STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015320	A. Building B. Wing	01/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Enterprise Health & Rehabilitation Center	300 Plaza Drive Enterprise, AL 36331

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(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 - Immediate jeopardy to resident health or safety 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** Based on interviews, resident's medical records, review of Facility Reported Incidents (FRIs) received by the State Agency, the facility's investigative files, and facility policies titled Abuse, Neglect, and Exploitation, Social Media Use, Cell Phones, and Confidentiality Statement, the facility failed to protect the residents' right to be free from sexual abuse perpetrated by other residents, physical abuse perpetrated by other residents, and exploitation/mental abuse perpetrated staff. Specifically:1. On 02/11/2025 the facility failed to protect Resident Identifier (RI) #168's right to be free from sexual abuse. On 02/11/2025 around 7:30 PM, Certified Nursing Assistant (CNA) #13 was making rounds on the Memory Care Unit (MCU) and observed RI #168 sitting on RI #97's bed. CNA #13 observed RI #97 fondling RI # 168's genitalia with his/her hand in RI #168's brief. RI #168 had history of wandering into other residents' rooms. RI #97 had a known history of touching staff in a sexually inappropriate manner. Following the incident RI #97 was transferred off of the MCU and was moved back to the MCU on 03/05/2025.It was determined the facility's noncompliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.12 Freedom from Abuse, Neglect and Exploitation.On 01/16/2026 at 6:30 PM, the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Assistant Administrator were provided a copy of the Immediate Jeopardy (IJ) template and notified of the findings of immediate jeopardy and substandard quality of care in the area of Freedom from Abuse, Neglect, and Exploitation at F600- Free from Abuse and Neglect. The IJ began on 02/11/2025 and continued until 01/18/2026 when the survey team verified that onsite corrective actions had been implemented.2. The facility further failed to protect RI #143 from mental abuse/exploitation when a photograph of the resident in a vulnerable position was shared on a social media site without the resident's knowledge or consent. The photo did not include the resident's face or genitalia.3. The facility failed to protect RI #11's right to be free from physical abuse perpetrated by RI #169. On 01/05/2026 CNA #17 witnessed RI #169 physically abuse RI #11 when he/she hit RI #11 on the arm in the dining room. RI #169 had a history of aggressive behaviors, which included verbal and physical aggression. The facility failed to provide adequate supervision and interventions for RI #169 to prevent other residents from being abused. RI #11 stated his/her arm hurt after being hit by RI #169.These deficient practices were cited as a result of the investigations of facility reported incident/complaint/report numbers 471526 and 271095.These failures affected five of six residents reviewed for abuse concerns during the survey. Findings include: Cross Reference F607 and F867. Review of the facility's policy titled, Abuse, Neglect and Exploitation, with an implemented date of 04/04/2018, and a revised date of 01/01/2024, revealed: (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Policy: It is the policy of the facility to provide for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Definitions: . Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Sexual Abuse is non-consensual sexual contact of any type with a resident. Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment. Mental Abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. Mental abuse also includes abuse that is facilitated or caused by nursing home staff taking or using photographs or recording in any manner that would demean or humiliate a resident(s). Alleged Violation is a situation that is observed or reported by staff, resident. or others but has not yet been investigated and, if verified, could be indication of noncompliance with Federal requirements related to mistreatment, exploitation, neglect, or abuse. Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse. of residents. c. Include training for new and existing staff on activities that constitute abuse, . exploitation. dementia management and resident abuse prevention. 3. The facility will provide ongoing oversight and supervision and supervision of staff in order to assure that its policies are implemented as written. The components of the facility abuse prohibition plan are discussed herein: 1. Screening . B. Prospective residents will be screened to determine whether the facility has the capability and capacity to provide the necessary care and services for each resident admitted to the facility. 1. An assessment of the individual's functional and mood/behavior status. and special needs will be reviewed prior to admission. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. The facility will make individual determinations in consideration of current staffing patterns, . physical environment. II. Employee Training . C. Training topics will include: 5. Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect such as: a. Aggressive and/or catastrophic reactions of residents; b. Wandering. c. Resistance to care d. Outburst or yelling out. III. Prevention of Abuse, Neglect and Exploitation The facility will implement policies and procedures to prevent all types of abuse. and exploitation. establishing policies and protocols for preventing sexual abuse. A. Establishing a safe environment.establishing policies and protocols for preventing sexual abuse. B. Identifying, correcting and intervening in situations in which abuse.is more likely to occur. C. Assuring an assessment of the resources needed to provide care and services . D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect. On 02/11/2025 at 9:47 PM the State Agency received a Facility Reported Incident (FRI) alleging that RI #97 was in his/her room and was observed with his/her hand in the brief of RI #168. RI #97 was admitted to the facility on [DATE] with diagnosis to include myocardial infarction, hemiplegia affecting right dominant side, anxiety disorder, unspecified intellectual disabilities, mood disorder and mild cognitive impairment. A review of RI #97's quarterly MDS assessment with an Assessment Reference Date (ARD) of 04/04/2025 documented that RI #97 had short term and long-term memory impairment indicating cognitive impairment. RI #97's Functional Abilities indicated wheelchair use, lower extremity impairment. Mobility assessment indicated for walking was not attempted and RI #97 did not perform this activity prior to the current illness. A review of RI #97's comprehensive care plan titled Care Plan Report revealed: Focus (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Behaviors . AEB [as evidenced by] . yelling out without purpose, purposefully sliding him/herself to the floor out of wheelchair, refusing care/medications, verbally abusive toward, combative during care, throwing things at staff (i.e. {such as} call light, wedge, pillows bedside table, meal trays etc.), sexually inappropriate toward staff and hx. (history) of possibly other residents. He/she takes psychotropic medications for behavior. Date initiated: 08/12/2024 Revised on 10/27/2025 . Interventions . Administer medications for behavior per MD order, observing for efficacy and adverse reactions . educate on the importance of being compliant and accepting all care. Explain/reinforce why behavior is inappropriate and/or unacceptable. Notify MD, Sponsor, Psych, and Social Services of any changes. The care plan did not provide directions to staff regarding how or when RI #97 needed to be supervised. A record review (census list/room change) indicated RI #97 was moved on multiple occasions while in the facility. RI #97 was admitted on [DATE] and was not admitted to the MCU. On 01/05/2024 RI #97 was moved to the MCU, a secured unit, due to behaviors. On 02/11/2025 after the sexual abuse allegation resident was moved off the MCU until transferred to a behavioral hospital on [DATE]. Upon readmission on [DATE], RI #97 was not placed on the MCU. RI #97 was transferred back to the MCU on 03/05/2025. A review of RI #97's Progress Notes revealed the following documented behaviors from 12/18/2024 through 03/15/2025: On 12/18/2024 RN #20 documented that RI #97 was yelling out, refusing medications and care and was attempting to touch