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| S 000 | Initial Comments | S 000 | | |
| S9999 | Final Observations | S9999 | | |

S 000 Initial Comments

Complaint Investigation: 2427210/IL177756

Facility Reported Incident of 8-20-24/IL177925

S9999 Final Observations

Statement of Licensure Violatons:

300.610a)
300.1210b)
300.1210c)
300.1220b)3)
300.3210t)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing

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care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.

Section 300.3210 General

t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

These requirements were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to protect a resident (R2) from sexual abuse by another resident (R1) and failed to ensure a resident (R4) was free from

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physical abuse by another resident (R3) with a known history of verbal and physical aggression for two of four residents reviewed for abuse in a sample of six. This failure resulted in R3 verbally yelling and physically slamming his door on R4's hand. R4 sustained bleeding lacerations and fractures to three fingers on R4's right hand which required hospitalization evaluation where 12 sutures were placed to R4's fingers; further surgical intervention is pending. These failures have the potential to affect R4 and other dementia residents residing in the facility.

Findings include:

1. The facility's Abuse Prevention Program policy, dated 10/2022, documents, "This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents." This policy continues with "This facility is committed to protecting our residents from abuse, neglect, exploitation, misappropriation of property and mistreatment by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals." This policy also states "Abuse means any physical or

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mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical hare, pain, or mental anguish to a resident...The term 'willful' in the definition of 'abuse' means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm."

The facility's undated Residents Rights Statement documents, "All residents have a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. This facility will protect and promote the rights of each resident, including each of the following rights: 38. The resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion ...47. The facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible."

R3's current Face sheet documents diagnoses including but not limited to Restlessness and Agitation, Acute Kidney Failure, and Cognitive Communication Deficit

R3's Minimum Data Set/MDS assessment, dated 7/15/24, documents R3 as cognitively intact with behaviors including physical symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually), verbal symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others), rejection of cares, and wandering.

R3's Documentation Survey Reports for behavior

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tracking, dated August 2024 and September 2024, document R3 displayed behaviors including yelling/screaming, kicking/hitting, grabbing, pinching/scratching/spitting, wandering, abusive language, threatening behavior, sexually inappropriate and rejection of cares. R3 had one or more of these type of behaviors on one or more shifts on the following dates: 8/4, 8/9, 8/10 - 8/12, 8/14 - 8/16, 8/19 - 8/22, 8/24, 8/25, 8/28 - 8/30, 9/1, 9/3, and 9/8/24. Also documented is (R3's) response to staff interventions including any one or more of these responses: Increased activity/mobility/agitation, Combative (physically and/or verbally), and Unable to redirect/engage.

R3's Progress Note, dated 8/1/24 by V11 Licensed Practical Nurse/LPN, documents, "Resident became combative upon room entry."

R3's Progress Note, dated 8/11/24 by V12 Registered Nurse/RN, documents, "Describe behavior: Patient (R3) slammed peer's (R4's) hands into his (R3's) door when she (R4) was standing in his doorway. Patient (R3) was cursing at peer (R4) stating 'get out of my f***ing room or I will hurt you.' Before staff could diffuse situation patient (R3) did slam both (R4's) hands into his door. Environmental, Physiological, Psychosocial factors/triggers: Patient (R3) is easily agitated with aggressive tendencies and stated after slamming peer's (R3's) hands into the door, 'I don't f***ing care if I hurt her (R4) or not, damn b**ch does not need to be in here.' While assessing peer (R4) out in the hall patient (R3) came out of room shouting that he did not cause this harm but rather staff. Patient (R3) was making false accusations against staff stating that they slammed her (R4's) hands into the door. Intervention: Reviewed with patient (R3) that we needed to take care of peer (R4) involved and

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that they needed to go back into their room which he (R3) slammed the door and told all staff 'We can go f*** ourselves.' Resident response: did not come out of room. Notifications made: Director of Nursing notified."

