STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335281	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Absolut Ctr for Nursing & Rehab Aurora Park L L C	292 Main Street East Aurora, NY 14052

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36415 Based on interview and record review conducted during a Complaint investigation (#NY00347404) during a Standard survey completed on 12/20/2024, it was determined the facility did not protect residents from sexual abuse for two (Resident #165 and Resident #151) of seven residents reviewed. Specifically, residents who lacked ability to consent were observed undressed and in bed together. The policy and procedure titled Abuse Prohibition dated 02/2023 documented that residents have a right to be free from abuse including sexual abuse. The policy and procedure titled Abuse Prohibition Staff Responsible for Coordinating and Implementing dated 11/19/2021 documented that the Administrator is responsible for preventing abuse of the residents. The findings are: 1. Resident #165 was admitted to the facility with diagnoses of Alzheimer's disease and dementia. The Minimum Data Set (a resident assessment tool) dated 5/30/24 documented Resident #165 was severely cognitively impaired and had wandering behaviors. The comprehensive care plan dated 5/24/24 documented Resident #165 had wandering behaviors and displayed promiscuous behaviors at times. Resident #165 was alert and oriented to person only and could ambulate independently in their room and in the hall. The Patient Resident's Rights and Responsibilities dated 5/29/24 documented that Resident #165 was unable to give consent due to cognitive capacity. The Determination of Capacity dated 5/31/24 documented Resident #165 lacked the capacity to make health care decision and the reason for this lack of capacity was due to Alzheimer's disease. The Mini Mental State Examination dated 6/4/24 documented Resident #165 scored a 13 out of 30 which indicates that Resident #165 severely cognitively impaired. Review of a progress note written on 6/3/2024 at 4:35 PM by the Director of Social Work documented that capacity determination was signed by provider and the concurring provider stated that Resident #165 does not have capacity to make their own medical decisions. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #151 was admitted to the facility with diagnoses of dementia and Parkinson's disease. Review of the Minimum Data Set, dated dated dated [DATE] documented Resident #151 was moderately cognitively impaired and had wandering behaviors. The comprehensive care plan dated 5/21/2024 documented Resident #151 had an alteration in decision making skills related to dementia. The comprehensive care plan documented the resident encourages others behavioral tendencies at times. Additionally, it documented a potential for alteration in mood and behavior patterns related to dementia and adjustment difficulties. Review of the patients' rights and responsibilities dated 5/21/2024 documented Resident #151 does not have capacity to give consent. Review of the determination of capacity dated 5/23/2024 documented that Resident #151 lacks the capacity to make health care decisions. It documented that the lack of capacity was due to dementia. An incident report dated 7/6/2024 at 4:45 PM completed by Licensed Practical Nurse Supervisor #2 documented while doing their medication pass, Licensed Practical Nurse #4 walked into Resident #151's room and found Resident #151 sitting on their bed with Resident #165 without clothes on. Resident #151 stated at this time, that it had been [AGE] years since I had sex, and they (Resident #165) were willing. The incident report documented that Resident #165 was dressed and escorted from the room. It documented that both residents were assessed for injuries, and none were found. Review of an investigation statement dated 7/6/2024 documented that Licensed Practical Nurse #4 walked into Resident #151's room to pass medications and found Resident #151 and Resident #165 unclothed in Resident 151's bed. The statement documented that Licensed Practical Nurse #4 instructed Resident #165 and Resident #151 to get dressed. Licensed Practical Nurse #4 then notified Licensed Practical Nurse Supervisor #3 and other staff. An investigation report dated 7/11/2024 documented that Resident #165 was last seen by staff at 3:15 PM on 7/6/2024. Resident #165 was found close to the genital area of Resident #151 by Licensed Practical Nurse #4 on 7/6/2024 at 4:45 PM. The investigation documented the residents were noted to be unclothed in Resident #151's room. Resident #165 was dressed by staff and re-directed out of the room. Resident #151 stated they did not have sex with Resident #165 but Resident #165 did perform oral sex on them. The conclusion of the investigation documented the residents' cognitive status, they were unable to give consent for sexual activities and this was reported to the New York State Department of Health. Review of a progress note from the Psychiatric Nurse Practitioner dated 7/16/2024 documented that Resident #165 was seen for sexual inappropriateness. The progress noted documented that Resident #165 had poor insight, poor memory, and poor judgement due to dementia. During an interview on 12/18/2024 at 1:22 PM, Certified Nurse Aide #1 stated that staff were looking for Resident #165 prior to the incident, but they did not witness anything between Resident #165 and Resident #151. During an interview on 12/19/24 at 9:27 AM, Social Worker #1 stated Resident #151 does not have the capacity to consent. They stated residents with dementia cannot consent to anything. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/19/24 at 9:36 AM, the Director of Social Work stated that non-consenting adults having sex would be considered abuse. They stated that Resident #151 does not have capacity to consent. During an interview on 12/19/2024 at 10:33 AM, the Assistant Director of Nursing stated because there was no psychosocial harm between Resident #165 and Resident #151, there was no abuse. They stated that Resident #165's going into other residents' rooms was a new behavior and that's why Resident #165 was put on one-to-one supervision to prevent Resident #165 from repeating this wandering behavior. During an interview on 12/19/2024 at 1:11 PM, Resident #151's responsibility party stated visited Resident #151 right after the incident occurred. They stated that Resident #151 told them that Resident #165 had performed oral sex on them. The Responsible Party stated they spoke to Resident #151 about informed consent and that other residents might not be able to consent to sex. During an interview on 12/19/2024 at 1:21 PM, Licensed Practical Nurse #4 stated they stand by what was in their statement. They stated that if two residents do not have the ability to consent to sex, then it was considered abuse. During an interview on 12/19/2024 at 3:58 PM, Resident #165's responsible party stated they were not aware that Resident #165 was unclothed and in bed with Resident #151. The facility informed them that Resident #165 was fully clothed, and that Resident #151 only had their pants down. They stated the facility informed them they couldn't find Resident #165 for over an hour and that the security cameras were not working on the memory unit. During an interview on 12/19/2024 at 4:33 PM, the Medical Director stated that if residents cannot consent to sex, then it was considered abuse. They stated that they do not believe Resident #165 could consent. During an interview on 12/20/2024 at 9:26 AM, the Psychiatric Nurse Practitioner stated that Resident #165 does not have the capacity to consent. Two residents who don't have the capacity to consent; can't consent to sex so they would consider this abuse. During an interview on 12/20/2024 at 12:08 PM with local law enforcement, they stated that they were called to the facility concerning an incident between two residents. They stated that the facility told them the contact was consensual and they did not initiate an investigation because of what the facility told them. During an interview on 12/20/2024 at 12:23 PM, Licensed Practical Nurse Supervisor #3 stated that Resident #165 does not have the ability to say yes or no. Resident #165 was put on one to one supervision after the incident because they did not want Resident #165 to wander in and out of other residents' rooms to protect them and other residents from possible abuse. They stated they had contacted the local police department because they thought it may have been abuse. During an interview on 12/20/2024 at 1:21 PM, the Director of Nursing stated that what happened between Resident #151 and Resident #165 was not abuse because nothing was witnessed. The Director of Nursing stated that a reasonable amount of time to do a Registered Nurse assessment for an incident between two residents was 12 to 24 hours after the incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/20/2024 at 1:36 PM, Licensed Practical Nurse #2 stated that confused residents do not have the ability to consent. They stated that two residents unclothed in a room together would be considered abuse and should be reported right away to the Director of Nursing or Administrator. During an interview on 12/20/2024 at 1:44 PM, Registered Nurse Supervisor #2 stated they started their shift at 7:00 PM on 7/6/2024. They had assessed Resident #151 a little after 7:00 PM when they started their rounds, and they did not find any injuries on the resident at that time. Registered Nurse Supervisor #2 stated they did not assess Resident #165 right away because the resident was sleeping. They stated they assessed Resident #165 around 1:00 AM when Resident #165 was receiving a medication and they did not observe any marks or injuries at that time. Registered Nurse Supervisor #2 stated at the time of the incident, there didn't seem to be a sense of urgency, so they assumed there was no abuse involved. During an interview on 12/20/24 at 2:06 PM Licensed Practical Nurse Inservice Coordinator #1 stated, if two residents who lacked capacity to consent were found naked in bed together it would be considered abuse. 10 NYCRR 415.4(b)(1)(i)