of alleged incident has been completed. After reviewing camera footage and interviewing all parties, it was determined that no type of abuse occurred between the two residents who were kissing at their own will and holding hands while having a conversation, neither reported being forced by the other and both were showing affection and compassion towards each other...Social Work to set up Care Conference with IDT and both Guardians (separately) to discuss situation of residents wanting to show affection towards each other by kissing and PDA (public displays of affection). Residents GA's were notified of the kissing event and conferences will be offered." The investigation form documented AS 'B', AS 'C', and Nurse 'D' as witnesses to the incident. On 8/3/23 at 12:07 PM, an interview was conducted with AS 'C'. When queried about what happened with R801 and R802 on 6/22/23, AS 'C' reported she was in the			

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	activities room which has a large window with view of the outside patio where residents can sit outside. AS 'C' reported R801 was seated on a bench and R802 was seated in a wheelchair next to the bench, holding hands at times, and they kissed. AS 'C' explained at some point, R802 wheeled to the corner of the patio out of view and R801 stood up and followed to the corner. AS 'C' further explained that when they could not see the residents, they (AS 'C' and a coworker) went outside to see what was going on. AS 'C' observed R801's leg up on R802's lap and R802 moved his hand away from R801's genital area when we asked what they were doing. AS 'C' reported neither resident denied doing anything. When queried about whether there were any interventions in place at that time for supervision of R801 and R802, AS 'C' reported we were supposed to keep on eye on them for that reason. They were allowed to be "kissy and hold hands" but "people have seen them do more than that". On 8/3/23 at 12:36 PM, a phone interview was attempted with AS 'B'. AS 'B' was not available for interview prior to the end of the survey. On 8/3/23 at 1:04 PM, an interview was conducted with AD 'A'. When queried about what happened on 6/22/23 between R801 and R802, AD 'A' reported she was walking into the activities room with Nurse 'D' and the activities staff were going out the door to the patio to try to separate R801 and R802. When queried about why they were trying to separate the residents, AD 'A' reported they said "It appeared like (R802) was touching (R801's) vagina and (R801's) leg was propped up". AD 'A' reported she notified the			

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FOUR SEASONS NURSING CENTER OF WESTLAND	**8365 NEWBURGH RD WESTLAND, MI 48185**

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	Administrator and had the staff write statements that were turned into the Administrator. When queried about any known sexual behaviors by either resident, AD 'A' reported they were always together, had been seen kissing and holding hands, and something they made inappropriate sexual comments to each other in front of other residents and would have to be separated and removed from the activity. On 8/3/23 at 1:25 PM, an interview was conducted with Nurse 'D'. When queried about what happened with R801 and R802 on 6/22/23, Nurse 'D' reported she came to the activities room to buy a snack and the activities aides said, "(R802) and (R801) are out there!!". Nurse 'D' reported she did not remember exactly what they said, but thought they were engaged in sexual activity. When Nurse 'D' went outside, the residents were separated and not touching each other, but R802's "pants were unbuckled." Nurse 'D' explained she was R802's assigned nurse on 6/22/23. When queried about what was in place for supervision of R802 on 6/22/23 and if he was permitted to go to the patio unsupervised by staff, Nurse 'D' explained that the door to the patio remained unlocked unless it was night time or there was extreme weather. According to Nurse 'D', residents can open the door and go outside on the patio which was fenced in with no access outside of the patio. When queried about the last time Nurse 'D' saw R802 on 6/22/23, Nurse 'D' explained R802 had been in an activity and she was unaware he was outside on the patio, but that he was on "15 minute checks at that time" because "his wife didn't want him being intimate with (R801)". Nurse 'D' reported she wrote a handwritten statement that was turned into the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	824350	A. BUILDING _____ B. WING _____	8/3/2023