R3's Progress Note, dated 8/22/24 by V3 Director of Nursing/DON, documents, "Staff approached this nurse stating resident (R3) punched CNA (Certified Nursing Assistant/V11) in the stomach and the face. (V11) states when (V11) went into resident room to deliver room tray to resident (R3) when he (R3) punched her (V11) in the stomach and then the face. (V11) has notable red mark to her stomach where resident (R3) punched her. Police called and resident (R3) stated to police, 'I have told them I don't want their food.' Police took report. Report number 26-01054. Resident sent to (named hospital) for psych (psychiatric) eval (evaluation)."

R3's Nurse Practitioner Progress Note, dated 8/23/24, includes but is not limited to: "Restlessness and agitation. Patient (R3) frequently having behaviors and agitation. He has made multiple attempts to harm staff and other residents. Staff injury reported today. Patient (R3) to be sent to the hospital for a psych evaluation. Patient (R3) is considered a threat to the safety of others and is not appropriate to reside in this long-term care setting. Patient refuses to see rounding mental health provider. HPI (History of Present Illness) Interval History: Staff report patient (R3) continues to have aggressive and harmful behaviors towards staff and other residents. Today, a staff member was providing patient with a meal tray and patient punched the staff member. He (R3) has had episodes of yelling while using profanity and hitting in the past. He often throws dishes in his room with the

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attempt to break them and subsequently poses risk to himself and staff members. Patient has previously slammed his door on another resident's fingers while yelling profanity at that resident. He has put other residents' safety at risk and vocalizes no remorse for injuring others. Patient is noncompliant with cares and medication orders despite frequent attempts to educate on the importance of bathing, eating, and taking medications as ordered."

R4's current Face sheet documents diagnoses including but not limited to Unspecified Dementia, Unspecified severity, without Behavioral disturbance, Psychotic disturbance, Mood disturbance, and Anxiety; Chronic Kidney disease, stage 3; Displaced Fracture of middle phalanx of right middle, right ring, and right little finger; Presence of Cardiac Pacemaker; Syncope and collapse, and Weakness.

R4's MDS assessment, dated 6/27/24, documents R4 is severely cognitively impaired and wanders.

R4's current Care plan includes a focus of: "(R4) has impaired cognitive function/dementia or impaired thought processes r/t (related to) Dementia "with interventions including but not limited to "(R4) requires approaches that maximize involvement in daily decision making and activity limit choices, use cueing, task segmentation, written lists, instructions."

R4's Progress Note, dated 8/11/24 by V12 Registered Nurse/RN, documents "Resident (R4) noted by staff walking into peers (R3's) room. Peer (R3) became immediately agitated and yelled 'get out of my f***ing room.' While staff was attempting to redirect resident (R4) out of peer's

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(R3's) room, Peer (R3) slammed the door and caught resident's (R4's) hands in the door. Immediate blood noted to right hand. Staff helped patient (R4) into chair and vitals started. Patient (R4) was found to be diaphoretic and very pale. Patient's (R4's) pulse ox (oximetry) was 76% upon assessment and patient (R4) was holding chest. Blood pressure was not palpable. Patient (R4) had head back in wheelchair...911 call placed for emergent transport to (named hospital)."

R4's Hospital After Visit Summary, dated 8/11/24, documents "Reason for Visit: Loss of Consciousness; Diagnoses: Loss of consciousness, Crushing injury of right hand, initial encounter."

R4's Progress Note, dated 8/11/24, documents, "Resident brought back to facility by daughter (POA/Power of Attorney) around (3:00pm), resident assessed and vitals WNL (within normal limits), x-ray done to right hand done by (named hospital) with no break/fractures, resident has no c/o (complaints of) pain, resident in wheelchair at nurses' station, no concerns at this time."

R4's Progress note, dated 8/12/24 by V17 Facility Nurse Practitioner, documents: "HPI (History of Present Illness) Interval History: Resident returns to the facility after being assessed by the ER (Emergency Room) after a hand injury. Patient had her hand shut in a door of another resident's room. The ER ruled out any fracture. Patient denies pain at this time but due to dementia is not an accurate historian. Bruising and scabbing noted on her right hand. She is able to move all finger and wrist joints without difficulty. Patient has PRN (as needed) Tylenol available for pain relief."