staff members inappropriately. On 12/20/2024, LPN #25 documented that RI #97 was touching staff inappropriately and then started hitting a CNA. On 01/04/2025, RN #26 documented that RI #97 was grabbing at nursing staff in sexual manner and staff were unable to redirect easily. On 01/23/2025 RN #30 documented Resident noted making loud animal like sounds this shift and staff reports resident making sexually inappropriate comments, you my girl friend and were gonna boom boom as he/she was thrusting himself/herself in the bed, staff redirected by telling the resident that it was inappropriate. On 01/29/2025 RN #10 documented that resident went to grab her breast. he/she got mad and stated no when trying to give meds. nurse tried again and RI #97 said no and continued to grab. nurse. again inappropriately. RN Supervisior and SS notified. On 01/31/2025 LPN #25 Behavior Note documented that RI #97 refused medications and when nurse attempted to perform body audit patient started swatting at nurse and trying to inappropriately touch nurse. On 02/03/2025 RN #29 documented two staff were unable to cut RI #97's (finger) nails because of how (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RI #97 moves hands around to tied to touch inappropriately. On 02/05/2025 Social Services Assistant (SSA) documented that in the three month look back RI #97 continued to have episodes of grabbing at staff inappropriately, combative with care (hitting, spitting, shoving items at staff) yelling out/attention seeking, verbally abusive (i.e. cursing and yelling) to staff, and non-compliant/rejecting care. RI #97 required two staff members to provide care due to inappropriate behaviors. RI #97 required a mechanical lift for transfers and was unable to ambulate. On 02/05/2025 LPN #28 documented that RI #97 had many episodes noted of being sexually inappropriate toward staff and noncompliant with care. On 02/08/2025 LPN #31 documented that RI #97 refused all medication. On 02/11/2025 RN #20 documented that an incident occurred earlier this shift with another resident, social services director notified. RI #97 was temporarily moved to room (named room number) on another unit. A Nurses Note dated 03/15/2025 documented by RN #35 documented . Inappropriate sexual behavior with new staff member. Redirected per staff and interaction stopped. (Resident) grabbed female staff members breast and patted her buttocks during care. RI #168 was admitted to the facility on [DATE] and had diagnoses to include: Alzheimer's Disease, Anxiety Disorder, Transient Ischemic Attack and Cerebral Infarction without residual deficits. A review of RI #168's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 01/23/2025 documented a Brief Interview for Mental Status (BIMS) score of 3 of 15, which indicated RI #168 had severe cognitive impairment. The MDS behavioral assessment indicated RI #168 wandered 4-6 days but less than daily and wandering placed RI #168 at significant risk of getting to potentially dangerous places and his/her wandering significantly intrudes on the privacy of others. A review of RI #168's Order Summary Report revealed an order dated 11/13/2024 for a Secure Care Monitor due to being at risk for elopement. A review of RI #168's Care Plans dated 02/06/2025 documented: Focus RI #168 is alert with confusion related to Alzheimer Disease. requires cueing and supervision with decision making. has episodes of wandering/exit seeking and wandering in and out of others' rooms. Secure Care Monitor was placed on 01/17/2025 to attempt to prevent elopement. Interventions Document any episodes of confusion/forgetfulness. Redirect away from exit doors as needed . A review of RI #168's progress note dated 02/04/2025 by the Hospice Nurse Practitioner documented that RI #168 was ambulatory and moved all extremities well. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of RI #168's progress notes from 01/17/2025 to 02/28/2025 documented 36 occasions of RI #168 wandering the hallways and in and out of other resident's rooms. On 01/14/2026 at 3:17 PM an interview was conducted with CNA #13 who witnessed the incident. CNA #13 said prior to the incident on 02/11/2025 she last saw the residents around 5:30 PM. CNA #13 said about 7:30 PM, she was walking through the hall and she saw RI #168 sitting on the side of RI #97's bed. RI #97 had his/her hand in RI #168's diaper and was fondling RI #168 private parts. CNA #13 said the way RI #97's hand was positioned she could see his/her hand moving. CNA #13 said she had not been instructed on how to watch or supervise a resident who wandered other than there being photos at the nurses' desk to identify residents who wandered or were at risk for elopement. On 01/15/2026 at 9:50 AM, an interview was conducted with Registered Nurse (RN) #10 /Unit Manager. RN #10 stated RI #168 wandered almost constantly into other residents' rooms and she was not notified of each wandering episode. She stated she became aware of the 02/11/2025 incident involving RI #168 and RI #97 on 02/12/2025. RN #10 stated neither resident had the ability to consent sexually. RN #10 stated following the incident RI #97 was moved to another unit and then transferred to another facility for behavioral health services. RN #10 said RI #97 was readmitted to the facility on [DATE] to another hall then readmitted to MCU on 03/05/2025 due to disruptive behaviors such as yelling out and crying. RN #10 said the facility identified residents whose behaviors need to be reviewed by behavior management team by reviewing nursing documentation and the 24 hour report (shift to shift report) which was maintained in book at nurses' desk. RN #10 said there were two residents currently on the MCU who wandered and the facility staff monitored them and redirected them out of RI #97's room. RN #10 was asked, what actions had been implemented to ensure wandering, confused residents did not enter RI #97's room without supervision. RN #10 said the facility had training with the staff to redirect residents back to the hall or to their rooms. RN #10 said the facility monitored the residents who wandered and redirected them, but there was no staff assigned to monitor wandering residents. When asked could RI #97 sexually abuse another wandering resident, she said yes, it could happen again. On 01/15/2026 at 5:43 PM an interview was conducted with SSD/Abuse Coordinator. The SSD was asked how it would make a reasonable person feel to have someone touching or rubbing their private parts without permission. The SSD said that person would probably holler out and feel embarrassed and feel violated. On 01/16/2026 at 11:50 AM a follow-up interview was conducted with SSD who stated the staff did not observe RI #168 wander into RI #97's room because they were in other rooms at the time. The SSD stated neither RI #97 nor RI #168 had the ability to consent to sexual activity. The SSD read the facility policy and verbalized that sexual abuse was defined as non-consensual sexual contact with any resident. The SSD said non-consensual sexual contact occurred between RI #97 and RI #168. On 01/16/2026 at 2:54 PM during a follow-up interview with the DON, the DON said staff should round every two hours or more frequently to monitor or supervise a resident with history of wandering. The DON was asked what could have been done to prevent the abuse of RI #168 on 02/11/2025. The DON said more frequent monitoring of RI #168. The DON was asked how would a reasonable person feel if someone came up to them and started rubbing on their private parts; she said it would not make her feel very well and violated.On 01/16/2026 at 3:55 PM an interview was conducted with the Administrator (ADM). The ADM stated RI #97 could remain on MCU after allegations of sexual touching, allegation of sexual abuse and touching inappropriately because he did not feel like he/she posed a threat to other residents. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This deficient practice was cited as a result of the investigation of a Facility Reported Incident, complaint/report number 471525.