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	Administrator. On 8/3/23 at 2:26 PM, video footage of the patio on 6/22/23 was reviewed with the Administrator. The video reviewed was a recording of the screen of the video footage taken with the Administrator's cell phone and therefore there were parts where the time was unable to be viewed. Review of the video footage revealed R801 seated on a bench on the patio and R802 was seated in a wheelchair. They appeared to be having a conversation with occasional hand holding. At one point, R802 was observed to wheel to the corner of the patio out of view of the camera. Due to the way the video footage was recorded with the Administrator's phone, the time is not visible on the recording. Then, R801 stood up and walked over to the corner of the patio out of view of the camera (time not visible). Shortly after the residents were out of view, staff identified as AS 'G' (who was not included in the facility's documented investigation) who was the first person to come outside, then AS 'C', and Nurse 'D' were observed outside moving toward where R801 and R802 were (not visible on the camera). On 8/3/23 at 2:27 PM, an interview was conducted with the Administrator, who was the facility's Abuse Coordinator. When queried about how the facility determined whether a resident had the cognitive ability to give consent to sexual contact, the Administrator reported they looked at their BIMS, talked with the physician and psychiatrist, and talked to the residents' legal representatives. When queried about whether there was a formal assessment conducted by the facility to determine capacity to consent to sexual contact, the			

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	Administrator reported the facility did not have one. When queried about interventions that were implemented to ensure sexual contact did not occur between R802 and R801 beyond hand holding and kissing (documented as acceptable gestures by both resident's legal representatives), the Administrator reported R802 was moved to the locked unit on 5/19/23 because he was exit seeking after the facility attempted to separate him from R801. When queried about what was in place after R802 was moved from the locked unit back into the unlocked section of the facility, the Administrator reported the DON might know. At that time, the DON joined the interview. The DON reported R802 was placed on hourly checks from 6/21/23 for seven days. When queried about what the hourly checks were for, the DON explained to make sure R802 and R801's whereabouts were known and they were not in any closed off areas. When queried about whether that was adequate supervision when R801 and R802 were found outside engaging in sexual contact, the DON did not offer a response. When queried about the supervision provided for the patio area, the Administrator reported the patio is open to anyone between the hours of 10:00 AM and dusk. When queried about the scope of authority R801 and R802's legal representatives have in regards to making decisions about their sexual activities, the Administrator was not sure. The Administrator reported they did not appear to be upset during the care conference. Both representatives wanted to make sure that it did not go any further than hand holding or kissing. When queried about whether R801 and R802's legal representatives were notified about what was observed by AS 'C' and AS 'B', the			

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Administrator reported that she did not think anything actually happened based on her investigation. When queried about what care planned interventions were currently in place to prevent sexual activity from occurring between two residents who were unable to consent to it and whose legal representative did not consent to further than hand holding and kissing, the DON reported there was nothing specific in place, just to monitor them.

On 8/3/23 at 3:17 PM, an interview was conducted with AS 'G'. When queried about what happened with R801 and R802 on 6/22/23, AS 'G' reported the residents moved to the corner of the patio where they could no longer be viewed so AS 'G' and other staff ran outside to see what they were doing. AS 'G' observed R801 with her leg up on R802 and R802 was touching R801 between her legs. AS 'G' said it appeared R802 was touching R801 inside of her pants. When asked why they were concerned when R802 and R801 went out of view of the staff, AS 'G' stated, "They are not supposed to do all of that. They do like to kiss and stuff, but they can't do that." AS 'G' explained that R802 and R801 were not "shocked" when approached and were "not in a hurry" to stop. AS 'G' reported the residents were separated and she wrote a statement and left it on the activities room desk to be given to the Administrator.

Further review of R801's clinical record revealed the following:

An "Incompetency Form" signed by a psychologist on 6/30/23 and a physician on 7/18/23 that read, "(R801) is not competent at this time to understand Resident Rights or

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	make health care decisions. This is secondary to diagnosis of Alzheimer's Dementia". Review of R801's care plans revealed the following: A care plan initiated on 5/11/21 that read, "Alteration in cognition and thought processes 2' (secondary) to Dx of Alzheimer's Disease...requires...cues and redirection at times. She presents with cognitive fluctuation and impaired LTM (long term memory) and impaired STM (short term memory). She is able to make basic needs known, conversation is nonsensical at times. Unable to recall childrens names upon admis (admission)..." A care plan initiated on 8/11/21 that read, "...She also has shown public display of affection towards male peer of this facility..." There were no specific interventions that addressed the public display of affection toward a male peer. A care plan initiated on 8/12/22 that read, "...4/26/(23) public display of affection with male res (resident)..." There were no additional interventions added after 8/12/22 that addressed the public display of affections toward the male resident. There were no care plans to address what contact was acceptable for R801, what sexual contact was not permitted, whether R801 was able to consent to sexual contact, and what interventions were in place to monitor her behavior. Further review of R802's clinical record			