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| S9999 | Continued From page 8<br><br>R3 and R4's Progress Notes, dated 9/8/24 and 9/9/24 respectively, by V11 LPN, document, "(V11) was at the north nurse's station and had just hung up the phone with doctor about another resident and had started making notes. (V11) heard resident yelling 'get the f*** away from here, get the f*** out now.' (V11) slid (V11's) chair back away from the computer so that she could see where the commotion was taking place, (R4) was standing up in front of (R4's) wheelchair at (R3's) door with her (R4's) hand on the doorframe. (V11) jumped up from (V11's) chair at the north nurse's station and ran towards (R4) while trying to yell to (R3) that (V11) would get (R3), but before (V11) could finish the sentence and intervene, (R3) slammed the door shut while still yelling at (R4) saying 'stupid bitch, get the f*** away from here.' (R4's) hand was caught in the door and a loud crunching sound was heard. (R4) sat back in wheelchair and looked down at her hand which was bleeding and stated, 'that really hurts.' (V11) moved (R4) away from (R3's) room door to the north nurse's station and inspected (R4's) hand. (V11) could see visible open bleeding wounds to (R4's) right hand digits 3, 4 and 5. (V11) wrapped (R4's) hand with a towel to try and stop the bleeding. (V11) went to take a look into (R3's) room and (R3) started yelling for (V11) to 'get the f*** away from here nigger.' (R3) also stated 'I didn't do anything to (R4), she shouldn't have brung (sic) her ass into my room.' (V11) called out for help and started giving orders for an aide to stay with (R3) and for an aide to stay with (R4) while (V11) made necessary phone calls to the proper authorities, management, Dr. (doctor), and POA (Power of Attorney), resident was transported to (named) ED (Emergency Department), (V16 Medical Director), (V3) DON (Director of Nursing) and POA notified of | S9999 | | |

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incident."

R3's Progress note, dated 9/8/24 by V17 Facility Nurse Practitioner, includes but is not limited to: "HPI (History of Present Illness) Interval History: Provider notified of a repeated incidence of patient significantly harming another resident while slamming his room door on another resident's hand and using profanity to call that resident names and for them to get away from the door. This is not the first time he has injured another resident at the facility. He continues to have aggressive and harmful behaviors towards staff and other residents, with noted episodes of striking staff members. He still has episodes of yelling while using profanity and striking out at staff and other residents. He will throw dishes in his room with the attempt to break them and subsequently poses risk to himself and staff members. He once again puts other residents' safety at risk and vocalizes no remorse for the significant hand injury that occurred. Patient is noncompliant with cares and medication orders despite frequent attempts to educate on the importance of bathing, eating, and taking medications as ordered. He is to be sent to the hospital for a psychiatric evaluation due to continued outbursts of anger and physical aggression towards staff and other residents."

R4's X-ray report of right hand, dated 9/8/24, documents "Impression: 1. Acute posttraumatic fractures of the third-fifth digit middle phalanges."

R4's Progress Note, dated 9/9/24 by V17 Facility Nurse Practitioner documents: "HPI (History of Present Illness) Interval History: Patient returns to the facility after being evaluated at (named) ER (Emergency Room). Patient (R4) had her right hand slammed shut in the door of another

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resident's room. Per daughter, patient does have a fracture and is to follow up with ortho (orthopedics) tomorrow to discuss possible surgery. Patient denies any pain at this time but due to dementia, is not reliable with her ROS (Review of Systems). She does have noted stitches on the inside of her fingers. Multiple areas of dark bruising. Patient was started on a prophylactic antibiotic while at the ER to prevent infection. Patient also recently tested positive for COVID-19. She continues to have a clear runny nose, per baseline. No cough noted."