********** On 01/18/2026 the facility submitted an acceptable removal plan which documented: ********** Removal Plan F-600 1. Resident #97 was moved from the facility dementia unit on January 16, 2026. Resident now resides on Hall 5 unit, away from residents who have displayed active wandering behaviors. RI #97 was placed on 1:1 supervision on January 16, 2026, at approximately 5pm. January 18, 2026. Care plan updates for RI #97 were providing 1:1 care and relocating resident to a hall with non-active wandering residents. On January 17, 2026, the QAPI Committee reviewed the incident/allegation of sexual abuse incident that occurred February 11, 2025. The facility psychiatric provider, conducted a telehealth visit with RI #97 on January 16, 2026, at approximately 10pm and recommended changes to his medication regimen. These medication changes, room change, and 1:1 status were communicated to the resident's caregiver February 16, 2026. The DON/Designee updated the care plan for RI#97 January 18, 2026. Staff were notified of these updates January 16, 2026. On January 17, 2026, the QAPI Committee reviewed the incident/allegation of sexual abuse incident that occurred February 11, 2025. 2. All residents have the potential to be affected. On January 17, 2026, the facility DON/Designee reviewed all resident charts to ensure that any resident with a history of sexual behavior is appropriately placed on behavioral monitoring, has appropriate interventions in place to protect others from sexual behaviors, and will contact the physician for any resident in need orders regarding monitoring and behaviors. There were 169 residents reviewed and 4 residents identified with a history of sexual behaviors. The DON/Designee will be responsible for making any care plan revisions as needed and communicating them to the residents' caregivers and ensure communication. The only care plan update was RI #97 and the caregiver was notified on January 16, 2026 On January 18, 2026, the facility contacted Enterprise Police Department and made them aware of the incident that occurred on February 11, 2025, involving RI #97 and RI #168. Investigation case number is 2026000001962 3. On January 17, 2026, the facility administrator/designee updated the facility policy on abuse prevention, recognition, reporting and protection of residents during investigation. On January 17, 2026, the facility medical director and QAPI committee reviewed and approved the revised policy. On January 17, 2026, the facility administrator reviewed and revised the facility policy on investigating (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	allegations of abuse. On January 17, 2026, the facility medical director and QAPI committee reviewed and approved the revised policy. On January 17, 2026, the facility administrator in-serviced QAPI committee members on the updated policy on abuse prevention, reporting, and protection of residents during investigation. On January 17, 2026, the DON/ADON/designee(s) in-serviced facility staff on the updated policy on abuse prevention, reporting, and protection of residents during investigation. These in-services will be completed on January 18, 2026. Any staff member not in-serviced by January 18, 2026, will be in-serviced prior to working their shift by DON/ADON/Designee(s). This will be accomplished by cross referencing future schedules with the in-service list to determine workers who have not yet been in-serviced. Total number of employees in-serviced is 216 with 76 employees remaining. 4. On January 17, 2026, the facility administrator in-serviced DON/designee(s), on the updated policy on abuse prevention, reporting, and protection of residents during investigation, and were made aware of their responsibility to review all investigations involving potential sexual abuse. On January 18, 2026, the facility DON/Designee began reviewing all investigations involving potential sexual abuse daily for one month to ensure that all investigations are thorough and all resident protection actions have been taken. The DON/Designee will be responsible for immediate corrective action, if needed. Results of the DON/Designee audits will be reviewed by the facility QAPI committee, which will also be responsible for corrective action, if needed. ********** After reviewing the facility's information provided in their Removal Plan and verifying the immediate corrective actions had been implemented as of 01/18/2026. On 01/18/2026 the Immediate Jeopardy was removed and the scope/severity level of F600 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. ********** 2. On 09/06/2024 at 11:33 AM the State Agency received a Facility Reported Incident (FRI) alleging Mental Abuse. It was reported that Former Certified Nursing Assistant (FCNA) #6 posted a picture on Snapchat of a soiled resident who the facility identified as RI #143 with the caption F**ck this job. A policy titled Social Media Use with a reviewed date of 11/24/2020 documented: Policy: It is the policy of this company to avoid inappropriate use of social media and to protect the residents, staff, visitors, volunteers, and practitioners of this facility against misuse of social media content. Taking, keeping, or distributing unauthorized photographs or recordings of residents through multimedia messages or on social media networks is a violation of a resident's right to privacy and confidentiality. Staff members must recognize that they have an ethical and legal obligation to maintain resident privacy and confidentiality at all times . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Policy Explanation and Compliance Guidelines: 1. Employees are strictly prohibited from transmitting by way of any electronic media any resident-related image or information that may be reasonably anticipated to violate resident rights to confidentiality or privacy. This includes information that could degrade or embarrass the resident . Any employee who violates this policy may be subject to disciplinary action, up to and including termination. A facility document dated 06/06/2024 titled Cell Phones documented: Cell phones and any other smart devices (tablets, watches, etc.) are prohibited from use in all resident care areas including, but not limited to, resident rooms, showers, resident hallways, and dining areas when residents are present. Under no circumstances should employees take pictures, videos, or any other personal representations of any resident, family member, visitor, or staff member for the purpose of personal use, social media, or any other reason, Cell phones and tablets should be stored with other belongings in designated employee storage areas and not always be in possession. Devices may be used while on break so long as the previous guidelines are not violated. Failure to adhere to this policy is subject to disciplinary action up to and including termination. A facility document titled Confidentiality Statement was signed by FCNA #6 on 03/19/2024 documented: I understand and agree that the performance of my duties as an employee or contractor . I must hold resident information in confidence. I have read and understand the policy . on resident confidentiality. I understand that any violation of this policy is grounds for immediate termination of employment or of my contract, as applicable. RI #143 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include Anoxic brain damage, Spastic quadriplegic cerebral palsy, and Hemiplegia and hemiparesis following cerebral infraction affecting right dominant side. The Annual Minimum Data Set (MDS) for RI #143, with an Assessment Reference Date (ARD) of 08/03/2024, documented that RI #143 had unclear speech with slurred or mumbled words. The Brief Interview of Mental Status (BIMS) documented a score of 14 out of 15, indicating intact cognition. On 01/14/2026 at 3:02 PM RI #143 was questioned about the incident involving FCNA #6 that occurred in September 2024. RI #143 recalled the incident when an employee shared his/her picture on Snapchat. RI #143 said the facility notified him/her about the incident, which caused him/her to feel angry. When asked about FCNA #6 RI #143 stated she no longer worked at the facility. On 01/15/2026 at 4:25 PM during a follow up interview RI #143 stated the incident in September 2024 caused feelings of embarrassment and he/she was relieved that FCNA #6 was no longer employed at the facility. On 01/14/2026 at 5:14 PM FCNA #6 was asked about the incident involving RI #143 that occurred in September 2024. FCNA #6 recalled writing a statement and affirmed that the statement in the investigative file was correct. FCNA #6 stated she did not share a picture of RI #143 on social media. When asked about the types of social media accounts she possessed, she said Snapchat and Instagram. RI #143 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was asked why someone would claim she posted a picture of RI #143 on social media to which she replied she did not know but believed it was due to being disliked by other employees. When asked to recall her experience providing care to RI #143 on 09/05/2024 she said she responded to RI #143 activating the call light and requested assistance from