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	revealed the following: An "Incompetency Form" signed by a psychologist and physician on 6/30/23 that read, "(R802) is not competent at this time to understand Resident Rights or make health care decisions. This is secondary to diagnosis of Dementia". Review of R802's care plans revealed the following: A care plan initiated on 8/1/22 that read, "(R802) exhibits alt (alterations) in cognition...aeb (as evidenced by) A&Ox1-2 (alert and oriented to person and place), noted confusion to time and situation w/ short term memory loss and mod. (moderately) impaired decision making skills requiring cues and direction..." A care plan initiated on 5/2/23 that read, "(R802) is exhibiting Alt. in BEHAVIORS & MOOD...public display of affection towards another peer female of kissing..." An intervention was initiated on 5/2/23 that read, "Set boundaries and limits with res. that behaviors are not appropriate and to 'stop'" (It should be noted that the specific behaviors that should be stopped were not identified in the care plan. There were no other care plans that outlined what activities R802 was permitted to engage in and what sexual activities were not permitted or that R802 was not able to consent to sexual activity. There were no interventions that directed staff to monitor R802 for sexual activity.			

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F0609 SS= D	Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake Number: MI00137967 Based on interview and record review, the facility failed to report an allegation of sexual activity between two (R801 and R802) of two residents reviewed for abuse who were not cognitively able to consent to sexual activity, to the State Agency. Findings include:	F0609	Element #1 Residents #801 and #802 continue to reside in facility have shown no ill-effects for alleged incident. Element #2 Residents currently residing in the facility have the potential to be affected by alleged deficient practice. Facility has reviewed past 30 days of concerns and investigation to ensure proper reporting was completed if needed. Element #3 The facility policy on “Abuse and reporting alleged violations” has been reviewed and deemed appropriate. Facility Administrator was educated on Abuse and Reporting Alleged Violations by Regional Clinical Director. Element #4 Administrator and/or designee will conduct audits on any allegations/investigations 5x week x 4 weeks, 3x week x 4 weeks, then monthly thereafter until substantial compliance is achieved and maintained to ensure proper and timely reporting to State agency per regulation. Deficiencies will be immediately corrected. Results of audits will be provided to QAPI committee for review and further recommendations. The Administrator is responsible for sustained compliance.	8/23/2023

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	Review of a facility policy titled, "Abuse", updated on 5/24/23, revealed, in part, the following: "...Sexual Abuse...Non-consensual sexual contact of any type with a resident including but not limited to unwanted touch especially breasts or perineal area...The facility will ensure that all allegations involving abuse...are reported immediately to the Administrator and: Reported to the State Survey Agency immediately but not later than two hours after the allegation is made if the allegation involves abuse..." Review of a complaint submitted to the State Agency revealed an allegation that R801 was found outside on the patio with R802 engaging in sexual activity. The complaint further alleged that R801 was not able to consent to the sexual activity. On 8/3/23 at 11:10 AM, all incident reports and any investigations conducted by the facility for R802 between April 2023 and the current day were requested from the Administrator. Review of an investigation conducted by the facility revealed the following documentation: "On 6/22/23 at apprx (approximately) 4:15pm Activity Director (AD 'A') called and reported to Admin (Administrator) that on 6/22/23 at approx. 4:10pm, Activity staff (AS 'B' and AS 'C') were looking out window into patio area and they observed (R802) and (R801) sitting outside the window kissing and touching each other (on top of clothing). They immediately went outside with residents while (AD 'A') got (Nurse 'D') to go to patio as well. Resident both denied touching and became upset when they were asked to come inside by (Nurse 'D'), however both			

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residents did return back inside without incident. Both residents denied doing anything wrong with kissing each other and holding hands when interviewed by administrator on 6/22/23 at approx. 4:45pm and said they were just talking and enjoying each other's company when observed by staff being on patio kissing...Thorough investigation of alleged incident has been completed. After reviewing camera footage and interviewing all parties, it was determined that no type of abuse occurred between the two residents who were kissing at their own will and holding hands while having a conversation, neither reported being forced by the other and both were showing affection and compassion towards each other...Social Work to set up Care Conference with IDT and both Guardians (separately) to discuss situation of residents wanting to show affection towards each other by kissing and PDA (public displays of affection). Residents GA's were notified of the kissing event and conferences will be offered."