On 9/18/24, at 12:04pm, R4 sat in her room then got up and walked over to the door entrance of her room. R4 showed this writer R4's right hand. R4's middle, index and pinky fingers are inflamed and purplish red in color with sutures noted across the first knuckle of all three fingers. R4 denies pain except when closes fist, R4 stated "it doesn't feel too good." R4 is unable to recall how it happened and stated, "did my family put me here?" R4 then ambulated out of her room and wandered down the hall.

On 9/19/24, at 9:28am, R4 sat in a wheelchair and self-propelled in the hallway.

On 9/19/24, at 12:14pm, R4 stood in the hallway near the door of another resident's room. R4 ambulated a little further to the next resident's room and entered.

On 9/20/24, at 9:59am, R4 self-propelled in her wheelchair up and down the hallway. R4 followed then caught up to this writer and stated, "Did I go too fast? What's going on out there?" while looking towards an exit door.

On 9/19/24, at 9:31am, V13 Certified Nursing

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| S9999 | Continued From page 11<br><br>Assistant/CNA stated the following, "(R4) is supposed to be in a wheelchair unless a CNA ambulates with her. She is a wanderer and has dementia. She wanders by self-propelling in her wheelchair. She goes in/out of resident rooms...She holds onto door frames as she peers into resident rooms looking, not always going in ...She does it often and goes into a lot of rooms. After those two incidents we re-direct and try to keep her out of the center hallway especially if going towards his room in the center hallway. He usually left his door closed if he was in his room and leave it open when not in it. He was not a nice person...He was his own person, did not have dementia, refused cares and if we brought him water, he would bring it back out, slam it down and say I didn't want that. (R4) stops in doorways frequently every day."<br><br>On 9/19/24, at 9:41am, V14 CNA stated the following, "(R4) is a wanderer and has dementia. I was not working those days she got her hand caught in the door. She wanders in her wheelchair and sometimes leaves it and gets up to walk. I typically only work weekends so last weekend when I was working, I saw her hand with sore fingers. The nurse told me she got it slammed in the door and we were to keep her out of other peoples' rooms. I have seen (R4) go into resident rooms all the time. I kind of keep my eye on her and if she is going into another's room, I take her back to her room. She's got dementia so bad five minutes later she asks, 'where's my room.' When she walked, she braced herself by holding onto the doorframes. She does not get one on one supervision, but that would be a good idea. Can't have her in eyesight all the time. Keeping an eye on where she is all the time is impossible. She is here one minute and next minute she is down the hall. She's fast whether | S9999 | | |

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walking or in her wheelchair."

On 9/19/24, at 10:29am, V11 LPN stated the following: "I remember (R3 and R4's 9/8 incident). I was at nursing station on phone about another resident and hung up to write notes on the computer. I heard yelling so I swung my chair around and saw (R4) standing at (R3's) door but (R4) didn't go in. I could see (R4) peering into (R3's) room from the doorway standing up with (R4's) wheelchair behind (R4). I yelled out 'hey (R3)' but before I could finish the door went boom and I could hear (R4's) fingers crushing. Oh my god. (R4) sat down in her wheelchair and looked at her hand and said, 'wow that really hurts'. I don't think (R4) really understood. As I was going towards (R4) I could see the blood. I wheeled (R4) back towards the nurse's station while trying to call (V3 Director of Nursing/DON). The other nurse didn't know what to do. (R3) was still in his room yelling. He said, 'get away from here you nigger.' I said, 'you just smashed her fingers.' (R3) didn't care. (R3) said '(R4) shouldn't have brought her ass into my room.' (R4) is a wanderer and has dementia. She wanders in her wheelchair. (R4) likes to look around everywhere. We usually let her go about her business if she is in the wheelchair. She'll glide it around and look at things. (R4) just doesn't know what's going on. I thought (R4) would pass out or cry. (R3's) door is usually cracked open. I think (R4) may have gone into (R3's) room. (R4) was holding onto the doorframe when peering into (R3's) room. That is what (R4) would usually do and (R4) would do this when peering into other's rooms. I knew of their previous incident. I was on shift 8/11/24 and worked 2pm - 6:30am. That incident I did not see. I did see her fingers - her index finger and even more sore her thumb had skin torn off. We spoke with (R3) and explained (R4) doesn't know and is