Certified Nursing Assistant (CNA) #9. While in the room FCNA #6 noted that RI #143 was cleaned due to feces being on his/her backside. FCNA #6 denied having her cell phone in RI #143's room while providing care and said it was against the rules to have a cell phone at work. When questioned about the training she received from the facility she indicated it included how to care for a resident, as well as training on abuse and dementia. FCNA #6 was asked about the concerns related to posting a resident's picture on social media and she stated it would be inappropriate as it would violate the rules of the facility and the resident's privacy. When asked what type of abuse this would be FCNA #6 said she did not know due to the length of time since the incident. The employee file for FCNA #6 included a signed confidentiality statement dated 03/19/2024, as well as a signed social media policy also dated 03/19/2024. On 01/15/2026 at 9:28 AM CNA #9 was questioned regarding the incident involving RI #143 that occurred in September 2024. CNA #9 indicated he was informed about the social media post and remembered providing a statement. CNA #9 confirmed that the statement in the file was his statement. He recalled being assigned to care for RI #143 and requested assistance from FCNA #6. He said RI #143 had a bowel movement, and both he and FCNA #6 attended to the resident by cleaning him/her and changing the bed linens. He said he stepped out of the room once to retrieve clean linens. When asked about FCNA #6's demeanor while caring for RI #143, he said she appeared somewhat annoyed at being asked for help but acted appropriately towards RI #143. CNA #9 said he did not observe FCNA #6 using a cell phone while providing care in the room and did not witness her taking a photograph of RI #143. CNA #9 said posting a picture of a resident on social media would constitute abuse and violate both policy and privacy regulations. A review of the facility investigative file revealed a witness statement from Licensed Practical Nurse (LPN) #7 dated 09/06/2024 that documented: FCNA #8 said Somebody must not want their job and I, LPN #7, said what do you mean and FCNA #8 said did you not see snapchat and I said what do you mean, I don't have very many people from work on my snapchat and FCNA #8 pulled up FCNA #6's snapchat with FCNA #6's name at the top. It was a picture of a resident who I could instantly point out as RI #143. In the picture was a resident with poop up his/her side and back and the caption F*** this job. FCNA #8 showed me this on 09-06-24 at approximately 8:30AM. I then reported this to my supervisor. In the picture you could clearly tell which resident it was because. part of the residents room being showed in the picture. On 01/15/2026 at 10:08 AM LPN #7 was questioned about the incident involving RI #143 that occurred on 09/06/2024. LPN #7 reviewed the statement contained in the investigative file and confirmed it was her statement. She indicated that in September 2024 she was working as a CNA and regularly provided care for RI #143. LPN #7 recalled that upon arriving at work on 09/06/2024. FCNA #8 showed her a picture on Snapchat from her phone, which she recognized as RI #143. She identified RI #143 by the personal items located on the bedside table. LPN #7 described the picture as showing a person's skin from the armpit to the ankle, which was covered in a brown substance that she identified as feces. She said no other body parts including RI #143's face were visible in the picture. When asked about the timing of the picture she assumed it had been taken the night before. LPN #7 said she would consider posting a picture of a resident on Snapchat to be a form of mental abuse and it would make a reasonable person embarrassed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/15/2026 at 3:37 PM during a follow up interview LPN #7 was asked about the number of individuals who could view stories on Snapchat. She responded that friends were able to see snaps that were posted and there was an option to make snaps private or to choose specific friends to view the images. She said she was not friends on Snapchat with FCNA #6 and viewed the picture of RI #143 on FCNA #8's personal Snapchat account on her phone. She said images on Snapchat were automatically erased after a period of 24 hours. When questioned about how many individuals co

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, resident's medical records, review of Facility Reported Incidents (FRIs) received by the State Agency, the facility's investigative files, and the facility policy titled Abuse, Neglect, and Exploitation, the facility failed to ensure its abuse policy was implemented to establish a safe environment and implement protocols for preventing, identifying, and investigating an allegation of sexual abuse on 02/11/2025. On 12/18/2024 Resident Identifier (RI) #97 began having documented episodes of sexually inappropriate behaviors towards staff. Progress notes in RI #97's medical record included seven entries of sexually inappropriate behaviors documented by six different staff members from 12/18/2024 until 02/11/2025. At that time, RI #97's room was in the facility's Memory Care Unit (MCU) which was identified by staff as a unit with wandering residents who have decreased cognition. RI #168 was on the MCU for wandering behaviors including entering other residents' rooms. On 02/11/2025 around 7:30 PM, Certified Nursing Assistant (CNA) #13 witnessed RI #97's hand in RI #168's brief and witnessed RI #97 fondling RI #168's genitalia. Following the incident RI #97 was moved to another unit and placed on 1:1 until transferred to another facility for evaluation. On 03/05/2025 RI #97 was moved again to the facility's Memory Care Unit. The facility did not provide directions to staff to ensure supervision was provided in a manner to prevent sexual abuse and that sexual abuse did not re-occur with RI #97 and other wandering residents with who lacked the ability to consent. The facility further failed to ensure the allegation was investigated in accordance with the facility's policy. The facility's investigation did not include accurate determination that abuse occurred or the cause of the incident. It was determined the facility's noncompliance with one or more requirements of participation has cause, or likely to cause, serious injury, harm, impairment or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.12 Freedom from Abuse, Neglect, and Exploitation. On 01/16/2026 at 6:30 PM, the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Assistant Administrator were provided the Immediate Jeopardy (IJ) templates and notified of the findings of substandard quality of care at the immediate jeopardy level of F607-Development Implement Abuse/Neglect, etc. Policies. The IJ began on 02/11/2025 and continued until 01/18/2026 when the survey team verified that onsite corrective actions had been implemented. The immediate jeopardy was removed on 01/18/2026. This deficient practice affected RI #97, one of six residents sampled for abuse and was a result of the investigation of a Facility Reported Incident (FRI) incident/complaint/report number 471525.Findings Include:Cross-Reference F600 and F867.A review of the facility's policy titled, Abuse, Neglect and Exploitation with a revised date of 01/01/2024 revealed the following: Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation .Definitions: .Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled the use of technology. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.Sexual Abuse is non-consensual sexual contact of any type with a resident.Policy Explanation and Compliance Guidelines: . 1. The facility will develop and implement written policies and procedures that:a. Prohibit and prevent abuse. of residents.b. Establish policies and procedures to investigate such (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	allegations .The components of the facility abuse prohibition plan are discussed herein: I. Screening .B. Prospective residents will be screened to determine whether the facility has the capability and capacity to provide the necessary care and services for each resident admitted to the facility.2. The facility will make individual determinations in consideration of current staffing patterns, . environment.II. Employee Training .B. Existing staff will receive annual education through planned in-services and as needed.C. Training topics will include: 1. Prohibiting and preventing all forms of abuse.2. Identifying what constitutes abuse.5. Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect such as:a. Aggressive and/or catastrophic reactions of residents;b. Wandering.c. Resistance to care;d. Outburst or yelling out. III. Prevention Of Abuse, Neglect and ExploitationThe facility will implement policies and procedures to prevent and prohibit all types of abuse. that achieves: A. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. B. Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation, . is more likely to occur with deployment of trained and qualified registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms; . D. The identification, ongoing assessment, care planning for appropriate intervention, and monitoring of residents with needs and behaviors which might lead to conflict .IV. Identification of Abuse, Neglect and Exploitation A. The facility will have written procedures to assist staff in identifying the different types of abuse-mental/verbal abuse, sexual abuse. This includes. certain resident to resident altercations.V. Investigation of Alleged Abuse, Neglect and Exploitation .A. An immediate investigation is warranted when. reports of abuse. occur.B. Written procedure for investigation include: .3. Investigating different types of alleged violations.4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetration, witnesses, and others who might have knowledge of the allegations;5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause: and 6. Providing complete and through documentation of the investigation .VI. Protection of ResidentThe facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: .B. Examining the alleged victim for any sign of injury, including a physical examination or psychological assessment if needed;C. Increased supervision of the alleged victim and residents; .VII. Reporting/Response A. The facility will have written procedures that include .5. Taking all necessary actions as a result if the investigation, which may include, but are not limited to, the following:a. Analyzing the occurrence (s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences; b. Defining how care provision will be change and/or improve to protect residents receiving services;c. Training of staff on changes made and demonstration of staff competency after training is implemented;d. Identification of staff responsible for implementation of corrective actions; e. The expected date for the implementation; andf. Identification of staff responsible for monitoring the implementation of the plan. RI #168 was admitted to the facility on [DATE] with a diagnosis to include Alzheimer's Disease. RI #168's Care Plan Report included Focus: . RI #168 has episodes of wandering/exit seeking and wandering in and out of others' rooms and impeding on others privacy r/t dx of Alzheimer Disease. Secure Care Monitor was placed on 01/17/2025 to attempt to prevent elopement. The interventions for the Focus included .Redirect away from exit doors if/as needed. RI #97 was admitted to the facility on (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] with diagnoses to include Hemiplegia and Hemiparesis Affecting Right Dominant Side, Unspecified Intellectual Disabilities and Mild Cognitive Impairment. A review of RI #97's comprehensive care plan titled Focus . RI #97 has episodes of attention-seeking (i.e., yelling out without purpose . refusing care/medications, verbally abusive toward staff, combative during care, throwing things at staff (i. e., call light, wedge, pillows, bedside table, meal tray, etc.) sexually inappropriate toward staff and history of possibly other residents related r/t his medical condition. Interventions . Administer medications for behaviors per Medical Doctor (MD) order, . Two staff members to provide care due to (d/t) sexually inappropriate episodes . A review of RI #97's Progress Notes revealed a Behavioral Note dated 01/29/2025 documented by RN #10, Memory Care Manager. The note included plan to speak with behavior management company about possibly starting medications to calm sexual urges and staff would continue to utilize two-persons with all care. On 02/11/2025 at 9:09 PM, the State Agency received a Facility Reported Incident (FRI) alleging that CNA #13 walked by RI #97's room and observed his/her hand in RI #168's brief. Action(s) taken by the facility in response documented RI #168 was calm and not in distress when staff member removed RI #168 from RI #97's room. RI #97 was moved to another hall for the time being while investigation was pending.The facility's investigative filed contained CNA #13's handwritten statement dated 02/11/2025. The statement included that at approximately 7:30 PM, she was making rounds and found RI #168 in RI #97's room sitting on the side of his/her bed. CNA #13 noticed RI #97's hand was inside of RI #168's pants and RI #97 was rubbing his/her private parts. CNA #13 immediately took RI #168 out of the room and reported the incident to Licensed Practical Nurse (LPN) #14. On 01/14/2026 at 3:17 PM an interview was conducted with CNA #13 regarding the incident which occurred on 02/11/2025 involving RI #97 and RI #168. CNA #13 said prior to the incident on 02/11/2025 around 7:30 PM, she last saw the residents around 5:30 PM. She said about 7:30 PM, she was walking through the hall and she saw RI #168 sitting on the side of RI #97's bed. RI #97 had his/her hand in RI #168's diaper and was fondling RI #168 private parts. CNA #13 said the way RI #97's hand was positioned she could see his/her hand moving. CNA #13 said she had not been instructed on how to watch or supervise a resident who wandered other than there being photos at the nurses' desk to identify residents who wandered or were at risk for elopement. The facility's investigative file contained one other handwritten statement dated 02/11/2025 by LPN #14. LPN #14 documented, at approximately 7:45 PM, CNA #13 reported to her an incident that occurred between RI #97 and RI #168. CNA #13 found RI #168 in RI #97's room and RI #97's hand was inside of RI #168's brief. On 01/15/2026 at 2:59 PM an interview was conducted with LPN #14 who stated that CNA #13 told her that RI #168 was standing by RI #97's bed and RI #97 had his/her hand down the front of RI #168's brief. LPN #14 stated there were three other CNA's on the unit that night. LPN #14 said she did not perform a body audit for either resident. The facility investigative file contained a typed statement, dated 02/11/2025 and signed by the Social Services Director who was the facility's Abuse Coordinator that included: Tuesday, February 11, 2025 @ (at) 7:30 PM.(Resident on Resident: Sexual Abuse Allegation)Closing Report/Plan of Action .Both residents have diagnosis of Dementia or Intellectual Disability. Staff members moved RI #97. due to the incident. The resident is not mobile and requires staff to help resident with transfers compared to RI #168 who is mobile and wanders through the memory care, which is the reason why the facility decided to move RI #97 instead of RI #168. facility will have to send resident out for a behavioral stay due to increased sexual inappropriate behaviors to staff and the incident with another resident. The facility had a staff member provide 1:1 care until . 02/17/2025.After reviewing all documents, information, and staff member interview of the allegation the facility finds the incident Sexual Abuse, resident on resident: Not Substantiated. The facility is (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	not able to substantiate the investigation due to not enough evidence of which resident initiated the situation as well as neither resident's [sic] were seen in distress at the time the staff noted the incident. Further review of RI #97's Progress Notes revealed:A Social Services note dated 02/12/2025 and signed by the SSD/Abuse Coordinator. The note included . resident will need to be sent out for a .behavior stay due to increase behaviors of being combative, yelling out, and being sexually inappropriate with staff. Resident continues to have these behaviors and they have increased the past 1-2 weeks.A Social Services note dated 02/24/2025 documented by Social Services Assistant (SSA) #27 that documented that RI #97 was readmitted to the facility from the behavioral hospital.A Nurses Note dated 02/27/2025 documented by LPN #34 documented that Resident has been yelling out throughout the shift, attempted to re-direct/re-orient resident, noneffective. increased behaviors of hitting staff members and attempting to grab staff members inappropriately.A Nurses Note dated 02/28/2025 documented by LPN #34 documented that RI #97 had sexually inappropriately behaviors toward staff members attempts of redirection noneffective.A Nurses