The investigation form documented AS 'B', AS 'C', and Nurse 'D' as witnesses to the incident.

Review of a typed "Witness Statement" dated 6/22/23 from Nurse 'D' (unsigned by Nurse 'D') revealed, "On 6/22/23 Activity Asst's informed me that (R802) was outside on the bench with (R801), they saw residents kissing and holding hands and touching each other on the arms and legs (on top of clothing). I immediately went outside with the activity asst's (assistants) to separate the residents and bring them both inside. Both residents were fully clothed (R802 did have his zipper down but brief was intact and in

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	proper position)..." Review of a typed "Witness Statement" dated 6/22/23 from Activities Staff (AS 'C') unsigned by AS 'C' revealed, "Myself and my co-worker (name of staff who gave the statement) were sitting in the activity room near the window charting, I noticed (R802) and (R801) were not on the bench anymore when I got up and looked closer out the window to the left I saw (R801) sitting on another bench with (R802) in his wheelchair, they were both kissing each other and touching each other with clothing on..." Review of a typed "Witness Statement" dated 6/22/23 from AS 'B' unsigned by AS 'B' revealed, "Myself and my co-worker (AS 'C') were sitting in the activity room near the window after completing a group and we noticed (R802) and (R801) sitting outside of the window in the corner kissing and touching each other..." The statements did not explain how R802 and R801 were "touching each other". On 8/3/23 at 12:07 PM, an interview was conducted with AS 'C'. When queried about what happened with R801 and R802 on 6/22/23, AS 'C' reported she was in the activities room which has a large window with view of the outside patio where residents can sit outside. AS 'C' reported R801 was seated on a bench and R802 was seated in a wheelchair next to the bench, holding hands at times, and they kissed. AS 'C' explained at some point, R802 wheeled to the corner of the patio out of view and R801 stood up and followed to the corner. AS 'C' further explained that when they could not see the residents, they (AS 'C' and a			

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	coworker) went outside to see what was going on. AS 'C' observed R801's leg up on R802's lap and R802 moved his hand away from R801's genital area when we asked what they were doing. AS 'C' reported neither resident denied doing anything. AS 'C' reported she wrote a handwritten statement and provided it to her manager to give to the Administrator. On 8/3/23 at 12:36 PM, a phone interview was attempted with AS 'B'. AS 'B' was not available for interview prior to the end of the survey. On 8/3/23 at 1:04 PM, an interview was conducted with Activities Director (AD 'A'). When queried about what happened on 6/22/23 between R801 and R802, AD 'A' reported she was walking into the activities room with Nurse 'D' and the activities staff were going out the door to the patio to try to separate R801 and R802. When queried about why they were trying to separate the residents, AD 'A' reported they said "It appeared like (R802) was touching (R801's) vagina and (R801's) leg was propped up". AD 'A' reported she notified the Administrator and had the staff write statements that were turned into the Administrator. On 8/3/23 at 1:25 PM, an interview was conducted with Nurse 'D'. When queried about what happened with R801 and R802 on 6/22/23, Nurse 'D' reported she came to the activities room to buy a snack and the activities aides said, "(R802) and (R801) are out there!!". Nurse 'D' reported she did not remember exactly what they said, but thought they were engaged in sexual activity. When Nurse 'D' went outside, the residents were separated and not touching each other,			

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	but R802's "pants were unbuckled." Nurse 'D' reported she wrote a handwritten statement to give to the Administrator. On 8/3/23 at 1:35 PM, the Administrator provided two hand written statements from Nurse 'D' and AS 'C' and explained they were part of the investigation. When queried, the Administrator reported there were no other handwritten statements from staff. Review of a handwritten and signed statement dated 6/22/23 from Nurse 'D' revealed the following: "I was doing visual checks on patient every hour per order but I was actually seeing him more often...I saw him in the main dining room attending the party this afternoon when I went to tend to another patient. Approximately 15 minutes later I went into the activity room to buy a water when one of the activity aides told me that resident was outside with a resident from another unit displaying inappropriate sexual behavior. I went outside...They were not touching each other but resident had his pants unzipped..." Review of a handwritten and signed statement dated 6/22/23 from AS 'C' revealed the following: "As me and my coworkers (AS 'B') and (AS 'G') were sitting down charting at the end of the day we looked out side and could see 2 residents (R801) and (R802) outside. We then looked back after maybe 2 minutes and could no longer see any part of (R801) other than her leg in the air. Me and my coworker (AS 'G') then went outside to see further what was happening getting a nurse on the way. The nurse then help me and coworker separate them from the corner they were in because as we walked out we could see (R801) sitting			

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down with her leg up and (R802) touching her inappropriately".