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harmless so if (R4) comes to (R3's) door let us know and we will get (R4). (R3) is stuck in his ways. (R3) is aggressive and throws things and cusses. (R3) can be sweet when wants something. (R3) said, 'you keep (R4) out of here;' there is no reasoning with (R3). We try to keep an eye on (R4) as much as we can. There is only so much we can do while doing our job. It wasn't even five minutes that she had got away. (R4's) room is northeast and she was down the hallway and if there I know (R4) is okay down there and I show (R4) her room. (R4) had stopped at the nurses' station before I made the call then (R4) was gone...(R4) wanders into rooms often - she is looking for her room...(R3) punched a staff person in the stomach and (R3) has thrown things at staff."

On 9/19/24, at 11:36am, V12 Registered Nurse/RN stated the following regarding R3 and R4's incident on 8/11/24: "(R4) tends to wander and was in the doorway of (R3) and we heard yelling. Before we got there (R3) went to slam the door and (R4) had her hand in the door...Her hand was bleeding. We sent her out for chest pain, and we wanted her hand checked too. (R4) was on her feet from the minute she woke up and wandered a lot. There was constant redirection back to her hall. She had dementia...We were trying to redirect (R4) but it was difficult as she was going all over the place. I am not aware of anything (increased supervision/monitoring) in place. No increased supervision - I don't know how we would do that. We were already constantly going to get her...(R4) was not in eyesight 100% of the time but (R4) was never in her room. She was always staff asking, 'what do I do now.' It was so odd the way it happened because I was three doors down. (R3) is very vocal and (R4) was at (R3's) doorway. It

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happened so fast. (R3) is very private. (R3) is a strange character and knows more to what he plays on. (R3) is not nice. He may have arguments at times with residents but no other aggressive incidents that I know of. I stopped working about Aug 20th or so. I did not know it happened again. We didn't do anything different for (R4) or (R3). We asked (V18 Previous Administrator) about it and (V18) said 'this did not result in an injury and (V18) will handle it.' We felt (R3) needed a psychiatric evaluation to see if something was going on. I believe this was (R3's) first time it was an actual behavior harming someone. It is kind of hard to keep someone like (R4) safe. Breaks my heart that it happened again."

On 9/19/24, at 12:54pm, V7 Social Service Director/SSD stated there was no increased supervision for (R4) or any care plan updates after the 8/11/24 for (R4's) wandering. V7 said, "I wasn't in any discussion about it. I was in on discussion after the 9/9/24 incident and it happened so fast; the police were called. Everything was in place to get her out of that situation by redirecting. We don't usually have people in here that do things like slamming doors on others". V7 denies that any increased supervision or monitoring of (R4) was put into place. Confirmed that since a second similar incident occurred redirecting didn't really work.

On 9/19/24, at 1:30pm, V3 Director of Nursing/DON stated the following: "On the 8/11 incident I was not there. I received a call from (V12 RN) when it happened. (V12) said (R4) was by (R3's) room in the hallway. (R3) became angry and slammed (R4's) hand in the door. (R4) became diaphoretic and was pale so we sent (R4) out to see if any injury to her hand and there