Note dated 03/15/2025 documented by RN #35 documented . Inappropriate sexual behavior with new staff member. Redirected per staff and interaction stopped. (Resident) grabbed female staff members breast and patted her buttocks during care.Nurses Notes dated 06/04/2025, 07/02/2025, 09/16/2025, 10/16/2025, 11/14/2025, and 12/04/2025 documented by RN #10 that included AP Med Review. Resident noted throwing meal trays to the floor, yelling out, being verbally and physically abusive to staff, touching female staff members inappropriately. These behaviors have picked back up in frequency over the last month redirection effective occasionally. On 01/15/2026 at 9:50 AM an interview was conducted with RN #10 regarding RI #97's behaviors. The surveyor read the nurses' progress notes to RN Unit Manager regarding RI #97's behaviors which started on 12/18/2024. RN #10 said before the incident she was aware of most of RI #97's documented behaviors and said RI #97 was refusing medications and touching staff and being sexually inappropriate. RN #10 said about a year ago staff they had a lot of reports of RI #97 refusing medications and touching sexually inappropriately. RN #10 said RI #97 usually attempted to touch or grab staff's breast or the private part. RN #10 stated after the incident, RI #97 was readmitted to another unit or hall at the facility on 02/24/2025. RN #10 said RI #97 was admitted to another unit because the facility was trying to ensure that the situation, sexually inappropriate behavior with another resident, did not occur again. RN #10 was asked, what was done to prevent recurrence while RI #97 was on the other unit. RN #10 said there were not that many residents who wandered on that hall. RN #10 said RI #97 was readmitted to the MCU on 03/05/2025 due to disruptive behaviors such as yelling out and crying. RN #10 was asked did the MCU have more wandering, confused residents than other units. RN #10 said, yes for the most part. RN #10 was asked had RI #97 had recent sexually inappropriate behaviors. RN #10 said, the note dated 12/05/2025 indicated RI #97 continued to touch female staff and have inappropriate behaviors that had picked up over the past few months. RN #10 was asked, what actions had been implemented to ensure wandering, confused residents did not enter RI #97's room without supervision. RN #10 said the facility had training with the staff to redirect residents back to the hall or to their rooms. RN #10 said the facility monitored the residents who wandered and redirected them, but there was no staff assigned to monitor wandering residents. When asked if RI #97 could sexually abuse another wandering resident, she said yes, it could. On 01/15/2026 at 5:43 PM an interview was conducted with the SSD/Abuse Coordinator. The SSD said the facility's behavior management team include nurse supervisors, the SSD, the DON, the Assistant DON (ADON), the Assistant ADM, and the ADM. The SSD was asked how the behavior monitoring team monitor residents with behaviors. The SSD said nurses did monthly assessments, anti-psychotic reports when behaviors were reported, and behaviors were then (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	reported to the behavior health services, hospice, or primary care doctor. The SSD said, the behavior monitoring team discussed the behaviors displayed and determined if any medications needed to be changed. The SSD was asked what interventions were put in place from December 2024 until February 2025 related to RI #97's and RI #168's behaviors. The SSD said RI #97 required two people to provide care, he/she was offered ice cream and cookies, talked to him/her, provided activities, and redirected. When asked did the facility do to prevent the incident from occurring, she said RI #97 liked his/her door open and they needed to monitor the other residents. The SSD said RI #168 wandered a lot and they had to redirect him/her. The SSD further said, the concern of RI #97 displaying sexually inappropriate behavior toward another resident was not knowing what occurred before CNA #13 entered the room or if it happened to another resident. The SSD said a reasonable person would have holler out, felt embarrassed and violated if someone touched their private parts. On 01/16/2026 at 11:50 AM a follow-up interview was conducted with the SSD. The SSD was asked, based on the facility's investigation, what was the cause of the alleged incident on 02/11/2025 involving RI #97 and RI #168. The SSD said they had no cause and neither of the residents could tell them what happened. The SSD was asked to explain how the facility analyzed the occurrence to determine why the abuse occurred and what changes were needed to prevent future occurrence. The SSD said neither of the residents involved were able to answer so they did not know. The SSD said per the facility's investigation, staff did not observe resident RI #168 enter resident RI #97's room because they were in other residents' rooms providing care. The SSD was asked how did she know all the staff were all in rooms if they were not interviewed. The SSD said when CNA #13 went into the room that was when she witnessed the incident with RI #168 and RI #97. The SSD said neither resident had the ability to consent, so there was nonconsensual sexual contact on 02/11/2025. On 01/16/2026 at 9:44 AM an interview with conducted with RN #11 who said, the incident that occurred on 02/11/2025 when RI #97 was found with his/her hands in RI #168's brief was considered abuse. On 01/16/2026 at 3:55 PM an interview was conducted with the Administrator (ADM). The ADM was asked about his role in managing resident's behaviors. He said he was responsible for oversight of the Social Service Director and Nursing, as well as other entities such as the Behavioral Health Services to ensure they are communicating with the other providers such as the Nurse Practitioner (NP) and Medical Director (MD). He said his role in the facility's abuse prevention program was to ensure that all policies and procedures were met per protocol, investigate and report incidents and ensure the incidents are investigated thoroughly. When asked what was his role in abuse investigations, the ADM said he oversaw and reviewed the findings with the SSD/Abuse Coordinator to substantiate and/or unsubstantiate the incidents. The ADM was asked about his involvement in the investigation of 02/11/2025 allegation involving RI #97 and RI #168. He said the Abuse Coordinator conducted the investigation and the Assistant Administrator signed off on it and he did not recall reviewing the findings of the investigation before it was sent to the State Agency. He said the facility process of investigating abuse included interviews with any and all known staff members involved in the incident, notifying the sponsor, Ombudsman, MD, assess assignment sheets, timecards and if applicable notify Law Enforcement. The ADM said the goal of abuse investigations was to find out what happened to determine if the allegation was substantiated and identify means to ensure it does not happen again. When asked what could have been done to prevent this abuse from occurring, he said he did not know. ********** 01/18/2026, the facility submitted an acceptable removal plan, which documented:Removal Plan for F6071. Resident #97 was moved from the (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility dementia unit on January 16, 2026. Resident now resides on Hall 5 unit, away from residents who have displayed active wandering behaviors. RI #97 was placed on 1:1 supervision on January 16, 2026, at approximately 5pm.January 18, 2026. Care plan updates for RI #97 were providing 1:1 care and relocating resident to a hall with non-active wandering residents. On January 17, 2026, the QAPI Committee reviewed the incident/allegation of sexual abuse incident that occurred February 11, 2025.The facility psychiatric provider, conducted a telehealth visit with RI#97 on January 16, 2026, at approximately 10pm and recommended changes to his medication regimen. These medication changes, room change, and 1:1 status were communicated to the resident's caregiver February 16, 2026. The DON/Designee updated the care plan for RI#97 January 18, 2026. Staff were notified of these updates January 16, 2026. On January 17, 2026, the QAPI Committee reviewed the incident/allegation of sexual abuse incident that occurred February 11, 2025.2. All residents have the potential to be affected.On January 17, 2026, the facility DON/Designee reviewed all resident charts to ensure that any resident with a history of sexual behavior is appropriately placed on behavioral