On 8/3/23 at 2:26 PM, video footage of the patio on 6/22/23 was reviewed with the Administrator. R802 and R801 moved out of view of the camera at some point and AS 'G', AS 'C', and Nurse 'D' are observed to come outside. The residents were unable to be viewed once they moved to the corner of the patio.

There was no statement included in the facility's investigation from AS 'G' and the typed statements included originally did not reflect the actual hand written statements provided by AS 'C' and Nurse 'D'.

On 8/3/23 at 2:27 PM, an interview was conducted with the Administrator, who was the facility's Abuse Coordinator. When queried about how the facility determined whether a resident had the cognitive ability to give consent to sexual contact, the Administrator reported they looked at their BIMS, talked with the physician and psychiatrist, and talked to the residents' legal representatives. When queried about whether there was a formal assessment conducted by the facility to determine capacity to consent to sexual contact, the Administrator reported the facility did not have one. When queried about whether R801 and R802 were cognitively able to consent to sexual activity, the Administrator reported they were not able to and their legal representatives had consented to hand holding and kissing. When queried about why the observed sexual contact between R801 and R802 on 6/22/23 was not reported to the State Agency, the Administrator reported she did not think anything actually

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	happened after she conducted the investigation and stated, "I understand that it should have been reported". Review of R801's clinical record revealed R801 was admitted into the facility on 5/5/21 with a diagnosis of Alzheimer's Disease. Review of a Minimum Data Set (MDS) assessment dated 5/12/23 revealed R801 had moderately impaired cognition, no behaviors, and was able to walk independently. Review of an "Incompetency Form" signed by a psychologist on 6/30/23 and a physician on 7/18/23 revealed, "(R801) is not competent at this time to understand Resident Rights or make health care decisions. This is secondary to diagnosis of Alzheimer's Dementia". Review of R801's progress notes revealed the following: A "Social Work" progress note dated 4/26/23 that documented, "Social worker had contacted daughter of (R801) to speak of the public display of affection that occurred between (R801) and male resident the night before (kiss). Daughter questioned on protocol and what steps are being taken especially with (R801) having some memory concerns. Social worker indicated that (R801) and other resident would be closely monitored to make sure that things do not escalate." A "Social Work" progress note dated 5/19/23 documented, "Social worker had contacted daughter... in regards to public display of affection between (R801) and male resident. Social worker admitted that male resident			

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was being transferred to Autumn Unit for separation of the two residents. Daughter was content with this however expressed that she believes that (R801) will potentially be frustrated and agitated over the weekend due to not being able to see the male resident. Social worker indicated that staff will monitor (R801) with her being adding to be seen by psych and psychologist in the next handful of days."

A "Social Work" progress note dated 6/27/23 documented, "Care conference took place today with IDT (interdisciplinary) team and family (daughters-by phone). Part of the conversation included the topic of the relationship with male resident and the public display of affection that has taken place. Both of the daughters realize that both parties are equally seeking each other out and the mental sadness that comes into play when separated. Daughters both verbalized that they are content with the hand holding and potential risk of kissing however they hope things will not go further between (R801) and male resident. It was reported by administrator that they will be on visual checks the next several days to make sure of the appropriateness between them. Present for above conversation include unit managers, DON (Director of Nursing), administrator and this social worker."

Review of R802's clinical record revealed R802 was admitted into the facility on 7/29/22 with a diagnosis of dementia. Review of a MDS assessment dated 5/5/23 revealed R802 had moderately impaired cognition and was independent for locomotion on the unit using a wheelchair.