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| S9999 | Continued From page 15<br>was not. As for (R4), we try to redirect her away and do our best and watching (R3) and staff approaching when (R3) is getting worked up. (R4) is a known wanderer and has dementia. (R4) hovers in a doorway, looks in, then keeps going." V3 confirmed redirecting was already in place for R4 prior to this incident. V3 stated, "The 9/8 incident happened at night on 2nd shift. I got called by (V11 LPN). (V11) said (V11) was at the nurse's desk and could see (R3's) room. (V11) heard (R3) screaming and cussing at (R4). (V11) tried to get there but (R3) had slammed (R4's) hands on the door again. When (V11) got there (R4's) hand was visibly injured, cut open and bleeding. It appeared that (R4) had just used (R3s) doorframe to stand. (R4) sat right back down afterwards. We called the cops on (R3). (R4) was sent to a separate hospital for evaluation. (R4) had three fractured fingers and 12 sutures total to all three fingers, ring middle and pinky. (R4) has an ortho (orthopedic) referral for surgery. (R4) had COVID so will need to be rescheduled till clear of COVID. We sent (R3) for a psych (psychiatric) eval (evaluation). (R3) was deemed decisional. We called the hospital about (R3) being aggressive and noncompliant. (R3) has been sent out several times for psych evals and they send him back. I sent (R3) in once. (R3) became aggressive on staff when they went to change him. Cops were called and (R3) hit the cop... (R3) hit (V15 CNA) in the face and stomach when (V15) was taking his room tray in. We called the cops. All three incidents occurred within 30 days. We tried to reason with (R3). (R3) was mean on purpose. We don't have the staff to do one on one supervision. We are not a locked unit; no way to watch her every second. We do our best to keep our eye on her. It was a busy night, and everyone was busy right after dinner hour laying people down and the nurse was on | S9999 | | |

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the phone. There was a lot going on. Obviously, I want to protect (R4), but it could have been anybody. He was mean and impulsive all the time. I think (R3) was dangerous in general; not an (R4) thing. (R3) refused psych evals with our psych (psychiatric doctor) and refused meds (medications).

On 9/20/24, at 1:36pm, V3 DON stated, "(R3) was aggressive any chance he got. (R3) would break dishes, cuss us out or become aggressive. (R3) did this almost on a daily basis. It got to this point where (R3) started calling the cops. (R3) was decisional and knew what he was doing. (R3) was choosing these behaviors like threatening staff and residents so we started calling cops on him...(R3) refused a psychiatric evaluation and refused his medications frequently."

The Facility Incident Report Form, regarding a Reportable Event, documents an abuse allegation occurred on 9/8/24 at 7:30pm involving R3 and R4.

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2. The facility policy, Abuse Prevention Program, dated 10/2022 directs staff, "This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. This assumes that all instances of abuse of residents, even those in a coma, cause physical harm or pain or mental anguish. Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion or sexual assault."

The facility Incident Report Form, "Date of

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Occurrence 8/19/24 at 7:30 P.M. Initial: Staff member (V6/Laundry Aide) reported to the Abuse Prevention Coordinator (V3/Director of Nurses) designee that R1 was allegedly touching R2 inappropriately in the dining room. R1 and R2 immediately separated. R2 assessed, no injuries noted. R1 being seen by psych (psychiatric services) and NP (Nurse Practitioner). Investigation initiated, final to follow. POA (Power of Attorney) of R2 notified. R1 is his own representative. MD (Medical Doctor) notified. Local Authorities notified."

R1's facility Admission Record documents that R1 was admitted to the facility on 03/08/2024 with the following diagnoses: Senile Degeneration of Brain, Chronic Kidney Disease and Adjustment Disorder.

R1's Minimum Data Set Assessment, dated 6/12/2024 documents R1's cognitive status as 12 out of 15 (moderate cognitive impairment).

R1's Nursing Progress Note, dated 8/20/2024 documents, "Incident was reported to the writer by a staff member. Staff member reports seeing the resident in close proximity to a female resident in the dining room. Staff member saw resident's hand on the thigh of the female resident."

R2's facility Admission Record documents that R2 was admitted to the facility on 08/07/2020 with the following diagnosis: Alzheimer's Disease.

R2's Minimum Data Set Assessment, dated 7/4/20204 documents R2's cognitive status as 3 out of 15 (cognitively impaired).