monitoring, has appropriate interventions in place to protect others from sexual behaviors, and will contact the physician for any resident in need orders regarding monitoring and behaviors. There were 169 residents reviewed and 4 residents identified with a history of sexual behaviors. The DON/Designee will be responsible for making any care plan revisions as needed and communicating them to the residents' caregivers and ensure communication. The only care plan update was RI #97 and the caregiver was notified on January 16, 2026On January 18, 2026, the facility contacted Enterprise Police Department and made them aware of the incident that occurred on February 11, 2025, involving RI#97 and RI#168. Investigation case number is 20260000019623. On January 17, 2026, the facility administrator/designee updated the facility policy on abuse prevention, recognition, reporting and protection of residents during investigation. On January 17, 2026, the facility medical director and QAPI committee reviewed and approved the revised policy. On January 17, 2026, the facility administrator reviewed and revised the facility policy on investigating allegations of abuse. On January 17, 2026, the facility medical director and QAPI committee reviewed and approved the revised policy.On January 17, 2026, the facility administrator in-serviced QAPI committee members on the updated policy on abuse prevention, reporting, and protection of residents during investigation.On January 17, 2026, the DON/ADON/designee(s) in-serviced facility staff on the updated policy on abuse prevention, reporting, and protection of residents during investigation. These in-services will be completed on January 18, 2026. Any staff member not in-serviced by January 18, 2026, will be in-serviced prior to working their shift by DON/ADON/Designee(s). This will be accomplished by cross referencing future schedules with the in-service list to determine workers who have not yet been in-serviced. Total number of employees in-serviced is 216 with 76 employees remaining.4. On January 17, 2026, the facility administrator in-serviced DON/designee(s), on the updated policy on abuse prevention, reporting, and protection of residents during investigation, and were made aware of their responsibility to review all investigations involving potential sexual abuse.On January 18, 2026, the facility DON/Designee began reviewing all investigations involving potential sexual abuse daily for one month to ensure that all investigations are thorough and all resident protection actions have been taken. The DON/Designee will be responsible for immediate corrective action, if needed. Results of the DON/Designee audits will be reviewed by the facility QAPI committee, which will also be responsible for corrective action, if needed. **********After reviewing the facility's information provided in their Removal Plan and verifying onsite through interview, observation, and record review the immediate corrective actions were implemented as of 01/18/2026.On 01/18/2026 the Immediate (continued on next page)

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	015320	A. Building B. Wing	01/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Enterprise Health & Rehabilitation Center	300 Plaza Drive Enterprise, AL 36331

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Jeopardy was removed and the scope/severity level of F607 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview, review of the Online report submitted to State Agency and facility policy, titled Abuse, Neglect and Exploitation the facility failed to report an allegation of sexual abuse on 02/11/2025 to local law enforcement when Resident Identifier (RI) #97 was found with his/her hands in RI #168's brief.This affected two out of six residents sampled for abuse.Findings include:Review of the facility's policy titled, Abuse, Neglect and Exploitation, with a revised date of 01/01/2024 documented: Policy: It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse. Definitions: Sexual Abuse is non-consensual sexual contact of any type with a resident. Law enforcement is the full range of potential responders to elder abuse. including: police, sheriffs, detectives, public safety officers, corrections personnel; prosecutors, medical examiners; investigators and coroners. VII. Reporting /Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: .Review of the Online Incident Reporting System Report dated 02/11/2025, documented, . Incident Type . Abuse - Sexual . 17)Date and time of incident or alleged incident: 02/11/2025 18)Time: 07:30 PM 19)Narrative summary of incident: Staff member walked by resident, (RI #97)'s room and saw resident, (RI #168) standing over resident's bed with (RI #97)'s hand down (RI #168)'s brief. 27)Was the incident reported to a law enforcement agency? No .On 01/18/2026 at 4:47 PM an interview was conducted with Social Service Director (SSD)/Abuse Coordinator. The SSD stated law enforcement should be notified when abuse was alleged. The SSD said law enforcement was not notified of the incident that occurred on 02/11/2025 when RI #97 was found with his/her hand down RI #168's brief. The SSD said the facility's abuse policy was not followed and the concern not reporting the allegation to law enforcement was vulnerable residents were at risk.This deficient practice was cited as a result of investigation of complaint # 471525.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review, interview, the facility's policy titled Abuse, Neglect, and Exploitation, and the facility plan titled Quality Assurance and Performance Improvement (QAPI) Plan the facility failed to implement an effective QAPI program related to a resident-to-resident sexual abuse incident.Specifically, the facility's Quality Assurance Committee failed to review the incident to verify that a thorough investigation was conducted, failed to the incident as abuse, and failed to analyze contributing risk factors including residents wandering without supervision on a unit with a resident who had a documented history of sexually inappropriate behavior toward staff. Additionally QAPI failed to identify the need for systemic actions, as the involved resident was later returned to the unit without documented safeguards, and staff were not provided direction to ensure supervision of wandering, cognitively impaired residents in a manner that prevented entry into other resident's rooms without supervision. These failures allowed unsafe conditions to persist and placed residents at risk for serious harm.The facility did not provide documentation to support that the allegation of resident-on-resident abuse that occurred on 02/11/2025 was reviewed to ensure an investigation was conducted in a manner to identify contributing or causal factors to be corrected and prevent recurrence.It was determined the facility's noncompliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.75 Quality Assurance and Performance Improvement.On 01/16/2026 at 6:30 PM, the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Assistant Administrator were provided a copy of the Immediate Jeopardy (IJ) template and notified of the findings of immediate jeopardy in the area of Quality Assurance and Performance Improvement at F867-QAPI/QAA Improvement Activities. The IJ began on 02/11/2025 and continued until 01/18/2026 when the survey team verified that onsite corrective actions had been implemented. The immediate jeopardy was removed on 01/18/2026.This deficiency was cited as the result of the investigation of complaint /report number 471525.Findings Include: Cross Reference F600 and F607. A QAPI plan dated August 27, 2025 documented: . Vision - Our facility's purpose focuses on our goals and aspirations. It is the framework for our efforts to improve processes and care. Mission - Our mission guides the actions of the organization. Our mission is to create a culture of ongoing performance improvement to support a life worth living for those entrusted to our care. Purpose - Our QAPI process will support the vision and mission of the organization. The purpose of QAPI in our facility is to focus on our vision and mission by including all residents, staff members, and family members in the performance improvement process to support a care environment that nurtures meaningful relationships. Guiding Principles - The beliefs and philosophy of our organization as it pertains to quality assurance performance improvement. Our guiding principles guide what we do, why we do it, and how we will conduct our QAPI processes. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Guiding Principles #1 Our care practices are guided by a structured Quality Assurance Performance improvement process. Guiding Principle #2 All staff members acknowledge their commitment to performance improvement and their perspective roles in the process. Guiding Principle #3 We focus on systems and processes and encourage our staff to identify potential errors and system breakdowns. Guiding Principle #4 We set goals to improve performance, measure our progress towards the goals, and revise the goal when necessary. Scope of Services - The scope of services outlines the type of care and services our organization provides. These services will impact quality of care, quality of life, resident choice, and care transitions. QAPI Goals- Using the vision, mission, purpose and guiding principles we developed our goals by stating what we want to accomplish, how we will measure our progress, how we will determine an achievable goal, how the goal is determined to be relevant to the care we deliver, and how we will choose a timeline to attain the goal. A review of the facility's policy titled, Abuse, Neglect and Exploitation with a revised date of 01/01/2024 revealed the following: . VII. Reporting/Response A. The facility will have written procedures that include . 5. Taking all necessary actions as a result if the investigation, which may include, but are not limited to, the following: a. Analyzing the occurrence (s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences; b. Defining how care provision will be change and/or improve to protect residents receiving services; c. Training of staff on changes made and demonstration of staff competency after training is implemented; d. Identification of staff responsible for implementation of corrective actions; e. The expected date for the implementation; and f. Identification of staff responsible for monitoring the implementation of the plan. VIII. Coordination with QAPI A. The facility has written policies and procedures that define how staff will communicate and (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	coordinate situations of abuse. with the QAPI program. 1. Cases of physical or sexual abuse. will be reviewed for and receive corrective action and tracking by the QAA Committee. This coordinated effort results in the QAA Committee determining: a. If a thorough investigation was conducted; b. Whether the resident is protected; c. Whether an analysis was conducted as to why the situation occurred; d. Risk factors that contribute to the abuse. and; e. Whether there is a need for further systemic action such as: i. Insight on needed revisions to the policies and procedures that prohibit abuse. ii. Increased training on specific components of identifying and reporting that staff may not be aware of or are confused about, iv. Measures to identify the implementation of corrective actions and timeframes, v. Tracking patterns of similar occurrences. On 01/16/2026 at 3:55 PM the Administrator (ADM) was questioned about the sexual abuse incident involving RI #97 and RI #168. The ADM said that all allegations of abuse are discussed in QAPI. The ADM said he did not recall reviewing the investigation before it was submitted to the State Agency. The ADM stated the incident was reviewed on 03/27/2025 in QAPI and the team discussed the people involved, what happened, how the facility would do things differently and interventions. When asked if a thorough investigation was conducted, he said not all aspects were in the documentation, but the facility believed a thorough investigation was completed when the final report was submitted. The ADM was asked if QAPI determined systemic changes were needed and he stated no because the mental capacity of both residents did not warrant any further action and separation of the residents was sufficient. The ADM was unsure what could have been done to prevent this abuse from occurring. This deficient practice was cited as a result of the investigation of a Facility Reported Incident, complaint/report number 471525. ********** On 01/18/2026, the facility submitted an acceptable removal plan, which documented: ********** Removal Plan for F867 1. Resident #97 was moved from the facility dementia unit on January 16, 2026. Resident now resides on Hall 5 unit, away from residents who have displayed active wandering behaviors. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RI #97 was placed on 1:1 supervision on January 16, 2026, at approximately 5pm. January 18, 2026. Care plan updates for RI #97 were providing 1:1 care and relocating resident to a hall with non-active wandering residents. On January 17, 2026, the QAPI Committee reviewed the incident/allegation of sexual abuse incident that occurred February 11, 2025. The facility psychiatric provider, conducted a telehealth visit with RI#97 on January 16, 2026, at approximately 10pm and recommended changes to his medication regimen. These medication changes, room change, and 1:1 status were communicated to the resident's caregiver February 16, 2026. The DON/Designee updated the care plan for RI#97 January 18, 2026. Staff were notified of these updates January 16, 2026. On January 17, 2026, the QAPI Committee reviewed the incident/allegation of sexual abuse incident that occurred February 11, 2025. 2. All residents have the potential to be affected. On January 17, 2026, the facility DON/Designee reviewed all resident charts to ensure that any resident with a history of sexual behavior is appropriately placed on behavioral monitoring, has appropriate interventions in place to protect others from sexual behaviors, and will contact the physician for any resident in need orders regarding monitoring and behaviors. There were 169 residents reviewed and 4 residents identified with a history of sexual behaviors. The DON/Designee will be responsible for making any care plan revisions as needed and communicating them to the residents' caregivers and ensure communication. The only care plan update was RI #97 and the caregiver was notified on January 16, 2026 On January 18, 2026, the facility contacted Enterprise Police Department and made them aware of the incident that occurred on February 11, 2025, involving RI#97 and RI#168. Investigation case number is 2026000001962 3. On January 17, 2026, the facility administrator/designee updated the facility policy on abuse prevention, recognition, reporting and protection of residents during investigation. On January 17, 2026, the facility medical director and QAPI committee reviewed and approved the revised policy. On January 17, 2026, the facility administrator reviewed and revised the facility policy on investigating allegations of abuse. On January 17, 2026, the facility medical director and QAPI committee reviewed and approved the revised policy. On January 17, 2026, the facility administrator in-serviced QAPI committee members on the updated policy on abuse prevention, reporting, and protection of residents during investigation. On January 17, 2026, the DON/ADON/designee(s) in-serviced facility staff on the updated policy on abuse prevention, reporting, and protection of residents during investigation. These in-services will be completed on January 18, 2026. Any staff member not in-serviced by January 18, 2026, will be in-serviced prior to working their shift by DON/ADON/Designee(s). This will be accomplished by cross referencing future schedules with the in-service list to determine workers who have not yet been in-serviced. Total number of employees in-serviced is 216 with 76 employees remaining. 4. On January 17, 2026, the facility administrator in-serviced DON/designee(s), on the updated policy on abuse prevention, reporting, and protection of residents during investigation, and were made (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	aware of their responsibility to review all investigations involving potential sexual abuse. On January 18, 2026, the facility DON/Designee began reviewing all investigations involving potential sexual abuse daily for one month to ensure that all investigations are thorough and all resident protection actions have been taken. The DON/Designee will be responsible for immediate corrective action, if needed. Results of the DON/Designee audits will be reviewed by the facility QAPI committee, which will also be responsible for corrective action, if needed. ********** After onsite review of the facility's information provided in their Removal Plan and verifying the immediate corrective actions had been implemented as of 01/18/2026. On 01/18/2026 the Immediate Jeopardy was removed and the scope/severity level of F867 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.