Review of an "Incompetency Form" signed

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	by a psychologist and physician on 6/30/23 revealed, "(R802) is not competent at this time to understand Resident Rights or make health care decisions. This is secondary to diagnosis of Dementia". Review of R802's progress notes revealed the following: A "Social Work" note dated 4/26/23 documented, "Social worker had contacted spouse of (R802) to speak of the public display of affection that occurred between (R802) and female resident the night before (kiss). Spouse did not seem concerned at this time of the situation due to the dementia of (R802). Social worker indicated that (R802) and other resident would be closely monitored to make sure that things do not escalate." A "Social Work" progress note dated 6/27/23 documented, "Care conference took place today with IDT team and spouse of (R802), by phone. Part of the conversation included the topic of the relationship with female resident and the public display of affection that has taken place. Spouse admitted that she is ultimately content with hand holding and kissing that may occur between (R802) and the female resident. Spouse is not content with anything beyond the hand holding and kissing at this time. Education was provided that both (R802) and the female resident equally seek each other out and the mental sadness that comes into play when separated. It was reported by administrator that they will be on visual checks the next several days to make sure of the appropriateness between them...Present for above conversation include unit managers, DON, administrator and this			

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	social worker."			
F0610 SS= D	Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake Number: MI00137967 Based on interview and record review, the facility failed to thoroughly and accurately investigate an allegation of sexual activity between two (R801 and R802) of two residents reviewed for abuse who were not cognitively able to consent to sexual activity, to the State Agency, resulting in the lack of development of new interventions to prevent future occurrences of sexual activity between the two residents. Findings include: Review of a facility policy titled, "Abuse", updated on 5/24/23, revealed, in part, the following: "...Sexual Abuse...Non-consensual sexual contact of any type with a resident	F0610	Element #1 Residents #801 and #802 continue to reside in facility and show no ill-effects from alleged incident. Resident #801 and #802's care plans and reviewed and updated to reflect interventions regarding sexual activity, what is permitted, what should be monitored, and what interventions staff should use to prevent it. Residents #801 and #802 have been placed on q hour checks. Facility has reviewed past investigation file. Element #2 Residents currently residing in the facility have the potential to be affected by alleged deficient practice. Facility has reviewed past 30 days of concerns and investigation to ensure proper investigation was completed thoroughly and accurately. Element #3 Facility policy on Abuse was reviewed and deemed appropriate. Facility Administrator was educated on Abuse and ensuring the center conducts a timely, thorough, and objective investigation of any allegation of abuse by Regional Clinical Director. Element #4 Administrator and/or designee will conduct audits on any allegations/investigations 5x week x 4 weeks, 3x week x 4 weeks, then monthly thereafter until substantial compliance is achieved and maintained to ensure the center conducts a timely, thorough, and objective investigation of any allegation of abuse. Deficiencies will be immediately corrected. Results of audits will be provided to QAPI committee for review and further recommendations. The Administrator is responsible for sustained compliance.	8/23/2023

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	including but not limited to unwanted touch especially breasts or perineal area...Key to investigating abuse allegations is an environment that facilitates that reporting of such allegations. Once reported, the center conducts a timely, thorough, and objective investigation of any allegation of abuse...The investigation process includes: ...Determining the purpose of the investigation and issue(s) to be investigated, whether or not the alleged violation has occurred, the extent, and cause. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses...Providing complete and thorough documentation of the investigation...Whether the incident/allegation is substantiated or unsubstantiated the Administrator and/or DON (Director of Nursing) or designee will...Ensure involved patient/resident's plan of care is reviewed and revised, as appropriate, consistent with the results of the investigation..." Review of a complaint submitted to the State Agency revealed an allegation that R801 was found outside on the patio with R802 engaging in sexual activity. The complaint further alleged that R801 was not able to consent to the sexual activity. On 8/3/23 at 11:10 AM, all incident reports and any investigations conducted by the facility for R802 between April 2023 and the current day were requested from the Administrator. Review of an investigation conducted by the facility revealed the following documentation: "On 6/22/23 at apprx (approximately) 4:15pm Activity Director (AD 'A') called and reported to Admin (Administrator) that on 6/22/23 at			