R2's current Care Plan includes the following

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| S9999 | Continued From page 18<br>Focus Area: (R2) has impaired cognitive function/dementia or impaired thought processes related to Alzheimer's, Dementia, Delusional Disorders, Mood Disorder. Also included are the following Interventions: (R2) needs supervision and assistance with all decision making.<br><br>The facility Incident Report Form dated August 26, 2024, documents, "Final: Investigation completed. Interviews with staff and resident completed. Per interview with R1, resident adamantly denies allegations stating he is 95 years old and has no sexual desires and would not touch anyone in an inappropriate manner. R1 has resided at the facility for a long time and has not had any behaviors or inappropriate interactions. This would be completely out of character for him. R1 states he might touch a resident on the hand to offer comfort or greeting but would never do anything inappropriate. It must be noted that R1 has impaired vision and is almost blind. It is highly likely that he could have made contact accidentally. R1 is alert and oriented X 2 with a BIMS (Brief Interview for Mental Status) of 12 and a hospice patient. R2 is not interviewable due to advanced dementia. (R2) is alert and oriented X 1 with a BIMS of 3. V1 the staff member who reported this incident states she was cleaning the dining room. R2 was sitting with her back to V1 as she walked further into the dining room, she observed R1 and R2 sitting across from each other knee to knee. V1 reports she observed R1's hand on R2's thigh. It appeared to be near the groin area of R2. R2's hands were positioned beside her in her wheelchair. V1 then told R1 to remove his hands and went and got the nurse who separated R1 and R2. V1 stated R2 was wearing long pants which were fully intact. V1 reports that no other staff or residents observed the incident. Peer | S9999 | | |

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| S9999 | Continued From page 19<br><br>reviews done with other women on the unit, none of which mentioned any sexual misconduct during their stays. R2 was assessed and no injury or evidence of sexual interaction was found. IDT (Interdisciplinary Team) met and reviewed plan of care for both R1 and R2 and updated accordingly. R1 UA (urinalysis) is negative, was seen by NP (Nurse Practitioner) who did med (medication) review. R1 refused to have psych (Psychiatric) eval (evaluation). R1 will continue to be monitored for any inappropriate conduct. The investigation determined insufficient evidence to substantiate abuse due to lack of intent, physical or mental distress."<br><br>On 9/18/2024 at 1:24 P.M., V6/Laundry Aide stated, "On (8/19/24) around 7:15 in the evening, I saw (R1) touching (R2) in her crotch. They were sitting side by side in the ADR (Activity Dining Room). They were the only two in the room. I happened to be walking through. Their wheelchairs were side by side. (R1's) left hand was on (R2's) inner right thigh and (R1's) right hand was in (R2's) crouch. It was on the outside of (R2's) gray sweatpants. I was able to see the position of his hands clearly. Her hands were down by her side. (R2) wasn't saying anything. (R1) was talking really low to (R2). I could not make out what (R1) was saying to (R2). (R1) was very angry when he saw me. He yelled at me and said, 'I am very offended of your presence.' (R1) immediately withdrew his hand. I went to the nurse; I don't know what her name is. She is an Agency nurse. She still works here. The nurse came into the ADR and separated them and told (R1) to keep his hands to himself. (R1) was still very angry with me, telling me that I was a dirty person and had a dirty mind. The nurse had me come to the nurse's station and write a statement. V8/CNA (Certified Nursing Assistant) was | S9999 | | |

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| S9999 | Continued From page 20<br><br>standing at the nurse's station talking to V3/DON (Director of Nurses) on the phone. He took a picture of my statement with his phone and sent it to (V3). (R1) likes to flirt with all the ladies. (R1) says he is looking for a lover."<br><br>On 9/19/24 at 9:20 A.M., R1 stated, "I have lived here for a few years. (R2) is my friend. I love her. I have touched (R2) many times, on the hand and face. I don't see (R2) much anymore. I miss (R2)."<br><br>On 9/19/24 at 10:00 A.M., V11/Agency Nurse stated, "I recall the incident that happened (between R1 and R2 on 8/19/24). (R1) likes to think he's a ladies' man. (R1)'s always talking to the ladies and calling them his girlfriends. (R1) likes to say, 'I have everything I need, except a lover.'" (A) | S9999 | | |