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	approx. 4:10pm, Activity staff (AS 'B' and AS 'C') were looking out window into patio area and they observed (R802) and (R801) sitting outside the window kissing and touching each other (on top of clothing). They immediately went outside with residents while (AD 'A') got (Nurse 'D') to go to patio as well. Resident both denied touching and became upset when they were asked to come inside by (Nurse 'D'), however both residents did return back inside without incident. Both residents denied doing anything wrong with kissing each other and holding hands when interviewed by administrator on 6/22/23 at approx. 4:45pm and said they were just talking and enjoying each other's company when observed by staff being on patio kissing...Thorough investigation of alleged incident has been completed. After reviewing camera footage and interviewing all parties, it was determined that no type of abuse occurred between the two residents who were kissing at their own will and holding hands while having a conversation, neither reported being forced by the other and both were showing affection and compassion towards each other...Social Work to set up Care Conference with IDT and both Guardians (separately) to discuss situation of residents wanting to show affection towards each other by kissing and PDA (public displays of affection). Residents GA's were notified of the kissing event and conferences will be offered." The investigation form documented AS 'B', AS 'C', and Nurse 'D' as witnesses to the incident. Review of a typed "Witness Statement" dated 6/22/23 from Nurse 'D' (unsigned by			

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	Nurse 'D') revealed, "On 6/22/23 Activity Asst's informed me that (R802) was outside on the bench with (R801), they saw residents kissing and holding hands and touching each other on the arms and legs (on top of clothing). I immediately went outside with the activity asst's (assistants) to separate the residents and bring them both inside. Both residents were fully clothed (R802 did have his zipper down but brief was intact and in proper position)..." Review of a typed "Witness Statement" dated 6/22/23 from Activities Staff (AS 'C') unsigned by AS 'C' revealed, "Myself and my co-worker (name of staff who gave the statement) were sitting in the activity room near the window charting, I noticed (R802) and (R801) were not on the bench anymore when I got up and looked closer out the window to the left I saw (R801) sitting on another bench with (R802) in his wheelchair, they were both kissing each other and touching each other with clothing on..." Review of a typed "Witness Statement" dated 6/22/23 from AS 'B' unsigned by AS 'B' revealed, "Myself and my co-worker (AS 'C') were sitting in the activity room near the window after completing a group and we noticed (R802) and (R801) sitting outside of the window in the corner kissing and touching each other..." The statements did detail what was meant by "touching each other". On 8/3/23 at 12:07 PM, an interview was conducted with AS 'C'. When queried about what happened with R801 and R802 on 6/22/23, AS 'C' reported she was in the activities room which has a large window			

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	with view of the outside patio where residents can sit outside. AS 'C' reported R801 was seated on a bench and R802 was seated in a wheelchair next to the bench, holding hands at times, and they kissed. AS 'C' explained at some point, R802 wheeled to the corner of the patio out of view and R801 stood up and followed to the corner. AS 'C' further explained that when they could not see the residents, they (AS 'C' and a coworker) went outside to see what was going on. AS 'C' observed R801's leg up on R802's lap and R802 moved his hand away from R801's genital area when we asked what they were doing. AS 'C' reported neither resident denied doing anything. AS 'C' reported she wrote a handwritten statement and provided it to her manager to give to the Administrator. On 8/3/23 at 12:36 PM, a phone interview was attempted with AS 'B'. AS 'B' was not available for interview prior to the end of the survey. On 8/3/23 at 1:04 PM, an interview was conducted with Activities Director (AD 'A'). When queried about what happened on 6/22/23 between R801 and R802, AD 'A' reported she was walking into the activities room with Nurse 'D' and the activities staff were going out the door to the patio to try to separate R801 and R802. When queried about why they were trying to separate the residents, AD 'A' reported they said "It appeared like (R802) was touching (R801's) vagina and (R801's) leg was propped up". AD 'A' reported she notified the Administrator and had the staff write statements that were turned into the Administrator. On 8/3/23 at 1:25 PM, an interview was			

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conducted with Nurse 'D'. When queried about what happened with R801 and R802 on 6/22/23, Nurse 'D' reported she came to the activities room to buy a snack and the activities aides said, "(R802) and (R801) are out there!!". Nurse 'D' reported she did not remember exactly what they said, but thought they were engaged in sexual activity. When Nurse 'D' went outside, the residents were separated and not touching each other, but R802's "pants were unbuckled." Nurse 'D' reported she wrote a handwritten statement to give to the Administrator.

On 8/3/23 at 1:35 PM, the Administrator provided two hand written statements from Nurse 'D' and AS 'C' and explained they were part of the investigation. When queried, the Administrator reported there were no other handwritten statements from staff.

Review of a handwritten and signed statement dated 6/22/23 from Nurse 'D' revealed the following: "I was doing visual checks on patient every hour per order but I was actually seeing him more often...I saw him in the main dining room attending the party this afternoon when I went to tend to another patient. Approximately 15 minutes later I went into the activity room to buy a water when one of the activity aides told me that resident was outside with a resident from another unit displaying inappropriate sexual behavior. I went outside...They were not touching each other but resident had his pants unzipped..."

Review of a handwritten and signed statement dated 6/22/23 from AS 'C' revealed the following: "As me and my coworkers (AS 'B') and (AS 'G') were sitting down charting at the end of the day we

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looked out side and could see 2 residents (R801) and (R802) outside. We then looked back after maybe 2 minutes and could no longer see any part of (R801) other than her leg in the air. Me and my coworker (AS 'G') then went outside to see further what was happening getting a nurse on the way. The nurse then help me and coworker separate them from the corner they were in because as we walked out we could see (R801) sitting down with her leg up and (R802) touching her inappropriately".

It should be noted that the summary of the facility's investigation did not include the details regarding the touching being sexual in nature as written in the original handwritten statements from AS 'C' and Nurse 'D'. The facility's investigation did not include any statement from AS 'G' who was a witness to the incident and who reported she wrote a statement.

On 8/3/23 at 2:26 PM, video footage of the patio on 6/22/23 was reviewed with the Administrator. R802 and R801 moved out of view of the camera at some point and AS 'G', AS 'C', and Nurse 'D' are observed to come outside. The residents were unable to be viewed once they moved to the corner of the patio.

On 8/3/23 at 2:27 PM, an interview was conducted with the Administrator, who was the facility's Abuse Coordinator. When queried about how the facility determined whether a resident had the cognitive ability to give consent to sexual contact, the Administrator reported they looked at their BIMS, talked with the physician and psychiatrist, and talked to the residents' legal representatives. When queried about

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	whether there was a formal assessment conducted by the facility to determine capacity to consent to sexual contact, the Administrator reported the facility did not have one. When queried about whether R801 and R802 were cognitively able to consent to sexual activity, the Administrator reported they were not able to and their legal representatives had consented to hand holding and kissing. When queried about why the observed sexual contact that was included in the written statements by staff was not included in the final investigation documentation, the Administrator did not offer a response. When queried about the scope of authority R801 and R802's legal representatives have in regards to making decisions about their sexual activities, the Administrator was not sure. The Administrator reported they did not appear to be upset during the care conference. Both representatives wanted to make sure that it did not go any further than hand holding or kissing. When queried about whether R801 and R802's legal representatives were notified about what was observed by AS 'C' and AS 'B', the Administrator reported that she did not think anything actually happened based on her investigation. It was unclear whether the allegations that were observed were reported to the legal representatives of R801 and R802. When queried about what care planned interventions were currently in place to prevent sexual activity from occurring between two residents who were unable to consent to it and whose legal representative did not consent to further than hand holding and kissing, the DON reported there was currently nothing specific in place, just to monitor them.			

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	Review of R802's clinical record revealed R802 was admitted into the facility on 7/29/22 with a diagnosis of dementia. Review of a MDS assessment dated 5/5/23 revealed R802 had moderately impaired cognition and was independent for locomotion on the unit using a wheelchair. Review of an "Incompetency Form" signed by a psychologist and physician on 6/30/23 revealed, "(R802) is not competent at this time to understand Resident Rights or make health care decisions. This is secondary to diagnosis of Dementia". Review of R802's progress notes revealed the following: A "Social Work" progress note dated 6/27/23 documented, "Care conference took place today with IDT team and spouse of (R802), by phone. Part of the conversation included the topic of the relationship with female resident and the public display of affection that has taken place. Spouse admitted that she is ultimately content with hand holding and kissing that may occur between (R802) and the female resident. Spouse is not content with anything beyond the hand holding and kissing at this time. Education was provided that both (R802) and the female resident equally seek each other out and the mental sadness that comes into play when separated. It was reported by administrator that they will be on visual checks the next several days to make sure of the appropriateness between them...Present for above conversation include unit managers, DON, administrator and this social worker."			

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	Review of R801 and R802's care plans revealed no specific interventions regarding sexual activity, what was permitted, what should be monitored, and what interventions should be used to prevent it.			